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Federal Register

Tuesday
April 1, 1986

Briefings on How To Use the Federal Register—
For information on briefings in Dallas, TX, see announcement on the inside cover of this issue.

Selected Subjects

Administrative Practice and Procedure
Personnel Management Office
Revenue Sharing Office

Air Pollution Control
Environmental Protection Agency

Cable Television
Federal Communications Commission

Communications Common Carriers
Federal Communications Commission

Fisheries
National Oceanic and Atmospheric Administration

Food Assistance Programs
Food and Nutrition Service

Food Grades and Standards
Agricultural Marketing Service

Food Stamps
Food and Nutrition Service

Government Employees
Personnel Management Office

Government Property Management
General Services Administration

Grant Programs—Education
Public Health Service

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Housing and Urban Development Department

Government Procurement
Interior Department

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Questions and requests for specific information may be directed to the telephone numbers listed under INFORMATION AND ASSISTANCE in the READER AIDS section of this issue.

How To Cite This Publication: Use the volume number and the page number. Example: 51 FR 12345.

Hazardous Substances
Environmental Protection Agency

Marine Safety
Coast Guard

Medical Devices
Food and Drug Administration

Medicare
Health Care Financing Administration

Milk Marketing Orders
Agricultural Marketing Service

Organization and Functions (Government Agencies)
Customs Service
United States Information Agency

Peanuts
Agricultural Stabilization and Conservation Service

Privacy
Navy Department

Probation and Parole
Parole Commission

Radio Broadcasting
Federal Communications Commission

Reporting and Recordkeeping Requirements
Economic Analysis Bureau
Equal Employment Opportunity Commission

Surface Mining
Surface Mining Reclamation and Enforcement Office

Technical Assistance
Soil Conservation Service

Television Broadcasting
Federal Communications Commission

THE FEDERAL REGISTER: WHAT IT IS AND HOW TO USE IT

FOR: Any person who uses the Federal Register and Code of Federal Regulations.

WHO: The Office of the Federal Register.

WHAT: Free public briefings (approximately 2 1/2 hours) to present:
1. The regulatory process, with a focus on the Federal Register system and the public's role in the development of regulations.
2. The relationship between the Federal Register and Code of Federal Regulations.
3. The important elements of typical Federal Register documents.
4. An introduction to the finding aids of the FR/CFR system.

WHY: To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

DALLAS, TX

WHEN: April 23; at 1:30 pm.

WHERE: Room 7A23,
Earl Cabell Federal Building,
1100 Commerce Street, Dallas, TX.

RESERVATIONS: local numbers:
Dallas 214-767-8585
Ft. Worth 817-334-3624
Austin 512-472-5494
Houston 713-229-2552
San Antonio 512-224-4471,
for reservations

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Federal Register
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This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.
The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 530

Special Salary Rate Schedules for Recruitment and Retention

AGENCY: Office of Personnel Management.

ACTION: Interim rule, with comments invited.

SUMMARY: The Office of Personnel Management (OPM) is revising its regulations on the establishment, adjustment, and termination of special salary rate schedules. Specifically, we are deleting provisions which require that comments be obtained on proposals to establish, adjust, or terminate special salary rate schedules, and that these schedules be published in the **Federal Register**. These revisions will accelerate the effective date of newly established or increased special salary rates.

EFFECTIVE DATE: April 1, 1986. Comments must be received on or before May 1, 1986.

ADDRESS: Send or deliver written comments to the Office of Personnel Management, Compensation Group, Allowances and Special Rates Division (FR), Room 3353, 1900 E Street, NW., Washington, DC 20415.

FOR FURTHER INFORMATION CONTACT: William M. Gualtieri, (202) 632–7858.

SUPPLEMENTARY INFORMATION:

Law

Section 5303 of Title 5, United States Code, authorizes the President to establish special minimum rates of basic pay for one or more grades, occupational groups, series, classes, or subdivisions of classes subject to statutory pay schedules, in one or more areas or locations, when the pay rates in private enterprise are so substantially above the statutory pay rates for the positions concerned as to handicap significantly the Government's recruitment or retention of well-qualified persons.

Executive Order

Section 301(a) of Executive Order 11721 of May 23, 1973, as amended, authorizes OPM to exercise the authority conferred upon the President by the provisions of section 5303 of title 5, United States Code, to establish and revise special minimum pay rates and rate ranges and to prescribe conversion rules for adjusting an employee's pay for positions classified under the General Schedule and certain other pay systems.

Regulations

We are revising our regulations to delete provisions in §§530.303(a), 530.304(a), and 530.305 which require that comments be obtained on proposals to establish, adjust, or terminate special salary rate schedules, and that these schedules be published in the **Federal Register**. We are also deleting § 530.307 which lists the special salary rate schedules authorized. The statute provides a mechanism for the Government to quickly staff its hard-to-fill positions and keep them filled by offering certain employees pay, in most instances, substantially higher than the statutory rates. Following the notice-and-comment procedures of the Administrative Procedure Act (5 U.S.C. 553) has only served to delay the date our special salary rate actions can take effect, needlessly prolonging agency staffing problems.

Further, with the passage of Pub. L. 99–251, "Federal Employees Benefits Improvement Act of 1986," Congress specifically removed the requirement to follow notice-and-comment procedures when establishing any schedules or rates of basic pay when the underlying procedures, methodology, or criteria used to establish such schedules or rates were earlier codified in accordance with administrative procedure. (Special salary rate criteria appear in 5 CFR 530.303.) Accordingly, we are removing the cited provisions from our regulations so we can expeditiously alleviate agency staffing problems by accelerating the effective date of newly established or increased special salary rates. Moreover, whenever we decide to reduce or terminate special salary rates, employees in the affected positions suffer no loss because our regulations provide that no employee's pay will be reduced because of these actions. While we are changing the regulations to address real problems associated with the delays inherent in the current procedures, we nonetheless solicit comments on our actions.

Under section 553(b)(3)(B) of title 5 of the United States Code, I find that good cause exists for waiving the general notice of proposed rulemaking and making these regulations effective upon publication. The regulations are being made effective immediately to ensure that agencies are able to expeditiously address their staffing needs for positions which are critical to successfully accomplishing their respective missions.

E.O. 12291, Federal Regulation

I have determined that this is not a major rule as defined under section 1(b) of E.O. 12291, Federal Regulation.

Regulatory Flexibility Act

I certify that this regulation will not have a signficant economic impact on a substantial number of small entities because it applies only to Federal employees and agencies.

List of Subjects in 5 CFR Part 530

Administrative practice and procedure, U.S. Government employees, Wages.

Office of Personnel Management.
Constance Horner,
Director.

Accordingly, OPM is amending Subpart C of Part 530 of Title 5, Code of Federal Regulations, as follows:

PART 530—PAY RATES AND SYSTEMS (GENERAL)

1. The authority citation for Part 530 continues to read as follows:

Authority: 5 U.S.C. 5303, and Chapter 54; E.O. 11721, as amended.

§ 530.303 [Amended]

2. In § 530.303, the fourth and fifth sentences of paragraph (a) are removed.

§ 530.304 [Amended]

3. In § 530.304, the second and third sentences of paragraph (a) are removed.

§ 530.305 [Amended]

4. In § 530.305, the third sentence is removed.

§ 530.307 [Removed]

5. Section 530.307 is removed.

* * * * *

[FR Doc. 86-7160 Filed 3-31-86; 8:45 am]
BILLING CODE 6325-01-M

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Part 247

Commodity Supplemental Food Program Amended Administrative Funding Formula

AGENCY: Food and Nutrition Service, USDA.

ACTION: Final rule.

SUMMARY: This final rule amends the Commodity Supplemental Food Program (CSFP) regulations to change the formula for providing funds to State agencies for program administration, consistent with the mandate of Pub. L. 99-198, amending Section 5(a) of the Agriculture and Consumer Protection Act of 1973.

EFFECTIVE DATE: October 1, 1985.

FOR FURTHER INFORMATION CONTACT: Patrick J. Clerkin, Director, Supplemental Food Programs Division, Food and Nutrition Service, USDA, 3101 Park Center Drive, Alexandria, Virginia 22302, during regular business hours (8:30 a.m. to 5:00 p.m.), Monday through Friday.

SUPPLEMENTARY INFORMATION:

Classification

This final rule has been reviewed under Executive Order 12291, and has been determined to be *not major*. The Department does not anticipate that this rule will have an impact on the economy of $100 million or more. This rule will not result in a major increase in costs or prices for consumers; individual industries; Federal, State or local government agencies; or geographic regions. Nor will this rule have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This rule has been reviewed with regard to the requirements of the Regulatory Flexibility Act (5 U.S.C. 601-612). Pursuant to that review, the Administrator of the Food and Nutrition Service has determined that this final rule does not have a significant economic impact on a substantial number of small entities. This rule does not contain reporting or recordkeeping requirements subject to approval by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

This change to the CSFP administrative funding formula is a nondiscretionary mandate of Pub. L. 99-198. Because the nondiscretionary nature of this rule makes notice and comment impracticable and unnecessary, Robert E. Leard has certified that good cause exists for making this rule effective without public comment. In addition, the rule is effective less than 30 days following the date of promulgation because the legislation stipulates that the revised administrative funding formula shall be in effect for "each of the fiscal years 1986 through 1990." Therefore, this rule has the retroactive effective date of October 1, 1985. Further, since the rule merely implements a nondiscretionary provision of Pub. L. 99-198, it constitutes an interpretive rule, and notice and comment rulemaking and a 30-day period before making it effective are not required.

This program is listed in the Catalog of Federal Domestic Assistance Programs under No. 10.565 and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials (7 CFR 3015, Subpart V, and final rule related notice published June 24, 1983 (48 FR 29114)).

Background

On December 23, 1985, the President signed the Food Security Act of 1985 (Pub. L. 99-198). Section 1562 of this law amends section 5(a) of the Agricultural and Consumer Protection Act of 1973 (7 U.S.C. 612c note) as amended most recently by Pub. L. 98-92. This regulation implements the amendment by requiring that CSFP administrative funding be available nationwise in amounts equal to the CSFP administrative costs of State and local agencies, except that such funding may not exceed 15 percent of the sum of (1) the annual amount appropriated for the program and (2) the value of commodities provided without charge by the Department to States and distributed to participants by CSFP local agencies both as part of, and in addition to, program food packages. The second category of funding cited above is specifically changed by the law and this regulation.

At times, some commodities purchased under the authority of the Commodity Credit Corporation (CCC) have been provided without charge to States for distribution to CSFP participants. These foods have been provided to participants either as part of the CSFP food package, or in addition to the package. Previous legislation provided administrative money on the basis of the value of those foods in the food package.

Section 5(a) of the Agriculture and Consumer Protection Act of 1973, as amended by Pub. L. 99-198, increases the potential amount of administrative funding available to States. It includes 15 percent of the value of "all additional commodities donated by the Secretary to State and local agencies that are provided without charge or credit for distribution to program participants." The calculation of base administrative funding, which as stated above is 15 percent of the appropriation, is not changed by the Act or this rule.

List of Subjects in 7 CFR Part 247

Agricultural commodities, food assistance programs, Maternal and child health, Infants and children, Public assistance programs, Nutrition, Women, Commodity Supplemental Food Program.

Accordingly, 7 CFR Part 247 is amended as follows:

1. The authority citation for Part 247 is revised to read as follows:

Authority: Sec. 5, Pub. L. 93-86, 87 Stat. 249, as added by sec. 1304(b)(2), Pub. L. 95-113, 91 Stat. 980 (7 U.S.C. 612c note); sec. 1335, Pub. L. 97-98, 95 Stat. 1293 (7 U.S.C. 612c note); sec. 209, Pub. L. 98-8, 97 Stat. 35 (7 U.S.C. 612c note); sec. 2(8), Pub. L. 98-92, 97 Stat. 611 (7 U.S.C. 612c note); sec. 1562 Pub. L. 99-198, 99 Stat. 1590 (7 U.S.C. 612c note).

2. Section 247.10 is amended by revising paragraph (b)(1) and the first two sentences of paragraph (b)(3) to read as follows:

§ 247.10 Administrative funding.

* * * * *

(b) *State agency funding.* (1) Funds for total State administrative costs for each fiscal year shall be allocated by FNS based on 15 percent of the sum of the annual appropriation for the program and the value of commodities provided without charge or credit by the Department to States and distributed by local agencies as part of, and in addition to, the food package.

* * * * *

(3) In addition to the funding provided under paragraph (b)(2) of this section, States shall receive administrative funding to support distribution of commodities provided without charge or credit by the Department to States and distributed as part of, and in addition to, the program food package. Prior to the beginning of each fiscal year, FNS shall estimate the value of such commodities

expected to be distributed to participants by local agencies in each State during the fiscal year. * * *

* * * * *

Dated: March 26, 1986.

Robert E. Leard,

Administrator.

[FR Doc. 86-7158 Filed 3-31-86; 8:45 am]

BILLING CODE 3410-30-M

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7 CFR Parts 272 and 273

[Amdt. No. 270]

Food Stamp Program; Provisions on Earned Income, Shelter and Dependent Care Deductions, Resource Limits and Sales Tax on Food Stamp Purchases

AGENCY: Food and Nutrition Service, USDA.

ACTION: Final rule.

SUMMARY: This action amends Food Stamp Program (FSP) regulations to implement certain provisions of the Food Security Act of 1985 within legislative time constraints. This action: (1) Increases the maximum resource limit for nonelderly households to $2,000; (2) expands the $3,000 maximum resource limit for elderly households to include one-person households; (3) increases the earned income deduction from 18 percent to 20 percent; (4) separates the combined shelter/dependent care maximum deduction limit for nonelderly/nondisabled households; (5) increases the maximum limit for the dependent care deduction for nonelderly/nondisabled households to $160 per household with no allowance for inflation adjustments; and (6) prohibits participation in the Program of a State in which State and/or local sales taxes are collected on food stamp purchases.

EFFECTIVE DATE: May 1, 1986.

FOR FURTHER INFORMATION CONTACT: Bruce Clutter, Branch Chief, Eligibility and Monitoring Branch, Program Development Division, Family Nutrition Programs, Food and Nutrition Service, USDA, Alexandria, Va. 22110, (703) 756-3460. Copies of the Regulatory Impact Analysis, which is summarized in the preamble, are also available from Mr. Clutter.

SUPPLEMENTARY INFORMATION:

Classification

Executive Order 12291

This action has been reviewed under Executive Order 12291 and Secretary's Memorandum No. 1519-1. The Department considers this a major action because it will increase the Food Stamp Program's cost by more than $100 million. Also, there may be a reduction of more than $100 million in State and local sales taxes on food purchased with food stamps. It is expected that competition, employment, investment, productivity and innovation will remain unaffected. There will be no effect on the competition of United States-based enterprises with foreign-based enterprises.

Executive Order 12372

The Food Stamp Program is listed in the Catalog of Federal Domestic Assistance under No. *10.551*. For the reasons set forth in the final rule and related Notice to 7 CFR 3015, Subpart V (48 FR 29115), this Program is excluded from the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Regulatory Flexibility Act

This action has been reviewed with regard to the requirements of the Regulatory Flexibility Act of 1980. Robert E. Leard, Administrator of the Food and Nutrition Service, has certified that this final action could have a significant economic impact on States in which State and local sales taxes are collected on food purchased with food stamps. This action will also increase the amount of money spent on food through food stamps by an amount equal to the revenue loss to the State and local governments. However, this money will be distributed among 250,000 eligible food stamp vendors, so the effect on any one vendor will not be significant.

Memorandum of Law

Pursuant to section 4(c) of Executive Order 12291, the Department has determined that this rule is within the authority delegated by law.

Regulatory Impact Analysis

Need for Action

This action is required by Sections 4(a), 5(e) and 5(g) of the Food Stamp Act, as amended by sections 1505, 1511 and 1514 of Pub. L. 99-198 (99 Stat. 1354), Food Security Act of 1985, enacted December 23, 1985. Pub. L. 99-198 separates the combined deduction limits allowed for excess shelter/dependent care expenses for nonelderly/nondisabled households, sets the dependent care deduction amount for these households at $160 a month with no allowance for inflation adjustments, increases the earned income deduction from 18 percent to 20 percent, raises the maximum resource eligibility limit for nonelderly households to $2,000, expands the $3,000 maximum resource limit for elderly households to include one-person elderly households, and prohibits participation in the Program by any State in which State and/or local sales taxes are collected on food purchased with food stamps.

Benefits

This action increases the number of potentially eligible food stamp recipients and the food purchasing power of potential and current Program participants.

Costs

It is estimated that this action will increase the cost of the Program by approximately $69 million in Fiscal Year 1986 and $181 million in Fiscal Year 1987.

Effects on Small Entities

a. It is estimated that 38 States would, in total, lose revenues of more than $100 million.

b. State and local welfare agencies are affected to the extent that they administer the Program.

c. Food vendors in States where sales taxes are collected on purchases made with food stamps are affected because they can no longer be required by State and local laws to collect sales taxes on food stamp purchases. Some food vendors will be affected by having to reprogram automated cash registers to exclude State and local food sales taxes on food stamp purchases. Food vendors are also affected to the extent that more money will be spent on food through food stamps. However, this money will be distributed among the Nation's eligible food stamp vendors, so the effect on any one vendor will not be significant.

Public Participation

This action is being finalized without prior notice of proposed rulemaking or public comment. The provisions of this final action are mandated by statute and are nondiscretionary in nature. Thus, this action constitutes an interpretive rule for which notice and public comment are not required under 5 U.S.C. 553(b). The statute mandates that the deductions and resource limit provisions of this action be implemented on May 1, 1986 and links the implementation of the sales tax provision to the convening of each individual State legislature's next regular session. Therefore, this action must be promulgated as quickly as possible. Similarly, because the provisions are nondiscretionary, notice and public comment are unnecessary

and contrary to the public interest and good cause is found pursuant to 5 U.S.C. 553(b) for promulgating this action without such procedures.

Paperwork Reduction Act

This action does not contain any reporting and/or recordkeeping requirements subject to approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Background

Earned Income Deduction

Section 5(e) of the Food Stamp Act, as amended by section 1511 of Pub. L. 99–198, mandates an increase in the earned income deduction applicable to working households from 18 percent to 20 percent, returning it to the level that was in effect prior to Fiscal Year 1982.

This final action amends 7 CFR 273.9(d) to raise the earned income deduction to 20 percent. This final action also makes conforming amendments to 7 CFR 273.10 and 7 CFR 273.11.

Excess Shelter/Dependent Care Deduction

The Food Stamp Act provides for an income deduction to take into account dependent care costs incurred by households. Prior to Pub. L. 99–198, the amount of the deduction was limited to the income deduction amount granted for excess shelter expenses incurred by households. Nonelderly/nondisabled households which incurred both excess shelter and dependent care costs were limited to a combined deduction amount which could not exceed the dollar limit placed on the excess shelter deduction. Elderly/disabled households are entitled to an uncapped excess shelter deduction amount, but are subject to a dependent care deduction capped at the excess shelter deduction limit applied to nonelderly/nondisabled households. The excess shelter deduction limit is adjusted annually to account for cost-of-living changes in certain shelter expenses, thus automatically resulting in an annual inflation adjustment to the dependent care deduction limit.

Section 5(e) of the Food Stamp Act, as amended by Section 1511 of Pub. L. 98–198, eliminates the combined deduction requirement for nonelderly/nondisabled households and sets the separate dependent care deduction amount at $160 monthly with no allowance for annual inflation adjustments. The new dependent care deduction amount is applicable to nonelderly/nondisabled households only. While the legislative history discussed application of this new deduction rate to elderly/disabled households as well, the language of the Act continues to reflect that elderly/disabled households are entitled to a dependent care deduction capped at the excess shelter expense deduction limit for nonelderly/nondisabled households. Thus, elderly/disabled households are entitled to a dependent care deduction (currently capped at $139 and changed by Pub. L. 99–198 to $147) which is subject to annual inflation adjustments. Nonelderly/nondisabled households are entitled to a dependent care deduction of $160 with no allowance for annual inflation adjustments.

This final action amends 7 CFR 273.9(d) and 7 CFR 273.10(e) to provide for a separate dependent care deduction limit of $160 a month with no allowance for annual inflation adjustments for nonelderly/nondisabled households. The excess shelter expense deduction is also being raised under Pub. L. 99–198 and will continue to be adjusted annually for cost-of-living changes. That provision will be addressed in a separate **Federal Register** publication.

Resource Limits

Section 5(g) of the Food Stamp Act, as amended by section 1514 of Pub. L. 99–198, raises the maximum resource eligibility limit for nonelderly households from $1,500 to $2,000. That Section also expands the $3,000 resource eligibility limit for elderly households to include one-person elderly households. Prior to Pub. L. 99–198, the Act limited the $3,000 resource limit to households of two or more persons with at least one elderly member.

This final action amends 7 CFR 273.8 to reflect a $2,000 resource limit for nonelderly households and expansion of the $3,000 resource limit to single member elderly households. This action also makes a conforming amendment to 7 CFR 273.12. Households of two or more persons with at least one elderly member would continue to be subject to the $3,000 resource limit.

State and Local Sales Taxes

Section 4(a) of the Food Stamp Act, as amended by section 1505 of Pub. L. 99–198, prohibits participation in the Program by States in which State or local food sales taxes are collected on food stamp purchases. Prior to Pub. L. 99–198, the Food Stamp Act contained no such prohibition. At least 38 States have instituted such taxes. The net effect of collecting such taxes is a reduction in the food buying power of food stamp households by a percentage equal to the percentage of the sales tax. Thus, a food stamp household in a State with a 5-percent food sales tax included on food stamp food purchases is in effect only receiving a benefit equal to 95 percent of the Thrifty Food Plan.

The legislative history shows that the purpose of the sales tax provision is to preserve the food purchasing power of Food Stamp Program participants. For example, referring to the States' practice of collecting sales taxes on food stamp purchases, the House Committee Report states, "Federal dollars provided for food assistance should not be diverted to other purposes." H.R. Rep. No. 99–271, 99th Cong., 1st Sess., pg. 140, (1985). Therefore, any tax or fee collected by a State or locality having the effect of reducing the purchasing power of Food Stamp Program participants on food stamp purchases is covered by the new statutory provision, whether or not that tax is actually named a "sales tax." The Department also notes that the new provision explicitly grants the Secretary authority to determine whether a tax is a sales tax. Congress would not have granted such authority to the Secretary if it had meant to include only taxes which were named "sales taxes."

"Purchases made with food stamp coupons" refers to all purchases defined as "eligible foods" at 7 CFR 271.2. Some States don't tax most foods, but do tax other selected items which are defined as food for the Food Stamp Program such as soda pop, seeds and seedlings, and fishing equipment (in Alaska). Since Congress provided no basis for exempting such items, the Department must interpret that congressional intent was to have the sales tax provision apply to all items listed in the definition of "eligible foods" at 7 CFR 271.2.

Mandatory exemption from sales tax applies only to those portions of a total purchase paid for with food stamp coupons. For example, a recipient paying for $25 worth of groceries with $10 in coupons and $15 in cash, must have sales tax exempted on $10 worth of the purchase.

This final action amends 7 CFR 272.1 to prohibit participation in the Food Stamp Program by any State in which State or local sales taxes or other types of taxes or fees are collected on food stamp purchases.

Implementation

In accordance with Sections 1511 and 1514 of Pub. L. 99–198, State agencies shall implement the deductions and resource limit provisions of this rulemaking on May 1, 1986. If, for any reason, a State agency fails to implement these provisions on that date, households shall be provided the lost benefits which they would have received if the State agency had

implemented these provisions as required.

Implementation of the sales tax provision is set by the statute as the first day of the fiscal year that begins in the calendar year in which the first session of a State's legislature convenes following enactment of the Food Security Act of 1985. A "regular session" is a session which is convened to discuss the State's usual wide array of statutory and budgetary business, not one that is convened as an emergency single-issue session. Some States split legislative sessions into budgetary sessions and statutory sessions. A budgetary session is considered a "regular session" when this budgetary session has internal rules of procedure which allow the introduction of statutory issues, even if these have stringent requirements, such as majority approval, voice vote, etc. The Food Security Act was enacted December 23, 1985. Since almost all State legislatures meet yearly, the implementation date of this provision for most States is October 1, 1986.

Congress was aware, however, that circumstances could arise that warranted giving States more time to implement the provision. The Act grants the Secretary the authority to extend the implementation date to no later than October 1, 1987. The authority to give such extensions is limited by the statute to: (1) situations in which meeting the earlier implementation date would adversely affect the administration of the Program or (2) situations in which retailers would not have sufficient time to implement the tax changes by the earlier date.

In accordance with the statute, a State must show that at least one of the above two problems would arise if the earlier implementation date was adhered to. In addition, the Department is requiring the State to report when it would be in full compliance with the provision if an extension was granted. Again, it should be emphasized that the Department has no authority to grant extensions beyond October 1, 1987.

List of Subjects

7 CFR Part 272

Alaska, Civil rights, Food stamps, Grant programs-social programs, Reporting and recordkeeping requirements.

7 CFR Part 273

Administrative practices and procedure, Aliens, Claims, Food stamps, Fraud, Grant programs-social programs, Penalties, Reporting and recordkeeping requirements, Social Security, Students.

Accordingly, Part 272 and 273 are amended as follows:

1. The authority citations for Parts 272 and 273 continue to read as follows:

Authority: 91 Stat. 978 (7 U.S.C. 2011–2029).

PART 272—REQUIREMENTS FOR PARTICIPATING STATE AGENCIES

2. In s272.1:

(a) the title heading for paragraph (a) is revised:

(b) the title heading for paragraph (b) is removed, the text of paragraph (b) is added to the end of paragraph (a), and a new paragraph (b) is added; and

(c) paragraph (g) is amended by adding a new paragraph (74) to the end of paragraph (g).

The revision and additions read as follows:

§ 272.1 General terms and conditions.

(a) *Coupons Do Not Reduce Benefits.* * * *

(b) *No Sales Taxes on Food Stamp Purchases.* A State shall not participate in the Food Stamp Program if State or local sales taxes or other taxes or fees, including but not limited to excise taxes, are collected within the State on purchases made with food stamp coupons. "Purchases made with food coupons" for purposes of this provision shall refer to purchases of "eligible foods" as defined in § 271.2. Where the total value of groceries being bought by the recipient is larger than the amount of coupons being presented by the recipient, only the portion of the sale made in exchange for food stamps must be exempt from taxation in order for a State to satisfy the requirements of this provision. Although a food stamp recipient may use a combination of cash and food stamps in making a food purchase, only the dollar amount represented by the food coupons needs to be exempt from taxation.

* * * * *

(g) *Implementation.* * * *

(74) Amendment No. 270. (1) State agencies shall implement the earned income and dependent care deduction amounts and the resource limit provisions of Amendment No. 270 on May 1, 1986. If, for any reason, a State agency fails to implement these provisions on that date, households shall be provided the lost benefits which they would have received if the State agency had implemented these provisions as required.

(2) The provisions of § 272.1(b) regarding the prohibiton of State or local sales taxes on foods purchased with food stamp coupons shall be implemented on October 1 of the calender year during which the first regular session of each State's Legislature is convened following enactment of Pub. L. 99–198 (enacted December 23, 1985). A "regular session" means a scheduled session of a State's legislature convened to address the usual range of statutory and budgetary issues. A "budgetary" session of a legislature shall be considered a "regular session" if State rules allow for statutory issues to be introduced at these "budgetary" sessions even if rules governing these special procedures are stringent.

(i) FNS may approve a delay in the above implementation date if a State provides FNS a request documenting that such date would either: (A) Have an adverse and disruptive effect on the administration of the Food Stamp Program in such State; or (B) would provide inadequate time for retail stores to implement required changes in sales tax policy.

(ii) FNS has no authority to approve any State implementation schedule with an effective date later than October 1, 1987.

PART 273—CERTIFICATION OF ELIGIBLE HOUSEHOLDS

§ 273.8 [Amended]

3. In § 273.8:

(a) paragraph (b) is amended by replacing the reference to "$1,500" with a reference to "$2,000" and by removing the phrase "of two or more members"; and

(b) paragraph (i)(4) is amended by replacing the reference to "$1,500" with a reference to "$2,000".

4. In § 273.9:

(a) paragraph (d)(2) is amended by replacing the first word of the paragraph "Eighteen" with the world "Twenty".

(b) the last sentence of paragraph (d)(4) is revised and a new sentence is added to the end of paragraph (d)(4); and

(c) the second sentence of paragraph (d)(5) is revised.

The revisions and addition read as follows:

§ 273.9 Income and deductions.

* * * * *

(d) *Income deductions.* * * *

(4) * * * The maximum monthly allowable dependent care deduction amount for households containing an elderly or disabled member (as defined in § 271.2) in the 48 contiguous States and the District of Columbia, and the maximum allowable amounts for such households in Alaska, Hawaii, Guam, and the Virgin Islands are adjusted annually and are prescribed in general Notices published in the **Federal Register**. Effective May 1, 1986, the maximum monthly allowable dependent care deduction amount for households not containing an elderly or disabled member (as defined in § 271.2) in the 48 contiguous States and the District of Columbia, Alaska, Hawaii, Guam and the Virgin Islands is $160 and shall not be adjusted.

(5) * * * The shelter deduction shall not exceed the maximum limit established for the area. * * *

* * * * *

5. In § 273.10, paragraph (e)(1)(i)(B) is amended by replacing the reference to "18 percent" with a reference to "20 percent" and by replacing the reference to "82 percent" with a reference to "80 percent", paragraph (e)(1)(i)(E) is amended by removing the phrase "for the area" appearing in the first sentence and by removing all text appearing after the first sentence of paragraph (e)(1)(i)(E) and adding a new sentence, and paragraph (e)(1)(i)(G) is amended by removing the second sentence.

The addition reads as follows:

§ 273.10 Determining household eligibility and benefit levels.

* * * * *

(e) *Calculating net income and benefit levels.*

(l) *Net monthly income.* * * *

(i) * * *

(E) * * * If the household is entitled to an excess shelter deduction, compute the household's excess shelter deduction in accordance with paragraph (e)(1)(i)(F) of this section.

* * * * *

§ 273.11 [Amended]

6. In § 273.11, paragraphs (a)(2)(iii), (a)(4)(ii)(C), (b)(1)(iii), (c)(2)(iii), (h)(2)(i), and (h)(2)(ii) are amended by replacing the reference to "18" with a reference to "20".

§ 273.12 [Amended]

7. In § 273.12, paragraphs (a)(1)(v) is amended by replacing the reference to "1,500" with a reference to "$2,000".

Dated: March 26, 1986.

John W. Bode,

Assistant Secretary for Food and Consumer Services.

[FR Doc. 86-7135 Filed 3-31-86; 8:45 am]

BILLING CODE 3410-30-M

DEPARTMENT OF COMMERCE

Bureau of Economic Analysis

15 CFR Part 806

[Docket No. 60346-6046]

U.S. Direct Investment Abroad; Quarterly Report Form BE-577

AGENCY: Bureau of Economic Analysis, Commerce.

ACTION: Final rule.

SUMMARY: This final rule amends 15 CFR Part 806 by increasing the exemption level from $10,000,000 to $15,000,000 for quarterly report form BE-577, Direct Transactions of U.S. Reporter With Foreign Affiliate.

The purpose of the change is to effect a reduction in the number of reports filed by U.S. companies concerning transactions with their foreign affiliates and thus significantly reduce the reporting burden.

EFFECTIVE DATE: The rules will be effective May 1, 1986, commencing with reports covering the first quarter of calendar year 1986.

FOR FURTHER INFORMATION CONTACT: Ralph Kozlow, International Investment Division, Bureau of Economic Analysis, U.S. Department of Commerce, Washington, DC 20230, (202)523-0661.

SUPPLEMENTARY INFORMATION: Notice and comment are not necessary because the effect of the change is to increase the exemption level of reporting in a sample survey, and thus reduce the burden on those who must report. Further, due to the effects of economic growth, exchange rate changes, and inflation moving more companies above the exemption level since the last time it was increased, the effect of the current increase is to return sample to universe coverage closer to where it originally was.

Executive Order 12291

BEA has determined that this final rulemaking is not "major" as defined in E.O 12291 because it is not likely to result in:

(1) an annual effect on the economy of $100 million or more;

(2) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

(3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Paperwork Reduction Act

The collection of information requirements in these final rules have been approved by OMB (OMB No. 0608-0004).

Regulatory Flexibility Act

The Regulatory Flexibility Act does not apply to this rule because the rule was not required to be promulgated as a proposed rule before issuance as a final rule by Section 553 of the Administrative Procedure Act or by any other law. Accordingly, neither an initial nor final Regulatory Flexibility Analysis has been or will be prepared.

List of Subjects in 15 CFR Part 806

Balance of payments, Investments abroad, Reporting and recordkeeping requirements.

Dated: March 4, 1986.

Allan H. Young,

Director, Bureau of Economic Analysis.

PART 806—[AMENDED]

15 CFR, Part 806, is amended as follows:

1. The authority citation for Part 806 is revised to read as follows:

Authority: 5 U.S.C. 301, 22 U.S.C. 3101-3108, and E.O. 11961, as amended.

2. The authority citations following each section of Part 806 are removed.

§ 806.14 [Amended]

3. In 806.14(e) remove the (1) designation and change the exemption level of $10,000,000 to read $15,000,000.

[FR Doc. 86-6599 Filed 3-31-86; 8:45 am]

BILLING CODE 3510-06-M

DEPARTMENT OF THE TREASURY

Customs Service

19 CFR Parts 18, 24, 112, 113, 141, 144, 146, 178 and 191

[T.D. 86-16]

Foreign Trade Zones; Specialized and General Provisions

Correction

In FR Doc. 86-2399 beginning on page 5040 in the issue of Tuesday, February 11, 1986, make the following corrections:

1. On page 5046, in the first column, in the fourth line "§ 156.73" should read "§ 146.73".

2. In the same column, in the sixteenth line from the bottom, "146.7,1" should read "146.71".

§ 146.8 [Corrected]

3. On page 5052, in the second column, in § 146.8, in the fourth line, "of" should read "or".

§ 146.71 [Corrected]

4. In § 146.71(d), on page 5062, in the first column, the first line should read "(d) *Retention or return of merchandise*".

BILLING CODE 1505-01

19 CFR Parts 24 and 191

[T.D. 86-16]

Foreign Trade Zones; Specialized and General Provisions; Correction

AGENCY: U.S. Customs Service, Department of the Treasury.

ACTION: Final rule; correction.

SUMMARY: This document corrects two errors in a document which amended the Customs Regulations relating to foreign trade zones by providing a new audit-inspection method of zone supervision by Customs. The document was published as T.D. 86-16 in the **Federal Register** on Tuesday, February 11, 1986 (51 FR 5040).

FOR FURTHER INFORMATION CONTACT: Marcus Sircus, Regulatory Audit Division, U.S. Customs Service, 1301 Constitution Avenue, NW., Washington, D.C. 20229 (202-566-2812).

SUPPLEMENTARY INFORMATION: .

Background

In FR Doc. 86-2399, appearing at page 5040 in the issue of Tuesday, February 11, 1986, on page 5063, in the second column, under the heading "§ 24.13 [Amended]," the explanation of the amendment to § 24.13 is incorrectly worded. The correct explanation reads as follows:

§ 24.13 [Amended]

2. Section 24.13 is amended by inserting, in the first sentence of paragraph (c), the words "a foreign trade zone operator" before the words "and bonded warehouse proprietors", and by inserting, in the first sentence of paragraph (f), the words "foreign trade zone operator or" before the words "Customs bonded warehouse proprietor".

On page 5064, in the third column, under the heading "**§ 191.165 Same condition drawback merchandise and merchandise not conforming to sample or specifications or shipped without the consent of the consignee.**", the first paragraph, with the heading "Drawback entry", is incorrectly cited, parenthetically, as paragraph "(d)". The correct parenthetical citation should be paragraph "(b)".

Dated: March 27, 1986.

B. James Fritz,

Director, Regulations Control and Disclosure Law Division.

[FR Doc. 86-7227 Filed 3-31-86; 8:45 am]

BILLING CODE 4820-02-M

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19 CFR Part 101

(T.D. 86-71)

Customs Regulations Amendment Relating to the Customs Field Organization in Roberts Landing, MI

AGENCY: Customs Service, Treasury.

ACTION: Closing of Customs station.

SUMMARY: This document closes the Roberts Landing, Michigan, Customs station. Given the small volume of traffic crossing the Canadian-U.S. border at this point, and its proximity to other Customs stations, we believe the closure is warranted and in the public interest. This change will enable Customs and the Immigration and Naturalization Service to obtain more efficient use of their personnel, facilities, and resources, as well as realize a substantial annual savings.

EFFECTIVE DATE: May 1, 1986.

FOR FURTHER INFORMATION CONTACT: Bernie Harris, Office of Inspection and Control, U.S. Customs Service, 1301 Constitution Avenue, NW., Washington, D.C. 20229 (202-566-8157).

SUPPLEMENTARY INFORMATION:

Background

Customs ports of entry and stations are locations where Customs officers are placed for the purpose of accepting the entry of merchandise, collecting duties, examining baggage, clearning passengers, and enforcing the various provisions of the customs laws and other laws.

The significant difference between ports of entry and stations is that at stations, the Federal Government is reimbursed for:

(1) The salaries and expenses of its officers or employees for services rendered in connection with the entry or clearance of vessels; and

(2) Except as otherwise provided by the Customs Regulations, the expenses (including any per diem allowed in lieu of subsistence), but not the salaries of its officers or employees, for service rendered in connection with the entry or delivery of merchandise.

As part of Customs continuing program to obtain more efficient use of its personnel, facilities, and resources, and to provide better service to importers, carriers, and the public, by a document published in the **Federal Register** on October 17, 1985 (50 FR 42036), Customs proposed to amend § 101.4(c), Customs Regulations (19 CFR 101.4(c)), by deleting Roberts Landing, Michigan, from the list of designated Customs stations.

The Roberts Landing Customs station, located in the Detroit, Michigan, Customs district, is one of three auto ferry stations on the St. Clair River between the Customs ports of Port Huron and Detroit. Roberts Landing is a river crossing only; there is no town or village on the U.S. side of the river. Customs has determined that it is not cost-effective to maintain this station in view of the following factors: Its traffic is almost exclusively non-commercial; the ferry boat at the landing is too small to transport any vehicle larger than a medium size camper; the station is closed each year for a period of from 2 weeks to 4 months due to various reasons (vessel repairs, weather, river ice, etc.); the other two ferry stations on the St. Clair River (Algonac, which is 3 miles south; and Marine City, which is 5 miles north) are so close to Roberts Landing that minimal inconvenience will be caused to diverted traffic, and these other two stations could easily handle any overflow without incurring any increase in their operating costs. The Immigration and Naturalization Service has decided not to fill their vacant Inspector position located there. Closing Roberts Landing would enable Customs to realize a savings of over $100,000 annually.

Discussion of Comments

Twenty-four comments were received in response to the notice, all opposed. The comments came from both Canadian residents and U.S. residents. There were two basic reasons expressed by the commenters for disapproving the closing; the negative economic impact resulting from the loss of tourism on both sides of the border, and the personal inconvenience to area Canadian and U.S. residents. Although we appreciate the concerns of the commenters, they do not mitigate the Congressional mandate to make more efficient use of our personnel, facilities, and resources. The fact remains that Roberts Landing is one of three auto ferry stations within an eight mile stretch of border. The close proximity of the stations at Algonac and Marine City minimizes any inconvenience occasioned by the closing of Roberts Landing. Customs can save more than $100,000 annually at a station where there is virtually no commercial traffic. Thus, the closing of Roberts Landing is warranted. Accordingly, the list of Customs districts, stations, and ports of entry having supervision, in § 101.4(c) is amended to reflect this change.

List of Subjects in 19 CFR Part 101

Customs duties and inspection, Imports, Organization and functions (Government agencies).

Amendments to the Regulations

PART 101—GENERAL PROVISIONS

1. The authority citation for Part 101, Customs Regulations (19 CFR Part 101), continues to read as follows:

Authority: 5 U.S.C. 301, 19 U.S.C. 1, 66, 1202 (Gen. Hdnote 11), 1624, Reorganization Plan 1 of 1965, 3 CFR 1965 Supp.

2. The list of Customs districts, stations, and ports of entry having supervision, in § 101.4(c) is amended as follows:

By removing "Roberts Landing, Mich. (Mail: Route 1, Algonac, Mich.)." from the column headed "Customs stations" and by removing "Port Huron" from the column headed "Port of entry having supervision" in the Detroit, Michigan, Customs district.

Executive Order 12291

Because the amendment relates to the organization of Customs it is not a regulation or rule subject to E.O. 12291, pursuant to section 1(a)(3) of that E.O.

Regulatory Flexibility Act

Pursuant to the provisions of § 3 of the Regulatory Flexibility Act (Pub. L. 96–354, 5 U.S.C. 601, *et seq.*), it is hereby certified that the amendment will not have a significant economic impact on a substantial number of small entities. Accordingly, it is not subject to the regulatory analysis or other requirements of 5 U.S.C. 603 and 604.

Drafting Information

The principal author of this document was Glen E. Vereb, Regulations Control Branch, Office of Regulations and Rulings, U.S. Customs Service. However, personnel from other Customs offices participated in its development.

William von Raab,

Commissioner of Customs.

Approved March 14, 1986.

Francis A. Keating, II,

Assistant Secretary of the Treasury.

[FR Doc. 86–7142 Filed 3–31–86; 8:45 am]

BILLING CODE 4820–02–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 74 and 82

[Docket Nos. 83C–0012 and 84C–0426]

D&C Green No. 6; Listing as a Color Additive for Coloring Absorbable Sutures

Correction

In FR Doc. 86–6315 beginning on page 9780 in the issue of Friday, March 21, 1986, make the following corrections:

1. On page 9783, first column, second complete paragraph, second line, insert "is" between "risk" and "to". In the second column, seventh line, "ploy" should read "poly".

2. On page 9785, first column, in the **"AUTHORITY"**, third line, "317" should read "371".

BILLING CODE 1505–01

21 CFR Part 558

Antibiotic, Nitrofuran, and Sulfonamide Drugs in the Feed of Animals; Republication of Regulation

Correction

In FR Doc. 86–5434 beginning on page 8811 in the issue of Friday, March 14, 1986, make the following corrections:

1. On page 8812, in § 558.15(g)(1), in the table, last column, in the tenth and thirteenth lines from the bottom, "salmonellosis" was misspelled.

2. On page 8813, in § 558.15(g)(1), in the table, first column, seventh line, "Do." should read "Pfizer, Inc.".

BILLING CODE 1505–01–M

UNITED STATES INFORMATION AGENCY

22 CFR Parts 501, 503, 505, 506, 511, 516 and 525

Nomenclature and Address Changes

AGENCY: United States Information Agency.

ACTION: Final rule.

SUMMARY: The United States Information Agency (USIA) on a yearly basis updates 22 CFR Chapter V. The amendments reflected are "housekeeping" changes. USIA offices were relocated two years ago and some changes of address have not been reflected in previous revisions of the 22 CFR. Also, due to reorganizations of the Office of Congressional and Public Liaison and the Office of the General Counsel, these two office symbols and names of offices were changed to reflect the redistribution of responsibilities. These amendments will not impose any substantive regulatory requirements on persons subject to the changes.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Charles N. Canestro, USIA Management Plans and Analysis Staff, Room 818, 301 Fourth Street SW., Washington, D.C., 20547, (202) 485–8676.

SUPPLEMENTARY INFORMATION:

List of Subjects

22 CFR Part 501

Foreign service.

22 CFR Part 503

Freedom of information.

22 CFR Part 505

Privacy.

22 CFR Part 506

Government employees.

22 CFR Part 511

Claims.

22 CFR Part 516

Cultural exchange programs, Government employees.

22 CFR Part 525

Administrative practice and procedure, Conflict of interests.

The following is a part by part summary of the amendments to 22 CFR.

PART 501—APPOINTMENT OF FOREIGN SERVICE INFORMATION OFFICERS

1. The authority citation for Part 501 continues to read as follows:

Authority: 22 U.S.C. 1221 et seq.; E.O. 11434 of Nov. 8, 1968 (33 FR 16485).

§ 501.13 [Amended]

2. Section 501.13(b)(2) reference to Director or Deputy Director of Personnel Services is revised to read Director of Personnel.

3. Section 501.13(c)(4) reference to the Office of Personnel Services (MGT/P) is revised to read Office of Personnel (M/P).

4. Section 501.13(f)(3)(i) reference to MGT/P is revised to read M/P.

5. Section 501.13(f)(5)(i) reference to Director or Deputy Director of Personnel Services is revised to read Director of Personnel.

6. Section 501.13(i)(2) reference to Director of Personnel Services is revised to read Director of Personnel.

§ 501.14 [Amended]

7. Section 501.14(a)(2) Note, reference to Assistant Director of Personnel Services is revised to read Director of Personnel.

8. Section 501.14(a)(2) Note, reference to Director or Deputy Director of Personnel Services is revised to read Director of Personnel.

9. Section 501.14(b) reference to Assistant Director of Personnel Services is revised to read Director of Personnel.

10. Section 501.14(e) (1) and (3) references to the Director of Personnel

Services are revised to read Director of Personnel.

PART 503—AVAILABILITY OF RECORDS

1. The authority citation for Part 503 continues to read as follows:

Authority: 22 U.S.C. 2658; 31 U.S.C. 483a; 5 U.S.C. 552 as amended by Pub L. 93–502, 88 Stat. 1561; E.O. 10477, as amended, 18 FR 4540 3 CFR 1949–1953 Comp., page 958, at 22 U.S.C.A. 811a; E.O. 11652, 37 FR 5209, 3 CFR (1974), page 339, unless otherwise noted.

2. Part 503 all references to the address 1750 Pennsylvania Avenue, NW, are revised to read 301 4th Street, SW.

§ 503.3 [Amended]

3. Section 503.3 the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison. (The First Occurrence)

4. Section 503.3 the reference to the Contract and Procurement Division, Office of Administrative Services is revised to read Office of Contracts.

5. Section 503.3 the reference to the Employment Br., Office of Personnel Services is revised to read Domestic Personnel Division, Office of Personnel.

6. Section 503.3 the reference to the Foreign Service Recruitment, Office of Personnel Services is revised to read Foreign Service Personnel Division, Office of Personnel.

7. Section 503.3 the reference to the Office of Congressional and Public Liaison is revised to read Office of Public Liaison. (The Second Occurrence)

8. Section 503.3 the reference to the address 1717 H Street, NW, is revised to read 300 C Street, SW.

9. Section 503.3 the reference to the address 1776 Pennsylvania Avenue, NW, is revised to read 301 4th Street, SW.

§ 503.5 [Amended]

10. Section 503.5(b) the reference to The Management Analysis/Regulations Staff, Associate Directorate for Management is revised to read The Management Plans and Analysis Staff, Bureau of Management.

11. Section 503.5(b) the reference to 1425 K Street, NW, is revised to read 301 4th Street, SW.

§ 503.6 [Amended]

12 Section 503.6(a) all references to Office of Congressional and Public Liaison (CPL) are revised to read Office of General Counsel and Congressional Liaison (GC).

13. Section 503.6(a) After the reference: Initial Request. The reference Freedom of Information Act is revised to read the Freedom of Information Act Coordinator.

14. Section 503.6(a) After the reference "Initial Request:" the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

15. Section 503.6(a) After the reference "Appeal:" insert on a separate line "Chairman, Committee on Public Information Policy".

16. Section 503.6(a) After the reference "Appeal:" the reference to the Office of Congressional and Public Liaison is revised to read the Office of Public Liaison.

17. Section 503.6(b)(1) the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

18. Section 503.6(b(2) the reference to the Office of Congressional and Public Liaison is revised to read Office of Public Liaison.

19. Section 503.6((b)(4) the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

20. Section 503.6(b)(4) the reference to CPL is revised to read GC.

21. Section 503.6(c)(2)(i) the reference to the Director of Congressional and Public Liaison is revised to read Director of Public Liaison

22. Section 503.6(c)(2)(v) the reference to the Director of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

23. Section 503.6(c)(2)(vii) the reference to the Director of Congressional and Public Liaison is revised to read Director of Public Liaison.

PART 505—PRIVACY ACT POLICIES AND PROCEDURES

1. The authority citation for Part 505 continues to read as follows:

Authority: Pub. L. 93–579, 88 Stat. 1897; 5 U.S.C. 552a.

2. Part 505 all references to the address 1750 Pennsylvania Avenue NW, are revised to read 301 4th Street, SW.

§ 505.3 [Amended]

3. Section 505.3 all references to the Office of Congressional and Public Liaison are revised to read Office of General Counsel and Congressional Liaison.

§ 505.4 [Amended]

4. Section 505.4(a)(1) the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

5. Section 505.4(a)(1) the reference to the hours 9:00 a.m. to 4:00 p.m. is revised to read 8:15 a.m. to 5:00 p.m.

§ 505.5 [Amended]

6. Section 505.5(b)(1) the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

7. Section 505.5(f)(5) The reference to (CPL) is revised to read Office of Public Liaison (PL).

§ 505.7 [Amended]

8. Section 505.7(a)(1) the reference to the Office of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

9. Section 505.7(a)(1) the reference to the Director of Congressional and Public Liaison is revised to read Director of Public Liaison.

10. Section 505.7(a)(2) the reference to the Director of Congressional and Public Liaison is revised to read Director of Public Liaison.

11. Section 505.7(b) the reference to the Director of Congressional and Public Liaison is revised to read Director of Public Liaison.

§ 505.11 [Amended]

12. Section 505.11(c) the word back is revised to read bank.

13. Section 505.11(c) the reference to the Director of Congressional and Public Liaison is revised to read Office of General Counsel and Congressional Liaison.

§ 505.15 [Amended]

14. Section 505.15 (a), (b) and (c) all references to MGT/S are revised to read M/S.

15. Section 505.15 (c) and (d) all references to MGT/P are revised to read M/P.

16. Section 505.15(c) all references to MGT/E are revised to read M/E.

17. Section 505.15(d) all references to MGT/PT are revised to read M/PT.

PART 506—PART-TIME CAREER EMPLOYMENT PROGRAM

1. The authority citation for Part 506 continues to read as follows:

Authority: 5 U.S.C. 3401 (note and 3402).

§ 506.4 [Amended]

2. Section 506.4 the reference to the Office of Personnel Services is revised to read Office of Personnel.

§ 506.5 [Amended]

3. Section 506.5 the reference to the Office of Personnel Services is revised to read Office of Personnel.

PART 511—FEDERAL TORT CLAIMS PROCEDURE

1. The authority citation for Part 511 continues to read as follows:

Authority: 5 U.S.C. 301.

§ 511.4 [Amended]

2. Section 511.4(b) the reference to the Office of the General Counsel is revised to read Office of the General Counsel and Congressional Liaison.

3. Section 511.4(b) the reference to the address 1750 Pennsylvania Avenue, NW, is revised to read 301 4th Street, SW.

PART 516—PARTICIPATION BY FEDERAL EMPLOYEES IN CULTURAL EXCHANGE PROGRAMS OF FOREIGN COUNTRIES

1. The authority citation for Part 516 continues to read as follows:

Authority: Sec. 108A (Pub. L. 94–350, 90 Stat. 823) added to the Mutual Educational and Cultural Exchange Act, as amended, 75 Stat. 527–28, 22 U.S.C. 2451 et seq.; and under Executive Orders 11034 and 12048, as amended, Reorganization Plan No. 2 of 1977 and the Continuity Order (Continuity of Operations) of April 1, 1978 (43 FR 15371).

§ 516.2 [Amended]

2. Section 516.2 the reference to the International Communication Agency is revised to read the United States Information Agency.

PART 525—ADMINISTRATIVE ENFORCEMENT PROCEDURES OF POST-EMPLOYMENT RESTRICTIONS

1. The authority citation for Part 525 continues to read as follows:

Authority: 18 U.S.C. 207(j).

§ 525.16 [Amended]

2. Section 525.16 the reference to the Director, Office of Personnel Services is revised to read Director of Personnel.

Dated: March 26, 1986.

Woodward Kingman,

Associate Director for Management.

[FR Doc. 86–7129 Filed 3–31–86; 8:45 am]

BILLING CODE 8230–01–M

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22 CFR Part 504

Organization of USIA; Correction

AGENCY: United States Information Agency.

ACTION: Final rule; correction.

SUMMARY: The United States Information Agency on a yearly basis updates 22 CFR Part 504 outlining the organizational changes and office moves which have occurred during the past year. This document corrects an error which appeared in our submission published in 51 FR 10192, March 25, 1986.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Charles N. Canestro, USIA Management Plans and Analysis Staff, Room 818, 301 Fourth Street SW, Washington, DC 20547, (202) 485–8676.

SUPPLEMENTARY INFORMATION:

List of Subjects in 22 CFR Part 504

Organization and functions (Government agencies).

In 51 FR 10192, USIA published its final version of the revision to 22 CFR Part 504 regarding the organization of the Agency. Inadvertently, a sentence was omitted from paragraph 504.2(e)(1)(vi) on page 10194. The following sentence should be added at the end of paragraph 504.2(e)(1)(vi):

(vi) The Office of the General Counsel and Congressional Liaison (GC). ..... "The Office passes on all requests made under the Freedom of Information and Privacy Acts."

Dated: March 28, 1986.

Charles N. Canestro,

Federal Register Liaison.

[FR Doc. 86–7249 Filed 3–31–86; 8:45 am]

BILLING CODE 8230–01–M

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 602

[T.D. 8074]

Income Taxes; Section 338 International Aspects of Stock Acquisitions and Target Corporation Assets

AGENCY: Internal Revenue Service, Treasury.

ACTION: Correction to temporary regulations.

SUMMARY: This document contains corrections to Treasury Decision 8074 which was published in the **Federal Register** on February 12, 1986 (51 FR 5163). T.D. 8074 issued temporary regulations relating to international aspects of section 338 of the Internal Revenue Code of 1954, as added by the Tax Equity and Fiscal Responsibility Act of 1982 and as amended by the Technical Corrections Act of 1982 and the Tax Reform Act of 1984.

EFFECTIVE DATE: These corrections are effective February 12, 1986.

FOR FURTHER INFORMATION CONTACT: Keith E. Stanley of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224 (Attn: CC:LR:T). Telephone 202–566–3458 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

On February 12, 1986, the **Federal Register** published (51 FR 5163) Treasury Decision 8074 which set forth temporary regulations relating to the international aspects of section 338 of the Internal Revenue Code of 1954. The text of the temporary regulations also served as the text for a notice of proposed rulemaking that was published at page 5208 in the proposed rules section of the same issue of the **Federal Register.**

Need for Correction

As published, T.D. 8074 contains one typographical error, five omissions, and one instance where previously revised language was inadvertently restored to its prior form.

Correction of Publication

Accordingly, the publication of Treasury Decision 8074, which was the subject of FR Doc. 86–2951, is corrected as follows:

Paragraph 1. In the preamble, page 5168, first column, fifteenth line, the language "eligible targets. The transitional" is removed and the language "eligible targets. The transitional stock" is added in its place.

Par. 2. In the preamble, page 5172, second column:

a. In line five, the language "if that foreign P group member (1) is not" is removed and the language "unless that foreign P group member (1) is" is added in its place.

b. In line nine, the word "not" is removed.

c. In line fifteen, the language "does not" is removed.

d. In line sixteen, the word "purchase" is removed and the word "purchases" is added in its place.

e. In line eighteen, the language "(or of an affected target), and (4) does" is removed and the language "(or of an affected target), or (4)" is added in its place.

f. In line nineteen, the language "not hold" is removed and the word "holds" is added in its place.

§ 1.338–5T [Amended]

Par. 3. In § 1.338–5T(c), on page 5174, third column, paragraph (2)(iii)(A), line twenty, the word "his" is removed and the word "this" is added in its place.

Par. 4. In § 1.338–5T(c)(6), on page 5178, second column, *Example (8)*, first sentence, the language "FS" is removed and the language "FS and FT does not satisfy the 50 percent gross income test of paragraph (c)(5)(i) of this section for the 3-year period preceding 1986" is added in its place.

Par. 5. In § 1.338–5T(c)(6), on page 5179, second column, *Example (17)* (iv), line seven, the word "had" is added between "been" and "FT2".

Par. 6. In § 1.338–5T(j)(6)(ii)(A), page 5188, first column, the period is removed at the end of the paragraph and the language, "that is not subject to the special asset consistency rule of paragraph (c)(4)(i) of this section (applicable in the case of a regular exclusion election)." is added in its place.

Par. 7. In the amendatory language for § 1.338–4T, on page 5194, second column, paragraph (8)(l), the language "January 1, 1986' " that appears at the end of that paragraph is removed and the language " 'January 1, 1986' " is added in its place.

Paul A. Francis,

Acting Director, Legislation and Regulations Division.

[FR Doc. 86–7202 Filed 3–31–86; 8:45 am]

BILLING CODE 4830–01–M

DEPARTMENT OF JUSTICE

Parole Commission

28 CFR Part 2

Paroling, Recommitting and Supervising Federal Prisoners

AGENCY: United States Parole Commission, Justice.

ACTION: Final rule.

SUMMARY: The U.S. Parole Commission is amending its procedure in regard to the submission of supervision reports by U.S. Probation Officers. Instead of submitting the initial supervision report on a parolee after completion of twelve (12) months of continuous supervision, 28 CFR 2.42 (Probation Officer's Reports to Commission) will now require that that first report be submitted after the completion of twenty-four (24) months of continuous supervision. Subsequent reports will continue to be submitted on an annual basis. Such change will result in considerable workload savings for both the Parole Commission and the Probation Service while continuing to conform to the statutory requirement that the Parole Commission review the status of parolees to determine the need for continued supervision (42 U.S.C. 4211(b)).

EFFECTIVE DATE: May 1, 1986.

FOR FURTHER INFORMATION CONTACT: Alan J. Chaset, Deputy Director of Research and Program Development, U.S. Parole Commission, 5550 Friendship Blvd., Chevy Chase, Maryland 20815, Telephone (301) 492–5980.

SUPPLEMENTARY INFORMATION: Under current procedures, the Probation Service is required to prepare and submit to the Parole Commission a supervision report on each parolee after the completion of the first year of supervision and for each year thereafter. 28 CFR 2.42. The Parole Commission is changing the requirement as regards to submission of the initial supervision report: that first report will now be submitted after completion of two years of supervision. Such supervision reports provide the Commission with, among other things, information to be reviewed in determining whether to continue or terminate parole supervision per 42 U.S.C 4211(b). Since that statutory subsection calls upon the Parole Commission to review parolees' status two years after release and at least annually thereafter, this procedural revision will continue to comport with the Congressional mandate.

The change in procedure will result, however, in a considerable workload savings for both the Parole Commission and the Probation Service, a savings now necessitated because of budgetary constraints and deficit reduction legislation. Since early termination of supervision is not normally considered until after two years of continuous supervision and since requests for warrants, conditions modifications, and other negative actions generally are submitted by separate memoranda, the preparation, submission and review of the approximately 6,000 initial supervision reports each year serves minimal purposes. Furthermore, since the Probation Service has enhanced its internal procedures to require a supervisory case review every six months, whatever activity may be summarized in these initial reports will have already been brought to the attention of the Commission if action on the part of the Commission is warranted.

It is to be stressed, however, that although the Parole Commission will now require initial reports only after twenty-four months of supervision, those Youth Correction Act cases that fall under the special provisions imposed by *Watts* v. *Hadden*, 651 F.2d 1354 (10th Cir. 1981), are not affected by this revision: A supervision report after the first year of supervision will continue to be required in those cases.

This rule change will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act.

List of Subjects in 28 CFR Part 2

Administrative practice and procedure, Prisoners, Probation and Parole.

Part 2—[AMENDED]

1. The authority citation for 28 CFR Part 2 continues to read:

Authority: 18 U.S.C. 4203(a)(1) and 4204(a)(6).

2. 28 CFR 2.42 is revised to read as follows:

§ 2.42 Probation Officer's Reports to Commission.

A supervision report shall be submitted by the responsible probation officer to the Commission for each parolee after the completion of 24 months of continuous supervision and annually thereafter. The probation officer shall submit such additional reports as the Commission may direct.

Dated: March 11, 1986.

Benjamin F. Baer,

Chairman, U.S. Parole Commission.

[FR Doc. 86–6883 Filed 3–31–86; 8:45 am]

BILLING CODE 4410–01–M

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Part 1602

Records and Reports; Local Union Equal Employment Opportunity Report (EEO–3)

AGENCY: Equal Employment Opportunity Commission.

ACTION: Final rule.

SUMMARY: The Equal Employment Opportunity Commission is amending its reporting regulations that cover unlawful employment practices by local unions. The amendment will reduce the filing requirements from once a year to once every two years for these unions. This change will reduce the reporting burden on local unions. This action is consistent with the goal of the Paperwork Reduction Act to minimize the federal paperwork burden.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Joachim Neckere, Director, Survey Division, phone: (703) 756–6020.

SUPPLEMENTARY INFORMATION: EEOC published a notice of proposed rulemaking (50 FR 31196) on August 1, 1985, proposing to amend the Regulation set forth at 29 CFR 1602.22. This action makes final the amendment of that regulation exactly as proposed in the August 1, 1985 notice. Section 709(c) of Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e–8(c), requires employers to make and keep records relevant to a determination of whether unlawful employment practices have been or are being committed and to make reports therefrom as required by the Equal Employment Opportunity Commission. Accordingly, the Commission has issued regulations which set forth the reporting requirements for various kinds of employers. Local unions in their capacity as employers have been required to submit annual reports to the EEOC. The Commission's experience with the use of local union reports indicates that a biennial collection of this information will adequately serve the Commission's needs and purposes for collecting the data. The change to biennial reporting is intended to reduce the reporting burden on local unions. This action is consistent with the goal of the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.*, to minimize the federal paperwork burden. The Commission will require affected unions to file reports every other year thus substantially reducing the reporting burden. Note, however, that the recordkeeping requirements of § 1602.27 remain unchanged.

Comments: No comments were received by the Commission concerning the change in this regulation.

Since the decreased reporting requirement will not prejudice but will benefit local unions, the Commission concludes that a formal public hearing is not necessary.

This regulation has been reviewed in accordance with Executive Order 12291. It does not require a regulatory impact analysis under Section 3 of that Order.

Similarly, the Commission certifies under 5 U.S.C. 3605 (b), enacted by the Regulatory Flexibility Act (Pub. L. 96–354), that this rule will not result in a significant impact on a substantial number of small entities. Therefore, a regulatory flexibility analysis is not required.

List of Subjects in 29 CFR Part 1602

Equal employment opportunity reporting requirements, Recordkeeping requirements.

OMB Control Number: 3047–0006.

The amended regulation appears below.

By virtue of the authority vested in the Commission under section 709(c) of Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e–8(c), the Equal Employment Opportunity Commission hereby publishes the amendment to § 1602.22 of its regulations on Recordkeeping and Reports at Title 29 of The Code of Federal Regulations.

Signed at Washington, DC this 19th day of March 1986.

For the Commission.

Clarence Thomas,

Chairman.

PART 1602—RECORDS AND REPORTS

Accordingly, EEOC amends 29 CFR—Part 1602 as follows:

1. The authority citation for Part 1602 is revised to read as set forth below and the authority citations following all the sections in Part 1602 are removed.

Authority: Secs. 709, 713, 78 Stat. 263, 265; 42 U.S.C. 2000e–8–12; 44 U.S.C. 3501 et seq.

2. Section 1602.22 is revised to read as follows:

§ 1602.22 Requirements for filing and preserving copy of report.

On or before December 31, 1986, and biennially thereafter, every labor organization subject to Title VII of the Civil Rights Act of 1964, as amended, shall file with the Commission or its delegate an executed copy of Local Union Report EEO–3 in conformity with the directions set forth in the form and accompanying instructions, provided that the labor organization has 100 or more members at any time during the 12 months preceding the due date of the report, and is a "local union" (as that term is commonly understood) or an independent or unaffiliated union. Labor organizations required to report are those which perform, in a specific jurisdiction, the functions ordinarily performed by a local union, whether or not they are so designated. Every local union or a labor organization acting in its behalf, shall retain at all times among the records maintained in the ordinary course of its affairs a copy of the most recent report filed, and shall make the same available if requested by an officer, agent, or employee of the Commission under the authority of section 709 of Title VII. It is the responsibility of all persons required to file to obtain from the Commission or its delegate necessary supplies of the form.

(Approved by the Office of Management and Budget under control number 3046–0006)

[FR Doc. 86–7161 Filed 3–31–86; 8:45 am]

BILLING CODE 6570–06–M

DEPARTMENT OF DEFENSE

Department of the Navy

32 CFR Part 701

Availability of Department of the Navy Records and Publication of Department of the Navy Documents Affecting the Public

AGENCY: Department of the Navy, DoD.

ACTION: Final Rule; Amendment.

SUMMARY: The Navy is amending its rules to permit the specific exemption from certain provisions of the Privacy Act for a new record system established under the Privacy Act. This exemption will permit the withholding of certain information from a particular Navy record system.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Gwendolyn R. Aitken, Privacy Act Coordinator, Office of the Chief of Naval Operations (OP–09B30), Department of the Navy, The Pentagon, Washington, D.C. 20350–2000, tele: (202) 694–2004, Autovon: 224–2004.

SUPPLEMENTARY INFORMATION: On February 28, 1986, at 51 FR 7090, the Department of the Navy published a proposed rulemaking amendment for a specific exemption from certain provisions of the Privacy Act of 1974 (5 U.S.C. 552a) for a new system of records established under the Privacy Act. This new record system, identified as N05330–3, is entitled: "Faculty Professional Files" and was published at 51 FR 6779 on February 26, 1986. The new specific exemption rule under 5 U.S.C. 552a(k)(5) will exempt disclosure of investigatory material in the record system compiled for determining suitability for employment.

No comments were received from the proposed rulemaking at 51 FR 7090 on February 28, 1986, and therefore, the rule amendment is adopted as final by the Navy.

List of Subjects in 32 CFR Part 701

Privacy, Exemption, Investigative information, Records.

PART 701—[AMENDED]

Accordingly, Subpart G of 32 CFR Part 701 is amended as follows:

1. The authority citation for Part 701 continues to read as follows:

Authority: Privacy Act of 1974, Pub. L. 93–579, 88 Stat. 1896 (5 U.S.C. 552a), 32 CFR 286a.

2. Add paragraph (n) to § 701.117

Subpart G—Privacy Act Exemptions

* * * * *

§ 701.117 Exemption for specific Navy records systems.

* * * * *

(n) *Naval Postgraduate School.*

(1) *ID–N05300–3.*

System name. Faculty Professional Files.

Exemption. Portions of this system of records are exempt from the following subsections of Title 5 U.S.C. 552a: (c)(3), (d), e(4), (G) and (H), and (f).

Authority: 5 U.S.C. 552a(k)(5).

Reasons. Exempted portions of this system contain information considered relevant and necessary to make a determination as to the qualifications, eligibility, or suitability for Federal employment, and was obtained by providing an express or implied promise to the source that his/her identity would not be revealed to the subject of the record.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

March 27, 1986.

[FR Doc. 86–7199 Filed 3–31–86; 8:45 am]

BILLING CODE 3810–01–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[COTP Wilmington, NC Reg. 86–03]

Safety Zone Regulations; the Atlantic Intracoastal Waterway Between Mile 228 and Mile 332 and the Shallotte River From the Atlantic Intracoastal Waterway to Its Confluence With Mill Pond Creek

AGENCY: Coast Guard, DOT.

ACTION: Emergency rule.

SUMMARY: The Coast Guard is establishing a safety zone which encompasses an area on the Atlantic Intracoastal Waterway between mile 228 and mile 332, and the Shallotte River from Atlantic Intracoastal Waterway to its confluence with Mill Pond Creek. This zone is needed to protect vessel traffic in the vicinity from a safety hazard associated with a barge grounding and personnel cleaning up an oil spill. Entry into this zone is prohibited unless authorized by the Captain of the Port.

EFFECTIVE DATES: This regulation becomes effective at 1:00 a.m., Eastern Standard Time, March 18, 1986. It terminates at 12:00 p.m., Eastern Standard Time, March 30, 1986.

FOR FURTHER INFORMATION CONTACT: LCDR K.A. MOLL, Chief of the Operations Department, U.S. Coast Guard Marine Safety Office, Suite 500, 272 N. Front Street, Wilmington, North Carolina 28401–3907, Phone: 919 343–4892.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 553, a notice of proposed rulemaking was not published for this regulation and good cause exists for making it effective in less than 30 days after **Federal Register** publication. Publishing an NPRM and delaying its effective date would have been contrary to the public interest since immediate action was needed to prevent possible loss of life or injury to personnel and damage to transiting vessels during this operation.

Drafting Information

The drafter of this regulation is Lieutenant Commander K.A. MOLL, Project Officer, for the Captain of the Port.

Discussion of Regulations

The hazard requiring this regulation resulted from damage to the tank barge Edgar O'Sikes and an oil spill resulting from this damage. The Safety Zone is being established until the barge is removed and cleanup operations completed.

List of Subjects in 33 CFR Part 165

Harbors Marine Safety, Navigation (water), Security Measures, Vessels, Waterways.

PART 165—[AMENDED]

Regulation

In consideration of the foregoing, Part 165 of Title 33, Code of Federal Regulations, is amended as follows:

1. The authority citation continues to read:

Authority: 33 U.S.C. 1225 and 1231; 50 U.S.C. 191; 49 C.F.R. 1.46, and 33 C.F.R. 1.05–1(g), 6.04–6 and 160.5.

2. A new § 165.T503 is added to read as follows:

§ 165.T503 Emergency temporary safety zone.

(a) *Location.* The following defines the safety zone: An area on the Atlantic Intracoastal Waterway between mile 328 and mile 332 and the Shallotte River from the Atlantic Intracoastal Waterway to its confluence with Mill Pond Creek.

(b) *Regulations.* In accordance with the general regulations in 165.23 of this part, entry into this zone is prohibited unless authorized by the Captain of the Port.

Dated: March 18, 1986.

D.H. Whitten,

Captain, U.S. Coast Guard, Captain of the Port, Wilmington, NC.

[FR Doc. 86–7015 Filed 3–31–86; 8:45 am]

BILLING CODE 4910–14–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A–1–FRL–2992–6]

Approval and Promulgation of Implementation Plans, Massachusetts; Temporary Sulfur-in-Fuel Revision for Phillips Academy in Andover

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is today approving a revision to the Massachusetts State Implementation Plan (SIP) which will allow Phillips Academy in Andover, Massachusetts to increase the sulfur content of its residual fuel oil for up to 30 months. The burning of less expensive, higher sulfur content fuel oil will provide this source with some of the capital needed to implement permanent energy conservation measures.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Cynthia L. Greene, (617) 223–5133.

ADDRESSES: Copies of the Massachusetts submittal, which is incorporated by reference, are available for public inspection during regular business hours at the Environmental Protection Agency, Region I, Room 2313, JFK Federal Building, Boston, Massachusetts 02203; Public Information Reference Unit, Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460; Office of the Federal Register, 1100 L Street, NW., Room 8401, Washington, DC and the Department of Environmental Quality Engineering, 8th Floor, One Winter Street, Boston, Massachusetts 02108.

SUPPLEMENTARY INFORMATION: On February 8 and October 23, 1985, the Massachusetts DEQE submitted a SIP revision for Phillips Academy, in

Andover, Massachusetts. The revision allows the burning of 2.2% sulfur fuel in their boilers for 30 months or less. During this time period, Phillips Academy has committed to implementing permanent energy conservation measures. The facility will use the savings realized during the temporary (30 months or less) utilization of less expensive 2.2% sulfur fuel oil to defray the costs of implementing the permanent energy conservation measures. The facility will return to burning 1.0% sulfur fuel oil by September 1, 1988.

Background

This temporary sulfur-in-fuel revision is being approved pursuant to the provisions of Regulation 310 CMR 71.9, "Interim Sulfur-in-Fuel Limitation for Fossil Fuel Utilization Facilities Pending Energy Conservation Measures." EPA approved the addition of this regulation to the Massachusetts SIP on March 19, 1981 (46 FR 82677). It specifies the requirements and conditions which sources must meet in order to qualify for temporary sulfur-in-fuel relaxations and the procedures which the Massachusetts Department of Environmental Quality Engineering (DEQE) must use to determine that the emissions will not violate any National Ambient Air Quality Standards (NAAQS). Only sources rated at less than 250 million Btu per hour heat input, which are currently burning residual fuel oil, and have made a commitment to either (a) convert to an alternate fuel, or (b) implement conservation measures, are eligible for a temporary sulfur-in-fuel revision not to exceed 30 months. Further details on the requirements of Regulation 310 CMR 7.19 and EPA's reasons for approving it were discussed in a Notice of Proposed Rulemaking (NPR) published on December 16, 1980 (45 FR 82675). In the NPR, EPA also proposed approval of all individual sources that meet the eligibility requirements of this regulation.

EPA Evaluation

EPA has determined that the DEQE has approved Phillips Academy request to burn higher sulfur fuel oil in accordance with the provisions of Regulation 310 CMR 7.19, and agrees that no air quality standards will be violated by the temporary burning of 2.2% sulfur fuel oil at this facility. A PTMTP screening model was used which yields worst case 1-hour average concentrations. This modeling analysis predicted impacts well below the standards. Additionally, the stack height regulation is not applicable because the stack is less than 65 meters in height and the source emits less than 5,000 tons per year of SO_2.

EPA received no comments on its December 16, 1980 (45 FR 82675) proposal to approve individual sources of sulfur-in-fuel relaxations, and DEQE received no comments on its proposed approval of the temporary sulfur-in-fuel relaxation at the Phillips Academy facility in Andover. Since the public has had these other opportunities to comment, and since the Phillips Academy facility is a small source (each piece of equipment is less than 250 million Btu per hour heat input), EPA is taking final action today to approve this SIP revision without first publishing a new proposed rulemaking. EPA believes that publishing a new NPR is unnecessary. EPA finds good cause for making this action effective immediately because the implementation plan is already in effect under State law and imposes no additional regulatory burden.

Final action: EPA is approving the proposed temporary sulfur-in-fuel relaxation revision for Phillips Academy.

Under U.S.C. 605(b), the Administrator has certified that this action will not have significant economic impact on a substantial number of small entities (see 46 FR 8709).

The Office of Management and Budget has exempted this rule from the requirements of section 3 of Executive Order 12291.

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by June 2, 1986. This action may not be challenged later in proceedings to enforce its requirements (see 307(b)(2)).

List of Subjects in 40 CFR Part 52

Air pollution control, Ozone, Sulfur oxides, Nitrogen dioxide, Lead, Particulate matter, Carbon monoxide, and Hydrocarbons, Intergovernmental relations, Reporting and recordkeeping requirements.

Note: Incorporation by Reference for the State Implementation Plan for the Commonwealth of Massachusetts was approved by the Director of the **Federal Register** on July 1, 1982.

Dated: March 10, 1985.

Lee M. Thomas,

Administrator.

PART 52—[AMENDED]

Part 52, Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

Subpart W—Massachusetts

1. The authority citation for part 52 continues to read as follows:

Authority. 42 U.S.C. 7401–7642.

2. Section 52.1120, paragraph (c) is amended by adding paragraph (68) as follows:

§ 52.1120 Identification of Plan.

* * * * *

(c) * * *

(68) A revision submitted on February 8 and October 23, 1985 allowing the burning of 2.2% sulfur content fuel oil at the Phillips Academy facility in Andover, Massachusetts for a period of up to 30 months, commencing on April 1, 1986.

(i) *Incorporation by reference.* (A) Letter from Richard J. Chalpin, Acting Regional Engineer, to Phillips Academy, dated December 27, 1984 allowing the temporary use of less expensive 2.2% sulfur fuel oil (for 30 months from the date of publication), the savings from which will be used to implement permanent energy conservation measures to reduce on-site consumption of petroleum products by at least 50,000 gallons per year (estimated 82,000 gallons per year). At the end of the temporary use period, Phillips Academy will return to the use of 1.0% sulfur fuel oil. The particulate emission rate for the facility will not exceed 0.15 lbs. per million Btu.

(B) These specific requirements of Regulation 310 CMR 7.19 were agreed to in a Statement of Agreement, signed February 19, 1985.

(C) Memorandum to Donald C. Squires from Bruce K. Maillet dated October 4, 1985; subject: Response to EPA questions regarding Phillips Academy, outlines the permanent energy conservation measures to be used.

§ 52.1167 [Amended]

2. Section 52.1167, is amended by adding the following source to Table 52.1167 under the entry "310 CMR 7.19."

State citation	Title/subject	Date submitted by State	Date approved by EPA	Federal Register citation	52.1120(c)	Comments/unapproved section
• • •	• • •	• • •				
310 CMR 7.19	Interim sulfur-in-fuel limitations for fossil fuel utilization facilities pending conversion to an alternative fuel or implementation of permanent energy conservation measures.	02/08/85, 10/23/85.	[Federal Register Publication date].	[Federal Register Number]	68	Phillips Academy, Andover, MA to burn 2.2% until September 1, 1988.

[FR Doc. 86-6752 Filed 3-28-86; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Parts 60 and 61

[A-4-FRL-2994-8]

Standards of Performance for New Stationary Sources, National Emission Standards for Hazardous Air Pollutants, Tennessee; Delegation of Authority to Knox County

AGENCY: Environmental Protection Agency.

ACTION: Delegation of Authority.

SUMMARY: On February 3, 1986, Knox County requested that EPA delegate authority for implementation and enforcement of certain standards in 40 CFR Part 60 (Standards of Performance for Stationary Sources) and 40 CFR Part 61 (National Emission Standards for Hazardous Air Pollutants). Since EPA's review of pertinent Knox County laws, rules, and regulations showed them to be adequate for the implementation and enforcement of the federal standards, the Agency has made the delegation as requested.

EFFECTIVE DATE: The effective date of the delegation of authority to Knox County is March 3, 1986.

ADDRESSES: Copies of the request for delegation of authority and EPA's letter of delegation may be examined during normal business hours at the following locations.

Environmental Protection Agency, Region IV, Air Programs Branch, 345 Courtland Street, NE, Atlanta, GA 30365

Knox County Department of Air Pollution, City/County Building, Suite L222, 400 Main Street, Knoxville, TN 37902.

FOR FURTHER INFORMATION CONTACT: Rosalyn Hughes of the EPA Region IV Air Programs Branch, at the above address and telephone (404) 347-3286 (FTS: 257-3286).

SUPPLEMENTARY INFORMATION: Sections 101, 111(c)(1) and 112(d)(1) of the Clean Air Act authorize EPA to delegate authority to implement and enforce the standards set out in 40 CFR Part 60, Standards of Performance for New Stationary Sources (NSPS) and 40 CFR Part 61, National Emissions Standards for Hazardous Air Pollutants (NESHAP).

On December 13, 1985, EPA updated the authority for implementation and enforcement of the NSPS and NESHAP program to Knox County. On March 3, 1986, Knox County requested delegation of authority of NSPS for Subparts FFF (Flexible Vinyl and Urethane Coating and Printing) and LLL (Onshore Natural Gas Processing: SO_2 Emissions) and NESHAP for Subpart M (Asbestos).

After a thorough review of the request the Regional Administrator determined that such a delegation was appropriate for these source categories with all the conditions set forth in the delegation letter of December 13, 1986. Knox County sources subject to the requirements of Subparts FFF, LLL of 40 CFR Part 60 and Subpart M of 40 CFR Part 61 will now be under the jurisdiction of Knox County.

Authority: 42 U.S.C. 7401-7642.

List of Subjects in 40 CFR Parts 60 and 61

Air pollution control, aluminum, ammonium, sulfate plants, asphalt, cement industry, coal, copper, electric power plants, glass and glass products, grains, intergovernmental relations, iron, lead, metals, metallic minerals, motor vehicles, nitric acid plants, paper and paper products industry, petroleum, phosphate, sewage disposal, steel sulfuric acid plants, waste treatment and disposal, zinc, tires, can surface coating, sulfuric acid plants, industrial organic chemicals, organic solvent cleaners, fossil fuel-fired steam generators, fiberglass insulation, synthetic fibers, incorporation by reference, asbestos, beryllium, mercury, reporting and recordkeeping requirements, vinyl chloride.

Dated: March 20, 1986.

Sanford W. Harvey, Jr.,

Acting Regional Administrator.

[FR Doc. 86-7137 Filed 3-27-86; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 61

[OAR-FRL-2995-8]

National Emission Standards for Hazardous Air Pollutants; Amendments to General Provisions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) amended Subpart A, the General Provisions for national emission standards for hazardous air pollutants (NESHAPs), on November 7, 1985 (50 FR 46284). The promulgated amendments included a list of substances for which EPA has published a notice that included consideration of the serious health effects, including cancer, from ambient air exposure to the substance. This notice amends this list to include additional substances.

DATE: Effective April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Beth M. Hassett or Robert M. Schell, Pollutant Assessment Branch, Strategies and Air Standards Division (MD-12), Office of Air Quality Planning and Standards, U.S. Environmental Protection Agency, Research Triangle Park, N.C. 27711; FTS 629-5645 or (919) 541-5645.

SUPPLEMENTARY INFORMATION: On November 7, 1985 (FR 46284), EPA promulgated amendments to Subpart A of Part 61. These amendments included the publication of a list of substances for which the Agency has published a **Federal Register** notice which included consideration of serious health effects, including cancer, from ambient exposure to the substance. This list was published for informational purposes only. Publication of this list serves to inform the public as to the status of EPA's program for assessing potentially toxic air pollutants as well as to provide a useful reference for those **Federal Register** notices that EPA has published on potentially toxic air pollutants. This notice amends the previously published list to include recent notices which EPA has published for additional substances.

Paperwork Reduction Act

These amendments do not add any information collection burden for sources subject to standards currently in Part 61. Thus, this action is not an information collection request (ICR) under the Paperwork Reduction Act of 1980, 44 U.S.C. et seq.

Regulatory Flexibility Analysis Certification

Pursuant to the provisions of 5 U.S.C. 615(b), I hereby certify that these amendments to Part 61 will not have a significant economic impact on a substantial number of small entities. The amendments will not add any new regulatory requirements to Part 61, consequently, they will not add significant costs.

List of Subjects in 40 CFR Part 61

Asbestos, Beryllium, Benzene, Hazardous substances, Mercury, Radionuclides, Reporting and recordkeeping requirements, Vinyl Chloride.

Dated: March 26, 1986.

J. Craig Potter,

Assistant Administrator for Air and Radiation.

PART 61—[AMENDED]

1. The authority citation for Part 61 continues to read as follows:

Authority: 42 U.S.C. 7401, 7412, 7414, 7416, and 7601.

2. Section 61.01 paragraph (b) is amended by adding the following entries alphabetically in the alphabetized list of substances.

§ 61.01 Lists of pollutants and applicability of Part 61.

* * * * *

(b) * * *

1,3-Butadiene (50 FR 41466; October 10, 1985)
Cadmium (50 FR 42000; October 16, 1985)
Chloroform (50 FR 39626; September 27, 1985)
Chloroprene (50 FR 39632; September 27, 1985)
Ethylene Dichloride (50 FR 41994; October 16, 1985)
Ethylene Oxide (50 FR 40286; October 2, 1985)
Hexachlorocyclopentadiene (50 FR 40154; October 1, 1985)
Methylene Chloride (50 FR 42037; October 17, 1985)

* * * * *

[FR Doc. 86-7139 Filed 3-31-86; 8:45 am]

BILLING CODE 6560-50-M

GENERAL SERVICES ADMINISTRATION

41 CFR Part 101-20

[FPMR Temp. Reg. D-69, Supp. 5]

Federal Employee Parking; Temporary Regulation

AGENCY: Public Buildings Service, GSA.

ACTION: Temporary Regulation.

SUMMARY: This supplement extends to March 31, 1987, the expiration date of FPMR Temporary Regulation D-69. D-69 sets forth revised policies and procedures concerning Federal employee parking. The regulation was developed as part of an effort to review and streamline GSA's property management regulations.

DATES: Effective date: April 1, 1986.

Expiration date: March 31, 1987.

FOR FURTHER INFORMATION CONTACT: John Quigley, Acting Director, Assignment Division (202-566-0059).

SUPPLEMENTARY INFORMATION: The General Services Administration (GSA) has determined that this rule is not a major rule for the purpose of E.O. 12291 of February 17, 1981, because it is not likely to result in an annual effect on the economy of $100 million or more; a major increase in costs to consumers or others; or significant adverse effects. Therefore, a Regulatory Impact Analysis has not been prepared. GSA has based all administration decisions underlying this rule on adequate information concerning the need for, and consequences of, this rule; has determined that the potential benefits to society from this rule outweigh potential costs and has maximized the net benefits; and has chosen the alternative approach involving this least net cost to society.

(Sec. 205(c), 63 Stat. 390; 40 U.S.C. 486(c))

In 41 CFR Chapter 101 this temporary regulation is added to the appendix at the end of Subchapter D.

March 3, 1986.

Federal Property Management Regulations Temporary Regulation D-69

Supplement 5

To: Heads of Federal agencies

Subject: Federal Employee Parking

1. *Purpose.* This supplement extends the expiration date of FPMR Temporary Regulation D-69.

2. *Effective date.* April 1, 1986.

3. *Expiration date.* This supplement expires on March 31, 1987.

4. *Explanation of changes.* The expiration date in paragraph 3 of FPMR Temporary Regulation D-69 is revised to March 31, 1987.

Paul Trause,

Acting Administrator of General Services

[FR Doc. 86-7069 Filed 3-31-86; 8:45 am]

BILLING CODE 6820-23-M

41 CFR Part 101-39

[FPMR Amendment G-77]

Interagency Fleet Management Systems

AGENCY: Federal Supply Service, GSA.

ACTION: Final rule.

SUMMARY: The General Services Administration (GSA) is updating the policies and procedures concerning the management and operation of the Interagency Fleet Management System. Revisions to this part were made as a result of Interagency Motor Equipment Management Committee subcommittee recommendations and comments submitted by Federal agencies.

EFFECTIVE DATE: April 1, 1986.

FOR FURTHER INFORMATION CONTACT: Mr. Larry Frisbee, Federal Supply Service, Fleet Management Division (703-557-1288).

SUPPLEMENTARY INFORMATION: GSA has determined that this rule is not a major rule for the purposes of Executive Order 12291, dated February 17, 1981, because it is not likely to result in an annual effect on the economy of $100 million or more; a major increase in costs to consumers or others; or significant adverse effects. GSA has based all administrative decisions underlying this rule on adequate information concerning the need for, and consequences of, this rule; has determined that the potential benefits to society from this rule outweigh the potential costs and has maximized the net benefits; and has chosen the alternative approach involving the least net cost to society. A draft of proposed change to 41 CFR 101-39 was distributed to the members of the Interagency Motor Equipment Management Committee representing 19 major civilian executive agencies. Comments were received and reconciled, as appropriate. Subsequently, a proposed rule was published in the **Federal Register** on April 11, 1985 (50 FR 14260), requesting further comments from interested parties. A separate copy of the proposed rule was furnished to each member of the Interagency Advisory Committee on Regulatory Review. In response to the proposed rule, several additional agency

comments were received. These have also been adopted, where appropriate. The Federal Property Management Regulation (FPMR), Part 101–39 (41 CFR 101–39) is revised to reflect the current operating policies of the newly designated Interagency Fleet Management System (formerly the Interagency Motor Pools System.)

List of Subjects in CFR Part 101–39

Government property management, Motor vehicles, Safety and claims.

Title 41 CFR Part 101–39 is revised to read as follows:

PART 101–39—INTERAGENCY FLEET MANAGEMENT SYSTEMS

Sec.

101–39.000 Scope of part.

Subpart 101–39.0—General Provisions

101–39.001 Authority.
101–39.002 Applicability.
101–39.003 Financing.
101–39.004 Optional operations.

Subpart 101–39.1—Establishment, Modification, and Discontinuance of Interagency Fleet Management Systems

101–39.100 General.
101–39.101 Notice of intention to begin a study.
101–39.101–1 Agency cooperation.
101–39.102 Determinations.
101–39.102–1 Records, facilities, personnel, and appropriations.
101–39.102–2 Effective date of determination.
101–39.103 Agency appeals.
101–39.104 Notice of establishment of a fleet management system.
101–39.104–1 Transfers to a fleet management system.
101–39.104–2 Reimbursement.
101–39.105 Discontinuance or curtailment of service.
101–39.105–1 Transfers from discontinued or curtailed fleet management systems.
101–39.105–2 Agency requests to withdraw participation.
101–39.106 Unlimited exemptions.
101–39.107 Limited exemptions.

Subpart 101–39.2—Interagency Fleet Management System Services

101–39.200 Scope.
101–39.201 Services available.
101–39.202 Contractor authorized services.
101–39.203 Obtaining motor vehicles for a short-term use.
101–39.203–1 Obtaining motor vehicles while on temporary duty travel.
101–39.204 Obtaining motor vehicles for indefinite assignment.
101–39.205 Commercial leasing of motor vehicles.
101–39.206 Seasonal or unusual requirements.
101–39.207 Reimbursement for services.
101–39.208 Vehicles removed from defined areas.

Subpart 101–39.3—Use and Care of Interagency Fleet Management System Vehicles

101–39.300 General.
101–39.301 Utilization guidelines.
101–39.302 Rotation.
101–39.303 Maintenance.
101–39.304 Modification or installation of accessory equipment.
101–39.305 Storage.
101–39.306 Operator's packet.
101–39.307 Grounds for withdrawal of vehicle.

Subpart 101–39.4—Accidents and Claims

101–39.400 General.
101–39.401 Reporting of accidents.
101–39.402 Recommendations for disciplinary action.
101–39.403 Investigations.
101–39.404 Claims in favor of the Government.
101–39.405 Claims against the Government.
101–39.406 Responsibility for damages.
101–39.407 Accident records.

Subpart 101–39.5—101–39.48—[Reserved]

Subpart 101–39.49—Illustrations of Forms

101–39.4900 Scope of subpart.
101–39.4901 Standard forms.
101–39.4901–91 Standard Form 91, Operator's Report of Motor Vehicle Accident.
101–39.4901–91–A Standard Form 91–A, Investigation Report of Motor Vehicle Accident.
101–39.4901–94 Standard Form 94, Statement of Witness.
101–39.4903 Optional Forms.
101–39.4903–26 Optional Form 26, Data Bearing Upon Scope of Employment of Motor Vehicle Operator.

Authority: Sec. 205(c), 63 Stat. 390 (40 U.S.C. 486(c)).

§ 101–39.000 Scope of part.

This part prescribes policies governing the establishment and operation of Interagency Fleet Management Systems and operating procedures applicable to General Services Administration (GSA) Fleet Management Centers (referred to herein as the fleet management system and centers).

Subpart 101–39.0—General Provisions

§ 101–39.001 Authority.

Section 211 of the Federal Property and Administrative Services Act of 1949, as amended, (40 U.S.C. 491), requires that the Administrator of General Services will, to the extent that he determines that so doing is advantageous to the Government in terms of economy, efficiency, or service, and after consultation with, and with due regard to the program activities of the agencies concerned, (a) consolidate, take over, acquire, or arrange for the operation by any executive agency of motor vehicles and other related equipment and supplies for the purpose of establishing fleet management systems to serve the needs of executive agencies; and (b) provide for the establishment, maintenance, and operation (including servicing and storage) of fleet management systems for transportation of property or passengers, and for furnishing such motor vehicles and related services to executive agencies. The exercise of this authority is subject to regulations issued by the President, which are set forth in Executive Order 10579, dated November 30, 1954.

§ 101–39.002 Applicability.

The regulations in this part apply to all executive agencies of the Federal Government to the extent provided in the Act.

§ 101–39.003 Financing.

(a) Section 211(d) of the Federal Property and Administrative Services Act, 1949, as amended, provides that the General Supply Fund, provided for in section 109 of the Act, shall be available for use by or under the direction and control of the Administrator of General Services for paying all elements of cost incident to the establishment, maintenance, and operation of fleet management systems.

(b) When an agency other than GSA operates a fleet management system, the financing and accounting methods shall be developed by GSA in cooperation with the agency concerned.

§ 101–39.004 Optional operations.

Nothing in this part shall preclude the establishment or operation of fleet management systems by GSA or by other agencies which are to be operated on the basis of optional use by executive or other agencies under arrangements worked out between the agencies concerned and GSA.

Subpart 101–39.1—Establishment, Modification, and Discontinuance of Interagency Fleet Management Systems

§ 101–39.100 General.

GSA will conduct studies of the operation and costs of motor vehicle and motor vehicle services in selected geographical areas to determine the advisability of establishing fleet management systems.

(a) Based on these studies, the Administrator of General Services, with the assistance of the affected agencies, shall develop necessary data and cost statistics for use in determining the feasibility of establishing a fleet

management system in the geographical area studied.

(b) If the Administrator, GSA, determines that a fleet management system shall be established, a formal determination is prepared to that effect.

(c) In the event the Administrator, GSA, decides that the establishment of a fleet management system is not feasible, the head of each agency concerned will be notified.

(d) In the making of determinations for the establishment of fleet management systems, the Administrator, GSA, will, to the extent consistent with the provisions of section 1(b) of Executive Order 10579, observe the policies outlined in the Office of Management and Budget (OMB) Circular A–76, for the utilization of commercial facilities.

(e) Except as provided in this subpart, all Government motor vehicles subsequently acquired for official purposes which are stored, garaged, or operated within the boundaries of a fleet management system shall also be consolidated into and operated under the control of this system.

(f) Fleet management systems established under this subpart provide for furnishing motor vehicles and related services to executive agencies. So far as practicable, these services will also be furnished to any executive agency, mixed-ownership corporation, or the District of Columbia upon its request. Such services may be furnished, as determined by the Administrator, GSA, through the use, under rental or other arrangements, of motor vehicles of private fleet operators, commercial companies, local or interstate common carriers, or Government-owned motor vehicles, or combinations thereof.

§ 101–39.101 Notice of intention to begin a study.

When, after preliminary investigation, the Administrator, GSA, has ascertained the possibilities of economies to be derived through the establishment of a fleet management system in a specific area, he will notify the head of each agency concerned, at least 30 calendar days in advance of the intent to conduct a study to develop data and justification as to the advisability and feasibility of establishing a fleet management system. The notification, in writing, will include:

(a) The approximate geographical area to be included in the study; and

(b) The date on which the study will begin.

§ 101–39.101–1 Agency cooperation.

(a) As provided by Executive Order 10579, the head of each executive agency receiving notice that GSA will conduct a study will designate representatives with whom members of the GSA staff may consult and who will furnish information and assistance to the GSA staff, including reasonable opportunities to observe motor vehicle operations and facilities and to examine pertinent cost and other records. Such information shall include the inventory, management, operation, maintenance, and storage of motor vehicles, motor vehicle facilities, and motor vehicle services in the area, including location, use, need, cost, and personnel involved.

(b) In the absence of recorded information, GSA will assist in preparing agency estimates, if requested, or will develop the necessary data.

§ 101–39.102 Determinations.

Each determination to establish a fleet management system will include:

(a) A description of the proposed operation, including the types of service and the geographic area and executive agencies or parts of agencies to be served;

(b) The name of the executive agency designated to be responsible for operating the fleet management system and the reason for such designation;

(c) A statement indicating the motor vehicles and related equipment and supplies to be transferred and the amount of reimbursement, if any, to be made; and

(d) An analytical justification to accompany each determination, including a comparison of estimated costs of the present and proposed methods of operation, an estimate of the savings to be realized through the establishment of the proposed fleet management system, a description of the alternatives considered in making the determination, a statement concerning the availability of privately owned facilities and equipment, and the feasibility and estimated cost (immediate and long-term) of using such facilities and equipment.

§ 101–39.102–1 Records, facilities, personnel, and appropriations.

(a) If GSA decides to establish a fleet management system, GSA, with the assistance of the agencies concerned, will prepare and present to the Director, OMB, a schedule of those records, facilities, personnel, and appropriations, if any, that are proposed for transfer to the fleet management system. The Director, OMB, will determine the records, facilities, personnel, and appropriations, if any, to be transferred.

(b) The Administrator of General Services will furnish a copy of each determination, with a copy of the schedule of proposed transfer of records, facilities, personnel, and appropriations, to the Director, OMB, and to each agency affected.

§ 101–39.102–2 Effective date of determination.

Unless a longer time is allowed, any determination made by the Administrator, GSA, shall become binding on all affected executive agencies 45 calendar days after issuance, except with respect to any agency which appeals or requests an exemption from any determination in accordance with § 101–39.103.

§ 101–39.103 Agency appeals.

(a) Any executive agency may appeal or request exemption from any or all proposals affecting it which are contained in a determination. Appeals shall be submitted, in writing, within 45 calendar days from the date of the determination to the Director, OMB, with a copy to the Administrator of GSA. Appeals shall be accompanied by factual and objective supporting data and justification.

(b) The Director, OMB, will review any determination which an executive agency has appealed and will make a final decision on that appeal. The Director, OMB, will decide within 75 calendar days after he or she receives the appeal, or as soon thereafter as practicable, on the basis of information contained in GSA's determination, the executive agency appeal, and any supplementary data submitted by GSA and the contesting agency. The Director, OMB, will send copies of decisions to GSA and to the heads of other executive agencies concerned.

(c) With reference to each appeal, the decision of the Director, OMB, if he or she holds that the GSA's determination shall apply in whole or in part to the appealing agency, will state the extent to which the determination applies and the effective date of its application. To the extent that the decision on an appeal does not uphold GSA's determination the, determination will be of no force and effect.

§ 101–39.104 Notice of establishment of a fleet management system.

GSA will inform each affected agency of the time schedule for establishment of a fleet management system and of the agency's responsibility for transferring personnel, motor vehicles, maintenance, storage and service facilities, and other involved property. Arrangements will be made for discussions at the local level between the agencies concerned and the agency responsible for operating the fleet management system in order to

work out any problems pertaining to establishing and operating fleet management systems.

§ 101-39.104-1 Transfers to a fleet management system.

(a) All Government-owned motor vehicles acquired by executive agencies for official purposes which are operated, stored, or garaged within the designated area of a fleet management system (except those vehicles specifically exempt by § 101-39.106 and § 101-39.107, or by the determination of GSA, or by the decision of the Director, OMB, and other related equipment and supplies shall, when requested by the Administrator, GSA, in accordance with a determination, be transferred to the control and the responsibility of the fleet management system. Facilities, personnel, records, and appropriations, as determined by the Director, OMB, pursuant to § 101-39.-102-1, shall be included in the transfer.

(b) Transfers of Government-owned motor vehicles to the control and responsibility of the fleet management system shall be accomplished with transfer forms of the transferring agency or forms furnished by GSA. Each transferring agency shall:

(1) Prepare a transfer document listing each vehicle to be transferred;

(2) Forward a signed copy to the appropriate office of the GSA Regional Comptroller;

(3) Furnish two copies of the transfer document to the fleet management system receiving the vehicles; and

(4) Forward an additonal copy of the transfer document to the fleet management system, when a signed receipt is required by the transferring agency.

§ 101-39.104-2 Reimbursement.

Reimbursement for the motor vehicles and related equipment and supplies acquired by agencies through expenditure made from and not previously reimbursed to any revolving or trust fund authorized by law, shall be made by GSA in an amount equal to the fair market value of the vehicle, equipment, or supplies so taken over, as required by law (40 U.S.C. 491(g)).

§ 101-39.105 Discontinuance or curtailment of service.

(a) If, during any reasonable period not exceeding 2 successive fiscal years, no actual savings are realized from the operation of any fleet management system, the Administrator, GSA, will discontinue the fleet management system concerned.

(b) The Administrator, GSA, may discontinue or curtail a fleet management system when he or she determines that it is not the most economical method of providing the required motor vehicle service. The Administrator, GSA, will give at least 60 calendar days notice of his intent to the heads of executive agencies affected and to the Director, OMB, before taking action.

§ 101-39.105-1 Transfers from discontinued or curtailed fleet management systems.

When a fleet management system is discontinued or curtailed, transfers of vehicles and related equipment and supplies, personnel, records, facilities, and funds as may be appropriate will be made, subject to the approval of the Director, OMB. Reimbursement for motor vehicles and related equipment and supplies acquired by GSA through expenditure made from, and not previously reimbursed to the General Supply Fund, or any revolving or trust fund authorized by law, shall be made by the agency receiving the motor vehicles and related equipment and supplies in an amount equal to the fair market value, as required by law (40 U.S.C. 491(g)).

§ 101-39.105-2 Agency requests to withdraw participation.

(a) Executive agencies receiving motor vehicle services from fleet management systems may request discontinuance or curtailment of their participation after 1 year of participation or if the need for these services ceases. Requests shall be submitted to the Administrator, GSA, with factual justification.

(b) If the Administrator, GSA, does not agree with these requests and is unable to make arrangements which are mutually acceptable to GSA and the agency concerned, the agency's request for discontinuance or modification and the explanation of the Administrator, GSA, denying the request will be forwarded to the Director, OMB, who will make the final and binding decision.

§ 101-39.106 Unlimited exemptions.

Unlimited exemptions from inclusion in the fleet management system are granted to the specific organizational units or activities of executive agencies listed below:

(a) Any motor vehicle regularly used by an agency in the performance of investigative, law enforcement, or intelligence duties if the head of that agency or designee makes a determination, in writing (a copy of which shall be forwarded to the Administrator of General Services), that the exclusive control of such vehicles is essential to the effective performance of those duties. Vehicles regularly used for common administrative purposes not directly connected with the performance of law enforcement, investigative, or intelligence duties shall not be exempted from inclusion.

(b) Motor vehicles designed or used for military field training, combat, or tactical purposes, or used principally within the confines of a regularly established military installation.

(c) Any motor vehicle exempted from the display of conspicuous identification by the Administrator, GSA, when identification as a Government vehicle would interfere with the purpose for which it is acquired and used.

(d) Unless inclusion is mutually agreed upon by the Administrator, GSA, and the head of the agency concerned:

(1) Motor vehicles for the use of the heads of the executive agencies, ambassadors, ministers, charges d'affaires, and other principal diplomatic and consular officials.

(2) Motor vehicles regularly and principally used for the transportation of diplomats and representatives of foreign countries or by officers of the Department of State for the conduct of official business with representatives of foreign countries.

(3) Motor vehicles regularly used by the United States Postal Service for the distribution and transportation of mail.

§ 101-39.107 Limited exemptions.

The Administrator, GSA, may exempt those vehicles which, because of their design or the special purposes for which they are used, cannot, advantageously be incorporated in the fleet management system, if the exemption has been mutually agreed upon by the Administrator and the head of the executive agency concerned. Limited exemption will normally be restricted to:

(a) *Special-purpose motor vehicles.* Motor vehicles acquired for special purposes and which, because of special design, use, or fixed special equipment cannot advantageously be included in a consolidated operation. Such vehicles may include fire trucks, transit mix trucks, pole trailers, dollies, cable reels, trailer coaches; trucks with mounted equipment, such as air compressors, cranes, line maintenance equipment, snow removal equipment, and bituminous carrying equipment, and other similar equipment; or

(b) Motor vehicles operated outside the defined geographical area of the fleet management system. Motor vehicles which are operated almost entirely outside the geographical area of an established fleet management system, which are occasionally operated within the area for trips by field

employees to and from headquarters located within the area, but are not used for other transportation purposes within the area.

Subpart 101—39.2—Interagency Fleet Management System Services

§ 101-39.200 Scope.

This subpart defines the procedures for acquiring motor vehicles and related services provided by interagency fleet management systems. Local transportation services for Government personnel and property are provided by the system to efficiently meet the authorized requirements of participating agencies. These services may be furnished through commercial rental companies, private sector fleet operators, local or interstate common carriers, the Government, or a combination of the above.

§ 101-39.201 Services available.

Fleet management system vehicles and services shall be used in connection with official business only. Available fleet management system services may include any or all of the following:

(a) Motor vehicles for daily or short-term use, exclusive of temporary duty requirements;

(b) Motor vehicles for indefinite assignment;

(c) Shuttle run or similar services;

(d) Driver services;

(e) Bus or transit service; and

(f) Other related services, including servicing and storage of motor vehicles.

§ 101-39.202 Contractor authorized services.

(a) Agencies and authorized contractors and subcontractors shall use related fleet management system services solely for official purposes.

(b) To the extent available, agencies and authorized contractors and subcontractors may use fleet management system services on a reimbursable basis to provide maintenance, repair, storage, and service station services for Government-owned or -leased equipment which is not controlled by a fleet management center, or for authorized contractor-owned or -leased equipment used in the performance of Government contracts.

§ 101-39.203 Obtaining motor vehicles for short-term use.

Any participating Federal agency, bureau, or activity may obtain vehicles for short-term local use through the Interagency Fleet Management System. This support is available for official travel performed locally or within commuting distance of an employee's designated post of duty. Arrangements for these vehicles will be made by the fleet management center serving the local area. The requesting agency official or employee must be authorized to place orders for vehicle support and provide a complete billing address and GSA billed office address code (BOAC) at the time an order is placed. Agencies requiring a BOAC may obtain one by writing the General Services Administration, ATTN: FBF, Washington, DC 20406.

§ 101-39.203-1 Obtaining motor vehicles while on temporary duty (TDY) travel.

Federal employees on TDY requiring short-term use of vehicles in the destination area shall obtain service directly from the appropriate sources listed in the Federal Travel Directory (available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402).

§ 101-39.204 Obtaining motor vehicles for indefinite assignment.

(a) An agency requiring fewer than 5 additional vehicles at one time may contact the appropriate fleet management center or the appropriate GSA regional Customer Service Bureau Office, Attention: Regional Fleet Manager (see § 101-40.101-1), for a determination as to vehicle availability. If vehicles are available, arrangements for the assignments will be made by the issuing fleet management center.

(b) If a determination is made that support is not available for fewer than 5 vehicles, or if an agency requires 5 or more additional vehicles at one time, a written request shall be sent to the General Services Administration, ATTN: FBF, Washington, DC 20406. The request shall be made at the assistant secretary level (or designee) and include the following information, at a minimum:

(1) A certification that the request for the vehicle(s) has not been denied by the Congress, the Office of Management and Budget, or agency headquarters, and that public or private means of transportation are not suitable or available;

(2) The number and types of vehicles required is limited to passenger vehicle class IA, IB, or II unless the agency head (or designee) has certified that larger vehicle(s) are essential to the agency's mission;

(3) Location where vehicles are needed;

(4) Date required—earliest and latest date acceptable;

(5) Anticipated length of assignment;

(6) Projected utilization (normally in terms of miles);

(7) Certification of funding;

(8) Agency's billing address and BOAC;

(9) Agency contact, including name, address and telephone number;

(10) Program area requiring vehicles; and

(11) An indication of whether the agency requests leasing authority if GSA cannot provide the vehicles and the anticipated duration of the lease.

(c) The General Services Administration, ATTN: FBF, will advise the agency whether vehicle support can be provided through the Interagency Fleet Management System, or whether the agency should proceed with commercial leasing action.

§ 101-39.205 Commercial leasing of motor vehicles.

All new requirements for commercially leased motor vehicles, that are needed by Federal executive agencies for 60 consecutive days or more shall be submitted to the General Services Administration, ATTN: FBF, Washington, DC 20406 for appropriate action. The request shall include full justification of the need for the commercially leased vehicles and all information specified in § 101-39.204 (b)(1) through (b)(11). GSA will advise the agency that the vehicle support will be provided through the fleet management system, or that the agency should proceed with the commercial leasing action.

§ 101-39.206 Seasonal or unusual requirements.

Agencies or activities having seasonal or unusual requirements for vehicles or related services shall inform the fleet management center as far in advance as possible. Normally, notice shall be given not less than 3 months in advance of the need.

§ 101-39.207 Reimbursement for services.

(a) The using agency will be billed for fleet management system services provided for under this part at rates fixed by GSA. Such rates are designed to recover applicable costs and to reflect equitably the differentials in the operating cost of the various types and classes of vehicles. Rates will be reviewed periodically to determine that reimbursement is sufficient to recover applicable costs, and that rates for types and classes of vehicles or services are equitable.

(b) Fleet management system services provided to authorized cost reimbursable contractors and subcontractors may be billed directly to those activities or to the responsible agency.

(c) GSA Regional Administrators will issue, as appropriate, regional bulletins announcing the GSA vehicle rental rates applicable in their respective regions.

§ 101-39.208 Vehicles removed from defined areas.

(a) Normally, vehicles shall not be permanently operated outside the area served by the issuing fleet management system. However, when agency programs necessitate vehicle relocation for a period exceeding 90 calendar days, the agency shall notify the issuing fleet management center of the following:

(1) The location at which the vehicles are currently in use;

(2) The date the vehicles were moved to the present location; and

(3) The expected date the vehicles will be returned to the original location.

(b) When vehicles will be permanently relocated outside the area served by the issuing fleet management system, the affected fleet manager should transfer the vehicles to the fleet management center nearest the new use location.

Subpart 101-39.3—Use and Care of Interagency Fleet Management System Vehicles

§ 101-39.300 General.

(a) The objective of the fleet management system is to provide efficient and economical motor vehicle and related services to participating agencies. To attain this objective, policies and procedures for use and care of fleet management system vehicles provided to an agency or activity are prescribed in this subpart.

(b) To operate a motor vehicle furnished by a fleet management system, civilian employees of the Federal Government shall have a valid State, District of Columbia, or Commonwealth operator's permit for the type of vehicle to be operated and some form of agency identification. Specific regulations covering procedures and qualifications of Government motor vehicle operators are contained in 5 CFR Part 930, issued by the Office of Personnel Management.

(c) To operate a motor vehicle furnished by GSA, employees of Federal agencies shall wear safety belts whenever the vehicle is in operation.

(d) Reasonable diligence in the care of fleet management system vehicles shall be exercised by using agencies and operators at all times. Officials or employees failing to take proper care of a vehicle may be refused further vehicle issuance after reasonable notice has been provided by GSA to the head of the local activity concerned.

§ 101-39.301 Utilization guidelines.

The following guidelines may be employed by agencies requesting fleet management system services, or by GSA, to determine whether miles traveled necessitate a full-time vehicle assignment.

(a) Passenger-carrying vehicles. The utilization guidelines for passenger-carrying vehicles are a minimum of 3,000 miles per quarter or 12,000 miles per year.

(b) Light trucks and general purpose vehicles. The utilization guidelines for light trucks and general purpose vehicles are as follows:

(1) Light trucks and general purpose vehicles, 12,500 lbs. Gross Vehicle Weight Rating (GVWR) and under—10,000 miles per year.

(2) Trucks and general purpose vehicles, over 12,500 lbs. GVWR to 24,000 lbs. GVWR—7,500 miles per year.

(c) Heavy trucks and truck tractors. The utilization guidelines for heavy trucks and truck tractors are as follows:

(1) Heavy trucks and general purpose vehicles over 24,000 lbs. GVWR—7,500 miles per year.

(2) Truck tractors—10,000 miles per year.

(d) Other trucks and special purpose vehicles. Utilization guidelines for other trucks and special purpose vehicles have not been established. However, the head of the local office of the agency or his/her designee shall cooperate with fleet management center personnel in studying the use of this equipment and take necessary action to ensure that it is fully utilized or returned to the fleet management system.

§ 101-39.302 Rotation.

Fleet management system vehicles assigend on high mileage assignments may be rotated with those on low mileage assignments to assure more uniform overall fleet utilization. In cases where the continued use of a vehicle is essential but its miles traveled are not consistent with utilization guidelines, the using agency may be required to justify, in writing, retention of the vehicle.

§ 101-39.303 Maintenance.

In order to ensure uninterrupted operation of fleet management system vehicles, safety and preventive maintenance inspections will be performed at regularly scheduled intervals as directed by GSA. Users of fleet management system vehicles shall comply with the safety and preventive maintenance notices and instructions issued for the vehicle.

§ 101-39.304 Modification or installation of accessory equipment.

The modification of a fleet management system vehicle or the installation of accessory equipment on these vehicles can be accomplished only when approved by GSA. The request for such modification or installation shall be forwarded to the appropriate GSA regional Customer Service Bureau Office, Attention: Regional Fleet Manager, (see § 101-40.101-1), for consideration.

§ 101-39.305 Storage.

(a) Fleet management system vehicles shall be stored and parked at locations which provide protection from pilferage or damage. In the interest of economy, open storage shall be used whenever practicable and feasible.

(b) The cost of parking and storing GSA fleet management system vehicles is the responsibility of the using agency. Prior to the procurement of other than temporary parking accommodations in urban centers (see § 101-18.102), agencies shall determine the availability of Government-owned or -controlled parking space in accordance with the provisions of § 101-17.101-6.

§ 101-39.306 Operator's packet.

The fleet management system will provide each system vehicle with an operator's packet containing the following information and instructions. This information should remain in the vehicle at all times, except when inconsistent with authorized undercover operations.

(a) Driver's responsibilities;

(b) Requirement of use for official purposes only;

(c) Instruction for:

(1) Acquiring maintenance and repair authorizations;

(2) Acquiring emergency supplies, services, and repairs; and

(3) Reporting accidents.

(d) The telephone numbers of responsible fleet management center employees to be called in case of accident or emergency;

(e) Instructions on the use of the Standard Form 149, U.S. Government National Credit Card;

(f) List of contractors from which vehicle operators may purchase items authorized by the SF 149, U.S. Government National Credit Card;

(g) Accident reporting kit which contains:

(1) Standard Form 91, Operator's Report of Motor Vehicle Accident (for illustration of form, see § 101-39.4901-91);

(2) Standard Form 94, Statement of Witness (for illustration of form, see § 101–39.4901–94);

(3) Form CA 1, Employee's Notice of Injury or Occupational Disease; and

(4) Optional Form 26, Data Bearing Upon Scope of Employment of Motor Vehicle Operator (for illustration of form, see § 101–39.4903–26).

Note.—The vehicle operator or assignee shall be personally responsible for safeguarding and protecting the SF 149, U.S. Government National Credit Card.

§ 101–39.307 Grounds for withdrawal of vehicle.

GSA may withdraw the issued vehicle from further use by the agency involved if it is determined that the using agency has not complied with the provisions of § 101–39.3 or that the vehicle has been maintained or used improperly. Improper use includes, but is not limited to, credit card abuse and misuse, continued violation of traffic ordinances, at-fault accidents, reckless driving, driving while intoxicated, and use for other than official purposes.

Subpart 101–39.4—Accidents and Claims

§ 101–39.400 General.

Officials or employees responsible for the operation of fleet management system vehicles shall exercise every precaution to prevent accidents. In case of an accident, the employee or official concerned shall comply with the procedures established by this subpart.

§ 101–39.401 Reporting of accidents.

(a) The operator of the vehicle is responsible for notifying the following persons immediately, either in person or by telephone or telegram, of any accident in which the vehicle may be involved:

(1) The manager of the fleet management center issuing the vehicle;

(2) The employee's supervisor; and

(3) State, county, or municipal authorities, as required by law.

(b) In addition, the vehicle operator shall obtain and record information pertaining to the accident on Standard Form 91, Operator's Report of Motor Vehicle Accident (for illustration of form, see § 101–39.4901–91). Only one copy of the Standard Form 91 is required and shall be furnished to the vehicle operator's supervisor. The vehicle operator shall also obtain the names, addresses, and telephone numbers of any witnesses and, wherever possible, have witnesses complete Standard Form 94, Statement of Witness (For illustration of form, see § 101–39.4901–94), and submit the completed Standard Form 94 and other related information to his or her supervisor. The vehicle operator shall make no statements as to the responsibility for the accident except to his or her supervisor or to a Government investigating officer.

(c) Whenever a vehicle operator is injured and cannot comply with the above requirements, the agency to which the vehicle is issued shall report the accident to the State, county, or municipal authorities as required by law, notify the fleet manager of the center issuing the vehicle as soon as possible after the accident, and complete and process Standard Forms 91 and 94. A complete copy of the accident report shall be forwarded to the appropriate GSA office as outlined in the vehicle operator's packet.

§ 101–39.402 Recommendations for disciplinary action.

If a vehicle operator fails to report an accident involving a fleet management system vehicle in accordance with § 101–39.401, or if the operator has a record showing a high accident frequency or cost, GSA will notify the head of the operator's agency, and will advise that either failure to report an accident or poor record is considered by GSA to be sufficient justification for the agency to suspend the right of the employee to operate or use a fleet management system vehicle.

§ 101–39.403 Investigation.

(a) Every accident involving a fleet management system vehicle shall be investigated and a report furnished to the manager of the fleet management center which issued the vehicle.

(b) When property damage is less than $500 and no bodily injury is involved, a copy of Standard Form 91 and any other available supporting data shall be submitted.

(c) When property damage is $500 or more and/or bodily injury is involved, the agency employing the vehicle operator shall investigate the accident within 48 hours after the actual time of occurrence. If an agency has not established accident investigating procedures, GSA will investigate the accident. Also, GSA may investigate any accident involving a fleet management system vehicle when deemed necessary. Should such investigation develop additional information, the additional data or facts will be furnished to the using agency for its information.

(d) Two copies of the complete report of the investigation, including Standard Form 91–A, Investigation Report of Motor Vehicle Accident (for illustration of form, see § 101–39.4901–91–A), photographs, measurements, doctor's certificate of bodily injuries, police investigation reports, operator's statement, agency's findings and determinations, witnesses' statements, and any other pertinent data shall be furnished to the manager of the fleet management center issuing the vehicle.

§ 101–39.404 Claims in favor of the Government.

Whenever there is any indication that a party other than the operator of the fleet management system vehicle is at fault and that party can be reasonably identified, the agency responsible for investigating the accident shall submit all original documents and data pertaining to the accident and its investigation to the GSA Regional Counsel of the region that issued the vehicle. The Regional Counsel will initiate the necessary action to effect recovery of the Government's claim. Upon specific request of the using agency, the GSA Regional Counsel will notify that agency of the introduction of the Government's claim and provide pertinent information about the claim's progress and final settlement.

§ 101–39.405 Claims against the Government.

(a) Whenever a fleet management system vehicle is involved in an accident resulting in damage to the property of, or injury to, a third party, and the third party asserts a claim against the Government based on the alleged negligence of the vehicle operator (acting within the scope of his or her duties), it shall be the responsibility of the agency employing the person who was operating the fleet management system vehicle at the time of the accident to make every effort to settle the claim administratively to the extent that the agency is empowered to do so under the provisions of 28 U.S.C. 2672. It shall be the further responsibility of the agency, in the event that administrative settlement cannot be effected, to prepare completely, from an administrative standpoint, the Government's defense of the claim and thereafter to transmit the complete case, through appropriate agency channels, to the Department of Justice.

(b) Except for the exclusions listed in § 101–39.406, the agency employing the vehicle operator shall be financially responsible for damage to a fleet management system vehicle.

(c) If a suit is filed against the agency using a fleet management system vehicle, the agency shall furnish the appropriate GSA Regional Counsel with a copy of all papers served in the action. When requested, GSA's Regional

Counsel will cooperate with and assist the using agency and the Department of Justice in defense of any action against the United States, the using agency, or the operator of the vehicle, arising out of the use of a fleet management system vehicle.

§ 101-39.406 Responsibility for damages.

(a) GSA will charge the using agency all costs resulting from damage, including vandalism and theft, to a fleet management system vehicle which occurs during the period that the vehicle is assigned or issued to that agency, or to an employee of that agency; however, the using agency will not be held responsible for damages to the vehicle if it is determined by GSA, after a review of the documentation required by § 101-39.401, that damage to the vehicle occurred:

(1) As a result of the negligent or willful act of a party other than the agency (or the employee of that agency) to which the vehicle was assigned or issued, and the identity of the party can be reasonably determined;

(2) As a result of mechanical failure of the vehicle, and the using agency (or its employee) is not otherwise negligent. Proof of mechanical failure must be submitted; or

(3) As a result of normal wear and tear such as is expected in the operation of a similar vehicle.

(b) If an agency is held responsible for damages, GSA will charge all costs for removing and repairing the fleet management system vehicle to that agency. If the vehicle is damaged beyond economical repair, GSA will charge all costs to that agency, including the fair market value of the vehicle less any salvage value. Upon request, GSA will furnish an accident report regarding the incident to the agency. Each agency shall be responsible for disciplining its employees who are guilty of damaging fleet management system vehicles through misconduct or improper operation, including inattention.

(c) If an agency has information or facts that indicate that it was not responsible for an accident, the agency may furnish the data to GSA requesting that costs charged to and collected from it be credited to the agency. GSA will make the final determination of agency responsibility based upon Government as well as police accident reports and any available witness statements.

§ 101-39.407 Accident records.

If GSA's records of vehicle accidents indicate that a particular activity has had an unusually high accident frequency rate or a high accident cost per mile, GSA will so advise the using activity. Corrective action will be requested and GSA will cooperate in any reasonable manner possible to bring about improved performance.

Subparts 101-39.5—101-39.48—[Reserved]

Subpart 101-39.49—Illustrations of Forms

§ 101-39.4900 Scope of Subpart.

This subpart illustrates forms prescribed or available in connection with the regulations on Interagency Fleet Management Systems prescribed in Part 101-39.

§ 101-39.4901 Standard forms.

(a) Standard forms illustrated in this section show the format, text, and arrangement and provide a ready source of reference. The subsection numbers in this section correspond with the standard from numbers.

(b) Standard forms illustrated in this subpart 101-39.4901 may be obtained by submitting a requisition in FEDSTRIP format to the GSA regional office providing support to the requesting activity.

§ 101-39.4901-91 Standard Form 91, Operator's Report of Motor Vehicle Accident.

Note.—The form illustrated in § 101-39.4901-91 is filed with the original document and does not appear in the **Federal Register** or the Code of Federal Regulations.

§ 101-39.4901.91-A Standard Form 91-A, Investigation of Motor Vehicle Accident.

Note.—The form illustrated in § 101-39.4901-91-A is filed with the original document and does not appear in the **Federal Register** or the Code of Federal Regulations.

§ 101-39.4901.94 Standard Form 94, Statement of Witness.

Note.—The form illustrated in § 101-39.4901-94 is filed with the original document and does not appear in the **Federal Register** or the Code of Federal Regulations.

§ 101-39.4903 Optional forms.

(a) Optional forms illustrated in this § 101-39.4903 show their text, format and arrangement and provide a ready source of reference. The subsection numbers correspond with the optional form numbers.

(b) Optional forms illustrated in this § 101-39.4903 may be obtained by submitting a requisition in FEDSTRIP format to the GSA regional office providing support to the requesting activity.

§ 101-39.4903-26 Optional Form 26, Data Bearing Upon Scope of Employment of Motor Vehicle Operator.

Note.—The form illustrated in § 101-39.4903-26 is filed as part of the original document and does not appear in the **Federal Register** or the Code of Federal Regulations.

Dated: February 20, 1986.

Paul Trause,

Acting Administrator of General Services.

[FR Doc. 86-7070 Filed 3-31-86; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 57

Grants for Residency Training in Preventive Medicine

AGENCY: Public Health Service, HHS.

ACTION: Final regulations.

SUMMARY: These regulations govern the award of grants to accredited schools of medicine, osteopathy and public health to assist in the planning and development of new residency training programs in preventive medicine; in the maintenance and improvement of existing residency training programs; and in providing financial assistance to trainees in the residency programs.

EFFECTIVE DATE: These final regulations are effective on April 1, 1986, except for § 57.3004(e), § 57.3007(a) and § 57.3010. For additional information concerning this effective date, see the information collection requirements below.

FOR FURTHER INFORMATION CONTACT: Daniel N. Masica, M.D., Director, Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Parklawn Building, Room 4C25, 5600 Fishers Lane, Rockville, Maryland 20857; telephone number 301-443-6190.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of December 9, 1983 (48 FR 55272), the Assistant Secretary for Health, Department of Health and Human Services, with the approval of the Secretary, proposed to add a new Subpart EE to Part 57 of Title 42 of the Code of Federal Regulations to implement section 793 of the Public Health Service Act (the Act). This section, added by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, authorizes the Secretary to make grants to and enter into contracts with schools of medicine, osteopathy and public health to meet the costs of projects to plan and develop new residency training

programs and to maintain or improve existing residency training programs in preventive medicine. This provision also authorizes financial assistance to trainees enrolled in preventive medicine residency training programs.

Section 793 of the Act requires applicants to demonstrate that they have or will have available full-time faculty members with training and experience in the fields of preventive medicine and support from other faculty members trained in public health and the relevant specialties and disciplines. The regulations require that this condition be met by the end of one year of grant support. The one-year period is provided in order to allow reasonable time for applicants to recruit faculty necessary to meet this requirement.

The regulations define fields of preventive medicine to be the following group of basic components common to all preventive medicine specialties: biostatistics, epidemiology, administration of health and medical programs, environmental hazards to health, social, cultural and behavorial factors in medicine, and the application of prevention principles in clinical practice. This definition is based on the components of accredited preventive medicine residencies as determined by the Accreditation Council for Graduate Medical Education.

To assure that funding under this program is applied to programs that meet minimal standards, awards will only be made to applicants that have accredited preventive medicine residency training programs. Applicants that propose to start new programs must provide the Secretary with evidence of approval by the appropriate accrediting body before grant awards are made in each fiscal year.

According to statutory authorization, these regulations provide for financial assistance for preventive medicine residents. This assistance includes a stipend comparable to amounts paid to residents in other medical specialties. Financial assistance to trainees is limited by the regulations to two years of stipend support, excluding the clinical year of training. Clinical training is generally a prerequisite for most preventive medicine residency programs, and not a part of the residency training. In view of the limited number of preventive medicine residency programs which include the clinical year, support for this year is not provided.

These regulations establish a funding preference for projects that propose to conduct residency training in the areas of general preventive medicine or public health, and for projects that plan to train at least four residents in the academic year and four residents in the field year. The funding preference for general preventive medicine and public health residency training programs is established to promote the training of individuals who are especially needed to implement the Secretary's initiative of health promotion and disease prevention. The second funding preference is introduced to encourage applicants to enroll a minimum number of residents to insure the stimulating educational atmosphere that a good peer group normally provides.

The public comment period on the propose regulations closed on February 7, 1984. The Department received two letters responding to the proposed regulations. The comments received and the Department's response to these comments are presented below.

One respondent suggested that the two-year limit for stipend support to residents, § 57.3007, be reconsidered to provide three years of support, excluding the clinical year. The Department acknowledges that a fourth year of training is necessary for residents to meet board eligibility requirements. However, it is not required that this additional year of experience be obtained in a structured training program. Instead, the additional year requirement may be fulfilled by teaching, practice or research in preventive medicine. The Department believes that it must allocate the limited funds available to most effectively improve the supply of preventive medicine specialists. It was not considered cost-effective to support the additional year of training which usually can be obtained by the resident without stipend support. Therefore, the Department has made no change in the limitation of two years of stipend support to be provided to each resident.

The second respondent suggested that the definition of "Field year" in § 57.3002 be changed to indicate that the field year *"may be"* conducted at a site remote from the preventive medicine residency training program, rather than stating that it is *"generally conducted"* at a remote site. The Department has not adopted the suggested change since the definition does not establish a requirement that the field year of training be conducted at a site remote from that of the residency program. It is acknowledged that this year of training might not be conducted at a site remote from the training program in all instances, but that it is conducted at a site remote from the residency training program in most cases. The definition merely defines the term "Field year" as used throughout the regulations.

Also, this respondent indicated a belief that the regulations exclude support for occupational medicine residency training programs. The Department has made no changes in response to this comment since the definition of preventive medicine in § 57.3002 specifically includes the specialty of occupational health.

Lastly, the respondent commented that the extent to which the grant award will cover program costs is notably vague in § 57.3007. The Department believes that publication of detailed budget information in the regulations is not necessary since information concerning categorical budget items is provided in the instructions accompanying the application forms. Allowable and non-allowable expenses are discussed, by category, in the instructions in sufficient detail to assist the applicant in completing an application to the program.

Although not a result of public comment, the following changes have been made in the proposed regulations.

A new paragraph (e) has been added to § 57.3004 that requires all applicants to report their efforts to recruit minority and disadvantaged residents. This project requirement is added to alert applicants to the importance of providing opportunities for minority physicians to be trained and serve as preventive medicine specialists. Minority populations have special characteristics and health needs that may be best understood and addressed by a minority physician trained in a preventive medicine specialty.

The history of the program including the number of residents who successfully completed the program has been added to § 57.3005 as a new evaluation criterion. It is important that the viability of each applicant is clearly understood when considering which applications merit approval for funding. Also, (b)(ii) of this section has been changed to require applicants to plan to train at least four, rather than three, residents in both the academic year and in the field year to qualify for this funding preference. These numbers have been increased to encourage further expansion of the number of residents in training in view of a continuing shortage of preventive medicine specialists and through a larger cohort to provide a more stimulating educational atmosphere for the trainees.

Section 57.3006(a) has been changed to reflect that the project period will not exceed three years, instead of five years, before requiring the project to recompete for additional funding. Three years is considered to be an adequate

length of time for grantees to achieve development, improvement and/or expansion of their programs and an appropriate time to judge whether additional funding is warranted.

A sentence has been added to § 57.3007(a) that requires the applicant to document attempts to pursue other sources of funding. This change is to further impress on the applicant that funding through the grant program is intended to assist in the establishment of sound training programs that will eventually become capable of generating funds for continued operation through sources other than the Federal Government.

Section 57.3009 has been changed in total to conform this section to the published PHS Technical Amendments—Final Rule (9/27/84, 49 FR 38108).

Paperwork Reduction Act

The information collection requirements contained in § 57.3003 have been approved by the Office of Management and Budget (OMB) under control number 0915–0093. Sections 57.3004(e), 57.3007(a) and 57.3010 also contain information collection requirements. We will be submitting an information request to OMB for approval of these requirements under section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). These requirements will not be effective until the Department obtains OMB approval. A notice will be published in the **Federal Register** when approval is obtained.

Regulatory Flexibility Act and Executive Order 12291

These regulations govern a financial assistance program in which participation is *voluntary*. For this reason, the Secretary has determined that this rule is not a "major rule" under Executive Order 12291. Further, because the rule does not have a significant economic impact on a substantial number of small entities, a regulatory flexibility analysis under the Regulatory Flexibility Act of 1980 is not required.

List of Subjects in 42 CFR Part 57

Dental health, Education of the disadvantaged, Educational facilities, Educational study program, Emergency medical services, Grant programs—education, Grant programs—health, Health facilities, Health professions, Loan programs—health, Medical and dental schools, Scholarships and fellowships, Student aid.

Accordingly, Subpart EE is added to Part 57 of Title 42 of the Code of Federal Regulations, as set forth below.

(*Catalog of Federal Domestic Assistance*, No. 13.117, Grants for Residency Training in Preventive Medicine)

Dated: March 24, 1986.

Donald Ian Macdonald, M.D.,

Acting Assistant Secretary for Health

Approved: March 26, 1986.

Otis R. Bowen, M.D.,

Secretary.

PART 57—[AMENDED]

Subpart EE—Grants for Residency Training in Preventive Medicine

Sec.

57.3001 To what programs do these regulations apply?
57.3002 Definitions.
57.3003 Who is eligible to apply for a grant?
57.3004 Project requirements.
57.3005 How will applications be evaluated?
57.3006 How long does grant support last?
57.3007 How is the amount of the grant award determined?
57.3008 For what purposes may grant funds be spent?
57.3009 What additional Department regulations apply to grantees?
57.3010 What other audit and inspection requirements apply to grantees?
57.3011 Additional conditions.

Authority: Sec. 793, Public Health Service Act, 95 Stat. 928.

Subpart EE—Grants for Residency Training in Preventive Medicine

§ 57.3001 To what programs do these regulations apply?

These regulations apply to the award of grants under section 793 of the Public Health Service Act (42 U.S.C. 295h–1c) to schools of medicine, osteopathy and public health to meet the costs of projects to (a) plan and develop new approved residency training programs and to maintain or improve existing approved residency training programs in preventive medicine and (b) provide financial assistance to residency trainees enrolled in such programs.

§ 57.3002 Definitions.

"Academic year" means course work sufficient to satisfy the requirements for the Master of Public Health degree or its equivalent which is required by all approved residency programs. In the usual situation, this course work is taken during a single year.

"Act" means the Public Health Service Act, as amended.

"Approved residency training program" means the entirety or that part of a residency training program in preventive medicine which is fully or provisionally accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association.

"Clinical year" means postgraduate training which provides experience in direct patient care including ambulatory and inpatient experience. The one year of required training can be provided in an accredited program in one of the recognized clinical specialties or through clinical training sponsored by a preventive medicine residency training program. The clinical year is generally a prerequisite for the preventive medicine residency training program or the first year of such program.

"Field year" means specialized instruction and supervised experience in the resident's selected area of emphasis, and is usually one year in duration. The field year is usually the last year of the preventive medicine residency training program and is generally conducted at a site remote from that of such program.

"Fields of Preventive Medicine" means the following group of basic components common to all preventive medicine specialties (a) biostatistics, (b) epidemiology, (c) administration of health and medical programs, (d) environmental hazards to health, (e) social, cultural and behavorial factors in medicine, and (f) the application of preventive principles in clinical practice.

"Full-time faculty" means an individual or individuals who are employed as faculty of a school of medicine, osteopathy or public health on a full-time basis as defined by the general policies of the applicant institution.

"Nonprofit" as applied to any entity means an entity no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual.

"Preventive Medicine" is a specialized area of medical practice composed of distinct disciplines which use skills focusing on the health of defined populations in order to promote and maintain health and well-being and prevent disease, disability, and premature death. The specialties of preventive medicine are: general preventive medicine, public health, occupational health, and aerospace medicine.

"Program Director" means an individual appointed by the grantee institution to direct and supervise the residency training program who is certified or otherwise qualified as required by the Accreditation Council for Graduate Medical Education.

"Secretary" means the Secretary of Health and Human Services, and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

"State" means any one of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

§ 57.3003 Who is eligible to apply for a grant?

Accredited public or non-profit private schools of medicine, osteopathy or public health located in a State are eligible to apply for a grant by submitting an application at the time and in the form that the Secretary may prescribe. To be eligible for a grant, an applicant must demonstrate that it has, or will have by the end of one year of grant support, full-time faculty with training and experience in the fields of preventive medicine and support from other faculty members trained in public health and other relevant specialties and disciplines.

(Approved by the Office of Management and Budget under approval number 0915–0093)

§ 57.3004 Project requirements.

A project supported under this subpart must be conducted in accordance with the following requirements:

(a) Each project must have a project director who works at the grantee institution on an appointment consistent with other major departments, heads or will head the unit, and has relevant training and experience in preventive medicine.

(b) Each project must have an appropriate administrative and organizational plan and appropriate staff and facility resources for the achievement of stated objectives.

(c) Each project must systematically evaluate the educational program, including the performance and competence of trainees and faculty, the administration of the program, and the degree to which program and educational objectives are met.

(d) All field experiences must be supervised by a qualified faculty member.

(e) All applicants must either demonstrate an increase in minority and disadvantaged residents or show evidence of efforts to recruit minority and disadvantaged residents.

§ 57.3005 How will applications be evaluated?

(a) After consulting with the National Advisory Council on Health Professions Education, established by section 702 of the Act, the Secretary will decide which applications to approve by considering among other factors:

(1) The potential effectiveness of the proposed project in carrying out the training purposes of section 793 of the PHS Act;

(2) The extent of responsiveness to the project requirements described in § 57.3004;

(3) The administrative and management capability of the applicant to carry out the proposed project in a cost-effective manner;

(4) The degree to which the proposed training program emphasizes health promotion and disease prevention; and

(5) The degree to which the applicant demonstrates institutional commitment to the proposed program; and

(6) The history of the program including number of residents who successfully completed the program.

(b) In determining the priority for funding of applications approved under paragraph (a) of this section, the Secretary will consider: (1) The relative merit of the proposed project based upon the factors in paragraph (a) of this section, and (2) whether the proposed project will:

(i) Conduct residency training in the areas of general preventive medicine or public health; or

(ii) Train at least [four] residents in the academic year and four residents in the field year and provide evidence that the projected number can be realized from a current or projected applicant pool.

§ 57.3006 How long does grant support last?

(a) The notice of grant award specifies the length of time the Secretary intends to support the project without requiring the project to recompete for funds. This period, called the project period, will not exceed three years.

(b) Generally, the grant will initially be funded for one year, and subsequent continuation awards will also be for one year at a time. A grantee must submit a separate application to have the support continued for each subsequent year. Decisions regarding continuation awards and the funding levels of these awards will be made after consideration of such factors as the grantee's progress and management practices, existence of legislative authority, and the availability of funds. In all cases, continuation awards require a determination by the Secretary that continued funding is in the best interest of the Federal Government.

(c) Neither the approval of any application nor the award of any grant commits or obligates the Federal Government in any way to make any additional, supplemental, continuation or other award with respect to any approved application or portion of an approved application.

(d) Any balance of federally obligated grant funds remaining unobligated by the grantee at the end of a budget period may be carried forward to the next budget period, for use as prescribed by the Secretary, provided a continuation award is made. If at any time during a budget period it becomes apparent to the Secretary that the amount of Federal funds awarded and available to the grantee for that period, including any unobligated balance carried forward from prior periods, exceeds the grantee's needs for the period, the Secretary may adjust the amounts awarded by withdrawing the excess. A budget period is an interval of time (usually 12 months) into which the project period is divided for funding and reporting purposes.

§ 57.3007 How is the amount of the grant award determined?

(a) The amount of any award will be limited to that portion of the annual program costs which the Secretary determines, on the basis of the documentation required in the application, cannot reasonably be paid from other available funds. Moreover, the amount of any stipend will be limited to that portion of the annual amount normally paid to other residents by the applicant which the Secretary determines, on the basis of the documentation required in the application, cannot reasonably be paid from other available funds. The applicant must document attempts to pursue other sources of funding.

(b) Stipend support may only be given to residents in the academic and field years of training, and support to each resident is limited to two years of training, excluding the clinical year.

§ 57.3008 For what purposes may grant funds be spent?

(a) A grantee shall only spend funds it receives under this subpart according to the approved application and budget, the authorizing legislation, terms and conditions of the grant award, applicable cost principles specified in Subpart Q of 45 CFR Part 74, and these regulations.

(b) Grantees may not spend grant funds for sectarian instruction or for any religious purpose.

§ 57.3009 What additional Department regulations apply to grantees?

Several other regulations apply to grants under this subpart. These include, but are not limited to:

42 CFR Part 50, Subpart D—Public Health Service grant appeals procedure
45 CFR Part 16—Procedures of the Departmental Grant Appeals Board
45 CFR Part 46—Protection of human subjects
45 CFR Part 74—Administration of grants
45 CFR Part 75—Informal grant appeals procedures
45 CFR Part 80—Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964
45 CFR Part 81—Practice and procedure for hearings under Part 80 of this Title
45 CFR Part 83—Regulation for the administration and enforcement of Sections 799A and 845 of the Public Health Service Act [1]
45 CFR Part 84—Nondiscrimination on the basis of handicap in programs and activities receiving or benefiting from Federal financial assistance
45 CFR Part 86—Nondiscrimination on the basis of sex in education programs and activities receiving or benefiting from Federal financial assistance
45 CFR Part 91—Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance

§ 57.3010 What other audit and inspection requirements apply to grantees?

Each grantee must, in addition to the requirements of 45 CFR Part 74, meet the requirements of section 705 of the Act, concerning audit and inspection.

§ 57.3011 Additional conditions.

The Secretary may impose additional conditions in the grant award before or at the time of the award if he or she determines that these conditions are necessary to assure or protect the advancement of the approved activity, the interest of the public health, or the conservation of grant funds.

[FR Doc. 86-7130 Filed 3-31-86; 8:45 am]
BILLING CODE 4160-15-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 65

[CC Docket No. 84-800; Phase I; FCC 86-114]

Authorized Rates of Return for the Interstate Services of AT&T Communications and Exchange Telephone Carriers

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action codifies, and in addition addresses petitions for waiver and reconsideration of, the Commission's rules for determining and enforcing maximum allowable rates of return for the interstate services of AT&T and exchange telephone carriers. The original decision being reconsidered was published in the **Federal Register** on October 10, 1985, at page 41350. This action is taken by the Commission to balance the interests of ratepayers and investors by promoting just and reasonable rates. This action on reconsideration will establish an enforcement mechanism to ensure just and reasonable rates without imposing excessive burdens or costs on the carriers or the Commission.

EFFECTIVE DATE: April 30, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Steve Goodman, Common Carrier Bureau, (202) 632-0745.

SUPPLEMENTARY INFORMATION:

Memorandum Opinion and Order

Authorized Rates of Return for the Interstate Services of AT&T Communications and Exchange Telephone Carriers (CC Docket No. 84-800, Phase I).

This is a summary of the Commission's Memorandum Opinion and Order, CC Docket No. 84-800, Phase I, adopted March 13, 1986, and released March 24, 1986.

The full text of Commission Decisions are available for inspection and copying during normal business hours in the FCC Docket Branch (Room 230), 1919 M Street, Northwest, Washington, DC. The Complete text of this decision may also be purchased from the Commission's Copy Contractor, International Transcription Service, (202) 857-3800, 2100 M Street Northwest, Suite 140, Washington, DC 20037.

In this decision the Commission is addressing petitions for reconsideration and waiver of the Phase I Order in CC Docket No. 84-800. Petitions for reconsideration were filed by: AT&T, Ameritech, BellSouth, Bell Atlantic, Cincinnati Bell, GTE, NYNEX, Pacific, Southwestern Bell, United, US West, Southern New England and USTA. Petitions for waiver were submitted by: AT&T, Ameritech, Bell Atlantic and Cincinnati Bell.

In its reconsideration petition, AT&T seeks elimination of category-by-category review and expansion of the increment above the prescribed rate of return for setting the maximum allowable rate of return from one-half of one percent to three percent. In its waiver request, AT&T seeks relief for 1985 from the category-by-category earnings review, suggesting instead that the Commission only examine overall interstate returns for 1985.

The Commission rejects AT&T's claim that application of category-by-category refunds during 1985 would constitute unlawful retroactive ratemaking. Specific ICAM category ceilings were prescribed by the Commission in 1981 in CC Docket No. 79-63. The *Phase I Order* actually increased the flexibility accorded AT&T: the increment was raised from 25 basis points to 50 basis points; two ICAM categories rather than three were specified; and earnings will be reviewed over a two-year period rather than a single year. While the Phase I category-by-category refund obligation is not unlawful, there is merit to AT&T's claim that it would be inequitable to apply that requirement throughout 1985. For reasons largely beyond its control, AT&T was unable to have tariffs in effect for the first four months of 1985 that were designed to earn the authorized return on each of the categories. Therefore, the initial review period under the *Phase I Order* requirements for AT&T will begin May 1, 1985, and end December 31, 1986. Because the initial review period will be less than two full years, an additional ten basis points will be added to the increment for that twenty month period.

The Commission denied AT&T's reconsideration requests, however. The Commission will continue to review earnings on a category-by-category basis to prevent discrimination or cross-subsidization. With respect to AT&T's request for a larger increment, the Commission found that it had already fully considered AT&T's evidence when it granted AT&T a great deal more flexibility in the *Phase I Order* than AT&T had under the 1981 prescription. The arguments repeated by AT&T in its reconsideration petition do not compel or justify a 300 basis point increment.

The local exchange carriers (LEC's) has sought reconsideration of almost every aspect of the *Phase I Order*. The Commission agreed that it was possible to allow carriers to aggregate access elements more highly without negatively affecting the public interest. The Commission concluded that LEC earnings should be reviewed for three, rather than six, categories: Common Line, Special Access and Switched Traffic Sensitive. The Commission declined, however, to modify the requirement that earnings would be reviewed at the same geographic level as the tariffs filed by the carrier. The Commission found that carriers

[1] Section 799A of the Public Health Service Act was redesignated as section 704 by Pub. L. 94-484; section 845 of the Public Health Service Act was redesignated as section 855 by Pub. L. 94-63.

currently have the flexibility to correct alleged problems attributed to reviewing earnings on a state-by-state basis. The Commission denied Ameritech's petition for waiver, but it did state that for the initial review period it would review earnings on an aggregated basis for the entire period if geographically aggregated tariffs were in effect at the end of 1986.

The Commission also modified the beginning date of the initial review period for the LECs from June 1, 1985 to October 1, 1985. The Commission found that problems with the access tariffs in effect prior to October 1 compelled beginning the initial review period coincident with the effectiveness of the new access tariffs.

The Commission, in response to Southwestern Bell's petition for clarification, stated that carriers may be able to target individual access elements to earn at less than the authorized level without having to target every access element at that same, lower level. The inability of a carrier to target any element above the authorized return should serve to preclude predatory pricing.

The Commission additionally reviewed the other petitions for reconsideration and found that the parties raised issues previously addressed in the *Phase I Order*. Thus, because the parties failed to submit any new convincing arguments, the Commission denied the petitions claiming that: The Commission lacks authority to require refunds; refunds should take the form of reductions in a carrier's depreciation reserve deficiency; the exchange carriers should have the same increment as AT&T; and interest or refunds should be computed at the cost of short-term debt. Finally, in the interest of clarity, the Commission codified the rate of return enforcement obligations at Appendix A.

Throughout this proceeding the Commission has sought to balance carefully the interests of ratepayers and telephone company shareholders. To protect ratepayers, the Commission implemented an enforcement program that channels refunds to the class of customers responsible for the excessive earnings. At the same time, the Commission has provided carriers a reasonable opportunity to achieve their authorized rates of return.

Accordingly, it is ordered, that pursuant to 47 U.S.C. 151, 154 (i) and (j), 201, 202, 203, 205, 213, 215, 218, 219, 220, 403, and 405 and 5 U.S.C. 553, the *Phase I Order* adopted in this proceeding is modified to the extent set forth in this *Memorandum Opinion and Order*.

It is further ordered, that petitions for waiver, clarification or reconsideration of the *Phase I Order* are granted to the extent set forth herein, and are otherwise denied.

It is further ordered, that Part 65 of the Commission's Rules is amended as set forth below, effective April 30, 1986.

It is further ordered, that the Secretary shall cause a summary of this Order to be published in the **Federal Register**.

List of Subjects in 47 CFR Part 65

Communications common carriers, Rate of return, Refunds.

Federal Communications Commission.

William J. Tricarico,

Secretary.

PART 65—[AMENDED]

Part 65, Chapter 1 of Title 47, Code of Federal Regulations, is amended as follows:

1. The Authority citation for Part 67 continues to read as follows:

Authority: Secs. 4, 201, 202, 203, 205, 218, 403, 48 Stat., 1066, 1072, 1077, 1094, as amended, 47 U.S.C. 154, 201, 202, 203, 205, 218, 403.

2. Subpart F is added to read as follows:

Subpart F—Maximum Allowable Rates of Return

Sec.

65.700 Determining the maximum allowable rate of return.
65.701 Period of review.
65.702 Measurement of interstate service earnings.
65.703 Refunds.

Subpart F—Maximum Allowable Rates of Return

§ 65.700 Determining the maximum allowable rate of return.

(a) The maximum allowable rate of return for any exchange carrier's earnings on any access service category shall be determined by adding a fixed increment of four-tenths of one percent of the exchange carrier prescribed rate of return.

(b) The maximum allowable rate of return for any exchange carrier's overall interstate earnings for all access service categories shall be determined by adding a fixed increment of one-quarter of one percent to the exchange carrier prescribed rate of return.

(c) The maximum allowable rate of return for any dominant interexchange carrier that is subject to Interim Cost Allocation Manual shall be determined by adding a fixed increment of one-half of one percent to that interexchange carrier's prescribed rate of return. The maximum allowable rate of return shall apply to each Interim Cost Allocation Manual category.

§ 65.701 Period of review.

(a) For both exchange and interexchange carriers subject to this Part, interstate earnings shall be measured over a two year period to determine compliance with the maximum allowable rate of return. The review periods shall commence on January 1 in odd-numbered years and shall end on December 31 in even-numbered years.

(b) Notwithstanding other provisions in this Subpart, the initial exchange carrier period of review under this Part shall commence on October 1, 1985 and shall end on December 31, 1986. For purposes of the exchange carrier initial review period, the maximum allowable rate of return on overall interstate earnings shall be 13.1 percent, and the maximum allowable rate of return for any access service category shall be 13.25 percent.

§ 65.702 Measurement of interstate services earnings.

(a) For dominant interexchange carriers subject to this Part, earnings shall be measured separately for each Interim Cost Allocation Manual service category for purposes of determining compliance with the maximum allowable rate of return.

(b) For exchange carriers, earnings shall be measured separately for each access service category for purposes of determining compliance with the maximum allowable rate of return. The access service categories shall be: Special Access, Section 69.113; Common Line, Section 69.104–105; and an aggregated category consisting of Line Termination, Section 69.106, Intercept, Section 69.108, Local Switching, Section 69.107, Transport, Sections 69.111–112, and Information, Section 69.109. The Billing and Collection access element shall not be included in any access service category for purposes of this part. The Commission will also separately review exchange carrier overall interstate earnings subject to this Part for determining compliance with the maximum allowable rate of return determined by § 65.700(b).

(c) For exchange carriers, earnings shall be measured for purposes of determining compliance with the maximum allowable rates of return separately for each study area; provided, however, that if the carrier has filed or concurred in access tariffs aggregating costs and rates for two or more study areas, the earnings will be determined for the aggregated study

areas rather than for each study area separately. If an exchange carrier has not utilized the same level of study area aggregation during the entire two-year earnings review period, then the carrier's earnings will be measured for the entire two-year period on the basis of the tariffs in effect at the end of the second year of the two-year review period; provided, however, that if tariffs representing a higher level of study area aggregation were not in effect for at least eight months in the second year, then the carrier's earnings will be measured on the basis of the study area level of aggregation in effect for the majority of the two-year period; provided further, that any carrier that was not a member of the National Exchange Carrier Association or other voluntary pools for both years of the two-year review period will have its earnings reviewed individually for the full two-year period.

§ 65.703 Refunds

(a) Refunds shall be effected automatically if a carrier's earnings for any category of services, as set forth in § 65.702, exceed the maximum allowable rate of return. In determining whether a carrier's earnings exceed the maximum allowable rate of return, the reports filed by a carrier shall be deemed conclusively binding on the carrier.

(b) Notwithstanding § 69.2(b), refunds shall be effected by subsequent period reductions in the carrier's revenue requirements for the access elements that earned in excess of the maximum allowable rate of return; provided, however, that a carrier may, at its option, make payments directly to the customers responsible for the overearnings as a means of providing refunds. A carrier making refunds directly to customers shall distribute the refund to each customer in proportion to the revenues for that category paid by each customer during the review period.

(c) The base amount of the refund shall be computed for interexchange service categories or Special Access or Common Line service categories by determining the dollar amount of revenues that resulted in earnings that exceeded the carriers' average net investment during the review period multiplied by the maximum allowable rate of return. In addition, the amount of the refund shall include interest computed by multiplying the maximum allowable rate of return, expressed as an annual interest rate, times the base amount of the refund, for the period beginning on January 1 of the year after the end of the earnings review period in which the carrier overearned, and ending at the midpoint of the period in which the tariff reflecting the reduced revenue requirement is scheduled to be in effect; provided, however, that if a carrier elects to make a refund directly to customers, the interest shall accrue only until payment is made to the customer.

(d) The amount of the refund shall be computed for the exchange carrier's overall earnings or for the Switched Traffic Sensitive category using the methodology specified in § 65.703(c), except that the base amount of the refund shall be determined by computing the proportionate dollar reductions for each subcategory earning in excess of the maximum allowable rate of return, that when refunded, are sufficient to bring the earnings of the category as a whole down to the maximum allowable rate of return.

(e) For exchange carriers, tariffs reflecting the revenue requirement reductions effectuating the refund shall be filed by the carrier to become effective no later than January 1 of the year following the submission of the final report for the earning review period.

(f) For interexchange carriers subject to this Part, tariffs reflecting the revenue requirement reductions effectuating the refund shall be filed on 45 days notice no later than 60 days after submission of the final report for the earnings review period.

[FR Doc. 86-7165 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

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47 CFR Part 67

[CC Docket No. 78-72; CC Docket No. 80-286; FCC 86-121]

MTS and WATS Market Structure

AGENCY: Federal Communications Commission.

ACTION: Report and Order.

SUMMARY: This action adopts revisions to § 69.405(c) of the Commission's rules concerning the allocation of interstate expenses in Account 645, Local Commercial Operations, to the access charge rate elements. This action is taken by the Commission in order to allocate interstate expenses properly among the various access rate elements. This action will allocate the interstate expenses in Account 645, Local Commercial Operations, to the various rate elements based on cost causation principles.

EFFECTIVE DATE: June 1, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Barbara Lynch, Common Carrier Bureau, (202) 632-6363.

This is a summary of the Commission's report and order, CC Docket Nos. 78-72 and 80-286, adopted March 18, 1986, and released March 21, 1986.

The full text of Commission decisions are available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, Northwest, Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, (202) 857-3800, 2100 M Street, Northwest, Suite 140, Washington, DC. 20037.

Summary of Report and Order

1. On January 8, 1986, the Federal Communications Commission (FCC) issued a *Notice of Proposed Rulemaking* (Notice) (50 FR 2907; January 22, 1986) concerning the allocation of the interstate costs in Account 645, Local Commercial Operations, to the various access charge rate elements. In this *Report and Order* (Order), the FCC adopts the proposed revisions to § 69.405(c) set out in the *Notice*, with a few minor clarifications and modifications.

2. Presently, § 69.405(c) apportions these expenses among the access rate elements and the interexchange category in proportion to the expenses in Account 662, Revenue Accounting Expense, with the exception of those costs directly attributable to non-limited pay telephones which are assigned to the Common Line element. In the *Notice*, the FCC found that the current access charge rules may not produce a cost based division of these expenses among the access charge rate elements. Therefore, the FCC initiated this rulemaking proceeding and requested comments on proposed changes to § 69.405(c).

3. Twelve parties filed comments concerning our proposed revision of § 69.405(c) of the Commission's rules, and eight parties filed replies. Almost all of the commenting parties generally supported the basic approach set out in the proposed revision of § 69.405(c), stating that the proposed changes are reasonably based on cost causation principles and will produce an appropriate allocation of Account 645 costs among the access rate elements. However, most of the parties also suggested certain adjustments to the proposed rules.

4. A number of the parties argued that implementation of the revised

separations and access charge procedures for Account 645 costs should be deferred to January 1, 1987. The FCC concluded that the changes in the allocation and recovery of Account 645 costs should be implemented, as proposed, June 1, 1986, in the case of AT&T and all local exchange carrier study areas with more than 50,000 working loops (excluding WATS, wideband and private line loops). The additional seven month delay, until January 1, 1987, of the implementation of these changes proposed by certain parties was found to be unacceptable. For the same reasons, the FCC denied the requests filed by several parties for reconsideration or waiver of the effective date of the new separations procedures for Account 645 as well as their requests for deferral of the effective date for the corresponding Part 69 procedures adopted herein. The FCC did not act on the other aspects of the requests for reconsideration.

5. The FCC recognized that certain carriers will not be able to obtain all of the data necessary to recalculate their access charge rates to reflect the new separations and access rules in their access tariff filings of April 1, 1986. However, the FCC found that the carriers could reflect these changes in their upcoming access tariff filings on the basis of estimates, stating that they should make any necessary adjustments to their filings as soon as more precise information is available. The FCC also concluded that, in addition to sanctioning the use of estimated data, a simplified industry-wide approach to the implementation of the Part 69 changes may be appropriate for the period June 1, 1986, to January 1, 1987, in order to reduce the administrative burdens involved. As a result, the FCC waived § 0.291(h) of its rules and delegated authority to adopt such procedures to the Chief, Common Carrier Bureau.

6. Certain parties suggested changes in the FCC's proposed procedures for the allocation of presubscription service order processing costs among the access charge rate elements. The FCC found that its proposal for the allocation of presubscription service order processing costs among the Common Line, Line Termination, Local Switching, and Transport elements was reasonable. It stated that presubscription service order processing costs are generated when subscribers select an equal access interexchange carrier subsequent to the conversion of their end office to equal access. Since these costs are incurred in conjunction with the provision of switched interexchange service, the FCC found that it is reasonable to spread the recovery of these costs over the basic access charge elements applicable to such traffic. The FCC stated that allocating a portion of these costs to the Common Line element is consistent with this approach since a major portion of these costs are presently recovered from the interexchange carriers. In addition, although the FCC recognized that presubscription costs are generated by subscriber service requests, it found that to have the costs recovered from the subscribers through flat charges would be inappropriate in light of its decision to limit flat rate recovery of local loop costs to $2.00 a month for residential and single line business customers.

7. Contrary to the contentions of some of the parties, the FCC also concluded that the costs of end user service order processing, payment and collection, and billing inquiry associated with interstate private line and special access services should be divided between the Special Access category and the Billing and Collection element as proposed. It found that retaining the proposed procedures for the allocation of these costs between the Special Access and Billing and Collection rate elements will ensure proper cost recovery in the event local carriers provide service order processing, payment and collection and billing inquiry for interstate private line services offered by the interexchange carriers.

8. The FCC concluded that the end user service order processing, payment and collection and billing inquiry costs associated with MTS and WATS service should be allocated to the Interexchange category and the Billing and Collection element as proposed. It found that allocating all of these costs to the Billing and Collection element as proposed by certain parties appeared to result in the recovery of costs associated with the provision of local exchange carrier interstate toll services from the interexchange carriers.

9. The FCC also concluded that it is reasonable to allocate interexchange carrier service order processing, payment and collection and billing inquiry costs attributable to interstate switched access and message toll service including WATS, among the Common Line, Line Termination, Local Switching, Intercept and Transport elements despite objections by certain parties to the allocation of a portion of these costs to the Common Line element. Although these costs are associated with interexchange carrier provision of switched services, the FCC concluded that it is reasonable to allocate a portion of them to the Common Line element since a major portion of the common line costs are presently recovered from the interexchange carriers on a usage related basis, although it noted that reevaluation of this approach might be necessary if most common line costs were recovered directly from end users through flat charges. The FCC adopted a proposal to eliminate allocation of these costs to the Information element, agreeing with the contention of certain commenting parties that this element should recover costs associated with interexchange directory assistance, without bearing a portion of interexchange carrier service order processing, payment and collection and billing inquiry costs attributable to interstate switched access and message toll service including WATS.

10. The FCC also stated that it expected the carriers to use reasonable methods consistent with the separations procedures for attributing costs to the various service categories set out in § 69.405(c) of the rules. The FCC also required the carriers to describe the methodology used in attributing the interstate Account 645 costs to the various services in their tariff filings. Contrary to the contentions of certain parties, the FCC found that a new definition of the term "interexchange carrier" is unnecessary. The FCC noted that this term is used throughout Part 69 of the rules, stating that the establishment of a new definition of the term could have unanticipated effects in other areas. In addition, the FCC found no reason to defer implementation of the proposed changes to § 69.405(c) in light of its decision to detariff billing and collection services, noting that questions related to the allocation of costs between regulated and unregulated services will be examined in other proceedings.

11. The FCC also stated that it would not assign a portion of the local commercial costs associated with WATS service to the Special Access element as advocated by certain parties, although closed end WATS access lines will be treated as special access. The FCC concluded that it would be unduly difficult to implement such an approach and concluded that it was not necessary to achieve a reasonable allocation of these costs among the access rate elements.

12. Finally, the FCC stated that the information presently before it did not allow adoption of simplified separations or access charge procedures applicable to Account 645 for use by small telephone companies as suggested by certain parties. However, the FCC stated that it would welcome efforts by the industry to develop such procedures, but

it emphasized that any such procedures must produce results which approximate the effect which would be produced by the application of the revised rules.

13. The provisions of the Regulatory Flexibility Act, 5 U.S.C. §§601–12 are not applicable to this proceeding because the FCC has found that neither local exchange carriers nor AT&T come within the Regulatory Flexibility Act's definition of a small entity.

Ordering Clauses

14. Accordingly, it is ordered, That the proposed revisions to § 69.405(c) of the Commission's rules set forth in Appendix A of the *Report and Order* are adopted effective June 1, 1986.

15. It is further ordered, That authority to adopt simplified industry wide procedures for implementation of the Part 69 rule changes for the period June 1, 1986, to January 1, 1987, is delegated to the Chief, Common Carrier Bureau.

16. It is further ordered, That the requests for consideration or waiver of the new separations procedures for Account 645 costs discussed herein are denied to the extent that they seek modification of the June 1, 1986, effective date. It is further ordered, That these requests are denied to the extent that they seek deferral or waiver of the effective date of the corresponding Part 69 changes adopted herein.

List of Subjects in 47 CFR Part 69

Communications common carriers, Reporting and recordkeeping requirements, Telephone.

Federal Communications Commission
William J. Tricarico,
Secretary.

PART 69—ACCESS CHARGES

Part 69 of Title 47 of the Code of Federal Regulations is amended as follows:

1. The authority citation for Part 69 continues to read as follows:

Authority: Secs. 4, 201, 202, 203, 205, 218, 403, 48 Stat. 1066, 1070, 1072, 1077, 1094, as amended, 47 U.S.C. 154, 201, 202, 203, 205, 218, 403.

2. Section 69.405 is amended by revising paragraph (c) to read as follows:

§ 69.405 Commercial expenses.

* * * * *

(c) The procedures set out in paragraph (c)(1) of this section shall apply to study areas with more than 50,000 working loops, calculated as provided in § 67.611(a)(8), effective June 1, 1986. These procedures shall apply to study areas with 50,000 or fewer working loops, calculated as provided in § 67.611(a)(8), effective January 1, 1987. Prior to the effective date of the procedures set out in paragraph (c)(1) of this section, the procedures set out in paragraph (c)(2) of this section shall apply.

(1) Local Commercial expenses shall be assigned as follows:

(i) End user service order processing expenses attributable to presubscription shall be apportioned among the Common Line, Line Termination, Local Switching, Intercept and Transport elements in the same proportions as the investment apportioned to those elements pursuant to § 69.309.

(ii) End user service order processing, payment and collection, and billing inquiry expenses attributable to the company's own interstate private line and special access service shall be assigned to the Special Access element.

(iii) End user service order processing, payment and collection, and billing inquiry expenses attributable to interstate private line service offered by an interexchange carrier shall be assigned to the Billing and Collection element.

(iv) End user service order processing, payment and collection, and billing inquiry expenses attributable to the company's own interstate message toll service, including WATS, shall be assigned to the interexchange category. End user service order processing, payment and collection, and billing inquiry expenses attributable to interstate message toll service, including WATS, offered by an interexchange carrier shall be assigned to the Billing and Collection element. End user payment and collection and billing inquiry expenses attributable to End User Common Line access billing shall be assigned to the Common Line element.

(v) End user service order processing, payment and collection, and billing inquiry expenses attributable to TWX service shall be assigned to the Special Access element.

(vi) Interexchange carrier service order processing, payment and collection, and billing inquiry expenses attributable to private lines and special access shall be assigned to the Special Access element.

(vii) Interexchange carrier service order processing, payment and collection, and billing inquiry expenses attributable to interstate switched access and message toll, including WATS, shall be apportioned among the Common Line, Line Termination, Local Switching, Intercept and Transport elements in the same proportions as the investment apportioned to those elements pursuant to § 69.309.

(viii) Interexchange carrier service order processing, payment and collection, and billing inquiry expenses attributable to billing and collection service shall be assigned to the Billing and Collection element.

(ix) Coin collection and administration expenses shall be divided between limited and non-limited pay telephones. Coin collection and administration expenses attributable to limited pay telephones shall be assigned to the Limited Pay Telephone element. Coin collection and administration expenses attributable to non-limited pay telephone shall be assigned to the Common Line element.

(2) Prior to the effective dates of subsection (c)(1), Local Commercial expenses directly attributable to non-limited pay telephone collections shall be assigned to the Common Line element. All other Local Commercial expenses shall be apportioned among access elements and the interexchange category in the same porportions as Revenue Accounting expenses.

[FR Doc. 86–7157 Filed 3–31–86; 8:45 am]
BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 84–522; RM–4653]

FM Broadcast Station in Pinetop, AZ

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein affirms the allocation of Class C Channel 294 to Pinetop, Arizona, and denies the petition for reconsideration filed by KBW Associates, Inc. The allocation could provide Pinetop with its first local FM service.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Memorandum Opinion and Order

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations. (Pinetop, Arizona); MM Docket No. 84-522 RM-4653.

Adopted: March 13, 1986.
Released: March 27, 1986.

By the Chief, Policy and Rules Division:

1. The Commission has before it for consideration the petition for reconsideration filed by KBW Associates, Inc. ("KBW") of the *Report and order* [1] allocating Class C Channel 294 to Pinetop, Arizona, as the community's first local FM service. D&M, Inc. ("D&M"), the proponent of the Pinetop allocation, filed an opposition to the petition for reconsideration to which KBW responded. KBW also filed a Motion for Stay of any further procedures pending resolution of its reconsideration request.

2. KBW, licensee of Station KRFM and KVSL (AM), Show Low, Arizona, filed reply comments in response to the *Notice of Proposed Rule Making* [2] opposing the allocation. It contended that D&M had not provided the required showing of need for the requested channel, that the proposed allocation would preclude other, more deserving, communities from using the channel, and that the allocation of the high powered Class C channel was an inefficient use of the spectrum, arguing that if any channel were to be allocated to the small community it should be a Class A. In its reconsideration, KBW states that the Commission resolved two of the issues it had raised but failed to address the issues of spectrum efficiency and appropriateness of allocating a Class C channel to Pinetop. It argues that the Commission generally has refrained from allocating higher powered channels to small communities such as Pinetop unless there has been a compelling showing made that the new facility would provide service to significant unserved or underserved areas and that no Class A channel was available. KBW contends that the Commission still requires a showing of need for the higher powered channels if sought for small communities, even in light of the Commission's decision in *Revision of FM Assignment Policies and Procedures.* [3] It concludes by stating that, in light of the fact that no support for the higher powered channel was provided, the Channel 294 allotment should be rescinded and replaced with a Class A channel, if any.

3. D&M rebuts the arguments of KBW. It states that the Commission no longer has any policy concerning the size of a community vis-a-vis the class of channel which will be allocated. D&M contends that the Commission did rule on all the issues raised by KBW and, in fact, what it really seeks is to reargue the 1982 decision in *Revision of FM Assignment Policies and Procedures, supra.* It also points out that the Commission could not allocate a Class A frequency to Pinetop, although available, since no party expressed an interest in use of the lower powered channel.

4. KBW has misinterpreted the Commission's decision in *Revision of FM Assignment Policies and Procedures, supra.* The Commission may still request showings of need and the service which would be provided by a new allocation, as contended by KBW. However, we no longer routinely seek this information and in noncomparative cases, such as this one, no longer deem the information to be relevant. In revising this policy, the Commission stated:

> The theoretical advantage of assigning a Class A channel to a small town and a B/C channel to serve larger ones breaks down in many cases . . . . With this in mind we thought that this policy could be eliminated. This aspect of the Notice elicited virtually no response. Nor has the Commission's own experience since suggested a need to continue a policy that either refuses an assignment which fully meets the rules or makes it only after an extensive showing has been filed. Accordingly, we no longer intend to mandate the choice of channel based on community size. (90 F.C.C. 2d 88, at 97)

We see no reason here to digress from this policy. All interested parties were afforded ample opportunity to come forward with alternative uses for Channel 294. The only counterproposal which was filed sought an upgrade of facilities for Station KXJJ at Clifton, Arizona. However, this request was technically defective as it caused a short spacing to a Mexican allotment. Thus, with no other expressed interest in use of the channel, there was no more efficient use of the spectrum before the Commission. KBW's suggestion to substitute a Class A channel for the Class C at Pinetop is also without merit. As the Commission has held on numerous occasions, no channel will be allocated to a community without the assurance that the channel will be promptly applied for and activated. Here, no other party stepped forward and expressed a willingness to apply for a Pinetop allocation, either a Class A or C, and D&M expressly stated its unwillingness to apply for any channel other than a Class C. Thus, without the requisite interest, we will not allocate a Class A channel to Pinetop.

5. For the reason set forth above, we affirm the allocation of Class C Channel 294 to Pinetop, Arizona, as that community's first local FM service. Accordingly, it is ordered, that the petition for reconsideration filed by KBW Associates, Inc. is denied. It is further ordered, that the Motion for Stay filed by KBW Associates is dismissed as moot.

6. For further information concerning this proceeding, contact Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86-7153 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 85-214; RM-4921]

FM Broadcast Station in Wartburg, TN

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein allots Channel 267A to Wartburg, Tennessee, as that community's first FM service, at the request of Sandra Lavender.

EFFECTIVE DATE: May 2, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Report and Order (Proceeding Terminated)

In the matter of Amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations. (Wartburg, Tennessee); MM Docket No. 85-214 RM-4921.

Adopted: March 18, 1986.
Released: March 26, 1986.

By the Chief, Policy and Rules Division:

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[1] 50 FR 13031, published April 2, 1985.

[2] 49 FR 24408, published June 13, 1984.

[3] *Second Report and Order*, 90 F.C.C. 2d 88 (1982).

1. The Commission has before it for consideration the *Notice of Proposed Rule Making*, 50 FR 29452, published July 19, 1985, proposing the allocation of Channel 255A to Wartburg, Tennessee, as that community's first FM service. The *Notice* was adopted in response to a petition filed by Sandra Lavender ("petitioner"). Petitioner filed supporting comments reiterating her commitment to apply for the channel.

2. In a related proceeding (MM Docket No. 84–14, *Further Notice of Proposed Rule Making*, 50 FR 33607, published August 20, 1985) Channel 255A has been proposed for Livingston, Tennessee. The Wartburg and Livingston proposals are mutually exclusive based on the distance separation requirements. In order to provide for the allotment of Channel 255A in MM Docket 84–14 and in order to expedite the instant proceeding, we have determined that an alternate channel is available to Wartburg.[1] Our engineering study reveals that Channel 267A can be allotted to Wartburg in compliance with the minimum distance separation requirements of § 73.207 of the Commission's Rules with a site restriction of 8.5 kilometers (5.3 miles) north of the community in order to avoid short spacings to Station WUSY(FM), Channel 264 as Cleveland, Tennessee and Station WSGS(FM), Channel 266 at Hazard, Kentucky.

PART 73—[AMENDED]

3. Accordingly, in order to provide a first local service to Wartburg and pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective May 2, 1986, the FM Table of Allotments, § 73.202(b) of the Commission's Rules, is amended for the following community:

City	Channel No.
Wartburg, TN	267A

4. The filing window for applications on this channel will open on May 5, 1986, and close on May 19, 1986.

5. It is further ordered, that this proceeding is terminated.

6. For further information concerning this proceeding, contact Patricia Rawlings, Mass Media Bureau, (202) 634–6530.

[1] The allotment of Channel 267A here would permit us to consider a request to allot Channel 256A to Loudon, Tennessee (RM–5232).

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86–7144 Filed 3–31–86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 83–1122; RM–4342]

TV Broadcast Station in Murray, KY

AGENCY: Federal Communications Commission.

ACTION: Order.

SUMMARY: Action taken herein denies a petition for reconsideration filed by Low Power Television, Inc. requesting the substitution of UHF Television Channel 46 for Channel 38 at Murray, Kentucky.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: D. David Weston, Mass Media Bureau (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Memorandum Opinion and Order (Proceeding Terminated)

In the matter of amendment of § 73.606(b), Table of Assignments, Television Broadcast Stations (Murray, Kentucky); MM Docket No. 83–1122 RM–4342.

Adopted: March 18, 1986.
Released: March 27, 1986.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration, the Petition for Reconsideration of the *Report and Order*, 49 FR 32203, published August 13, 1984, which assigned UHF Television Channel 38 to Murray, Kentucky. Reconsideration of that decision is sought by Low Power Television, Inc. ("LPTI").

2. In response to the *Notice of Proposed Rule Making*, 49 FR 49891, published October 28, 1983, LPTI filed late comments without sufficient reason and these comments were not considered in this proceeding in accordance with the above *Order*. LPTI now seeks reconsideration arguing that its comments should have been considered because full service on Channel 38 will cause harmful interference to its Low Power Television Station W38AD, Jackson, Mississippi. LPTI requests that Channel 46 be substituted for Channel 38 to resolve the problem.

3. Commission records indicate that there is a pending application (BPCT–850315KG) for a full service TV station on Channel 38, Murray, Kentucky. Since the relief sought here is for a low power operation, we believe it is sufficient to state our general policy in this regard, which is to treat low power or television translator operations as a secondary use of a frequency and unprotected as against a proposed full broadcast use. See § 74.702(b) of the Commission's Rules and *Future Role of Low Power Television Broadcast*, 47 FR 96, published May 16, 1982. Thus, petitioner has set forth no valid reason for our reconsidering the *Report and Order* herein.

4. In view of the foregoing, the Petition for Reconsideration filed by Low Power Television, Inc. is denied.

5. It is further ordered, that this proceeding is terminated.

6. For further information concerning this proceeding, contact D. David Weston, Mass Media Bureau, (202) 634–6530.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86–7150 Filed 3–31–86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 85–69; RM–4889]

TV Broadcast Station in Poplar Bluff, MO

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action assigns UHF Television Channel 55 to Poplar Bluff, Missouri, in response to a petition filed by Bluff Communications, Co. The assignment could provide a second commercial broadcast service for Poplar Bluff.

EFFECTIVE DATE: May 1, 1986.

ADDRESS: Federal Communications Commission, Washington, DC. 20554.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of subjects in 47 CFR Part 73

Television broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Report and Order (Proceeding Terminated)

In the Matter of Amendment of § 73.606(b) Table of Assignments, TV Broadcast Stations. (Poplar Bluff, Missouri); MM Docket No. 85-69, RM-4889.

Adopted: March 18, 1986.
Released: March 25, 1986.

By the Chief, Policy and Rules Division:

1. The Commission has before it for consideration the *Notice of Proposed Rule Making*, 50 FR 14951, published April 16, 1985, in response to a petition filed by Bluff Communications, Co. ("petitioner"). The *Notice* proposed the assignment of UHF Television Channel 55 to Poplar Bluff, Missouri as its second commercial television channel. Petitioner filed comments in support of the *Notice* and restated its intention to apply for the channel.

2. Poplar Bluff (population 17,139),[1] the seat of Butler County (population 37,693), is located in southeastern Missouri, approximately 210 kilometers (130 miles) south of St. Louis. Currently, it is served by Station KPOB-TV Channel 15, and is assigned noncommercial educational Channel *26, which is unoccupied.

3. In view of the fact that the assignment could provide a second commercial channel to Poplar Bluff, we believe that the public interest would be served by assigning UHF Television Channel 55 to that community. Channel 55 can be assigned in conformance with the minimum distance separation requirements of § 73.610 of the Commission's Rules.

PART 73—[AMENDED]

4. Accordingly, pursuant to the authority contained in Sections 4(i), 5(c)(1), 303(g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective May 1, 1986, the Television Table of Assignments, § 73.606(b) of the Commission's Rules, is amended for the community listed below:

[1] Population figures were extracted from the 1980 U.S. Census.

City	Channel No.
Poplar Bluff, MO	15+, *26+, 55.

5. It is further orderd, that this proceeding is terminated.

6. For further information concerning the above, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86-7168 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 85-52; RM-4847; RM-4851]

TV Broadcast Stations Jackson, WY; Billings, MT; and Provo, UT

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein assigns VHF TV Channels 2 and 11 to Jackson, Wyoming, at the request of Metro Telecasting and Terrell Communications, respectively. In order to provide the first and second local television channels at Jackson, the offsets on Channel 2 at Billings, Montana, must be changed from "zero" to "minus" and on Channel *11 at Provo, Utah, from "plus" to "minus."

EFFECTIVE DATE: May 1, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of subjects in 47 CFR Part 73

Television broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 303, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Report and Order (Proceeding Terminated)

In the matter of amendment of § 73.606(b), Table of Assignments, Television Broadcast Stations. (Jackson, Wyoming; Billings, Montana; and Provo, Utah); MM Docket No. 85-52 RM-4847; RM-4851.

Adopted: March 20, 1986.
Released: March 25, 1986.

By the Chief, Policy and Rules Division:

1. The Commission considers herein the *Notice of Proposed Rule Making and Orders to Show Cause*, 50 FR 9074, published March 6, 1985, proposing the assignment of VHF Television Channels 2 and 11 to Jackson, Wyoming, in response to the requests of Metro Telecasting ("Metro") and Terrell Communications ("Terrell"), respectively. Supporting comments were filed by Metro and Terrell each reaffirming their interest in applying for the requested channel and by Ambassador Media Corporation ("Ambassador"), licensee of Station KPVI-TV, Pocatello, Idaho, stating its interest in applying for one of the channels. Comments were also filed by Brigham Young University ("BYU"), licensee of Station KBYU-TV, Channel *11, Provo, Utah. Both channels can be assigned in compliance with the Commission's minimum distance separation and other technical requirements if the offset of Station KTVQ (Channel 2) at Billings, Montana, is changed from "zero" to "minus" and the offset of Channel *11 at Provo, Utah, occupied by Station KBYU-TV, is changed from "plus" to "minus."

2. The licensees of Stations KBYU-TV and KTVQ were issued *Orders to Show Cause* why their licenses should not be modified to specify the changes in offsets in order to accommodate the proposal. Station KTVQ did not respond. Therefore, consistent with the language of the *Order*, KTVQ is deemed to consent to the change. BYU in its response, states that it has no objection to the change in its offset, if certain conditions are met. First, it requests that the eventual permittee for Channel 11 reimburse BYU for all reasonable expenses incurred as a result of its change in offset and that proof of reimbursement must accompany any application for license of the constructed facility. Secondly, it urges that it be given adequate notice and reasonable time to make the requested modification. It would prefer that the changes occur during the summer months.

3. Commission policy requires that the ultimate permittee of Channel 2 at Jackson, Wyoming reimburse Station KTVQ and the ultimate permittee of Channel 11 at Jackson reimburse Station KBYU for the reasonable expenses incurred by each as a result of their change in offsets. Metro, Terrell and Ambassador have all indicated their willingness to reimburse. We believe the

issues raised by KBYU concerning the construction permit for Channel 11 are reasonable and should be addressed in connection with the processing of the applications for these channels.

4. Jackson (population 4,511) the seat of Teton County (population 9,355) is located in western Wyoming, approximately 320 kilometers (200 miles) northeast of Salt Lake City, Utah. The population figures are from the 1980 U.S. Census.

5. In view of the foregoing, we believe the public interest would be served by assigning Channels 2 and 11 to Jackson, Wyoming, as that community's first and second television service.

6. Since Billings, Montana, is located within 320 kilometers (200 miles) of the United States-Canadian border, Canadian concurrence has been obtained.

PART 73—[AMENDED]

7. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 370(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective May 1, 1986, the TV Table of Assignments, § 73.606(b) of the Rules, is amended with regard to the following communities:

City	Channel No.
Billings, MT	2−, 6, 8, *11, 14, 20+
Provo, Utah	*11−, 16.
Jackson, Wyoming	2, 11+.

8. It is further ordered, that pursuant to section 316(a) of the Communications Act of 1934, as amended, the licenses of Station KTVQ, Billings, Montana and Station KBYU-TV, Provo, Utah, ARE MODIFIED to specify operation on Channels 2−, and *11−, respectively. Thus, the licensees are required to file a modification of license (Form 302) once the coordinated changes have taken place.

9. It is further ordered, that this proceeding is terminated.

10. For further information contact Patricia Rawlings, Mass Media Bureau, (202) 634–6530.

Federal Communications Commission.

Robert Ratcliffe,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86–7176 Filed 3–31–86; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 642

[Docket No. 60339–6039]

Coastal Migratory Pelagic Resources of the Gulf of Mexico and the South Atlantic

Correction

In FR Doc. 86–5836, beginning on page 9012 in the issue of Monday, March 17, 1986, make the following correction on page 9013, in the first column, under SUPPLEMENTARY INFORMATION, in the first paragraph, last line:

After 1986, add "(51 FR 8325, March 11, 1986".

BILLING CODE 1505-01-M

50 CFR Part 650

[Docket No. 50835–5169]

Atlantic Sea Scallop Fishery

Correction

In FR Doc. 85–26531 beginning on page 46069 in the issue of Wednesday, November 6, 1985, make the following corrections.

1. On page 46071, third column, in § 650.20, fourth line, "of" should read "or".

2. On page 46072, first column, in § 650.21(b)(1), second line, "or" should read "for".

BILLING CODE 1505-01-M

50 CFR Part 671

[Docket No. 50950–5182]

Fishery Conservation and Management; Tanner Crab off Alaska

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of season closure.

SUMMARY: The Director, Alaska Region, NMFS (Regional Director), has determined that the Tanner crab fishery in the Outer District and Eastern District of Registration Area H (Cook Inlet) must be closed in order to protect Tanner crab stocks. The Secretary of Commerce therefore issues this notice closing fishing for Tanner crab by vessels of the United States in the Outer and Eastern Districts. This section is intended as a management measure to conserve Tanner crab stocks.

DATE: This notice is effective at noon, Alaska Standard Time (AST), April 1, 1986. Public comments on this notice of closure are invited until April 14, 1986.

ADDRESSES: Comments should be sent to Robert W. McVey, Director, Alaska Region, National Marine Fisheries Service, P.O. Box 1668, Juneau, AK 99802. During the 15-day comment period, the data on which this notice is based will be available for public inspection during business hours (8:00 a.m. to 4:30 p.m. AST, weekdays) at the NMFS Alaska Regional Office, Federal Building, Room 453, 709 West Ninth Street, Juneau, Alaska.

FOR FURTHER INFORMATION CONTACT: Raymond E. Baglin (Fishery Management Biologist, NMFS), 907–586–7230.

SUPPLEMENTARY INFORMATION: The Fishery Management Plan for the Commercial Tanner Crab Fishery off the Coast of Alaska (FMP), which governs this fishery in the fishery conservation zone under the Magnuson Fishery Conservation and Management Act, provides for inseason adjustments of season and area openings and closures. Implementing regulations at § 671.27(b) specify that notices of these adjustments will be issued by the Secretary of Commerce under criteria set out in that section.

As of March 9, five vessels have delivered a total of 140,000 pounds of Tanner crabs from the Outer and Eastern Districts. Catch samples indicate that the eggs hatch and release period has started and that the major portion of the female population in each district will be egg-bearing by early April. Soft-shell crabs are also appearing in the catch from both districts, indicating the beginning of the molting and breeding period. The current occurrence of soft-shell crabs in these districts indicates that the breeding period has begun earlier than previously anticipated.

Based on the current soft-shell condition of crab in the fishery, the Regional Director has determined that the condition of the Tanner crab stock in the Outer and Eastern Districts is substantially different from the condition anticipated on November 1, the beginning of the fishing year, and that this difference reasonably supports the need to protect these Tanner crab stocks during the critical reproductive period. The Outer District and Eastern District as defined in § 671.26(e)(v) are closed by this notice until noon, Alaska Daylight Time, May 31, 1986, at which time the closure of these districts

prescribed in Table 1 of § 671.21(a) will begin.

This closure will become effective after this notice is filed for public inspection with the Office of the Federal Register and the closure is publicized for 48 hours through procedures of the Alaska Department of Fish and Game. Public comments on this notice of closure may be submitted to the Regional Director at the address above. If comments are received, the necessity of this closure will be reconsidered and a subsequent notice will be published in the **Federal Register**, either confirming this notice's continued effect, modifying it, or rescinding it.

Other Matters

Tanner crab stocks in the Outer and Eastern Districts of Registration Area H (Cook Inlet) will be subject to damage unless this closure takes effect promptly. NOAA therefore finds for good cause that advance opportunity for public comment on this notice is contrary to the public interest, and that no delay should occur in its effective date.

This action is taken under 50 CFR Part 671 and complies with Executive Order 12291.

List of Subjects in 50 CFR Part 671

Fisheries, Reporting and recordkeeping requirements.

(16 U.S.C. 1801 *et seq*).

Dated: March 27, 1986.

Carmen J. Blondin

Deputy Assistant Administrator For Fisheries Resource Management, National Marine Fisheries Service.

[FR Doc. 86-7133 Filed 3-31-86; 8:45 am]

BILLING CODE 3510-22-M

Proposed Rules

Federal Register
Vol. 51, No. 62
Tuesday, April 1, 1986

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 530

Special Salary Rate Schedules for Recruitment and Retention; Withdrawal of Proposed Regulations

AGENCY: Office of Personnel Management.

ACTION: Withdrawal of proposed regulations.

SUMMARY: The Office of Personnel Management (OPM) is withdrawing its proposed regulations on the establishment of certain special salary rate schedules. The proposed regulations are withdrawn because, with the passage of Pub. L. 99–251, "Federal Employees Benefits Improvement Act of 1986," Congress specifically removed the requirement to follow notice-and-comment procedures of the Administrative Procedure Act (5 U.S.C. 553) when establishing any schedules or rates of basic pay when the underlying procedures, methodology, or criteria used to establish such schedules or rates were earlier codified in accordance with administrative procedure. (Special salary rate criteria appear in 5 CFR 530.303.)

Instead, OPM will notify the affected agencies of the effective date of the final special salary rates referenced below directly. This will enable the special salary rates to take effect in a more expeditious manner.

Elsewhere in today's **Federal Register** issue is an interim rule on special salary rates which provides more detailed information on the rationale for withdrawing the proposed regulations.

FOR FURTHER INFORMATION CONTACT: William M. Gualtieri, (202) 632–7858.

SUPPLEMENTARY INFORMATION: Specifically, OPM is withdrawing regulations on proposals to establish special salary rate schedules for these occupations and locations: Police Officers and Pharmacists at Fort Ord, California; Agricultural Commodity Graders in New York City; and Medical Machine Technicians in Alaska (all published separately on November 14, 1985 at 50 FR 47057–47059); Computer Scientists in Warminsters Pennsylvania; Inhalation Therapy Technicians in Washington, DC (both published separately on December 17, 1985 at 50 FR 51397–51398); and Police Officers in Portsmouth, New Hampshire (published on January 6, 1986, at 51 FR 400. 400.)

List of Subjects in 5 CFR Part 530

Administrative practice and procedure, U.S. Government employees, Wages.

Office of Personnel Management.

Constance Horner,

Director.

[FR Doc. 86–7159 Filed 3–31–86; 8:45 am]

BILLING CODE 6325-01-M

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 52

Processed Fruits and Vegetables, Processed Products Thereof, and Certain Other Processed Food Products [1] Regulations Governing Inspection and Certification

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed rule.

SUMMARY: The purpose of this proposed rule is to revise the Regulations Governing Inspection and Certification of Processed Fruits and Vegetables and Certain Other Products. This proposal would (1) revise the sampling plans for lot inspection by restricting the lot size; (2) revise and readjust the schedule of fees and charges for inspection of processed fruits, vegetables, and certain other products; (3) provide for control of labels bearing approved grade or inspection marks when a contract is cancelled; (4) revise the approved identification section which allows for the use of the official sample marks; and (5) amend the definitions section and make editorial and other changes for clarification. The proposed revisions would adjust the fees to cover costs, provide for greater utilization of inspection services, and facilitate identification of products that would be officially sampled.

DATE: Comments must be received on or before: May 1, 1986.

ADDRESS: Interested persons are invited to submit written comments concerning this proposal. Comments must be sent in duplicate to the Docket Clerk, Fruit and Vegetable Division, Agricultural Marketing Service, U.S. Department of Agriculture, Room 2069, South Building, Washington, DC 20250. Comments should reference the date and page number of this issue of the **Federal Register** and will be made available for public inspection in the office of the Docket Clerk during regular business hours.

FOR FURTHER INFORMATION CONTACT: Raymondo O'Neal, Processed Products Branch, Fruit and Vegetable Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, DC 20250, Telephone (202) 447–5021.

SUPPLEMENTARY INFORMATION: This proposed rule has been reviewed under USDA procedures and Executive Order 12291 and has been designated as a "nonmajor" rule. It will not result in an annual effect on the economy of $100 million or more. There will be no major increase in cost or prices to consumers; individual industries; Federal, State, or local government agencies; or geographic regions. It will not result in significant effects on competition, employment, investments, productivity, innovations, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Administrator, Agricultural Marketing Service, has certified that this action will not have a significant economic impact on a substantial number of small entities, as defined in the Regulatory Flexibility Act, P.L. 96–354 (5 U.S.C. 601), because if reflects current marketing practices.

The Agricultural Marketing Act of 1946 authorizes the official inspection, grading, and certification of processed food products including processed fruits, vegetables, and processed products thereof. The Agricultural Marketing Service (AMS) makes available an

[1] May include the following: Honey; molasses, except for stockfeed; nuts and nut products, except oil; sugar (cane, beet, and maple); sirups (blended), sirups, except from grain; tea, cocoa, coffee, spices, condiments.

impartial, official inspection service for processed fruits and vegetables. Applicants may make use of this service to obtain inspection of agricultural products. The service is voluntary and self-supporting and is offered on a fee-for-service basis.

The regulations set forth sampling plans as the basis for assigning quality levels to lots of processed fruits and vegetables and related products. The sampling plans are designed to accept or reject the lot being sampled based on the sample results. The sampling plans for determining lot compliance now allow for a lot size with a representative maximum sample size or 60 sample units.

The proposed rule would limit the lot size to correspond to a sample size with a maximum of 29 sample units except where the Administrator has determined that the lot size may be increased. The following could cause an increase in sample size: (a) Numerous codes may make it necessary to exceed 29 sample units, or (b) appeal inspections or reinspections may be conducted where a sampling rate in excess of 29 sample units is required.

Inspection documents from preceding years indicate the sample size taken on a majority of lots was 29 sample units or less. By eliminating large lot sizes, submitted lots with non-uniform quality would be reduced, thereby increasing the reliability of the inspection results.

The schedule for fees and charges for services rendered to the processed fruit and vegetable industry are amended to reflect the costs associated with the program. Such services are authorized under the Agricultural Marketing Act (AMA) of 1946, section 203(h), which requires that fees be reasonable, and as nearly as possible, cover the cost of rendering the services.

Each fiscal year, the fees for services are reviewed and a cost analysis is performed to determine if such fees are adequate to recover the cost of providing the services. These analyses also help assure that our costs are kept to a minimum and any fee increases are those necessary to carry out an effective program. Since the last fee increase was May 11, 1982, there have been two government-wide salary increases and increased costs associated with providing the services.

Revising the fee rates will: (1) Provide a uniform charge for inspection to applicants, regardless of the expenses (transportation and subsistence costs) incurred by the inspection activity. These travel expenses will be incorporated into the hourly rate. The time required to travel to the applicant's location will continue to be charged at the set hourly rate; (2) provide an hourly rate for analyses and other applicable services where no travel expenses are incurred; and (3) increase the hourly rate and overtime to more closely reflect costs.

No appropriated funds are provided to the Agency to offset costs of rendering the services. Therefore, the agency must recover all expenses in full through user fees charged to the applicants which request the services.

Editorial changes and clarifications would be made in the definitions and other sections to more closely reflect current practices and procedures. One such proposed change would state that after an appeal inspection, a lot could not be further appealed without authorization from the Administrator. Another proposed change would allow certificates of loading to be issued in lieu of official certificates. it is also proposed that oral requests for inspection service may not be required to be reduced to writing in every case. New definitions would include the deletion of "subordinate inspector" and the addition of "in-plant sampler". The addition of the subdefinition "approved plant lot inspection" is proposed as a further characterization of inspection services.

The following table compares current fees and charges with proposed fees and charges for processed fruit and vegetable inspection with the new schedule as found in § 52.42, Schedule of fees:

Current	*Proposed*
Per inspector hour $24.00/hr plus $5.00/hr overtime Transportation and subsistence costs charged	Per inspector hour $29.00/hr plus $5.50/hr overtime. No transportation and subsistence costs charged. Holiday pay—when work is performed, and additional hour at the regular hourly rate will be charged for each hour worked.

Charges for micro, chemical, certain other special analyses and other applicable services as found in § 52.47:

Current	*Proposed*
$24.00/hr.	$25.00/hr.

Charges for copies of scoresheets as found in § 52.49:

Current	*Proposed*
$24.00/hr.	$25.00/hr.

Charges for additional copies of inspection certificates as found in § 52.50:

Current	*Proposed*
$24.00/hr	$25.00/hr.

Charges for year-round in-plant inspection services on a contract basis as found in § 52.52(c):

	Current	Proposed
(1) For personnel assigned on a year-round basis.	$19,000/hr	$22.00/hr.
(2) For personnel assigned on less than a year-round basis.	$21.00/hr	$27.00/hr.
	Transportation and subsistence cost charged.	No transportation and subsistence cost charged.
Each subordinate inspector on same shift with an inspector.	$14.00/hr	Delete subordinate inspector.
		Add in-plant sampler $14.00/hr.
		No transportation and subsistence costs charged.
(6) Overtime	All overtime hours charged at regular rate specified in (c)(1) and (2) plus $5.00 per hour.	All overtime hours charged at regular rate specified in (c)(1) and (2) plus $5.50 per hour.

Charges for less than year-round in-plant inspection services (four or more consecutive 40 hour weeks) on a contract basis as found in § 52.52(d):

	Current	Proposed
(1) Each Inspector.	$26.00/hr	$27.00/hr.[2]
		Add in-plant sampler $14.00/hr.
(5) Overtime	All overtime hours charged at regular rate specified in (d)(1) and (2) plus $5.00 per hour.	All overtime hours charged at regular rate specified in (d)(1) and (2) plus $5.50 per hour.

[2] Except a minimum of 8 hours per day in lieu of a minimum of 40 hours a week for intermittent type in-plant services and less than four weeks in-plant assignment will be billed in accordance with § 52.42.

The regulations set forth official grade and inspection marks of the United States Department of Agriculture (USDA) for use by fruit and vegetable processors. These processors contract for the fee-for-service grading programs of the Department and, as permitted, may use various types of approved identification marks for processed fruits and vegetables and other related products.

Presently, the regulations do not specifically provide for control of approved grade or inspection marks when a contract between the inspection service and an applicant is cancelled. Therefore, this proposal would provide

for Agency control of cancellation and disposition of such approved grade or inspection marks. This provision would aid in eliminating possible misuse of such labels and marks.

Processed products which have been sampled for inspection, at the option of the Department, are identified by an authorized representative of the Departrment, are identified by an authorized representative of the Department. The products are identified by stamping the shipping container covering such lot(s) with official "sample marks." Revision of the "sample marks" would increase utilization of the official marks by affixing a non-permanent field office designation. These "sample marks" would identify products officially sampled by a particular field office using a field office number in place of geographic location.

List of Subjects in 7 CFR Part 52

Processed fruits and vegetables, Food grades, Standards.

PART 52—AMENDED

Accordingly, the Regulations Governing Inspection and Certification of Processed Fruits and Vegetables, Processed Products Thereof, and Certain Other Processed Food Products (7 CFR 52.2, 52.7, 52.9, 52.24, 52.28, 52.37, 52.38, 52.39, 52.41, 52.42, 52.47, 52.48, 52.49, 52.50, 52.51, 52.52, 52.53) would be amended to read as follows:

1. The authority citation for Part 52 is revised to read as follows:

Authority: Agricultural Marketing Act of 1946, secs. 203, 205, 60 Stat. 1087, 1090 as amended (7 U.S.C. 1622, 1624).

2. Section 52.2 is amended as follows:

a. The definitions "Certificate of loading" and "Inspection Service; types of" are revised.

b. The definitions "In-plant sampler" and "Unofficial sample" are added.

c. The definition "Lot" is amended by revising the text preeceding (a) and revising (b).

d. The definition "Unofficially drawn sample" is removed.

§ 52.2 Terms defined.

* * * * *

Certificate of loading. Certificate of loading means a statement, either written or printed, issued pursuant to the regulations in this part, relative to checkloading of a processed product susequent to inspection thereof. The certificate of loading may be issued in lieu of an official inspection certificate when the same inspection procedures are applied and when authorized by the Administrator.

* * * * *

In-plant sampler. In-plant sampler means any employee of the Department authorized by the Administrator to draw samples of processed products and perform a limited number of miscellaneous duties in a plant operating under contract.

* * * * *

Inspection Service; types of. (a) Lot inspection means the inspection and grading of specific lots of processed fruits and vegetables which are located in plant warehouses, commercial storage, railway cars, trucks, or any other conveyance or storage facility.

(b) Approved plant-lot inspection means the inspection and grading of specific lots of processed fruits and vegetables which are located in plant warehouses, commercial storage, railway cars, trucks, or any other conveyance or storage facility. However, under "approved plant-lot inspection", the inspection service has knowledge that the products were processed or packaged in plants meeting the "plant, approved" definition. This means that the plant facilities, sanitation, and methods of operation have been surveyed and approved for specific product(s) by the Administrator as suitable and adequate for inspection or grading service in accordance with § 52.81 through 52.83 of this part.

(c) Continuous inspection is the conduct of inspection and grading services in an approved plant whereby one or more inspector(s) are present at all times the plant is in operation to make in-process checks on the preparation, processing, packing, and warehousing of all products under contract and to assure compliance with sanitary requirements.

(d) Pack certification is the conduct of inspection and grading services in an approved plant whereby one or more inspector(s) may make inspections of the preparation and processing of products under contract, but are not required to be present at all times the plant is in operation.

(1) Under a Designated Lot contract, inspector(s) will grade and certify only those lots designated by the applicant.

(2) Under a Quality Assurance contract, inspector(s) will use information available from the applicant's quality control records to certify lots, as requested, and will grade lots at random as often as necessary to verify the reliability of the applicant's quality control system.

* * * * *

Lot. Lot means any number of contrainers of the same size and type which contain a processed product of the same type and style located in the same warehouse or conveyance, and which is available for inspection service at any time: Provided, That the number of containers comprising a lot may not exceed the maximum number specified in the sampling plans in § 52.38 of this subpart: And further provided That:

* * * * *

(b) Under in-plant (in-process) inspection, the inspector is authorized to limit the number of containers of a processed product that may be included in a lot to a period of consecutive production equivalent to one production shift with a maximum of 24 hours of consecutive production.

* * * * *

Unofficial sample. Unofficial sample means any sample that has been selected by any person other than an inspector or licensed sampler, or by any other person not authorized by the Administrator pursuant to the regulations in this part.

3. Section 52.7 is revised to read as follows:

§ 52.7 Information required in connection with application.

(a) Application for inspection service shall be made in the English language and may be made orally (in person or by telephone), in writing, or by telegraph. If an application for inspection service is made orally, written confirmation may be required by the inspection service involved.

(b) In connection with each application for inspection service, there shall be furnished such information as may be necessary to perform an inspection on the processed product(s), including but not limited to, the name of the product, name and address of the packer or plant where such product was packed, the location of the product, its lot or car number, codes or other identification marks, the number of containers, the type and size of the containers, the interest of the applicant in the product, whether the lot has been inspected previous to the application by any Federal agency and the purpose for which inspection is desired.

4. Section 52.9 is revised to read as follows:

§ 52.9 Record of filing time.

A record showing the date when each application for inspection or for an appeal inspection is received shall be maintained.

5. Section 52.24 is amended by revising paragraph (a)(1) to read as follows:

§ 52.24 Where to file for an appeal inspection and information required.

(a) * * *

(1) The supervisor in the office that issued the inspection certificate on which the appeal covering the processed product is requested: or

* * * * *

6. Section 52.28 is revised to read as follows:

§ 52.28 Appeal inspection certificate.

After an appeal inspection has been completed, the lot(s) cannot be further appealed unless authorized by the Administrator. An appeal inspection certificate shall be issued showing the results of such appeal inspection; and such certificate shall supersede the inspection certificate previously issued for the processed product involved. Each appeal inspection certificate shall clearly identify the number and date of the inspection certificate which it supersedes. The superseded certificate shall become null and void upon the issuance of the appeal inspection certificate and shall no longer represent the quality or condition of the processed product described therein. The inspector or inspectors issuing an appeal inspection certificate shall forward notice of such issuance to such persons as he considers necessary to prevent misuse of the superseded certificate if the original and all copies of such superseded certificate have not previously been delivered to the inspector or inspectors issuing the appeal inspection certificate. The provisions in the regulations in this part concerning forms and certificates, issuance of certificates, and disposition of certificates shall apply to appeal inspection certificates, except that copies of such appeal inspection certificates shall be furnished all interested parties who received copies of the superseded certificate.

7. Section 52.37 is revised to read as follows:

§ 52.37 How official samples are to be identified and shipped.

Unless otherwise directed by the Administrator samples which are to be shipped to any office of inspection shall be forwarded to the office of inspection serving the area in which the processed products from which the samples were drawn is located. Such samples shall be shipped in a manner to avoid any material change in the quality or condition of the sample of the processed product. Containers shall be identified and properly sealed with tape. A facsimile of the "Officially Sampled" stamp shall be placed over the taped container. All transportation charges in connection with such shipments of samples shall be at the expense of the applicant.

8. Section 52.38 is amended by revising paragraphs (a), (f), and Tables I, II, III, IV, and V to read as follows:

§ 52.38 Sampling plans and procedures for determining lot compliance.

(a) Except as otherwise provided for in this section in connection with in-plant inspection and unless otherwise approved by the Administrator, samples shall be selected from each lot in the exact number of sample units indicated for the lot size in the applicable sampling plans. The lot size is to correspond to a sample size with a maximum of 29 sample units: Provided, that at the discretion of the inspection service, the number of sample units selected may be increased to the exact number of sample units indicated for any one of the larger sample sizes provided for in the appropriate plans. The sample size may be increased beyond 29 sample units in accordance with the following sampling plan:

Sample Size:	38	48	60
Acceptance Number:	5	6	7

* * * * *

(f) Sampling plans referred to in this section are those contained in Tables, I, II, III, IV, and V and (g)(1) and (g)(2) of this section which follow or any other plans which are applicable. For processed products not included in these tables, the minimum sample size shall be the exact number of sample units prescribed in the table, container group, and lot size that, as determined by the inspector, most closely resembles the product, type, container, size and amount of product to be sampled. The maximum sample size in Tables I, II, III, IV, V, (g)(1), (g)(2) and processed products not included in these tables is 29 sample units.

* * * * *

BILLING CODE 3410-01-M

SAMPLING PLANS AND ACCEPTANCE LEVELS
TABLE 1
CANNED OR SIMILARLY PROCESSED FRUITS, VEGETABLES, AND PRODUCTS CONTAINING UNITS OF SUCH SIZE AND CHARACTER AS TO BE READILY SEPARABLE

CONTAINER SIZE GROUP	LOT SIZE (NUMBER OF CONTAINERS) 1/				
Group 1 ANY TYPE CONTAINER OF A VOLUME NOT EXCEEDING THAT OF A NO. 303 SIZE CAN.	3,000 OR LESS	3,001 TO 12,000	12,001 TO 39,000	39,001 TO 84,000	84,001 TO 145,000
Group 2 ANY TYPE OF CONTAINER OF A VOLUME EXCEEDING THAT OF A NO. 303 SIZE CAN BUT NOT EXCEEDING THAT OF A NO. 3 CYLINDER SIZE CAN.	1,500 OR LESS	1,501 TO 6,000	6,001 TO 19,500	19,501 TO 42,000	42,001 TO 72,500
Group 3 ANY TYPE OF CONTAINER OF A VOLUME EXCEEDING THAT OF A NO. 3 CYLINDER SIZE CAN, BUT NOT EXCEEDING THAT OF A NO. 12 SIZE CAN.	750 OR LESS	751 TO 3,000	3,001 TO 9,750	9,751 TO 21,000	21,001 TO 36,250
Group 4 ANY TYPE OF CONTAINER OF A VOLUME EXCEEDING THAT OF A NO. 12 SIZE CAN.	CONVERT TO EQUIVALENT NUMBER OF 6 POUND NET WEIGHT CONTAINERS AND USE GROUP 3				
LOT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	13	21	29
ACCEPTANCE NUMBER	0	1	2	3	4
ON-LINE IN-PLANT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	6	13	21
ACCEPTANCE NUMBER	0	1	1	2	3

1/ Under on-line in-plant inspection, a 5% overrun in number of containers may be permitted by the inspector before going to the next larger sample size.

2/ When a standard sample unit size is not specified in the U.S. grade standards, the sample units for the various container size groups are as follows: Groups 1, 2, and 3 -- 1 container and its entire contents. Group 4 approximately 2 pounds of product. When determined by the inspector that a 2-pound sample unit is inadequate, a larger sample unit may be substituted.

TABLE II
FROZEN OR SIMILARLY PROCESSED FRUITS, VEGETABLES, AND PRODUCTS CONTAINING UNITS OF SUCH SIZE AND CHARACTER AS TO BE READILY SEPARABLE

CONTAINER SIZE GROUP	LOT SIZE (NUMBER OF CONTAINERS) 1/				
Group 1 ANY TYPE OF CONTAINER OF 1 POUND OR LESS NET WEIGHT	2,400 OR LESS	2,401 TO 9,600	9,601 TO 31,200	31,201 TO 67,200	67,201 TO 116,000
Group 2 ANY TYPE OF CONTAINER OVER 1 POUND BUT NOT OVER 2-1/2 POUNDS NET WEIGHT.	1,200 OR LESS	1,201 TO 4,800	4,801 TO 15,600	15,601 TO 33,600	33,601 TO 58,000
Group 3 ANY TYPE OF CONTAINER OVER 2-1/2 POUNDS.	CONVERT TO EQUIVALENT NUMBER OF 2-1/2 POUND CONTAINERS AND USE GROUP 2				
LOT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	13	21	29
ACCEPTANCE NUMBER	0	1	2	3	4
ON-LINE IN-PLANT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	6	13	21
ACCEPTANCE NUMBER	0	1	1	2	3

1/ Under on-line in-plant inspection, a 5% overrun in number of containers may be permitted by the inspector before going to the next larger sample size.

2/ When a standard sample unit size is not specified in the U.S. grade standards, the sample units for the various container size groups are as follows: Groups 1 and 2 - 1 container and its entire contents. Group 3 containers up to 10 pounds - approximately three pounds of product. When determined by the inspector that a 3-pound sample unit is inadequate, a larger sample unit or 1 or more containers and their entire contents may be substituted for 1 or more sample units of 3 pounds.

TABLE III

CANNED, FROZEN, OR OTHERWISE PROCESSED FRUITS, VEGETABLES, RELATED PRODUCTS OF A COMMINUTED, FLUID OR HOMOGENEOUS STATE

CONTAINER SIZE GROUP	LOT SIZE (NUMBER OF CONTAINERS) 1/				
Group 1 ANY TYPE OF CONTAINER OF 1 POUND OR LESS.	4,500 OR LESS	4,501 TO 18,000	18,001 TO 58,500	58,501 TO 126,000	126,001 TO 217,000
Group 2 ANY TYPE OF CONTAINER EXCEEDING 1 POUND BUT NOT EXCEEDING 60 OUNCES.	3,000 OR LESS	3,001 TO 12,000	12,001 TO 39,000	39,001 TO 84,000	84,001 TO 145,000
Group 3 ANY TYPE OF CONTAINER EXCEEDING 60 OUNCES BUT NOT EXCEEDING 10 POUNDS.	1,500 OR LESS	1,501 TO 6,000	6,001 TO 19,500	19,501 TO 42,000	42,001 TO 72,500
Group 4 ANY TYPE OF CONTAINER EXCEEDING 10 POUNDS.	CONVERT TO EQUIVALENT NUMBER OF 6 POUND CONTAINERS AND USE GROUP 3				
LOT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	13	21	29
ACCEPTANCE NUMBER	0	1	2	3	4
ON-LINE IN-PLANT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	6	13	21
ACCEPTANCE NUMBER	0	1	1	2	3

1/ Under on-line in-plant inspection, a 5% overrun in number of containers may be permitted by the inspector before going to the next larger sample size.

2/ When a standard sample unit size is not specified in the U.S. grade standards, the sample units for the various container size groups are as follows: Groups 1, 2, and 3 -- 1 container and its entire contents. A smaller sample unit may be substituted in group 3 at the inspector's discretion. Group 4 -- approximately 16 ounces of product. When determined by the inspector that a 16 ounce sample unit is inadequate, a larger sample unit may be substituted.

TABLE IV
DEHYDRATED (LOW-MOISTURE) FRUITS AND VEGETABLES

CONTAINER SIZE GROUP	LOT SIZE (NUMBER OF CONTAINERS) 1/				
Group 1 ANY TYPE OF CONTAINER OF 1 POUND OR LESS.	1,800 OR LESS	1,801 TO 7,200	7,201 TO 23,400	23,401 TO 50,400	50,401 TO 87,000
Group 2 ANY TYPE OF CONTAINER OVER 1 POUND BUT NOT OVER 6 POUNDS NET WEIGHT.	600 OR LESS	601 TO 2,400	2,401 TO 7,800	7,801 TO 16,800	16,801 TO 29,000
Group 3 ANY TYPE OF CONTAINER OVER 6 POUNDS.	CONVERT TO EQUIVALENT NUMBER OF 5 POUND CONTAINERS AND USE GROUP 2				
LOT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	13	21	29
ACCEPTANCE NUMBER	0	1	2	3	4
ON-LINE IN-PLANT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	6	13	21
ACCEPTANCE NUMBER	0	1	1	2	3

1/ Under on-line in-plant inspection, a 5% overrun in number of containers may be permitted by the inspector before going to the next larger sample size.

2/ When a standard sample unit size is not specified in the U.S. grade standards, the sample units for the various container size groups are as follows: Group 1 -- 1 container and its entire contents. Groups 2 and 3 -- 1 container and its entire contents or a smaller sample unit when determined by the inspector to be adequate.

TABLE V
DATES

CONTAINER SIZE GROUP	LOT SIZE (NUMBER OF CONTAINERS) 1/				
Group 1 ANY TYPE OF CONTAINER OF 1 POUND OR LESS NET WEIGHT.	2,400 OR LESS	2,401 TO 9,600	9,601 TO 31,200	31,201 TO 67,200	67,201 TO 116,000
Group 2 ANY TYPE OF CONTAINER OVER 1 POUND BUT NOT OVER 5 POUNDS NET WEIGHT.	800 OR LESS	801 TO 3,200	3,201 TO 10,400	10,401 TO 22,400	22,401 TO 38,667
Group 3 ANY TYPE OF CONTAINER OVER 5 POUNDS.	CONVERT TO EQUIVALENT NUMBER OF 5 POUND CONTAINERS AND USE GROUP 2				
LOT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	13	21	29
ACCEPTANCE NUMBER	0	1	2	3	4
ON-LINE IN-PLANT INSPECTION SAMPLE SIZE (NO. OF SAMPLE UNITS) 2/	3	6	6	13	21
ACCEPTANCE NUMBER	0	1	1	2	3

1/ Under on-line in-plant inspection, a 5% overrun in number of containers may be permitted by the inspector before going to the next larger sample size.

2/ Samples consist of 25 ounce sample units, each of which may be a composite of product from a sufficient number of individual containers from 1 case to make up the weight. When previous inspection results from a particular source so indicate, 1 composite sample of 25 ounces of product may be formed from the 3 sample units in the smallest sample size, and 2 composite samples of 25 ounces each may be formed from the 6 sample units in the next to smallest sample size. Sample units in larger sample sizes may not be further composited.

BILLING CODE 3410-02-C

9. Section 52.39 is revised to read as follows:

§ 52.39 Issuance of Certificate of Sampling.

Each inspector and each licensed sampler shall prepare and sign a certificate of sampling to cover the samples drawn by the respective person, except that in-plant inspectors who inspect the samples which they have drawn need not prepare a certificate of sampling. One copy of each certificate of sampling prepared shall be retained by the licensed sampler and the original and all other copies thereof shall be disposed of in accordance with the instructions of the Administrator.

10. Section 52.41 is revised to read as follows:

§ 52.41 Payment of fees and charges.

Fees and charges for any inspection service shall be paid by the interested party making the application for such service, in accordance with the applicable provisions of the regulations in this part, and if so required by the inspection service, an advance of funds prior to rendering inspection service in an amount suitable to the Administrator, or a surety bond suitable to the Administrator, shall be required as a guarantee of payment for the services rendered. All fees and charges for any inspection service peformed pursuant to the regulations in this part shall be paid by check, draft, or money order payable to the United States Department of Agriculture. Remittance shall be sent to the address specified on the bill for collection on or before the due date to avoid a late payment charge.

11. Section 52.42 is revised to read as follows:

§ 52.42 Schedule of fees.

Unless otherwise provided in a written agreement between the applicant and the Administrator, the fee for any inspection service performed under the regulations in part, shall be at the rate of $29.00 per hour plus an additional $5.50 per hour for all scheduled overtime hours. When work is performed on a holiday, an additional hour shall be charged at the regular hourly rate for each hour worked.

12. Section 52.47 is revised to read as follows:

§ 52.47 Fees to be charged for micro, chemical, certain other special analyses and other applicable services.

Fees for micro, chemical, and certain other special analyses, made at the request of the applicant, or because of additional specification requirements, and other applicable services, shall be at the rate of $25.00 per hour. Other applicable services include, but are not restricted to, grading unoffical samples, providing copies of score sheets and additional copies of certificates.

13. Section 52.48 is amended by revising paragraph (b) to read as follows:

§ 52.48 Charges for plant survey and sanitation inspection.

* * * * *

(b) Fees charged for a plant survey and a sanitation inspection under § 52.42 of this part will be credited back to plants entering into an in-plant inspection contract with AMS within 60 days of the survey.

14. Section 52.49 is revised to read as follows:

§ 52.49 Charges for copies of score sheets.

If the applicant for inspection service requests one or more copies of a score sheet referable to the processed product covered thereby, they may obtain such copies from the superviser in the office of inspection serving the area where the service was performed at a charge of ½ hour per copy in accordance with the rate in § 52.47: Provided, that no charge shall be made for one copy if requested in connection with the request for inspection.

15. Section 52.50 is revised to read as follows:

§ 52.50 Charges for additional copies of inspection certificates.

Charges for additional copies of inspection certificates issued in accordance with § 52.21 may be supplied to any financially interested party at a charge of ½ hour per certificate in accordance with the rate in § 52.47 for each seven (7), or fewer copies.

16. Section 52.51 is revised to read as follows:

§ 52.51 Travel and other expenses.

Charges may be made to cover the cost of travel time incurred in connection with the performance of any inspection service, including appeal inspections, at the rate of $29.00 per hour. This includes time spent waiting for transportation as well as time spent traveling, but not to exceed eight hours of travel time for any one person for any one day: And provided further, that if travel is by common carrier, no hourly charge may be made for travel time outside the employee's official work hours.

17. Section 52.52 is amended by revising paragraphs (c), and (d) to read as follows:

§ 52.52 Charges for inspection service on a contract basis.

(c) Charges for year-round in-plant inspection services on a contract basis will be billed to the applicant monthly for all hours worked with a minimum of 40 hours per week for each inspector assigned to perform the inspection services in accordance with the following schedule:

(1) For personnel assigned on a year-round basis: Each inspector—$22.00 per hour.

(2) For personnel assigned on less than a year-round basis: Each inspector—$27.00 per hour; In-plant sampler—$14.00 per hour.

(3) *Holiday pay.* An eight (8) hour charge will be made for each inspector assigned at their regular hourly rate. When work is performed, an additional hour at the regular hourly rate will be charged for each hour worked.

(4) *Night differential.* A 10 percent night differential charge will be made for all work performed between the hours of 6 p.m. and 6 a.m.

(5) *Overtime.* All overtime hours will be charged at the regular rates specified in paragraphs (c)(1) and (2) of this section plus $5.50 per hour.

(d) Charges for less than year-round in-plant inspection services (four or more consecutive 40 hour weeks) on a contract basis will be billed to the applicant monthly for all hours with a minimum of 40 hours for each inspector assigned to perform the inspection services in accordance with the following schedule: [3]

(1) Each inspector—$27.00 per hour [3]

(2) In-plant Sampler—$14.00 per hour.

(3) *Holiday pay.* An eight (8) hour charge will be made for each inspector assigned at their regular hourly rate. When work is performed, an additional hour at the regular hourly rate will be charged for each hour worked.

(4) *Night differential.* A 10 percent night differential will be charged for all work performed between the hours of 6 p.m. and 6 a.m.

(5) *Overtime.* All overtime hours will be charged at the regular rates specified in (d)(1) of this section plus $5.50 per hour.

* * * * *

17. Section 52.53 is amended by revising paragraphs (a)(2), (a)(3), (a)(4), (a)(5), (d), (e) and adding new paragraphs (a)(7) and (i) to read as follows:

---

[3] Except a minimum of 8 hours per day in lieu of a minimum of 40 hours a week for intermittent type in-plant services and less than four weeks in-plant assignment will be billed in accordance with § 52.42.

§ 52.53 Approved identification.

(a)* * *

(2) Have been produced or packed in an approved plant.

(3) Are truthfully and accurately labeled.

(4) When graded against a U.S. grade standard, meet the quality requirements for U.S. Grade C or better;

(5) Meet applicable fill weight and/or drained weight, Brix or other characteristics of a commodity related to market value;

(6) Have been certified, or have been inspected and are eligible for certification, by an inspector; and, in addition, meet the specific requirements stated in (b), (c), and (d) of this section.

(7) Labels and advertising material containing or referring to approved identification must be approved by USDA inspection service prior to use.

* * * * *

(d) *"Approved plant-lot inspection" grade and inspection marks.* Processed products that are produced in an approved plant as defined in § 52.2 and inspected and certified by an inspector on a lot basis may be labeled with on official mark as defined in § 52.3 when adequate control and use is approved. The use of official marks for this type of service is restricted to grade marks (with or without plain shield) and/or the statement "Inspected by the U.S. Department of Agriculture" (with or without plain shield). The official marks shall be similar in form and design as illustrated in figures 11 through 14. Failure to have all lots bearing official marks either inspected and certified or certified as produced in an approved plant shall cause the debarment of the user from receiving subsequent services, and such other actions as provided for in the Agricultural Marketing Act of 1946.

(e) *Sampling marks.* Processed products which have been sampled for inspection as provided in this part may, at the option of the Department, be identified by an authorized representative of the Department. The products are identified by stamping the container(s) comprising such lot(s), with an official "sampling mark", similar in form and design to the example in figure 15 of this section. The "sampling marks" will identify products officially sampled by a particular field office. Such mark will include a code identifying the field office performing the sampling.



FIGURE 15

* * * * *

(i) Disposition of labels bearing approved grade or inspection marks when a contract is cancelled. Upon cancellation of a contract, labels bearing approved grade or inspection marks shall remain under the control of the inspection service. The inspection service will approve disposition of said labels for destruction, sale or transfer to another approved plant, remove or obliterate the grade or inspection mark, or other action as may be agreed upon by all interested parties.

Done at Washington, DC, on: March 21, 1986.

William T. Manley,

Deputy Administrator Marketing Programs.

[FR Doc. 86-6849 Filed 3-31-86; 8:45 am]

BILLING CODE 3410-02-M

Soil Conservation Service

7 CFR Part 652

Relocation Assistance

AGENCY: Soil Conservation Service, USDA.

ACTION: Proposed rule.

SUMMARY: The Soil Conservation Service (SCS) published Part 652, Relocation Assistance in the **Federal Register** on April 17, 1974, to implement the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (Uniform Act) (42 U.S.C. 4601-4655), as implemented by the U.S. Department of Agriculture in 7 CFR Part 21. Since this publication, all federal agencies have been directed to publish a common rule to implement the Uniform Act to correct any inconsistencies and inequalities that may have existed with the different agencies' regulations. The U.S. Department of Agriculture published its common rule in the **Federal Register** on February 27, 1986, as 51 FR 7000-7040. The common rule does not require any further implementation by SCS. Therefore, SCS proposes to remove and reserve 7 CFR Part 652.

DATE: Comments are due June 2, 1986.

ADDRESS: Written comments on the proposed action should be addressed to: Deputy Chief for Administration, Soil Conservation Service, USDA, P.O. Box 2890, Washington, D.C. 20013 or telephone (202) 447-6297.

FOR FURTHER INFORMATION CONTACT: Wayne F. Maresch, Director, Administrative Services Division, Soil Conservation Service, USDA, P.O. Box 2890, Washington, D.C. 20013, or telephone (202) 447-5111.

SUPPLEMENTARY INFORMATION: The common rule set forth in 7 CFR Part 21 implements the Uniform Act which requires that owners of real property to be acquired for Federal or Federally-assisted programs, and persons displaced from their dwellings, businesses or farms as a result of such acquisition be provided fair, consistent, and equitable treatment. This common rule is so structured that further implementation below the Departmental level is not necessary. Section 652.3 pertains to an SCS delegation of authority that is not needed under the common rule.

List of Subjects in 7 CFR Part 652

Technical assistance, Water resources, Grant program--Natural resources.

PART 652—[RESERVED]

Accordingly, Chapter VI of Title 7 is proposed to be amended by removing and reserving Part 652.

Authority: 42 USC 4601-4655

Wilson Scaling,

Chief.

March 25, 1986.

[FR Doc. 86-7039 Filed 3-31-86; 8:45 am]

BILLING CODE 3410-16-M

Agricultural Marketing Service

7 CFR Part 1040

Milk in the Southern Michigan Marketing Area; Proposed Suspension of Certain Provisions of the Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed suspension of rules.

SUMMARY: This notice invites written comments on a proposal to suspend for the months of April through September

1986 the requirement in the Southern Michigan Federal milk order that a cooperative association deliver to pool distributing plants at least 50 percent of its members' producer milk in order to qualify its supply plants as pool plants under the order. The suspension was requested by a cooperative association that represents producers supplying milk to the fluid market. The association claims that the action is needed to avoid inefficient handling of milk and to ensure that dairy farmers historically associated with the Southern Michigan market will continue to share in the market's fluid milk sales.

DATE: Comments are due on or before April 8, 1986.

ADDRESS: Comments (two copies) should be sent to: Dairy Division, Agricultural Marketing Service, Room 2968–South Building, U.S. Department of Agriculture, Washington, DC 20250.

FUR FURTHER INFORMATION CONTACT: Richard A. Glandt, Marketing Specialist, Dairy Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, DC 20250, (202) 447–4829.

SUPPLEMENTARY INFORMATION: The Administrator of the Agricultural Marketing Service has certified that this proposed action would not have a significant economic impact on a substantial number of small entities. Such action would lessen the regulatory impact of the order on certain milk handlers and would tend to ensure that dairy farmers would continue to have their milk priced under the order and thereby receive the benefits that accrue from such pricing.

Notice is hereby given that, pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601 *et seq.*), the suspension of the following provisions of the order regulating the handling of milk in the Southern Michigan marketing area is being considered for April through September 1986:

1. In § 1040.7(b)(2), the words "if transfers from supply plants to plants described in paragraph (b)(5) of this section and by direct delivery from the farm to plants qualified under paragraph (a) of this section are:"

2. In § 1040.7(b)(2), paragraphs (i) and (ii).

All persons who want to send written data, views or arguments about the proposed suspension should send two copies to the Dairy Division, Agricultural Marketing Service, Room 2968–South Building, U.S. Department of Agriculture, Washington, DC 20250, by the 7th day after publication of this notice in the **Federal Register**. The period for filing comments is limited to seven days because a longer period would not provide the time needed to complete the required procedures and include April 1986 in the suspension period if this is found necessary.

The comments that are received will be made available for public inspection in the Dairy Division during normal business hours (7 CFR 1.27(b)).

Statement of Consideration

The proposed suspension would make inoperative for the months of April through September 1986 the provisions requiring a cooperative association to deliver at least 50 percent of its members' producer milk to pool distributing plants, either through its supply plants or directly from farms, in order to qualify the supply plants as pool plants.

Michigan Milk Producers Association (MMPA), which represents a substantial number of the producers supplying the market, requested the suspension and cited the following marketing conditions as support for its request. Class I utilization in the market, as a percentage of producer milk for 1985, was only 42 percent and therefore a 50 percent qualification requirement is impractical and burdensome. MMPA pools approximately 87 percent of its members' milk on the Southern Michigan market using the supply plant pooling standard. Milk production for the Southern Michigan market has increased approximately four percent during the first two months of 1986 compared to 1985 and at the same time the cooperative's Class I sales to distributing plants have decreased about ten percent from 1985. MMPA during February 1986, processed through its balancing plants about 86 percent of the market's reserve milk supply while its market share of producer milk was only 64 percent. This imbalance, MMPA anticipates, will become more severe during the spring flush months because other cooperative associations operating in the market lack sufficient manufacturing facilities.

The association said that the suspension is needed to avoid the inefficient handling of milk merely to assure pooling of supply plants and to insure that dairy farmers who have been historically associated with the Southern Michigan market will continue to share in the fluid milk sales of the market.

Accordingly, it may be appropriate to suspend the aforesaid provisions for the months of April through September 1986.

List of Subjects in 7 CFR Part 1040

Milk marketing orders, Milk, Dairy products.

The authority citation for 7 CFR Part 1040 continues to read as follows:

Authority: Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674.

Signed at Washington, DC, on March 26, 1986.

William T. Manley,

Deputy Administrator Marketing Programs.

[FR Doc. 86–7101 Filed 3–31–86; 8:45 am]

BILLING CODE 3410–02–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 74

[Docket No. 84N–0150]

D&C Green No. 6; Uniform Specifications

Correction

In FR Doc. 86–6316 beginning on page 9843 in the issue of Friday, March 21, 1986, make the following corrections:

1. In the heading of the document, the docket number was incorrect and should have appeared as set forth above.

2. On page 9844, first column, in the heading for B, "Safety Consideration" should read "Safety Considerations". In the same column, second complete paragraph under B, ninth line, "*P*-toluidine" should read "*p*-toluidine". In the third column, second complete paragraph, sixth line, "mich" should read "mice".

BILLING CODE 1505–01–M

21 CFR Part 150

[Docket No. 86N–0019]

Fruit Jelly and Fruit Preserves and Jams; Advance Notice of Proposed Rulemaking on the Possible Amendment of the U.S. Standards of Identity and Establishment of U.S. Standards of Quality and Fill of Container

Correction

In FR Doc. 86–5702 beginning on page 9063 in the issue of Monday, March 17, 1986, make the following corrections:

1. On page 9065, first column, in

2.2.2.2(c), second line, "this" should read "the".

2. On page 9066, in 4.1.1., under "Maximum level", first line, "Insufficient" should be two words.

3. On the same page, in 4.4.5., "Tarazine" should read "Tartrazine". The entry "4/5 *Preservatives*" should read "4.5 *Preservatives*". In 4.6.4., under "Maximum level", "CMP" should read "GMP".

4. On page 9067, second column, in 8.2.1., third line, "of" should read "for".

5. On page 9069, first column, in § 150.160(d)(2)(iv), first line, insert "the" between "In" and "case". In the second column, in § 150.160(d)(5), tenth line, "100" should read "1100". In § 150.160(e)(1), first line, "preserve of" should read "preserve or".

6. On the same page, third column, in the first line, "information" was misspelled.

BILLING CODE 1505-01-M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

23 CFR Part 645

Accommodation of Utilities

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice.

SUMMARY: The FHWA is issuing this notice to advise the public that it is reviewing its existing policy governing longitudinal utility use of Interstate (freeway) right-of-way (23a CFR 645, Subpart B) to determine if changes or modifications in this policy are needed. Present policy limits longitudinal utility use of the Interstate right-of-way within the access control limits. FHWA believes an overall review of policy is needed due to changes in technology and advancements in utilities configurations. FHWA will initiate the appropriate rulemaking in the near future requesting public comment.

FOR FURTHER INFORMATION CONTACT: James A. Carney, Office of Engineering, Federal Highway Administration, 400 Seventh Street, SW., Washington, D.C. 20590, Telephone: (202) 426-0450.

Issued on: March 27, 1986.

R.D. Morgan,

Executive Director, Federal Highway Administration.

[FR Doc. 86-7303 Filed 3-31-86; 10:14 am]

BILLING CODE 4910-22-M

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 935

Reopening and Extension of Public Comment Period on a Proposed Amendment to the Ohio Permanent Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSMRE), Interior.

ACTION: Reopening and extension of public comment period.

SUMMARY: By a letter dated January 15, 1986, Ohio submitted proposed program amendments to the rules of procedures for the Reclamation Board of Review (RBR, the Board). OSMRE published a notice in the **Federal Register** on February 26, 1986, announcing receipt of the amendments and inviting public comment on the adequacy of the proposed amendments (51 FR 6752).

By letter dated March 7, 1986, Ohio resubmitted the RBR rules as they were promulgated as final rules. The final rules contain some differences from the RBR rules that were announced in the February **Federal Register** and the proposed RBR rules previously approved by OSMRE on May 23, 1985 and September 18, 1985 (50 FR 21256, 50 FR 37848).

Accordingly, OSMRE is reopening and extending the comment period on Ohio's January 15, 1986 amendments as modified on March 7, 1986. This action is being taken to provide the public an opportunity to reconsider the adequacy of the proposed amendments.

DATES: Written comments, data or other relevant information relating to this rulemaking not received on or before 4:30 p.m. April 16, 1986, will not necessarily be considered in the Director's decision.

ADDRESSES: Written comments should be mailed or hand delivered to Ms. Nina Rose Hatfield, Director, Columbus Field Office, Office of Surface Mining Reclamation and Enforcement, 2242 South Hamilton Road, Room 202, Columbus, Ohio 43227; Telephone: (614) 866-0578.

Copies of the Ohio program, the proposed amendments and modification to the amendments, and all written comments received in response to this notice will be available for public review at the OSMRE Field Office listed above and at the OSMRE Headquarters Office and the Office of State regulatory authority listed below, during normal business hours, Monday through Friday, excluding holidays. Each requester may receive, free of charge, one single copy of the proposed amendments by contacting OSMRE's Columbus Field Office.

Office of Surface Mining Reclamation and Enforcement, 1100 "L" Street, N.W., Room 5315A, Washington, D.C. 20240

Ohio Division of Reclamation, Fountain Square, Building B, Columbus, Ohio 43224.

FOR FURTHER INFORMATION CONTACT: Ms. Nina Rose Hatfield, Director, Columbus Field Office, 2242 South Hamilton Road, Room 202, Columbus, Ohio 43227; Telephone: (614) 866-0578.

SUPPLEMENTARY INFORMATION:

I. Background

The Ohio program was approved effective by the Secretary of the Interior on August 16, 1982, by notice published in the August 10, 1982 **Federal Register** (47 FR 34688). Information pertinent to the general background, revisions, modifications, and amendments to the Ohio program submission, as well as the Secretary's findings, the disposition of comments, and a detailed explanation of the conditions of approval of the Ohio's program can be found in the August 10, 1982 **Federal Register**. Subsequent actions concerning the conditions of approval and program amendments are identified at 30 CFR 935.11 and 935.15.

II. Proposed Amendment

By a letter dated January 15, 1986, Ohio submitted proposed program amendments consisting of:

(1) Revisions to 1513-3-01 *Definitions*, "burden of persuasion" and "proffer";

(2) Revisions to 1513-3-02 *Internal regulations*, rules for a quorum, deciding tie votes, keeping records of the RBR's actions, issuance of subpoenas, and governing proceedings following amendment of the RBR's rules;

(3) Revisions to 1513-3-03 *Appearance and practice before the board*, concerning ethical standards of persons appearing before the board and representation before the RBR;

(4) Revisions to 1513-3-04 *Appeals to the RBR*, concerning identification of counsel, if counsel is used, contents of an appeal, and grounds for dismissing an appeal;

(5) Revisions to 1513-3-16 *Conduct of evidentiary hearings*, rules concerning evidence, stipulation, written testimony, witnesses, post-hearing briefs, and additional oral arguments;

(6) Revisions to 1513-3-17 *Voluntary dismissal and settlement* setting forth

rules for a settlement prior to a final order by the RBR; and

(7) Revisions to 1513–3–21 *Award of costs and expenses.*

OSMRE announced receipt of the amendments and initiated a public comment period on February 26, 1986 (51 FR 6752). The comment period closed on March 28, 1986.

While public comments were being solicited on Ohio's proposed RBR rules, the State finalized these rules (1513–3–01 to 1513–3–22). Ohio promulgates emergency rules and submits them to OSMRE for review and approval. When OSMRE approves an emergency rule, it does so with the caveat that the final rule must be promulgated in identical form to the rule approved by OSMRE. The final rules submitted to OSMRE by letter dated March 7, 1986, do not contain language identical to the amendments proposed in the February 26, 1986 **Federal Register.** The differences appear primarily at 1513–3–21, *Award of costs and expenses.* Therefore, OSMRE is reopening and extending the comment period.

The full text of the proposed amendments is available for review at the locations listed above under "ADDRESSES." OSMRE is now seeking public comment on the adequacy of Ohio's January 15, 1986 amendments in light of the March 7, 1986 final rules. If the Director determines that the proposed amendments are no less stringent than SMCRA and no less effective than the Federal regulations, the amendments will be approved and become part of the approved permanent program.

List of Subjects in 30 CFR Part 935

Coal mining, Intergovernmental relations, Surface mining, Underground mining.

Dated: March 26, 1986.

H. Leonard Richeson,

Acting Assistant Director, Program Operations.

[FR Doc. 86–7162 Filed 3–31–86; 8:45 am]

BILLING CODE 4310–05–M

DEPARTMENT OF THE TREASURY

Office of Revenue Sharing

31 CFR Part 51

Financial Assistance to Local Governments; Administrative Hearing Procedures

AGENCY: Office of Revenue Sharing, Treasury.

ACTION: Proposed rule.

SUMMARY: The proposed rule would amend 31 CFR Part 51, Subpart G, "Proceedings for Reduction in Entitlement, Withholding, or Suspension of Funds", to eliminate the administrative appeal and review by the Secretary currently permitted after an administrative hearing.

DATES: Written comments must be received on or before June 2, 1986.

ADDRESSES: Send comments to: Chief Counsel for Revenue Sharing; Office of Revenue Sharing, Treasury Department, Washington, DC 20226.

FOR FURTHER INFORMATION CONTACT: Richard S. Isen, Chief Counsel or Jacqueline L. Jackson, Attorney, Office of Chief Counsel for Revenue Sharing, Washington, DC 20226 Telephone: (202) 634–5182.

SUPPLEMENTARY INFORMATION:

Background

The Revenue Sharing regulations governing procedures for reduction in entitlement, withholding, or suspension of funds, 31 CFR Part 51, Subpart G, have not been substantially revised since they were published to implement the amendments to the civil rights provisions in the Revenue Sharing Act made by the State and Local Fiscal Assistance Amendments of 1976 (Pub. L. 94–488). The decision to streamline the appeals process, by eliminating the provision for Secretarial review of the decision of an administrative law judge, is proposed in light of ORS' experience with these proceedings over the intervening years. The changes will also conform the process more closely with the statutory scheme under which the decisions of an administrative law judge are directly appealable to the Federal courts. Although the President has proposed termination of the Revenue Sharing Program, these changes would be useful with respect to hearings conducted prior to the end of the Program.

The proposed changes are:

Section 51.210 Administrative law judge; powers.

Paragraph (b)(2) would be revised to eliminate the reference to an interlocutory administrative appeal during an administrative hearing. Paragraph (b)(10) would be revised to refer to the decision of the administrative law judge as the final agency action.

Section 51.211 Adminstrative hearings.

New sentences would be added to the end of paragraph (a) to specify that the administrative law judge issues the final agency decision concerning compliance with the Revenue Sharing Act, based upon the record.

A new paragraph (b)(1) would remove the reference to a summary proceeding prior to the preliminary decision. Whether or not to grant oral argument prior to this decision is at the discretion of the administrative law judge. Paragraph (b)(1) would also provide that the preliminary decision is to be issued within 60 days of the Director's receipt of the request for a hearing, as required in the Revenue Sharing Act at 31 U.S.C. 6717(d). The paragraph would also provide that the preliminary decision is not appealable. The statutory requirement for a hearing on the merits is preserved.

The new paragraph (b)(2) would state that the decision of the administrative law judge following completion of the hearing is the final decision of the agency. The hearing procedures set forth in the Revenue Sharing Act (31 U.S.C. 6718) describe in detail the authority of the Secretary of the Treasury, the administrative law judge and the appeal procedures for recipient governments. The Act provides that the Secretary has a nondiscretionary duty to withhold or terminate funding pursuant to the decision of the administrative law judge. The Act (31 U.S.C. 6722) provides for direct appeal to the applicable U.S. Court of Appeals and does not provide for review of the decision of the administrative law judge by the Secretary. Hence, the option for appeal to the Secretary is deleted from the regulations in the interest of streamlining the procedures applicable to the Revenue Sharing Program. The due process of recipient governments are fully protected since a full record will be created by the administrative law judge for use by a reviewing court. Therefore, the agency review provisions of the Administrative Procedure Act (5 U.S.C. 557) are not applicable to adjudications under the Revenue Sharing Act.

Section 51.217 Preliminary finding (for hearings under subpart E).

This section would be revised to delete the reference to the "initial decision" of the administrative law judge and add a reference to the "final decision."

Section 51.218 Final decision of the administrative law judge.

Current § 51.218 would be amended to delete the references to "initial decision" of the administrative law judge in the title and elsewhere and to add references to "final decision" in their places.

Section 51.219 Certification and transmittal of record and decision.

Current § 51.219 would be amended to delete the references to "initial decision" of the administrative law judge and add references to "final decision" in their places.

Section 51.221 Publicity of proceedings.

Current § 51.221, "Procedure on review of decision of administrative law judge" and 51.222, "Effect of absence of appeal or review of initial decision of administrative law judge" would be deleted for the reasons described above with respect to § 51.211. Section 51.223 would be redesignated § 51.221, and the references to "initial decision" and review of the decision of the administrative law judge would be deleted.

Section 51.222 Judicial review.

Current § 51.224 would be redesignated § 51.222 and the reference to the initial decision of the administrative law judge and review by the Secretary would be deleted. The reference in paragraph (d) to preparation of the record by the "Secretary" would be changed to "Director" since the Secretary would not longer have a role in the administrative hearing process.

Regulatory Flexibility Act

The Regulatory Flexibility Act of 1980 (Pub. L. 96–354, hereinafter referred to as the RFA) requires that regulations with significant economic impact on a substantial number of "small entities" should undergo regulatory flexibility analyses. With respect to the Revenue Sharing Program, small entities are defined as recipient governments with a population below 50,000. It is hereby certified that this proposal, if adopted, would not have a significant economic impact on small governmental units.

Executive Order 12291—"Federal Regulation"

The proposed regulations do not constitute a "major rule" within the meaning of Section 1(b) of Executive Order 12291, entitled "Federal Regulation." A regulatory analysis is not required.

List of Subjects in 31 CFR Part 51

Accounting, Administrative practice and procedure, Civil rights, Handicapped, Aged, Indians, Revenue Sharing, Reporting and recordkeeping requirements.

31 CFR Part 51, Subpart G, is, therefore, proposed to be amended in the manner set forth below:

Dated: February 7, 1986

Michael F. Hill,

Director, Office of Revenue Sharing.

Subpart G—Proceedings for Reduction in Entitlement, Withholding, or Suspension of Funds

1. The authority citation for Part 51 continues to read as follows:

Authority: 31 U.S.C. 6701 to 6724 and Treasury Department Order No. 224, dated January 26, 1973 (38 FR 3342) as amended by Treasury Department Order No. 103–1 dated March 18, 1982.

2. Section 51.210 is amended by revising paragraph (b) (2) and (10) to read as follows:

§ 51.210 Administrative law judge; powers.

* * * * *

(b) *Powers of administrative law judge.* * * *

(2) Make rulings upon motions and requests, including a motion for oral argument, prior to making a preliminary decision under Subpart E.

* * * * *

(10) Make findings of fact and conclusions of law and issue the premiminary decision and the final agency decision as authorized by this subpart.

3. Section 51.211 would be amended by revising paragraphs (a) and (b) to read as follows:

§ 51.211 Administrative hearings.

(a) *Administrative hearings for violations other than subpart E.* The administrative law judge shall preside at a hearing on the merits of the complaint. Testimony of witnesses shall be given under oath or affirmation. The hearing shall be stenographically recorded and transcribed. Hearings shall be conducted pursuant to section 7 of the Administrative Procedure Act (5 U.S.C. 556). Upon completion of the hearing, the administrative law judge shall issue the conclusions of law, findings of fact and the final agency decision based upon the record. The decision shall state whether or not the recipient government has complied with the provisions of the Act.

(b) *Administrative hearing under Subpart E.* A hearing requested by a recipient government, pursuant to § 51.65(a)(2) of Subpart E, shall be commenced by the Director within thirty (30) days of receipt of such request and shall be held before an administrative law judge. Testimony shall be given under oath or affirmation and shall provide for two decisions of the administrative law judge as follows:

(1) The administrative law judge shall issue a preliminary decision as to whether the recipient government is likely to prevail in demonstrating compliance with Subpart E. The preliminary decision shall be based upon the record of the case (including oral argument, if any) at that time, and shall be issued within 60 days after the request for a hearing is received by the Director. The preliminary decision is not appealable.

(2) After a preliminary decision and the completion of the hearing including oral arguments, if any, the administrative law judge shall issue the final decision in the case, based upon the complete record of the evidence, as soon as practicable. The final decision may also be based upon receipt of any proposed findings of fact and conclusions of law submitted by the parties, but in no event shall it be made later than 30 days after the conclusion of the hearing. The final decision may be combined with the preliminary hearing in the event that the administrative law judge decides that further proceedings are not necessary. The final decision of the administrative law judge shall constitute the final agency decision as described in § 51.218 of this part.

* * * * *

§ 51.217 [Amended]

4. Section 51.217 would be amended by changing the reference in paragraph (a)(2), fifth sentence, from "initial decision" to "final decision."

§ 51.218 [Amended]

5. Section 51.218 would be amended as follows:

a. Section 51.218 would be retitled "Final decision of the administrative law judge."

b. In § 51.218, the references to "initial decision" would be changed to "final decision" wherever they occur.

§ 51.219 [Amended]

6. Section 51.219 would be amended by changing the references in the first and second sentences from "initial decision" to "final decision."

§§ 51.221 and 51.222 [Removed]

§ 51.223 [Redesignated as § 51.221 and amended]

7. Sections 51.221 and 51.222 would be removed and § 51.223 would be redesignated § 51.221 and the first sentence of paragraph (c) would be revised to read as follows:

§ 51.221 Publicity of hearings.

* * * * *

(c) *Decisions of the administrative law judge.* The statement of findings and the decisions of the administrative law

judge in any hearings shall be indexed and maintained by the Director and made available for public inspection at the public documents room of the Department. * * *

§ 51.224 [Redesignated as § 51.222 and amended]

8. Section 51.224 would be amended as follows:

a. Section 51.224 would be redesignated § 51.222.

b. Paragraph (b) of redesignated § 51.222 would be revised to read as follows:

§ 51.222 Judicial review.

* * * * *

(b) *Appeal by the respondent.* A recipient government may appeal the final decision of the administrative law judge to the U.S. Court of Appeals, as provided by 31 U.S.C. 6722.

* * * * *

c. Paragraph (c) would be amended by removing the last sentence.

d. Paragraph (d) would be amended by changing the reference from "Secretary" in the first sentence to "Director."

[FR Doc. 86-7080 Filed 3-31-86; 8:45 am]

BILLING CODE 4810-28-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 50

[AD-FRL 2994-9]

National Ambient Air Quality Standards; Review of Criteria and Standards for Particulate Matter and Sulfur Oxides

AGENCY: Environmental Protection Agency.

ACTION: Notice.

SUMMARY: EPA plans to evaluate newly available scientific studies on the health effects of particulate matter and sulfur oxides by preparing an addendum to the criteria document for particulate matter and sulfur oxides and to assess the implications, if any, of such criteria revisions for the national ambient air quality standards for particulate matter and sulfur oxides by preparing separate addenda to the staff papers for these pollutants..

FOR FURTHER INFORMATION CONTACT: Dr. Lester D. Grant, Director, Environmental Criteria and Assessment Office (MD-52), Environmental Protection Agency, Research Triangle Park, North Carolina 27711, Telephone (919) 541-4173 or Bruce Jordan, Strategies and Air Standards Division, Office of Air Quality Planning and Standards (MD-12), Environmental Protection Agency, Research Triangle Park, North Carolina 27711, Telephone (919) 541-5655.

SUPPLEMENTARY INFORMATION: On March 20, 1984, EPA proposed revisions to the national ambient air quality standards for particulate matter and issued revised air quality criteria for particulate matter and sulfur oxides (49 FR 10408). As part of the standards review process, the Clean Air Scientific Advisory Committee (CASAC) met on December 16-17, 1985 to review the March 1984 proposal and to discuss the relevance of certain new scientific studies on the health effects of particulate matter that have emerged since the Committee completed its review of the criteria document for particulate matter and sulfur oxides (EPA-600/8-82-029 a, b, and c) and the particulate matter staff paper (EPA-450/5-82-001) in January 1982. Based on its preliminary review of the newly available data, the Committee recommended that the Agency prepare separate addenda to the criteria document and staff paper for the purpose of evaluating the relevant new studies and discussing their potential implications for standard-setting. In making this recommendation, CASAC made it clear that preparation of these addenda need not result in a re-examination of all major issues previously examined in the criteria document and staff paper but instead should be targeted and developed in an expeditious manner.

In the process of responding to CASAC's recommendations with respect to particulate matter, the Agency also examined the need to update the sulfur oxides portions of the criteria document and related staff paper (EPA-450/5-82-007). As in the case of particulate matter, a number of new studies of the health effects of sulfur dioxide have emerged since 1982 that warrant evaluation and consideration with respect to standard-setting.

In light of the CASAC recommendations and the Agency's own review, EPA plans to prepare an addendum to the air quality criteria for particulate matter and sulfur oxides (EPA-600/8-82-029 a, b, and c) that addresses both pollutants and separate addenda for the associated staff papers (EPA-450/5-82-001 and EPA-450/5-82-007). As recommended by CASAC, the Agency does not intend for these addenda to reexamine all of the available health effects information or related issues that have already been adequately addressed in the criteria document and the staff papers for particulate matter and sulfur oxides. Rather the addenda will focus on a limited set of scientific studies that have become available since completion of the criteria document in 1982 that might have implications for decisions on the proposed revisions to the national ambient air quality standards for particulate matter (49 FR 10408) and on the review of the national ambient air quality standards for sulfur oxides. It is the Agency's intent to proceed as expeditiously as possible and to avoid unnecessary delays in completing these actions.

The Agency plans for these addenda to undergo appropriate public and scientific review. The Environmental Criteria and Assessment Office will hold a public workshop this spring to assist in the preparation of the addendum to the criteria document and will provide an opportunity for the public to comment on an external review draft this summer. Separate notices will announce the workshop, the availability of the external review draft of the criteria document addendum and the staff paper addenda. Both the criteria document addendum and the staff paper addenda will be reviewed by CASAC at a public meeting scheduled for October of this year.

Dated: March 20, 1986.

J. Craig Potter,

Assistant Administrator for Air and Radiation.

[FR Doc. 86-6998 Filed 3-31-86; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 86-84; RM-5018]

FM Broadcast Station in Springfield, FL

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This action proposes the allotment of Channel 270A to Springfield, Florida, as its second FM channel, in response to a petition filed by Springfield Broadcasters.

DATES: Comments must be filed on or before May 15, 1986, and reply comments on or before May 30, 1986.

ADDRESS: Federal Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT:
Montrose H. Tyree, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Proposed Rulemaking

In the Matter of Amendment of §73.202(b), Table of Allotments, FM Broadcast Stations. (Springfield, Florida): MM Docket No. 86–84, Rm–5018.

Adopted: March 18, 1986.
Released: March 24, 1986.

By the Chief, Policy and Rules Division.

1. The Commission herein considers a petition for rule making filed by Springfield Broadcasters ("pititioner") requesting the allotment of Channel 286A to Springfield, Florida, as its second FM channel.[1] Petitioner stated its intention to apply for the channel.

2. In veiw of the fact that the proposed allotment could provide a second FM service to Springfield, the Commission proposes to amend the FM Table of Allotments, § 73.202(b) of the Rules with regard to Springfield, Florida, as follows:

City	Channel No.	
	Present	Proposed
Springfield, FL	240A	240A, 270A

3. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirement are contained in the attached Appendix and are incorporated by reference herein. NOTE: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

4. Interested parties may file comments on or before May 15, 1986, and reply comments on or before May 30, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Nancy L. Wolf, Dow, Lohnes and Albertson, 1255–23rd Street, NW., Washington, DC 20037.

5. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that Sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

6. For further information concerning this proceeding, contact Montrose H. Tyree, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promplty. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in § 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of services. (See § 1.420(a), (b) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original anf four copies of all comments, reply comments, pleadings briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference

[1] The petition as filed requested the allotment of Channel 286A at Springfield, Florida. That proposal conflicts with a rule making to allot Channel 286C2 to Panama City Beach, Florida (RM–5159). Since Channel 270A can be allotted to Springfield, the *Notice* will follow that approach. The channel can be alloted in compliance with the minimum distance separation requirements.

Room at its headquarterss, 1919 M Street, NW., Washington, D.C.

[FR Doc. 86-6830 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-83; RM-5127]

FM Broadcast Station in Humboldt, TN

AGENCY: Federal Communications Commission.

ACTION: Proposed Rule.

SUMMARY: Action taken herein, at the request of F. Darrell Boyd, proposes the allotment of Channel 229A to Humboldt, Tennessee, as that community's second FM service.

DATES: Comments must be filed on or before May 15, 1986, and reply comments on or before May 30, 1986.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Proposed Rulemaking

In the Matter of Amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations (Humboldt, Tennessee); MM Docket No. 86-83, RM-5127.

Adopted: March 18, 1986.

Released: March 24, 1986.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration a petition for rule making filed by F. Darrell Boyd ("petitioner"), seeking the allotment of FM Channel 229A to Humboldt, Tennessee, as that community's second FM service. Petitioner has stated his intention to apply for the channel. The channel can be alloted in compliance with the Commission's minimum distance separation requirements.

2. In view of the fact that Humboldt, Tennessee, could receive its second local FM service, the Commission finds it would be in the public interest to seek comments on the proposal to amend the FM Table of Allotments, §73.202(b) of the Commission's Rules, for the community:

City	Channel No.	
	Present	Proposed
Humboldt, TN	272A	229A, 272A

3. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

4. Interested parties may file comments on or before May 15, 1986, and reply comments on or before May 30, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Timothy K. Brady, 1116 Weisgarber Road, P.O. Box 10566, Knoxville, TN 37939-0566, (Counsel to petitioner).

5. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

6. For further information concerning this proceeding, contact Patricia Rawlings, Mass Media Bureau (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(c)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in the proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions

by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW, Washington, DC.

[FR Doc. 86-6831 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-85; RM-5186]

FM Broadcast Station in Waco, TX

AGENCY: Federal Communications Commission.

ACTION: Proposed Rule.

SUMMARY: Action taken herein, at the request of Kennelwood Broadcasting Company, proposes the allocation of Channel 277A to Waco, Texas, as that community's fifth FM service.

DATES: Comments must be filed on or before May 15, 1986, and reply comments on or before May 30, 1986.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

In the Matter of Amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations (Waco, Texas); MM Docket No. 86-85, RM-5186.

Adopted: March 18, 1986.
Released: March 24, 1986.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by Kennelwood Broadcasting Company ("petitioner"), seeking the allocation of Channel 277A to Waco, Texas, as that community's fifth FM service. Petitioner expressed its intention to apply for the channel, if allotted.

2. The channel can be alloted to Waco in compliance with the Commission's minimum distance separation requirements with a site restriction of 3.4 kilometers (2.1 miles) west of the community. This restriction is necessary to avoid short spacing to FM Station KJCS on Channel 277 at Nacogdoches, Texas.

3. In view of the fact that Waco, Texas could receive its fifth FM channel the Commission believes it would be in the public interest to seek comments on the proposal to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

City	Channel No.	
	Present	Proposed
Waco, TX	238, 248, 260, and 296A	238, 248, 260, 277A, and 296A

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note. A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before May 15, 1986, and reply comments on or before May 30, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Timothy K. Brady, Attorney at Law, 1116 Weisgarber Road, P.O. Box 10566, Knoxville, TN 37939 (Counsel for petitioner).

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend § 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding contact Patricia Rawlings, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in section 4(i), 5(c)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rule and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected a file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rule and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissons by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-6834 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-89; RM-5159]

FM Broadcast Station in Panama Beach City, FL

AGENCY: Federal Communications Commission.

ACTION: Proposed Rule.

SUMMARY: This action proposes to allot Channel 286C2 to Panama City Beach, Florida, as its second FM Channel, in response to a petition filed by John C. Drombosky.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Montrose H. Tyree, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 103, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Proposed Rule Making

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations (Panama Beach City, Florida); MM Docket No. 86-89, RM-5159.

Adopted: March 18, 1986.
Released: March 26, 1986.

By the Chief, Policy and Rules Division.

1. The Commission herein considers a petition for rule making filed by John C. Drombosky ("petitioner") which seeks to allot Channel 286C2 to Panama City Beach, Florida. The proposed allotment could provide for a second FM service to that community. Petitioner stated his intention to apply for the channel.

2. We believe that the petitioner's proposal warrants consideration. Channel 286C2 at Panama City Beach will require a site restriction 7.1 kilometers (4.4 miles) west of the city to avoid short spacing to Channel 287A Chattahooche, Florida. In view of the apparent need for a wide coverage area FM station, the Commission proposes to amend the FM Table of Allotments, § 73.202(b) of the Rules, as it pertains to Panama City Beach, Florida, as follows:

City	Channel No.	
	Present	Proposed
Panama City Beach, FL	261A	261A, 286C2

3. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

4. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Timothy K. Brady, 1116 Weisgarber Road, Post Office Box 10566, Knoxville, Tennessee 37939 (Counsel for petitioner).

5. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

6. For further information concerning this proceeding, contact Montrose H. Tyree, Mass Media Bureau (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(c)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7145 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-80; FM-5303; FCC 86-118]

FM Broadcast Station in Gary, IN

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This action proposes to change the reservation of channels in Gary, Indiana, from Channel *50 to Channel 56 and modify the permits accordingly pursuant to an exchange agreement from the two parties.

DATES: Comments must be filed on or before April 28, 1986, and reply comments on or before May 13, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Robert Hayne, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: .

List of subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

In the matter of amendment of § 73.606(b), Table of Assignments, Television Broadcast Stations (Gary, Indiana); MM Docket No. 86-80 and RM-5303.

This is a summary of the Commission's Notice of Proposed Rule Making, MM Docket No. 86-80, adopted March 13, 1986, and released March 21, 1986.

The full texts of Commission decisions are available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 1440, Washington, DC 20037.

Summary of Notice of Proposed Rule Making

1. In a companion *Report and Order* in MM Docket No. 85-41, the Commission amended § 1.420 of the Commission's Rules to provide for a procedure by which commercial and noncommercial educational television may exchange channels. This procedure provides for the submission of a petition for rule making and issuance of a *Notice* proposing a channel exchange setting forth the public interest considerations advanced in the petition for rule making.

2. The instant petition for rule making was filed by the permitees of noncommercial educational television station WCAE, Channel *50, Gary Indiana, and commercial television station WDAI, Channel 56, Gary, proposing to exchange channels. This would enable the commercial station to locate atop the Sears Tower and thereby be competitive with other Chicago area stations that also serve Gary. Also, the funds received by this noncommercial educational station would enable it to improve its programming service to Gary. The Commission has deemed these reasons sufficient to issue a *Notice* inviting public comment.

Ordering Clauses

3. This is a restricted notice and comment rule making proceedings *See* § 1.1229 of the Commission's Rules, 47 CFR § 1.1229, for rules governing permissible *ex parte* contacts.

4. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceeding to amend the TV Table of Assignments.

5. Pursuant to applicable procedures set forth in §§ 1.715 and 1.420 of the Commission's Rules, 47 CFR 1.415 and 1.420, interested parties may file

comments on or before April 28, 1986, and reply comments on or before May 13, 1986. All relevant and timely comments will be considered by the Commission before final action is taken in this proceeding.

6. Pursuant to authority found in sections 4(i), 5(e)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the TV Table of Assignments, § 73.606(b) of the commission's rules, as follows:

	Present	Proposed
Gary, IN	*50, 56	50, *56

Federal Communications Commission.

William J. Tricarico,

Secretary.

[FR Doc. 86-7163 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-92; RM-5226; RM-5315]

FM Broadcast Station in Bar Harbor, ME

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This action proposes the allotments of FM Channels 299 and 256B1 to Bar Harbor, Maine, in response to petitions filed by Sound Innovations, Inc., and Pierless Broadcasting Company, respectively. The proposed allotments could provide for a first and second broadcast service for the community.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communicatons Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerele, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations, (Bar Harbor, Maine); MM Docket No. 86-92, RM-5226 and RM-5315.

Adopted: March 18, 1986.

Released: March 26, 1986.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration are two separate petitions for rulemaking. Sound Innovations, Inc. ("Sound"), seeks the allocation of Class B FM Channel 299 to Bar Harbor, Maine. Pierless Broadcasting Company ("Pierless") requests the allotment of FM Channel 256B1[1] to Bar Harbor, Maine. The proposals could provide Bar Harbor with a first and second FM broadcast service. Sound and Pierless filed information in support of their requests and each stated its intention to file an application for the respective channel.

2. We believe the petitioners' proposals warrant consideration. Channel 299 and 256B1 can be allocated to Bar Harbor, Maine, in compliance with the minimum distance separation requirements of § 73.207 of the Commission's Rules. However, the proposals must conform with the technical requirements of § 73.1030(c) (1)-(5) of the rules regarding protection to the Commission's monitoring station at Belfast, Maine. Also, concurrence of the Canadian government is required since Bar Harbor is within 320 kilometers (200 miles) of the common U.S.-Canadian border.

3. In view of the fact that the proposed allocation could provide a first and second broadcast service to Bar Harbor, Maine, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

City	Channel No.	
	Present	Proposed
Bar Harbor, ME		256B1, 299

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

[1] Pierless Broadcasting originally requested the allotment of Channel 278B to Bar Harbor. However, the allotment of Channel 278B to Bar Harbor would be mutually exclusive with a petition to allocate 277B to Camden, Maine. Thus, on February 21, 1986, Pierless amended its petition to request the allotment of Channel 256B1 instead in order to avoid the conflict with the Camden proposal.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows:

Earl R. Stanley, Wilkinson, Barker, Knauer & Quinn, 1735 New York Avenue, NW., Washington, DC 20006 (Counsel for Sound Innovations, Inc.)

Steven A. Lancellotta, Wheeler and Wheeler, 1729 "H" Street, NW.—Suite 200, Washington, DC 20006 (Counsel for Pierless Broadcasting Co.)

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that Sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(c)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b)

and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed assignment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is assigned, and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice,* they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to assign a difference channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of Section 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7148 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-88; RM-5130]

FM Broadcast Station in Willards, MD

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This action proposes the allotment of FM Channel 246A to Willards, Maryland, in response to a petition filed by Keith A. Mayo. This allotment could provide a first local service to the community.

DATES: Comments must be filed on or before May 16, 1986, and reply comments on or before June 2, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of Amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations, (Willards, Maryland); MM Docket No. 86-88 and RM-5130.

Adopted: March 18, 1986.
Released: March 25, 1986.

By the Chief, Policy and Rules Division.

1. A petition for rule making has been filed by Keith A. Mayo ("petitioner"), seeking the allotment of FM Channel 246A to Willards, Maryland, as that community's first commercial FM service. Petitioner submitted information in support of the proposal and stated his intention to file an application for the channel.

2. Channel 246A can be allocated to Willards, Maryland, consistent with the minimum distance spacing requirements of the Commission's Rules provided there is a site restriction 3.4 kilometers (2.1 miles) east of Willards. The site restriction will prevent a short spacing to FM Channel 248A authorized to Station WICO, Salisbury, Maryland and Channel 245A (vacant) at Crisfield, Maryland.

3. In view of the fact that the proposed allocation could provide a first commercial FM service to Willards, Maryland, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

City	Channel No.	
	Present	Proposed
Willards, MD		246A

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by references herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before May 16, 1986, and reply comments on or before June 2, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: David Tillotson, Arent, Fox, Kintner, Plotkin & Kahn, 1050 Connecticut Avenue, NW., Washington, DC 20036-5339.

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to the Rule Making to Amend §§ 73.202(b), 73.504 and 73-606(b) of the Commission's Rules,* 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Kathleen

Scheuerle, Mass Media Bureau (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(c)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See. § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, N.W., Washington, D.C.

[FR Doc. 86–7172 Filed 3–31–86; 8:45 am]

BILLING CODE 6712–01–M

47 CFR Part 73

[MM Docket No. 86–86; RM–5009]

FM Broadcast Station in Clinton, OK

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes to substitute FM Channel 238C2 for Channel 237A at Clinton, Oklahoma, and modify the license of Station KCLI(FM) to specify operation on the new frequency. The substitution could provide Clinton with its first wide-coverage FM service.

DATES: Comments must be filed on or before May 16, 1986, and reply comments on or before June 2, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION

List of Subjects in 47 CFR Part 73:

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations, (Clinton, Oklahoma); MM Docket No. 86–86 and RM–5009.

Adopted: March 18, 1986.

Released: March 25, 1986

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration the petition for rule making filed by Media Max Broadcasting, Inc. ("petitioner"), licensee of FM Station KCLI, Channel 237A at Clinton, Oklahoma. Petitioner requests the substitution of Channel 238C2 for its present channel and the modification of its license to specify operation on the higher powered channel. Channel 238C2 can be allocated to Clinton in compliance with the Commission's mileage separation and other technical requirements.

2. In accordance with our established policy, we shall propose to modify the license of Station KCLI to specify operation on Channel 238C2. However, if another party should indicate an interest in the Class C2 allocation, the modification could not be implemented unless an additional equivalent channel is allotted. See, *Cheyenne, Wyoming*, 62 FCC 2d 63 (1976) and *Modification of FM and TV Station Licenses*, 98 FCC 2d 916 (1984).[1]

[1] Interested parties should consider the pending *Notice of Proposed Rule Making* in MM Docket No. 85–313 (50 FR 45329, published October 31, 1985) which proposes to permit FM stations to upgrade on adjacent channels in this type of proceeding without demonstrating the availability of an additional equivalent class of channel.

3. We believe the public interest would be served by proposing the channel allocation as it could provide Clinton with its first local wide-coverage FM service. Accordingly, we propose to amend the FM Table of Allotments, § 73.202(b) of the Rules, for the community listed below, to read as follows:

City	Channel No.	
	Present	Proposed
Clinton, Ok	237A	238C2

4. The Commission's authority to institute rule making proceedings, showing required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be alloted.

5. Interested parties may file comments on or before May 16, 1986, and reply comments on or before June 2, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Edward S. O'Neill, Esq., Gary P. Schonman, Esq., Bryan, Cave, McPheeters, & McRoberts, 1015—15th Street, NW., Suite 1000, Washington, DC 20005 (Counsel for petitoner).

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commisson's Rules. See, *Certification that section 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding contact Leslie K. Shapiro, Mass Media Bureau, (202) 734-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission's proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitoner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the perosn(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(e)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the Table of Assignments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed assignment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is assigned, and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to assign a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in § 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of Section 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7171 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-87; RM-5094]

FM Broadcast Station in Atlanta, TX

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein, at the request of Ark-La-Tex Broadcasting Company, proposes the substitution of Channel 259C2 for Channel 257A at Atlanta, Texas, in order to provide that community with its first wide coverage FM station.

DATES: Comments must be filed on or before May 16, 1986, and reply comments on or before June 2, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations, (Atlanta, Texas); MM Docket No. 86–87 and RM–5094.

Adopted: March 18, 1986.

Released: March 25, 1986.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by Ark-La-Tex Broadcasting Company ("petitioner"), licensee of Station KPYN (Channel 257A), Atlanta, Texas, seeking to substitute Class C2 Channel 259 for Channel 257A and to modify its license for Station KPYN to specify operation on the new frequency. The substitution can be made in compliance with the Commission's minimum distance separation requirements.

2. Petitioner submitted information in support of the proposal and states the expanded coverage to Atlanta would improve service to its audience in rural east Texas.

3. We believe the petitioner's proposal warrants consideration. Therefore, in accordance with our established policy, we shall propose to modify the license of Station KPYN to specify operation on Channel 259C2. However, should another party indicate an interest in the Class C2 allotment, the modification may not be implemented unless an additional equivalent channel is allotted.[1] See, *Modification of FM and TV Station Licensee*, MM Docket No. 83–1148, 98 F.C.C. 2d 916 (1984).

4. Accordingly, in order to provide Atlanta with its first wide coverage FM station, the Commission proposes to amend the FM Table of Allotments, § 73.202(b) of the Rules, with regard to the following community:

City	Channel No.	
	Present	Proposed
Atlanta, TX	257A	259C2

[1] Pending before the Commission is the *Notice of Proposed Rule Making* in MM Docket No. 85–313, 50 F.R. 45439, published October 31, 1985 proposing to permit FM stations to upgrade to adjacent superior classes of channel in their communities in this type of proceeding. Parties should consider this proposal when commenting in this proceeding.

5. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

6. Interested parties may file comments on or before May 16, 1986, and reply comments on or before June 2, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: James P. Riley, Donald M. Redmond, Fletcher, Heald & Hildreth, 1225 Connecticut Avenue, NW., Suite 400, Washington, DC 20036 (Counsel for petitioner).

7. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR. 11549, published February 9, 1981.

8. For further information concerning this proceeding contact Patricia Rawlings, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comments which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(c)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is alloted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed.

Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of Section 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7164 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-94; RM-4786; RM-4805]

FM Broadcast Station in Corpus Christi, TX

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes the allotment of Channel 204A to Corpus Christi, Texas, as that community's third local noncommercial educational FM service, at the request of Rebekah Christian Schools.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.504(a), Table of Allotments, Noncommercial Educational FM Broadcast Stations, (Corpus Christi, Texas); MM Docket No. 86-94, RM-4786 and RM-4805.[1]

Adopted: March 18, 1986.
Released: March 27, 1986.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration a petition for rule making filed by Rebekah Christian Schools ("petitioner"), proposing the allotment of Channel 204A to Corpus Christi, Texas, as that community's third local noncommercial educational FM service. Petitioner has indicated its intention to apply for the channel, if allotted.

2. A staff engineering study reveals that Channel 204A can be allotted in compliance with the Commission's minimum distance separation requirements. However, the distance between the proposal and Station KRIS-TV, Channel 6, Corpus Christi, Texas, is 22.4 kilometers (13.9 miles). Due to the proximity of Station KRIS-TV (Channel 6), petitioner or other interested parties should submit showings, in accordance with § 73.525 of the Commission's Rules, relating to interference protection for TV Channel 6. See, *Memorandum Opinion and Order*, Docket No. 20735, 50 FR 27954, published July 9, 1985. Such showings should describe the extent of predicted interference to Station KRIS-TV, and the proposed remedial measures. Moreover, since Corpus Christi is located within 320 kilometers (199 miles) of the U.S.-Mexican border, the proposal requires concurrence by the Mexican government.

3. In view of the above, the Commission believes it is in the public interest to seek comments on the proposal to allot Channel 204A to Corpus Christi as its third noncommercial educational FM service. Accordingly, we propose to amend the FM Broadcast Table of Allotments, § 73.504(a) of the Commission's Rules, as follows:

City	Channel No.
Corpus Christi, Texas	204A, 212, 220A

4. It is Ordered, That the Secretary SHALL SEND a copy of this *Notice of Proposed Rule Making* to the licensee of Station KRIS-TV, Gulf Coast Broadcasting Company, P.O. Box 840, Corpus Christi Texas 78403.

5. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the Appendix and are incorporated by reference herein. NOTE: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

6. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Wiley B. Cameron, Administrator, Rebekah Christian Schools, Route 3, Box 440-R, Corpus Christi, Texas 78415.

7. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the noncommercial educational FM Table of Allotments, § 73.504(a) of the Commission's rules. See, *Certification that Sections 603 and 604(a) of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

8. For further information concerning this proceeding, contact Patricia Rawlings, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the noncommercial educational FM Table of

[1] The Commission inadvertently assigned RM-4805 to this proposal in addition to RM-4786. Accordingly, RM-4805 is cancelled and will be treated as RM-4786 for this proceeding.

Allotments, § 73.504(a) of the Commission's Rules and Regulations, as set forth in the Notice of Proposed Rule Making to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in § 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7152 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-95; RM-5090]

FM Broadcast Station in Lytle, TX

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein, at the request of Stronghold Foundation, Inc., proposes the allotment of Channel 217A to Lytle, Texas, as that community's first noncommercial educational FM channel.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.504(a), Table of Allotments, Noncommercial Educational FM Broadcast Stations, (Lytle, Texas); MM Docket No. 86-95 and RM-5090.

Adopted: March 18, 1986.
Released: March 27, 1986.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration a petition for rule making filed by Stronghold Foundation, Inc. ("petitioner"), requesting the allotment of Channel 217A to Lytle, Texas, as that community's first noncommercial educational FM channel. Petitioner has stated that it will apply for the channel, if allotted.

2. Channel 217A can be allotted to Lytle in compliance with the Commission's minimum distance separation requirements with a site restriction of 11.2 kilometers (7.0 miles) southwest of the community. This restriction is imposed in order to avoid short spacing to Station KQXT (FM), Channel 270, at San Antonio, Texas.

3. Since Lytle is located within 320 kilometers (199 miles) of the common U.S.-Mexican border, the concurrence of the Mexican government must be obtained.

4. As this proposal could provide a first noncommercial educational FM broadcast service to Lytle, Texas, the Commission believes it is appropriate to solicit comments on the proposal to amend the noncommercial educational FM Table of Allotments, § 73.504(a) of the Commission's Rules, as follows:

City	Present	Proposed
Lytle, Texas		217A

5. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein. Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

6. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Ashton R. Hardy, Bradford D. Carey, Fawer, Brian, Hardy and Zatzkis, 700 Camp Street, New Orleans, Louisiana 70130-3702 (Counsel to petitioner).

7. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

8. For further information concerning this proceeding, contact Patricia Rawlings, Mass Media Bureau, (202) 634-6530. However, members of the

public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(l), 303(g) and (r), and 307(b) of the Communications act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, and original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7151 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-90; RM-5162]

FM Broadcast Station in Julesburg, CO

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes to allot FM Channel 243C1 to Julesburg, Colorado, as that community's first local service, in response to a petition filed by Vivian S. Lopez.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Nancy V. Joyner, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

Notice of Proposed Rule Making

In the Matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations. (Julesburg, Colorado); MM Docket No. 86-90 RM-5162.

Adopted: March 18, 1986.

Released: March 26, 1986.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by Vivian S. Lopez ("petitioner") requesting the allotment of FM Channel 243C1 to Julesburg, Colorado, as that community's first local service. Petitioner indicates that she will apply for the channel, either individually or as part of a group, if it is allotted.

2. A staff engineering analysis reveals that Channel 243C1 can be allotted to Julesburg in conformity with the minimum distance separation requirements of § 73.207 of the Commission's Rules.

3. Since the proposed allotment could provide a first local service to Julesburg, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, to include that community, as follows:

City	Channel No.	
	Present	Proposed
Julesburg, Colorado		243C1

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Richard R. Zaragoza, Esq., Carroll John Yung, Esq., Fisher, Wayland, Cooper and Leader, 1255–23rd Street, NW., Suite 800, Washington, DC 20037 (Counsel for Petitioner).

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding contact Nancy V. Joyner, Mass Media Bureau, (202) 634–6530. However members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration of court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(e)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showing Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed assignment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its presents intention to apply for the channel if it is assigned, and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to assign a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in § 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86–7147 Filed 3–31–86; 8:45 am]

BILLING CODE 6712–01–M

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47 CFR Part 73

[MM Docket No. 86–91; RM–5126]

FM Broadcast Station in Buffalo, MO

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This action proposes the allotment of FM Channel 260A to Buffalo, Missouri, in response to a petition filed by Mike Husmann. This allotment could provide for a first commercial FM service for the community.

DATES: Comments must be filed on or before May 19, 1986, and reply comments on or before June 3, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio Broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections and cited to text.

Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), Table of Allotments, FM Broadcast Stations. (Buffalo, Missouri); MM Docket No. 86–91 RM–5126.

Adopted: March 18, 1986.

Released: March 26, 1986.

By the Chief, Policy and Rules Division.

1. A petition for rule making has been filed by Mike Husmann [1] ("petitioner"), seeking the allotment of FM Channel 260A [2] to Buffalo, Missouri, as that

[1] Petitioner is the General Manager of Station KBFL, noncommercial Channel 212A, Buffalo, Missouri.

[2] Petitioner originally requested the allotment of either Channel 225A, 226A or 227A. We have substituted FM Channel 260A because each of the other requested channels conflicted with existing stations. In a supplemental filing on September 24, 1985, petitioner requested the allocation of FM Channel 283A to Buffalo. A staff study indicates that Channel 283A is short-spaced to Station KMYZ–FM, Channel 283, Pryor, Oklahoma, and to proposal to allot Channel 283C2 to Lebanon, Missouri (RM–5098).

community's first commercial FM service. Petitioner submitted information in support of the proposed and stated his intention to file an application for the channel.

2. Channel 260A can be allocated to Buffalo, Missouri, consistent with the minimum distance requirements of the Commission's Rules.

3. In view of the fact that the proposed allocation could provide a first commerical FM service to Buffalo, Missouri, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

City	Channel No.	
	Present	Proposed
Buffalo, Missouri		260A

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before May 19, 1986, and reply comments on or before June 3, 1986, and are advised to read the appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Mike Husmann, General Manager, KBFL, Locust at Main, Buffalo, Missouri 65622.

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that Sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

Ralph A. Haller,

Acting Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, DC.

[FR Doc. 86-7146 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 76

[MM Docket No. 85-349]

Carriage of Television Broadcast Signals by Cable Television Systems

AGENCY: Federal Communications Commission.

ACTION: Order requesting comments.

SUMMARY: Action taken herein requests additional comments in response to the *Submission of Joint Industry Agreement* filed March 21, 1986, by the National Association of Broadcasters and the National Cable Television Association in Docket No. 85-349. This *Order* requests comments concerning the agreement and, particularly, the constitutionality of the must carry rules proposed in the agreement. The parties submitted the agreement in response to the *Notice of Inquiry and Notice of Proposed Rule Making* in MM Docket No. 85-349. This *Order* also responds to a request for extension of time filed by the Motion Picture Association of America, a request for further comment period filed by Richard S. Leghorn, and requests for further comment period filed in reply comments by Heritage Communications, Inc., and Bloomington Comco, Inc.

DATE: Comments are due April 25, 1986.

ADDRESS: Federal Communications Commission, Washington, DC. 20554.

FOR FURTHER INFORMATION CONTACT: Alan Stillwell, Mass Media Bureau, (202) 632-6302.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 76

Cable television.

Order

In the matter of Amendment of Part 76 of the Commission's Rules Concerning Carriage of Television Broadcast Signals by Cable Television Systems; MM Docket No. 85-349.

Adopted: March 24, 1986

Released: March 25, 1986.

By the Acting Chief, Mass Media Bureau.

1. On July 19, 1985, the United States Court of Appeals ruled in *Quincy Cable TV, Inc.*, v. *FCC* (*Quincy*) that the Commission's mandatory signal carriage ("must carry") regulations for cable television systems were unconstitutional.[1] Three Petitions for Rule Making were filed subsequent to the *Quincy* decision asking the Commission to adopt new must carry regulations that would meet the constitutional concerns raised by the court. In response to these petitions, the Commission adopted a combined *Notice of Inquiry and Notice of Proposed Rule Making* ("*Notice*") in Docket No. 85-349, 50 FR 48232, to consider the matter of carriage of broadcast television signals by cable systems. In the *Notice*, the Commission specifically requested commenters to address the constitutionality, in light of *Quincy*, of any mandatory carriage rule proposed. In addition, the Commission invited parties to submit data and information concerning the impact of these proposals on the compulsory copyright licensing scheme and to address the Commission's authority with respect thereto.

2. On February 27, 1986, the National Association of Broadcasters ("NAB") and the National Cable Television Association ("NCTA") notified the Commission that they had reached a compromise agreement on new requirements for carriage of local television broadcast signals by cable systems and that they intended to recommend this agreement to the Commission. The Television Operators Caucus ("TOC") and the Association of Independent Television Stations, Inc. ("INTV") were also parties to this agreement. Along with notification of the compromise agreement, NAB and NCTA submitted a request to extent the time for filing comments in this proceeding to March 21, 1986. They indicated that the additional time was necessary to permit NCTA to obtain approval of its board of directors and then to formally submit the compromise agreement. The Commission granted this request for extension of time on March 3, 1986.[2]

3. The NAB, TOC, INTV and NCTA submitted their compromise agreement for new must carry rules to the Commission on March 21, 1986. We believe it is desirable to consider the must carry compromise agreement developed by the major broadcast and cable trade associations and the views of parties participating in this proceeding concerning that agreement in our deliberations on the cable signal carriage matter. However, as stated in the *Notice*, we also believe that this proceeding should be completed expeditiously. We conclude, therefore, that it is appropriate to provide a limited additional period of thirty days in which interested parties may file comments directed to the compromise agreement.[3]

4. Parties are invited to comment on any aspect of the compromise agreement. In addition, we seek comment and discussion with respect to several specific issues. The first of these concerns with extent to which the agreeing parties, each representing an industry group, have been able to successfully incorporate into the agreement the specific interests of the various discrete groups of the public involved, including in particular, the interests of broadcasters (noncommercial, commercial, VHF, UHF, new, established, general audience and narrowcast stations), cable system operators, alternative users of cable channels, cable system subscribers, nonsubscribers, and the public in general.

5. Second, we request comment on the extent to which the agreement successfully addresses the relevant constitutional concerns. In the *Quincy* decision, the court did not rule must carry rules *per se* to be unconstitutional.[4] Rather, the court indicated that any must carry rules should address specific harms and that any rules adopted should be narrowly tailored to protect only those broadcasters that are sufficiently at risk to warrant regulatory intervention. Thus, we request comment and information concerning the proper scope of any revised must carry rule and whether, in this regard, the proffered compromise agreement adequately restricts and focuses its effect.

6. Finally, we request comments on the more general, but fundamental, issue of whether local broadcast service and the concept of "localism" as a communications policy objective are sufficiently important Federal interests to warrant the intrusion on the First Amendment rights of cable operators which must carry obligations necessarily produce. In this connection, we also seek to determine whether any potential must carry rules should properly be considered an "incidental" burden on speech and, therefore, evaluated under the less stringent *O'Brien* test that the Court references in *Quincy*.[5]

7. Accordingly, it is ordered, That comments may be filed with respect to the compromise agreement described herein, and its effect and appropriateness in the context of the matters before us in this proceeding, until and including April 25, 1986. This action is taken pursuant to authority provided in section 4(i) of the Communications Act of 1934, as amended, and § 0.283 of the Commission's Rules.

8. It is further ordered, That the "Request of Richard S. Leghorn for Further Comment Period" is, to the extent indicated herein, dismissed as moot, and in all other respects is denied.

9. For further information concerning this proceeding, contact Alan Stillwell, Mass Media Bureau, (202) 632-6302.

Federal Communications Commission.

William H. Johnson,

Acting Chief, Mass Media Bureau.

[FR Doc. 86-7169 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

[1] *Quincy Cable TV, Inc. v FCC*, 768 F.2d 1434 (D.C. Cir. 1985), *petition for cert filed*, 54 U.S.L.W. 3229 (U.S. Sept. 23, 1985) (No. 85-502).

[2] *Order Granting Request for Extension of Time to File Reply Comments*, Mimeo No. 2937 (released March 3, 1986), 51 FR 8339 (published March 11, 1986).

[3] On March 14, 1986, the Motion Picture Association of America ("MPAA") requsted that the Commission afford parties until April 1, 1986, to file comments concerning the compromise agreement. Two parties filing reply comments—Heritage Communications, Inc., and Bloomington Comoc, Inc.,—also requested additional time in which to comment on the compromise agreement. In light of our action in this *Order*, we consider these requests to be moot. On March 21, 1986, Richard S. Leghorn ("Leghorn") filed a request seeking a further comment period, of unspecified length, in which parties might file additional comments directed to the compromise agreement and Leghorn's own "A/B switch and may carry" rule proposal. To the extent Leghorn requests an opportunity for comment on the compromise agreement, our action herein renders his request moot. With respect to the need for a further comment period concerning Leghorn's specific proposal, we believe that ample opportunity to comment on the substance of his proposal has been afforded and that an additional comment period on that matter is therefore unnecessary.

[4] *See Quincy, supra*, p. 59.

[5] *See United States v. O'Brien*, 391 U.S. 367, 377 (1968).

47 CFP Part 90

[PR Docket No. 86-37]

Private Land Mobile Services; Rules to Restrict the Use of Radio Transmitters with External Frequency Controls; Extension of Time To File Comments and Replies

AGENCY: Federal Communications Commission.

ACTION: Order extending time to file comments and replies.

SUMMARY: The Commission has received motions from the National Association of Business and Educational Radio, Inc. (NABER) and the Association of American Railroads seeking an extension of time for filing comments and reply comments in the above captioned Notice of Proposed Rule Making. By this action the Commission has granted, in part, the motions by extending the deadline for comments and reply comments to July 21, 1986 and August 5, 1986, respectively.

DATES: Comments are now due on July 21, 1986; Reply comments are now due on August 5, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Thomas L. Johnson, Private Radio Bureau, Land Mobile and Microwave Division, (202) 632-6497.

SUPPLEMENTARY INFORMATION: The Notice of Proposed Rule Making was published February 20, 1986, 51 FR 6149.

Order

In the matter of amendment of Part 90 of the Commission's Rules to Restrict the Use of Radio Transmitters with External Frequency Controls, PR Docket No. 86-37.

Adopted: March 20, 1986.
Released: March 24, 1986.

By the Deputy Chief, Private Radio Bureau.

1. The National Association of Business and Educational Radio, Inc. (NABER) and the Association of American Railroads (AAR) have requested a 180-day and 60-day extension of time, respectively, for filing comments and reply comments in the above captioned Notice of Proposed Rule Making.

2. The Commission adopted the Notice on January 30, 1986 and released it on February 12, 1986. Comments and reply comments were due by March 21, and April 7, 1986, respectively.

3. In support of its request, NABER indicates that documenting actual incidences of off-frequency operations from transmitters with external frequency selecting controls will be a complex and time consuming task. Additionally, manufacturers of land mobile radios must be given adequate time to develop alternative design specifications. The AAR points out that more time is needed to assess the impact of the proposed rulemaking on the railroad industry and to examine possible alternatives.

4. We are persuaded that NABER and the AAR along with all other interested parties should have additional time to compile a complete record in this proceeding. However, we do not believe that a grant of NABER's request for an extension of 180 days would be in the public interest. As stated in the Notice, we are concerned that as more and more of the subject radio units are sold the probability of interference to lawful land mobile radio operations increases dramatically. Therefore, we believe it is important to reach a decision in this proceeding as soon as possible. To this end and in the interest of allowing interested parties reasonable opportunity to prepare and file meaningful comments, we think a 120-day extension of the comment and reply comment deadlines would be proper.

5. Accordingly, it is ordered, pursuant to the authority set forth in § 0.331 of the Commission's Rules and Regulations, that interested parties have until July 21, 1986 to file comments and until August 5, 1986 to file reply comments in this proceeding.

6. The point of contact in this matter is Thomas L. Johnson, Land Mobil and Microwave Division, Private Radio Bureau, (202) 632-6497.

Federal Communications Commission.

Michael T.N. Fitch,

Deputy Chief, Private Radio Bureau.

[FR Doc. 86-7170 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF THE INTERIOR

48 CFR Parts 1401, 1405, 1406, 1408, 1414, 1415, 1419, 1420, 1428, 1437, 1452 and 1453

Acquisition Regulation; Miscellaneous Amendments

AGENCY: Department of the Interior, Office of the Secretary.

ACTION: Proposed Rule.

SUMMARY: This rule would amend the Department of the Interior Acquisition Regulation (DIAR) to implement the Competition in Contracting Act of 1984 (Pub. L. 98-369) and Federal Acquisition Circular (FAC) 84-5 and 84-13. The rule would also make changes in the DIAR procedures regarding the small and disadvantaged business program, insurance provisions, and the structured approach for determining profit and fee objectives.

DATE: Comments must be received on or before May 1, 1986.

ADDRESS: Interested parties should submit written comments to Mr. William Opdyke, Room 5522, Office of Acquisition and Property Management, Department of the Interior, 18th and C Streets, NW., Washington, D.C. 20240.

FOR FURTHER INFORMATION CONTACT: Mr. William Opdyke, Chief, Branch of Policy and Regulations, Office of Acquisition and Property Management, Department of the Interior, Washington, D.C. 20240, telephone (202) 343-3433.

SUPPLEMENTARY INFORMATION: This proposed rule primarily concerns agency procedures that are required for the Department's implementation of Pub. Law 98-369 and the corresponding changes made to the Federal Acquisition Regulation by FAC 84-5 and 84-13. In addition, minor revisions to the Department's small and disadvantaged business program regulations under the DIAR would be made in response to recommendations received from the House Subcommittee on SBA and SBIC Authority, Minority Enterprise, and General Small Business Problems, to amplify current regulatory provisions relating to small business subcontracting plans submitted by a small number of contractors. Changes would be made in the DIAR Indemnification clause in order to expressly limit its coverage to impose insurance requirements only. Format revisions would also be made in the DIAR to correct the manner in which cost of money for facilities capital is deducted from profit or fee prenegotiation objectives.

Primary Author

The primary author of this rule is Mr. William Opdyke, Office of Acquisition and Property Management, telephone (202) 343-3433.

Executive Order 12291, Paperwork Reduction Act, and Regulatory Flexibility Act

The Department has determined that this rule is not a major rule under Executive Order 12291 and certifies that it will not have a significant economic effect on a substantial number of small entities since no new requirements are being imposed on parties eligible to contract with the Department or small entities. The information collection requirements referred to in this rule are prescribed by FAR 19.704(a) and are the responsibility of the FAR Secretariat.

General Services Administration. This rule does not contain any new information collection requirements.

List of Subjects in 48 CFR Parts 1401, 1405, 1406, 1408, 1414, 1415, 1419, 1420, 1428, 1437, 1452 and 1453

Government procurement.

For the reasons set out in the preamble, Chapter 14 of Title 48 of the Code of Federal Regulations is proposed to be amended as set forth below.

Dated: March 10, 1986.

Joseph E. Doddridge,

Assistant Secretary of the Interior.

1. The authority citations for 48 CF Parts 1401, 1405, 1406, 1408, 1414, 1415, 1419, 1420, 1428, 1437, 1452, and 1453 continue to read as follows:

Authority: Sec. 205(c), 63 Stat. 390, 40 U.S.C. 486(c), and 5 U.S.C. 301.

PART 1401—DEPARTMENT OF THE INTERIOR ACQUISITION REGULATION SYSTEM

1401.301 [Amended]

2. Section 1401.301(a) is amended by removing the reference to "FAR 1.301(a)" in the second sentence and inserting in its place the reference "FAR 1.301(a)(1)."

3. Section 1401.301(b) is amended by removing the reference to "FAR 1.301(b)" in the second sentence and inserting in its place the reference "FAR 1.301(a)(2)."

4. Section 1401.303 is amended by revising the title to read as follows:

1401.303 Publication and codification.

PART 1405—PUBLICIZING CONTRACT ACTIONS

5. A new Subpart 1405.2 is added to read as follows:

Subpart 1405.2—Synopses of Proposed Contract Actions

1405.202 Exceptions.
1405.207 Preparation and transmittal of synopses.

Subpart 1405.2—Synopses of Proposed Contract Actions

1405.202 Exceptions.

The Assistant Secretary—Policy, Budget and Administration is authorized to make the determination in FAR 5.202(2). A written determination documenting the reasons why advance notice is not appropriate or reasonable shall be submitted by the head of the contracting activity to the Director, Office of Acquisition and Property Management for further action including communication with the officials listed in FAR 5.202(b).

1405.207 Preparation and transmittal of synopses.

(a) In addition to the information required in FAR 5.207, each synopsis of a proposed sole source contract action shall include:

(1) A clear description of specific contractor qualifications or capabilities required to perform the work and meet the Government's minimum needs; and

(2) Information to be provided by prospective contractors and all factors to be used in evaluating this information, in order to determine whether more than one source can meet the Government's needs.

(b) In the event the information in (a)(1) or (a)(2) above is too lengthy to be included in the synopsis, the synopsis shall indicate the address at which this information may be examined or obtained.

6. A new Part 1406 is added to read as follows:

PART 1406—COMPETITION REQUIREMENTS

Subpart 1406.3—Other than Full and Open Competition

1406.370 Class justifications.

Subpart 1406.5—Competition Advocates

1406.501 Requirement.
1406.502 Duties and responsibilities.

Authority: Sec. 205(c), 63 Stat. 390, 40 U.S.C. 486(c), and 5 U.S.C. 301.

Subpart 1406.3—Other Than Full and Open Competition

1406.370 Class justifications.

(a) Appendix A to 48 CFR Chapter 14 contains an approved class justification for other than full and open competition for acquiring supplies or services from the Federal Prison Industries, Inc., in accordance with FAR Subpart 8.6. This justification shall be used, as prescribed in 1408.670, to meet the requirements of FAR 6.302–5(c)(2).

(b) Appendix B to 48 CFR Chapter 14 contains an approved class justification for other than full and open competition for acquiring printing and related supplies from the Government Printing Office in accordance with FAR Subpart 8.8. This justification shall be used, as prescribed in 1408.870, to meet the requirements of FAR 6.302–5(c)(2).

Subpart 1406.5—Competition Advocates

1406.501 Requirement.

(a) The competition advocate for the Department of the Interior is the Chief, Division of Acquisition and Grants, Office of Acquisition and Property Management.

(b) Competition advocates for each bureau and office shall be as designated by the Assistant Secretary—Policy, Budget and Administration.

1406.502 Duties and responsibilities.

(a) The Chief, Division of Acquisition and Grants, Office of Acquisition and Property Management is responsible for preparing and submitting the annual report required by FAR 6.502(a)(3).

(b) The Director, Office of Acquisition and Property Management is responsible for preparing an annual report to Congress required by section 2732 of Public Law 98–369. The report shall be submitted to the Assistant Secretary—Policy, Budget and Administration for transmittal to each House of Congress. Bureau competition advocates shall furnish certain information, as may be required, to assist the Director, Office of Acquisition and Property Management in preparing the report.

PART 1408—REQUIRED SOURCES OF SUPPLIES AND SERVICES

7. A new Subpart 1408.6, consisting of section 1408.670, is added to read as follows:

Subpart 1408.6—Acquisition from Federal Prison Industries, Inc.

1408.670 Justification for other than full and open competition.

When acquiring supplies or services from Federal Prison Industries, Inc. (UNICOR) in accordance with the procedures in FAR Subpart 8.6, the contracting officer shall use the class justification contained in Appendix A to 48 CFR Chapter 14 to meet the requirements of FAR 6.302–5(c)(2). In addition, the contracting officer shall prepare a separate file memorandum for each acquisition which states that:

(a) The supplies or services to be acquired from UNICOR are contained on the "Schedule of Products made in Federal Penal and Correctional Institutions;"

(b) The anticipated cost to the Government of the supplies or services to be acquired from UNICOR is to be fair and reasonable; and

(c) The information in the class justification contained in Appendix A is accurate and complete as it pertains to the individual acquisition.

8. A new section 1408.870 is added to read as follows:

1408.870 Justification for other than full and open competition.

When acquiring printing and related supplies from the Government Printing

Office (GPO) in accordance with the procedures in FAR Subpart 8.8, the contracting officer shall use the class justification contained in Appendix B to 48 CFR Chapter 14 to meet the requirements of FAR 6.302–5(c)(2). In addition, the contracting officer shall prepare a separate file memorandum for each acquisition which states that:

(a) The printing or related supplies to be acquired are of the type defined in FAR 8.801;

(b) The anticipated cost to the Government of the printing or related supplies to be acquired from or through GPO is to be fair and reasonable; and

(c) The information in the class justification contained in Appendix B is accurate and complete as it pertains to the individual acquisition.

PART 1414—SEALED BIDDING

9. The title of Part 1414 is revised to read as set forth above.

10. Sections 1414.404 and 1414.404–1 are added to read as follows:

1414.404 Rejection of bids.

1414.404–1 Cancellation of invitations after opening.

The chief of the contracting office is authorized to make the written determination in FAR 14.404–1(c).

PART 1415—CONTRACTING BY NEGOTIATION

11. Section 1415.608 is added to read as follows:

1415.608 Proposal evaluation.

The chief of the contracting officer is authorized to make the determination in FAR 15.608(b).

1415.902 [Amended]

12. Section 1415.902(d) is amended by removing the reference "1415.905–1(a)(5)" and inserting in its place the reference "1415.905–1(a)(3)".

1415.905 [Amended]

13. Section 1415.905(b) is amended by removing the reference "1415.905(a)(5)" and inserting in its place the reference "1415.905(a)(4)."

1415.905–1 [Amended]

14. Section 1415.905–1 is amended by removing the last sentence of paragraph (a)(5) and inserting this sentence at the end of paragraph (a)(3); redesignating paragraph (a)(4) as paragraph (a)(5), and redesignating paragraph (a)(5) as paragraph (a)(4).

1415.905–70 [Amended]

15. Section 1415.905–70(b)(1) is amended by removing in the third sentence the words "other cost" and inserting in their place the words "conversion related indirect costs."

PART 1419—SMALL BUSINESS AND SMALL DISADVANTAGED BUSINESS CONCERNS

16. A new section 1419.705–6 is added to read as follows:

1419.705–6 Postaward responsibilities of the contracting officer.

In addition to the actions specified in FAR 19.705–6, the contracting officer shall also be responsible for the following:

(a) Forwarding a copy of each approved subcontracting plan to OSDBU within 10 working days after approval of the plan.

(b) Ensuring that the contractor is forwarding the original copy of the Standard Form 295, Summary Subcontracting Report, to the Department of the Interior, Director, OSDBU, 18th and C Streets, N.W., Washington, D.C. 20240, Room 2747.

(c) Forwarding a copy of the Standard Form 294, Subcontracting Report for Individual Contracts, received from individual contractors, within 10 working days, to OSDBU.

(d) Conducting on-site business and economic development program management reviews (see 504 DM 1) of a prime contractor's small and disadvantaged business subcontracting program. Reviews shall be conducted as required based on problems perceived such as insufficient progress in meeting subcontracting goals. The results of the review shall be documented in writing using the format shown at 1453.303–71. At the discretion of the contracting officer, the Business Utilization and Development Specialists (BUDS) may conduct the reviews. In addition to required bureau/office internal distribution, a copy of the review report shall be submitted to OSDBU within 25 working days after completion of the review.

PART 1420—LABOR SURPLUS AREA CONCERNS

17. Section 1420.102 is amended by adding as additional sentence to read as follows:

1420.102 General policy.

* * * Annual goals for contract awards to labor surplus area concerns on a set-aside basis shall be established by the heads of contracting activities using the procedures prescribed in 1419.202–70(b).

PART 1428—BONDS AND INSURANCE

18. Section 1428.301 is amended by revising the title of the clause referenced in the second sentence to read "Liability Insurance—Department of the Interior."

PART 1437—SERVICE CONTRACTING

19. Section 1437.7001 is amended be revising the first sentence to read as follows:

1437.7001 Policy.

Contracts for real property appraisal services shall be awarded in accordance with FAR 37.105. * * *

20. Section 1437.7002(a) is amended by revising the first sentence to read as follows:

1437.7002 Contractor qualification requirements.

(a) Prior to award of a contract for real property appraisal services when the services are required in support of future anticipated court actions, the contracting officer shall obtain written concurrence from the Assistant U.S. Attorney assigned to represent the Government in the matter that the source to be selected possesses the necessary qualifications for adequate contract performance. * * *

PART 1452—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

1452.228–70 [Amended]

21. Section 1452.228–70 is amended by revising its caption to read "Liability insurance"; changing the title of the clause to read "Liability Insurance—Department of the Interior (JUL 1985)," and amending paragraph (a) of the clause by removing the first two sentences and inserting in their place the following: "(a) The Contractor shall procure and maintain during the term of this contract and any extension thereof liability insurance in form satisfactory to the Contracting Officer by an insurance company which is acceptable to the Contracting Officer." * * *

PART 1453—FORMS

22. Section 1453.219–73 is added as follows:

1453.219–73 Subcontracting plan review.

The format shown in 1453.303–71 shall be used in documenting the results of the management review required in 1419.705–6.

23. Sections 1453.303–DI–1920, and 1453.303–70 are revised to read as follows:

1453.303 DI–1920, Department of the Interior, Form DI–1920, Structured Approach for Profit/Fee Objective.

BILLING CODE 4310–10–M

STRUCTURED APPROACH FOR PROFIT/FEE OBJECTIVE

DEPARTMENT OF THE INTERIOR

CONTRACTOR	RFP/CONTRACT NO.	MOD. NO.

FACTOR/SUBFACTOR	WEIGHT RANGE	Column A(%) WEIGHT ASSIGNED		Column B($) PRENEGOTIATION COST OBJECTIVE		Column C($) PROFIT/FEE OBJECTIVE (COLUMN A × COLUMN B)
CONTRACTOR EFFORT						
Material Acquisition						
	1% to 4%		×		=	
			×		=	
			×		=	
			×		=	
			×		=	
Conversion of Direct Labor						
	4% to 12%		×		=	
			×		=	
			×		=	
			×		=	
			×		=	
Conversion-Related Indirect Costs (Subtract Facilities Capital Cost of Money)						
	3% to 8%		×		=	
			×		=	
			×		=	
			×		=	
			×		=	
Other Costs						
	1% to 3%		×		=	
			×		=	
			×		=	
			×		=	
			×		=	
General Mangement						
	4% to 8%		×		=	
			×		=	
			×		=	
			×		=	
			×		=	
			×		=	
			×		=	
1 Total Contractor Effort (Add Columns)				$		$
OTHER FACTORS	WEIGHT RANGE	WEIGHT ASSIGNED		TOTAL COST OBJECTIVE (FROM LINE 1, COLUMN B)		PROFIT/FEE OBJECTIVE (COLUMN A × COLUMN B)
2 Contract Cost Risk	0% to 7%		×		=	
3 Federal Socioeconomic Programs	+ − 0.5%		×		=	
4 Capital Investments	+ − 2%		×		=	
5 Cost Control and Other Past Accomplishments	+ − 1%		×		=	
6 Independent Development			×		=	
TOTAL PROFIT/FEE OBJECTIVE (ADD LINES 1-6, COLUMN C)						$

DIAR (48 CFR) 1453.215-71

DI-1920
(Revised August 1985)

BILLING CODE 4310-10-C

1453.303-70 Sample subcontracting plan outline format.

SMALL BUSINESS AND SMALL DISADVANTAGED BUSINESS SUBCONTRACTING PLAN OUTLINE FORMAT

Date:
Contractor:
Address:
Solicitation or Contract Number:
Item/Service:

The following, together with any attachments, is hereby submitted as a Subcontracting Plan to satisfy the applicable requirements of Public Law 95-507.

1. (a) The following goals will be applicable to any contract awarded as a result of this solicitation.

(i) Total dollars planned to be subcontracted to both large and small business under this contract $——.

Goals	Percent	Dollars
(ii) Small Business [1]		
(iii) Small Disadv. Business [2]		

[1] Small business: Percent of total planned subcontracting dollars (i) under this contract which will go to subcontractors who are small business concerns. Total dollars planned to be subcontracted to small business.

[2] Small disadvantaged business: Percent to total planned subcontracting dollars (i) under this contract which will go to subcontractors which are small business concerns owned and controlled by socially and economically disadvantaged individuals. Total dollars planned to be subcontracted to small disadvantaged businesses.

(b) The principal products and services that (name of bidder/offeror) anticipates to be subcontracted under this contract and the identification of the type of business concern planned to be utilized are as follows:

List Products and Services	Type of Business to be Utilized (Check block)	
	Small Bus.	Small Disadv. Bus.
	( )	( )
	( )	( )
	( )	( )
	( )	( )

(c) The following method was used in developing subcontract goals (e.g., what source lists were used and what organizations were or will be contacted to obtain SB of SDB sources)

(d) Indirect and overhead costs (check one): ( ) have been ( ) have not been included in the goals specified in 1(a)(ii) and 1(a)(iii).

If "have been" is checked, explain the method used in determining the proportionate share of indirect and overhead costs to be incurred with small business and small disadvantaged business subcontractors. If "have not been" is checked, explain why products or services included in the overhead and indirect cost base cannot be subcontracted to small business or small disadvantaged business.

2. The following individual will administer the subcontracting program:

Name:
Title:
Address:
Telephone:

This individual's specific duties, as they relate to the firm's subcontracting program, are as follows: General overall responsibility for review, monitoring and execution of the plan including but not limited to:

(a) Obtaining small and small disadvantaged business sources from all applicable agencies such as SBA and MBDA.

(b) Assuring inclusion of SB and SDB firms in all solicitations where appropriate.

(c) Attending or arranging for attendance at Business Opportunity Workshops, Minority Business Enterprise Seminars, Trade Fairs, etc.

(d) Conducting or arranging for the conduct of motivational training for purchasing personnel pursant to the intent of Pub. L. 95-507.

(e) Monitoring attainment of proposed goals.

(f) Reviewing solicitations to delete statements, clauses, and other provisions which may tend to prohibit SB and SDB participation.

3. The bidder (offeror) agrees to initiate the following actions to assure that small and small disadvantaged business concerns will have an equitable opportunity to compete for subcontracts:

(a) Outreach efforts shall be established as follows:

(i) Contacts with minority and small business trade associations. Name at least three (3).

(ii) Contacts with business development organizations. Name at least two (2).

(iii) Attendance at small and minority business procurement conferences and trade fairs. Provide examples.

(b) The following internal efforts shall be conducted so as to guide and encourage buyers:

(i) Periodic workshops, seminars, and training programs.

(ii) Activities shall be monitored so as to evaluate compliance with this subcontracting plan.

(c) Small and disadvantaged business source lists, guides, and other relevant data identifying small and disadvantaged business vendors shall be maintained and utilized by the buyer in soliciting subcontracts.

(d) Additions to (or deletions from) the above listed efforts are as follows:

4. The bidder (offeror) agrees that the clause entitled "Utilization of Small Business Concerns and Small Disadvantaged Business Concerns" will be included in all subcontracts which offer further subcontracting opportunities, and all subcontractors, except small business concerns, which receive subcontracts in excess of $500,000 or in the case of a contract for the construction of any public facility, $1,000,000, will be required to adopt and comply with a subcontracting plan similar to this one. Such plans will be reviewed by comparing them with the provisions of Pub. L. 95-507, and assuring that all minimum requirements of an acceptable subcontracting plan shall be determined on a case-by-case basis depending on the supplies/services involved, the availability of potential small and disadvantaged subcontractors, and prior experience. Once approved and implemented, plans will be monitored through the submission of periodic reports, and/or, as time and availability of funds permit, periodic visits to the subcontractor facilities or reviews of applicable records and subcontracting program progress.

5. The bidder (offeror) agrees to cooperate in any studies or surveys as may be required by the contracting agency or the Small Business Administration in order to determine the extent of compliance by the bidder with the subcontracting plan. Additionally, the bidder (offeror) agrees to assure that its subcontractors agree to submit Standard Forms 294 and 295.

6. The bidder (offeror) agrees to maintain at least the following types of records to document compliance with this subcontracting plan:

(a) Small and disadvantaged business source lists, guides and other data identifying SB and SDB vendors.

(b) Organizations contacted for small and disadvantaged business sources.

(c) On a contract-by-contract basis, records on all subcontract solicitations over $100,000, indicating on each solicitation (1) whether small businesses were solicited, and if not; (2) whether small disadvantaged businesses were solicited, and if not, why not; and (3) reasons of the failure of solicited small businesses or small disadvantaged businesses to receive the subcontract award.

(d) Records to support other outreach efforts: contacts with Minority and Small Business Trade Associations, Business Development Organizations, and attendance at small and minority business procurement conferences and trade fairs.

(e) Records to support internal activities to guide and encourage buyers: workshops, seminars, training programs, and monitoring activities to evaluate compliance.

(f) On a contract-by-contract basis, records to support award data submitted to the Government to include name and address of subcontractor.

7. The bidder (offeror) agrees to:

(a) Assist small and small disadvantaged business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the bidder's (offeror's) lists of potential small business and small disadvantaged subcontractors are excessively long, reasonable effort shall be made to give all such concerns an opportunity to compete over a period of time.

(b) Provide adequate and timely consideration of the potentialities of small and small disadvantaged business concerns in all "make-or-buy" decisions.

(c) Counsel and discuss subcontracting opportunities with representatives of small and small disadvantaged business firms.

Signed:
Typed Name:
Title:
Date:

24. Section 1453.303-71 is added to read as follows:

153.303-71 Format for review of contractor's subcontracting program.

Format for Review of Contractor's Subcontracting Program

Part I—General Information

1. Contractor's name and address (Included Zip Code)

2. Contractor's subcontracting plan administrator (Small Business Liaison Officer—SBLO)

3. Business Utilization and Development Specialist (BUDS)

4. Contracting Officer (CO) or Administrative Contracting Officer (ACO)

5. Small Business Administration Subcontracting Specialist

6. Date of (a) Last review (b) This review

7. Period covered by this review (a) From (b) To

8. Total active DOI contracts (a) Number (b) Face Value

9. Total subcontracting potential estimated to be (a) Substantial (over 50%), (b) Moderate (30–50%), (c) Minimal (less than 30%), (d) Unknown.

10. Active contracts over $500,000 ($1 million if construction) that do not contain approved plans.

(a) Number, (b) Face value, (Identify and explain rationale for absence of plan).

11. Active Contracts with Individual Subcontracting Plans. (a) Number, (b) Face value.

Part II—Contractor's Overall Performance Under Individual Subcontracting Plans

(Explain any negative findings, using Part III if additional space is required. Identify any exceptions that do not apply to all contracts detailed in Part 1. This Part is to be reviewed in depth at least annually, and updated as required during interim reviews.)

1. Has a company wide policy statement been issued? Yes/No. If yes, by whom and date? How was it promulgated throughout the company?

2. Is the SBLO identified in Part I above responsible for all individualsubcontracting plans detailed in Part 1? Yes/No. Does the SBLO have adequate authority and responsibility to administer programs effectively? Yes/No. To whom does SBLO report?

3. Is there also a corporate SBLO? Yes/No. If Yes, describe relationship between this division and the coporate SBLO.

4. Does contractor have an effective training program, particularly for buyers? Yes/No. Describe any incentive programs established for buyers or technicians to assist Small and Disadvantaged (SADB) firms.

5. Does the contractor arrange solicitations, provide adequate bid preparation time, and adjust quantities, delivery schedules and specifications to enhance participation of SADB firms in the bidding process? Yes/No.

6. Does the contractor provide counseling assistance to SADB firms referred to it by the BUDS and by the SBA representative? Yes/No. Is such counseling effective? Yes/No.

7. Does the contractor provide technical, financial or other assistance to SADB firms? Yes/No. If yes, describe.

8. Does contractor counsel SADB firms as to why they may have failed to receive an award? Yes/No.

9. Does the contractor use DOI, SBA and other source lists to incease bidding opportunities? Yes/No. If yes, are listings being used effectively? Yes/No.

10. Does the contractor describe the method used in estabishing individual contract goals? Yes/No. Is the method satisfactory? Yes/No. Is it detailed in the master plan? Yes/No. Is it detailed in subcontracting plans? Yes/No.

11. Are overhead items included in individual contract goals? Yes/No. If yes, does the contractor have a written procedure as to how these goals are to be allocated to individual contracts? Yes/No.

12. Does the contractor submit SF 294's and SF 295's in a timely manner? Yes/No. Are they accurate? Yes/No.

13. Describe the method used by BUDS in verifying accuracy of data reported on SF 294 and SF 295.

14. Does SF 295 contain allocable portions of overhead items as well as performance on individual contracts that do not require plans? Yes/No.

15. Describe methods used by contractor to monitor performance in meeting goals, including feedback mechanisms.

16. Are there written procedures to implement the program? Yes/No. If yes, are they adequate to assure effective performance? Yes/No.

17. Is the contractor making satisfactory progress towards meeting all individual plan subcontracting goals? Yes/No. If no, explain in detail.

18. Check the appropriate box to indicate the records maintained by contractor.

( ) Small and disadvantaged business source lists, guides and other data identifying SADB vendors.

( ) Organizations contacted for small and disadvantaged business sources.

( ) Subcontract solicitations over $100,000, indicating on each solicitation:

(1) Whether small business was solicited, and if not why not.

(2) Whether small disadvantaged business was solicited, and if not why not.

(3) The reasons for the failure of solicited small businesses or small disadvantaged businesses to receive the subcontract award.

( ) Outreach Efforts:

(1) Contacts with Minority and SB Trade Associations, etc.

(2) Contacts with business development organizations, etc.

(3) Attendance at small and minority business procurement conferences and trade fairs.

( ) Internal activities to guide and encourage buyers:

(1) Workshops, (2) Seminars, (3) Training programs, (4) Monitoring activities to evaluate compliance.

( ) Award data to include name and address of subcontractor.

( ) Certifications from small, small disadvantaged, women owned, and labor surplus area business concerns.

19. Does the contractor use flow-down subcontracting plan clauses as required by its prime contract clauses? Yes/No. If yes, does the contractor obtain and review subcontractor plans to assure that a subcontractor's plan is in consonance with its own plan? Yes/No.

20. Does the contractor monitor subcontractor's performance against plan? Yes/No. If yes, how?

21. Do any of the individual subcontracting plans contain special features such as an incentive clause to which the above questions do not particularly apply? Yes/No. If yes, describe the special features and contractor's performance in detail.

22. Does the contractor have an acceptable Labor Surplus Area program, including records and reports? Yes/No.

23. Does the contractor recognize its obligation to use its best efforts in awarding subcontracts to women-owned business concerns, as required by FAR 52.219–13? Yes/No.

Part III Remarks

(Cross reference all remarks to appropriate section in this report)

Part IV—Summary and Recommendation

1. Exit interview conducted with the following contractor representatives: ————, on (date).

2. SBA representative —— did —— did not participate in this review.

3. Contractor's performance in complying with subcontracting program and individual subcontracting plan requirements is:

Outstanding Acceptable
Marginal Unsatisfactory

(a) If performance is outstanding or acceptable, summarizes basis for this rating:

(b) If performance is marginal or unsatisfactory, detail reason as appropriate and:

(i) Summarize program or plan deficiencies.

(ii) Identify recommendations made to the contractor to correct deficiencies.

25. Appendices A and B to 48 CFR Chapter 14 are added to read as follows:

Appendix A—Department of the Interior Class Justification for Use of Other Than Full and Open Competition in Acquisitions From the Federal Prison Industries, Inc. (UNICOR)

1. The Department of the Interior purchases supplies of the classes listed in the "Schedule of Products made in Fedral Penal and Correctional Institutions" (Schedule) at prices not exceeding current market prices, in accordance with Federal Acquisition Regulation (FAR) Subpart 8.6.

2. Purchases of services that are listed on the Schedule are made by the Department after consideration has been given to purchase of such services from Workshops for the Blind and Other Severely Handicapped in accordance with FAR Subpart 8.7. Purchases are made at prices that do not exceed current market prices.

3. Purchases of supplies and services discussed above are required to be made from UNICOR pursuant to 15 U.S.C. 4142. Therefore, the authority for permitting use of other than full and open competition for these purchases is 41 U.S.C. 253(c)(5).

4. No effort can be made to solicit offers from sources other than UNICOR except where clearance is obtained pursuant to FAR 8.605 or exceptions apply as listed in FAR 8.606.

5. No synopsis notice has been published for the required supplies or services since purchases from UNICOR are exempt from publication requirements in accordance with FAR 5.202(a)(4).

6. By separate memorandum in the contract file, the contracting officer shall certify that:

(a) The supplies or services to be acquired from UNICOR are contained on the Schedule;

(b) The anticipated cost to the Government of the supplies or services to be acquired from UNICOR is fair and reasonable; and

(c) The information in this class justification is accurate and complete as it pertains to the individual acquisition.

7. This class justification is made in accordance with FAR Subpart 6.3 and approved pursuant to section 303(f)(1)(B) of the Federal Property and Administrative Services Act of 1949, as amended.

Secretary of the Interior.

Date

Appendix B—Department of the Interior Class Justification for Use of Other Than Full and Open Competition in Acquisitions of Printing and Related Supplies From the Government Printing Office (GPO)

1. The Department of the Interior purchasers Government printing and related supplies as defined in Federal Acquisition Regulation (FAR) 8.801.

2. Purchases of printing and related supplies of the type discussed above are required to be made from or through the GPO pursuant to 44 U.S.C. 501 and FAR Subpart 8.8.

3. No efforts can be made to solicit offers fromn sources other than GPO except as permitted by the Joint Committee on Printing in accordance with FAR 8.802.

4. No synopsis notice has been published for the required printing and related supplies since these purchases are exempt from publication requirements in accordance with FAR 5.202(a)(4).

5. By separate memorandum in the contract file, the contracting officer shall certify that:

(a) The printing or related supplies to be acquired are of the type defined in FAR 8.801;

(b) The anticipated cost to the Government of the printing or related supplies to be acquired from or through GPO is fair and reasonable; and

(c) The information contained in this class justification is accurate and complete as it pertains to the individual acquisition.

6. This class justification is made in accordance with FAR Subpart 6.3 and approved pursuant to Section 303(f)(1)(B) of the Federal Property and Administrative Services Act of 1949, as amended.

Secretary of the Interior.

Date

[FR Doc. 86-6892, Filed 3-31-86; 8:45 am]
BILLING CODE 4310-10-M

Notices

Federal Register
Vol. 51, No. 62
Tuesday, April 1, 1986

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Citizens' Advisory Committee on Equal Opportunity; Meeting Clarification

The location of the Citizens' Advisory Committee meeting scheduled for April 5–11, 1986 in Altamonte Springs, Florida was changed to Baton Rouge, Louisiana, April 7–9, 1986.

Details concerning the Baton Rouge meeting were announced in the **Federal Register** of March 18, 1986 (51 FR 9233).

Lawrence Bembry,

Associate Director, Equal Opportunity Office of Advocacy and Enterprise.

[FR Doc. 86–7177 Filed 3–31–86; 8:45 am]

BILLING CODE 3410–94–M

Office of the Secretary

Meat Import Limitations; Second Quarterly Estimate

Public Law 88–482, enacted August 22, 1964, as amended by Public Law 96–177 (hereinafter referred to as the "Act"), provides for limiting the quantity of fresh, chilled, or frozen meat of cattle, sheep except lambs, and goats (TSUS 106.10, 106.22, and 106.25), and certain prepared or preserved beef and veal products (TSUS 107.55, 107.61, and 107.62) which may be improted into the United States in any calendar year. Such limitations are to be imposed when the Secretary of Agriculture estimates that imports of articles provided for in TSUS 106.10, 106.22, 106.25, 107.55 and 107.62 (hereinafter referred to as "meat articles"), in the absence of limitations under the Act during such calendar year, would equal or exceed 110 percent of the estimated aggregate quantity of meat articles prescribed for calendar year 1986 by subsection 2(c) as adjusted under subsection 2(d) of the Act.

As published on January 2, 1986 (51 FR 44), the estimated aggregate quantity of meat articles prescribed by subsection 2(c), as adjusted by subsection 2(d) of the Act, for calendar year 1986 is 1,309 million pounds.

In accordance with the requirements of the Act, I have determined that the second quarterly estimate for 1986 of the aggregate quantity of meat articles which would, in the absence of limitations under the Act, be imported during calendar year 1986 is 1,390 million pounds.

Done at Washington, D.C. this 26th day of March, 1986.

Richard E. Lyng,

Secretary.

[FR Doc. 86–7068 Filed 3–28–86; 8:45 am]

BILLING CODE 3410–10–M

Federal Grain Inspection Service

Designation Renewal of Detroit Grain Inspection Service, Inc. (MI)

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: This notice announces the designation renewal of Detroit Grain Inspection Service, Inc. (Detroit), as an official agency responsible for providing official services under the U.S. Grain Standards Act, as Amended (Act).

EFFECTIVE DATE: May 1, 1986.

ADDRESS: James R. Conrad, Chief, Review Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 1647 South Building, Washington, DC 20250.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Executive Order and Departmental Regulation do not apply to this action.

FGIS announced that Detroit's designation terminates on April 31, 1986, and requested applications for official agency designation to provide official services within specified geographic areas in the October 25, 1985, **Federal Register** (50 FR 43428). Applications were to be postmarked by November 25, 1985. Detroit was the only applicant for its designation and applied for designation renewal in the area currently assigned to that agency.

FGIS announced the applicant name and requested comments on the same in the December 27, 1985, **Federal Register** (50 FR 52976). Comments were to be postmarked by February 10, 1986. No comments were received regarding Detroit's designation renewal.

FGIS evaluated all available information regarding the designation criteria in section 7(f)(1)(A) of the Act, and in accordance with section 7(f)(1)(B), determined that Detroit is able to provide official services in the geographic area for which FGIS is renewing its designation. Effective May 1, 1986, and terminating April 30, 1989, Detroit will provide official inspection services in its specified geographic area, which is the entire area previously described in the October 25 **Federal Register.**

A specified service point, for the purpose of this notice, is a city, town, or other location specified by an agency for the performance of official inspection or Class X or Class Y weighing services and where the agency and one or more of its inspectors or weighers is located. In addition to the specified service points within the assigned georgraphic area, an agency will provide official services not requiring an inspector or weigher to all locations within its georgraphic area.

Interested persons may contact the Review Branch, specified in the address section of this notice, to obtain a list of an agency's specified service points. Interested persons also may obtain a list of the specified service points by contacting the agency at the following address:

Detroit Grain Inspection Service, Inc.,
P.O. Box 176, Emmett, MI 48022

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*).

Dated: March 7, 1986.

J.T. Abshier,

Director, Compliance Division.

[FR Doc. 86–6900 Filed 3–27–86; 8:45 am]

BILLING CODE 3410–EN–M

Designation of Michigan Grain Inspection Services, Inc. (MI), and Request for Designation Applicants To Provide Official Services in the Southwestern Michigan Area

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: This notice announces the designation of Michigan Grain Inspection Services, Inc., as an official agency responsible for providing official services in northern Michigan under the U.S. Grain Standards Act, as Amended (Act). FGIS has determined that the designation of Grain Inspection Services, Inc., will not be renewed. Since there was no qualified applicant for designation in the southwestern Michigan area, FGIS is again requesting applications for designation to provide official services in that area only.

EFFECTIVE DATE: May 1, 1986.

DATE: Applications to be postmarked on or before May 1, 1986.

ADDRESS: Applications must be submitted to James R. Conrad, Chief, Review Branch, Compliance Divison, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 1647 South Building, Washington, DC 20250. All applications received will be made available for public inspection at the above address during regular business hours.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore the Executive Order and Departmental Regulation do not apply to this action.

FGIS announced that Grain Inspection Service, Inc.'s (Battle Creek) designation terminates on April 30, 1986, and requested applications for official agency designation to provide official services within a specified geographic area in Michigan in the October 25, 1985, **Federal Register** (50 FR 43429). Applications were to be postmarked by November 25, 1985. FGIS received two applications for the Battle Creek designation. Battle Creek applied for designation renewal in the entire geographic area currently assigned to that agency. Andrew J. Matako, Reese, Michigan, proposed to establish Michigan Grain Inspection Services, Inc. (Michigan Grain), and applied for designation in only a portion of the geographic area presently assigned to Battle Creek.

FGIS announced the applicant names and requested comments on the same in the December 27, 1985, **Federal Register** (50 FR 52976). This notice also contained a description of that portion of Battle Creek's area that Michigan Grain applied for. Comments were to be postmarked by February 19, 1986. No comments were received regarding designation of either Battle Creek or Michigan Grain.

FGIS evaluated all available information regarding the designation criteria in section 7(f)(1)(A) of the Act, and in accordance with section 7(f)(1)(B), determined that (1) Michigan Grain is better able than any other applicant to provide official services in the geographic area for which it applied; and (2) pursuant to section 7(g)(1) of the Act, Battle Creek's designation will not be renewed. Therefore, FGIS is designating Michigan Grain to provide such services. Effective May 1, 1986, and terminating April 30, 1989, Michigan Grain will provide official inspection services in its assigned geographic area, which is the area previously described in the December 27 **Federal Register**. In accordance with the Act and regulations, the designation of Battle Creek will terminate on April 30, 1986.

A specified service point, for the purpose of this notice, is a city, town, or other location specified by an agency for the performance of official inspection or Class X or Class Y weighing services and where the agency and one or more of its inspectors or weighers is located. In addition to the specified service points within the assigned geographic area, an agency will provide official services not requiring an inspector or weigher to all locations within its geographic area.

Interested persons may contact the Review Branch, specified in the address section of this notice, to obtain a list of an agency's specified service points. Interested persons also may obtain a list of the specified service points by contacting the agency at the following address: Michigan Grain Inspection Services, Inc., 1770 South Reese Road, Reese, Michigan 48757.

Since there was no qualified applicant for the remainder of Battle Creek's geographic area, FGIS is again requesting applications for designation to provide official services in the specified geographic area located in southwestern Michigan.

Section 7(f)(1) of the Act specifies that the Administrator of FGIS is authorized, upon application by any qualified agency or person, to designate such agency or person to provide official services after a determination is made that the applicant is better able than any other applicant to provide official services in an assigned geographic area.

The geographic area, in the States of Michigan and Ohio, which may be assigned to the applicant selected for designation, is as follows:

In Michigan, the area is:

Bounded on the North by the northern and eastern Mason County lines; the northern and eastern Newago County lines; the northern Montcalm County line east to U.S. Route 131; U.S. Route 131 south to State Route 46; State Route 46 east to State Route 66; State Route 66 south to Washington Road; Washington Road east to the western Gratiot County line; the western Gratiot County line south to State Route 57; State Route 57 east to U.S. Route 27;

Bounded on the East by U.S. Route 27 south to U.S. Route 127; U.S. Route 127 south to the Michigan State line;

Bounded on the South by the southern Michigan State line west to Lake Michigan; and

Bounded on the West by the Lake Michigan shoreline north to the northern Mason County line.

In Ohio, the area includes Williams County.

The following location, outside of the foregoing contiguous geographic area, is presently part of this geographic area assignment: Crop Aid, Hudson, Lenawee County, Michigan.

An exception to the described geographic area is the following location situated inside this area which has been and will continue to be serviced by Detroit Grain Inspection Service, Inc.: St. Johns Coop., St. Johns, Clinton County, Michigan.

Interested parties are hereby given opportunity to apply for official agency designation to provide the official services in the geographic areas, as specified above, under the provisions of section 7(f) of the Act and § 800.196(d) of the regulations issued thereunder. Section 7(g)(1) of the Act states that official agencies' designations shall terminate not later than triennially and may be renewed according to the criteria and procedures prescribed in the Act. Accordingly, designation in the specified geographic area is for a period not to exceed 3 years. Parties wishing to apply for designation should contact the Review Branch, Compliance Division, at the address listed above for forms and information.

Applications and other available information will be considered in determining which applicant will be designated to provide official services in a geographic area.

Persons or firms located in this geographic area requiring official inspection service should contact the FGIS Saginaw Field Office at (517) 753–2482 to obtain such service beginning May 1, 1986, until such time as an applicant is designated to perform official services.

Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*)

Dated: March 14, 1986.

Neil E. Porter,

Acting Director, Compliance Division.

[FR Doc. 86–6901 Filed 3–31–86; 8:45 am]

BILLING CODE 3410-EN-M

Request for Comments on Designation Applicant in the Geographic Area Currently Assigned to Eastern Iowa Grain Inspection and Weighing Service, Inc. (IA)

AGENCY: Federal Grain Inspection Service.

ACTION: Notice.

SUMMARY: This notice requests comments from interested parties on the applicant for official agency designation in the geographic area currently assigned to Eastern Iowa Grain Inspection and Weighing Service, Inc. (Eastern Iowa).

DATE: Comments to be postmarked on or before May 16, 1986.

ADDRESS: Comments must be submitted, in writing, to Lewis Lebakken, Jr., Information Resources Staff, Resources Management Division, Federal Grain Inspection Service, U.S. Department of Agriculture, Room 0667, South Building, 1400 Independence Avenue, SW., Washington, DC 20250. All comments received will be made available for public inspection at the above address during regular business hours (7 CFR 1.27(b)).

FOR FURTHER INFORMATION CONTACT: Lewis Lebakken, Jr., telephone (202) 382–1738.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Executive Order and Departmental Regulation do not apply to this action.

FGIS requested applications for official agency designation to provide official services within a specified geographic area in the February 3, 1986, **Federal Register** (50 FR 4203). Applications were to be postmarked by March 5, 1986. Eastern Iowa was the only applicant for its designation and applied for designation renewal in the area currently assigned to that agency.

This notice provides interested persons the opportunity to present their comments concerning the designation applicant. All comments must be submitted to the Information Resources Staff, Resources Management Division, specified in the address section of this notices.

Comments and other available information will be considered in making a final decision. Notice of the final decision will be published in the **Federal Register**, and the applicant will be informed of the decision in writing.

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.)*

Dated: March 7, 1986.

J.T. Abshier,

Director, Compliance Division.

[FR Doc. 86–6902 Filed 3–31–86; 8:45 am]

BILLING CODE 3410-EN-M

Request for Designation Applicants To Provide Official Services in the Geographic Area Currently Assigned to Fostoria Grain Inspection (OH), Louisiana Department of Agriculture (LA), and North Carolina Department of Agriculture (NC)

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: Pursuant to the provisions of the U.S. Grain Standards Act, as Amended (Act), official agency designations shall terminate not later than triennially and may be renewed according to the criteria and procedures prescribed in the Act. This notice announces that the designation of three agencies will terminate, in accordance with the Act, and requests applications from parties, including the agencies currently designated, interested in being designated as the official agency to provide official services in the geographic area currently assigned to the specified agency. The official agencies are Fostoria Grain Inspection, Louisiana Department of Agriculture, and North Carolina Department of Agriculture.

DATE: Applications to be postmarked on or before May 13, 1986.

ADDRESS: Applications must be submitted to James R. Conrad, Chief, Review Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 1647 South Building, Washington, DC 20250. All applications received will be made available for public inspection at the above address during regular business hours.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Executive Order and Departmental Regulation do not apply to this action.

Section 7(f)(1) of the Act specifies that the Administrator of FGIS is authorized, upon application by any qualified agency or person, to designate such agency or person to provide official services after a determination is made that the applicant is better able than any other applicant to provide official services in an assigned geographic area.

Fostoria Grain Inspection (Fostoria), 626 West Fourth Street, P.O. Box 864, Fostoria, OH 44830, and North Carolina Department of Agriculture (North Carolina), P.O. Box 27647, Raleigh, NC 27611, were each designated under the Act as an official agency to provide inspection functions on October 1, 1983. Louisiana Department of Agriculture (Louisiana), P.O. Box 44456, Capitol Station, Baton Rouge, LA 70804, was designated on that date to provide inspection and weighing functions.

Each official agency's designation terminates on September 30, 1986. Section 7(g)(1) of the Act states that official agencies' designations shall terminate not later than triennially and may be renewed according to the criteria and procedures prescribed in the Act.

The geographic area presently assigned to Fostoria, in the State of Ohio, pursuant to section 7(f)(2) of the Act, which may be assigned to the applicant selected for designation, is as follows:

Bounded on the North by the northern and eastern Fulton County lines; the eastern Henry County line; the northern and eastern Wood County lines; the northern Sandusky County line east to State Route 590;

Bounded on the East by State Route 590 south to Seneca County; the northern Seneca County line east to State Route 53; State Route 53 south to Wyandot County; the northern Wyandot County line; the northern Crawford County line east to State Route 19; State Route 19 south to U.S. Route 30;

Bounded on the South by U.S. Route 30 west to the western Hancock County line; and

Bounded on the West by the Western Hancock County line; the southern Henry County line west to State Route 108; State Route 108 north to U.S. Route 24; U.S. Route 24 southwest to the Henry County line; the western Henry and Fulton County lines.

The geographic area presently assigned to Louisiana, pursuant to Section 7(f)(2) of the Act, which may be assigned to the applicant selected for designation, is the entire State of Louisiana, except those export port locations within the State.

The geographic area presently assigned to North Carolina, pursuant to section 7(f)(2) of the Act, which may be assigned to the applicant selected for designation, is the entire State of North Carolina, except those export port locations within the State.

Interested parties, including Fostoria, Louisiana, and North Carolina, are hereby given opportunity to apply for official agency designation to provide the official services in the geographic area, as specified above, under the provisions of section 7(f) of the Act and § 800.196(d) of the regulations issued thereunder. Designation in the specified geographic area is for the period beginning October 1, 1986, and ending September 30, 1989. Parties wishing to apply for designation should contact the Review Branch, Compliance Division, at the address listed above for forms and information.

Applications and other available information will be considered in determining which applicant will be designated to provide official services in a geographic area.

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*)

Dated: March 7, 1986.

J.T. Abshier,

Director, Compliance Division.

[FR Doc. 86–6903 Filed 3–31–86; 8:45 am]

BILLING CODE 3910-EN-M

Designation Renewal of Ohio Valley Grain Inspection (IN)

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: This notice announces the designation renewal of Ohio Valley Grain Inspection (Ohio Valley), as an official agency responsible for providing official services under the U.S. Grain Standards Act, as Amended (Act).

EFFECTIVE DATE: April 1, 1986.

ADDRESS: James R. Conrad, Chief, Review Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue SW., Room 1647 South Building, Washington, DC 20250.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Executive Order and Departmental Regulation do not apply to this action.

FGIS announced that Ohio Valley's designation terminates on March 31, 1986, and requested applications for official agency designation to provide official services within specified geographic areas in the September 20, 1985, **Federal Register** (50 FR 38146). Applications were to be postmarked by October 21, 1985. We received no applications for the Ohio Valley designation postmarked by that date. As a result, we again asked for applications within the Ohio Valley area in the December 2, 1985, **Federal Register** (50 FR 49434). Applications were to be postmarked by January 2, 1986. Ohio Valley was the only applicant for designation and applied for designation renewal in the area currently assigned to that agency.

FGIS announced the applicant name and requested comments on the same in the February 3, 1986, **Federal Register** (50 FR 4204). Comments were to be postmarked by March 5, 1986. No comments were received regarding Ohio Valley's designation renewal.

FGIS evaluated all available information regarding the designation criteria in section 7(f)(1)(A) of the Act, and in accordance with section 7(f)(1)(B), determined that Ohio Valley is able to provide official services in the geographic area for which FGIS is renewing its designation. Effective April 1, 1986, and terminating March 31, 1989, Ohio Valley will provide official inspection services in its specified geographic area, which is the entire area previously described in the September 20 **Federal Register**.

A specified service point, for the purpose of this notice, is a city, town, or other location specified by an agency for the performance of official inspection or Class X or Class Y weighing services and where the agency and one or more of its inspectors or weighers is located. In addition to the specified service points within the assigned geographic area, an agency will provide official services not requiring an inspector or weigher to all locations within its geographic area.

Interested persons may contact the Review Branch, specified in the address section of this notice, to obtain a list of an agency's specified service points. Interested persons also may obtain a list of the specified service points by contacting the agency at the following address: Ohio Valley Grain Inspection, P.O. Box 601, Newburgh, IN 47630.

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*)

Dated: March 7, 1986.

J.T. Abshier,

Director, Compliance Division.

[FR Doc. 86–6904 Filed 3–31–86; 8:45 am]

BILLING CODE 3410-EN-M

Designation of Keokuk Grain Inspection Service (IA)

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: This notice announces the designation of John H. Oliver, Inc., doing business as Keokuk Grain Inspection Service (Oliver, Inc.), as an official agency responsible for providing official services under the U.S. Grain Standards Act, as Amended (Act).

EFFECTIVE DATE: May 1, 1986.

ADDRESS: James R. Conrad, Chief, Review Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue SW, Room 1647 South Building, Washington DC 20250.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Executive Order and Department Regulation do not apply to this action.

FGIS announced that Keokuk Grain Inspection Service, Inc. (Keokuk), requested voluntary termination of its designation on January 1, 1986, and requested applications for official agency designation to provide official services within Keokuk's geographic area in the October 25, 1985, **Federal Register** (50 FR 43429). Applications were to be postmarked by November 25, 1985; Oliver, Inc., was the only applicant and applied for designation in the entire area available for assignment. Oliver, Inc., has been providing official inspection services in the area on an interim basis since January 1.

FGIS announced the applicant name and requested comments on the same in the December 27, 1985, **Federal Register** (50 FR 52976). Comments were to be postmarked by February 10, 1986. No comments were received regarding designation in the available geographic area.

FGIS evaluated all available information regarding the designation criteria in section 7(f)(1)(A) of the Act, and in accordance with section 7(f)(1)(B), determined that Oliver, Inc., is able to provide official services in the geographic area for which FGIS is designating it. Effective May 1, 1986, and terminating April 30, 1989, Oliver, Inc., will provide official inspection services in the specified geographic area, which is the entire area previously described in the October 25 **Federal Register.**

A specified service point, for the purpose of this notice, is a city, town, or other location specified by an agency for the performance of official inspection or Class X or Class Y weighing services and where the agency and one or more of its inspectors or weighers is located. In addition to the specified service points within the assigned geographic area, an agency will provide official services not requiring an inspector or weigher to all locations within its geographic area.

Interested persons may contact the Review Branch, specified in the address section of this notice, to obtain a list of an agency's specified service points. Interested persons also may obtain a list of the specified service points by contacting the agency at the following address: Keokuk Grain Inspection Service, 22 Prices Creek, Keokuk, IA 52632.

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*)

Dated: March 7, 1986.

J.T. Abshier,

Director, Compliance Division.

[FR Doc. 86–6905 Filed 3–31–86; 8:45 am]

BILLING CODE 3410-EN-M

Cancellation of Designation Issued to Ft. Smith-Van Buren Grain Inspection Service and Request for Designation Applicants (AR)

AGENCY: Federal Grain Inspection Service (FGIS), USDA.

ACTION: Notice.

SUMMARY: This notice announces the cancellation of designation of Ft. Smith-Van Buren Grain Inspection Service, effective April 17, 1986. A request for designation applicants is also included in this notice.

DATE: Applications to be postmarked on or before May 1, 1986.

ADDRESS: Applications must be submitted to James R. Conrad, Chief, Review Branch, Compliance Division, Federal Grain Inspection Service, U.S. Department of Agriculture, 1400 Independence Avenue SW., Room 1647 South Building, Washington, DC 20250. All applications received will be made available for public inspection at the above address during regular business hours.

FOR FURTHER INFORMATION CONTACT: James R. Conrad, telephone (202) 447–8525.

SUPPLEMENTARY INFORMATION: This action has been reviewed and determined not to be a rule or regulation as defined in Executive Order 12291 and Departmental Regulation 1512–1; therefore, the Exectuive Order and Departmental Regulation do not apply to this action.

This notice announces the cancellation of designation of Ft. Smith-Van Buren Grain Inspection Service (Ft. Smith), effective April 17, 1986. A request for designation applicants is also included in this notice.

Section 7(f)(1) of the U.S. Grain Standards Act, as amended (Act) specifies that the Adminstrator of FGIS is authorized, upon application by any qualified agency or person, to designate such agency or person to provide official services after a determination is made that the applicant is better able than any other applicant to provide official services in an assigned geographic area.

The geographic area in the States of Arkansas and Oklahoma, which is available for assignment to the applicant selected for the new designation, is as follows: Benton, Boone, Carroll, Crawford, Franklin, Johnson, Logan, Madison, Montgomery, Newton, Polk, Sebastian, Sevier, Scott, Washington, and Yell Counties, Arkansas. Adair, Cherokee, Choctaw, Delaware, Haskell, Latimer, Le Flore, McCurtain, McIntosh, Muskogee, Ottawa, Pittsburg, Pushmataha, and Sequoyah Counties, Oklahoma.

Interested parties are hereby given opportunity to apply for official agency designation to provide official inspection services in the georgraphic area, as specified above, under the provisions of section 7(f) of the Act and § 800.196(d) of the regulations issued thereunder. Section 7(g)(1) of the Act states that official agencies' designations shall terminate not later than triennially and may be renewed according to the criteria and procedures prescribed in the Act. Accordingly, designation in the specified georgraphic area is for a period not to exceed 3 years. Parties wishing to apply for designation should contact the Review Branch, Compliance Division, at the address listed above for forms and information.

Applications and other available information will be considered in determining which applicant will be designated to provide official services in a geographic area.

Persons or firms located in this geographic area requiring official inspection service should contact the FGIS Stuttgart Field Office at (501) 673–2508 to obtain such service beginning April 18, 1986, until such time as an applicant is designated to perform official services.

(Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*))

Dated: March 25, 1986.

J.T. Absher,

Director, Compliance Division.

[FR Doc. 86–6906 Filed 3–31–86; 8:45 am]

BILLING CODE 3410-EN-M

Food and Nutrition Service

Food Stamp Program: Food Stamp Program Deductions

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: The Department is increasing the maximum amounts for the excess shelter expense and dependent care deductions to certain Food Stamp Program households. These increases are required by law.

EFFECTIVE DATE: May 1, 1986.

FOR FURTHER INFORMATION CONTACT: Thomas O'Connor, Supervisor, State Management Section, Administration and Design Branch, Program Development Division, Family Nutrition Programs, Food and Nutrition Service, USDA, Alexandria, Virginia 22302 (703) 756–3385.

SUPPLEMENTARY INFORMATION

Publication

State agencies must implement this action on May 1, 1986, and need adequate advance notice of the new amounts to meet the implementation deadline. Based on regulations published at 47 FR 46485–46487 (October 19, 1982) statutory adjustments to the deductions are issued by General Notices published in the **Federal Register** and not through rulemaking proceedings.

Classification

Executive Order 12291. This action has been reviewed under Executive Order 12291 and Secretary's Memorandum 1512–1. This action will not have significant adverse effects upon competition, employment, investment, productivity, innovation, or upon the ability of United States-based enterprises to compete with foreign based enterprises in domestic or export markets. Therefore, the Department has classified this action as "not major."

Executive Order 12372. The Food Stamp Program is listed in the Catalog of Federal Domestic Assistance under No. 10.551. For the reasons set forth in the Final Rule related Notice to 7 CFR 3015, Subpart V (48 FR 29115) this program is excluded from the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Regulatory Flexibility Act. Robert E. Leard, Administrator of the Food and Nutrition Service, has certified that this action will not have a significant economic impact on a substantial number of small entities. The action will increase the amount of money spent on food through food stamps. However, this money will be distributed among the nation's food vendors, so the effect on any one vendor will not be significant.

Paperwork Reduction Act. This action does not contain reporting or recordkeeping requirements subject to approval by the Office of Management and Budget (OMB).

Regulatory Impact Analysis

Need for Action. This action is required by Section 5(e) of the Food Stamp Act of 1977, as amended by section 1511 of P.L. 88–198, enacted December 23, 1985. Section 1511 specified new amounts for the maximum excess shelter expense deduction for certain households effective May 1, 1986. The maximum dependent care deduction for households which contain an elderly or disabled member will also increase.

Benefits. This action increases maximum shelter deductions and dependent care deductions for certain households.

Costs. It is estimated that this action will increase the cost of the Food Stamp Program by approximately $14 million in Fiscal Year 1986.

Background

Deductions

Food stamp benefits are calculated on the basis of an individual household's net income. Deductions serve to lower household net income and thus increase benefits.

Shelter Deductions

Section 5(e) of the Food Stamp Act of 1977, as amended, provides that in computing household income, households shall be allowed a deduction for certain excess shelter expenses. However, there is a maximum amount for the excess shelter expense deduction, unless the household has an elderly or disabled member, in which case there is no maximum. The amount of the maximum excess shelter expense deduction for households without an elderly or disabled member was increased by Pub. L. 99–198. The maximum excess shelter expense deduction specified in the new legislation for the 48 States and D.C. is $147 per household per month. The new amounts for Alaska, Hawaii, Guam, and the Virgin Islands are $256, $210, $179, and $109, respectively (see table). These new amounts will be effective May 1, 1986.

Excess Shelter Expense Deductions Households Without Elderly or Disabled

	Previous deductions (effective 10–1–85)	Deductions effective 5–1–86
48 States and DC	$139	147
Alaska	242	256
Hawaii	199	210
Guam	169	179
Virgin Islands	102	109

The law provides for periodic adjustments in the maximum level of the excess shelter expense deduction. These adjustments take into account changes in the shelter (exclusive of homeowners' costs and maintenance and repair component of shelter costs), fuel, and utilities components of housing costs in the CPI–U published by the BLS. The next adjustment will be effective October 1, 1986 and will reflect changes for the twelve month period ending June 30, 1986.

Dependent Care Deductions

Section 5(e) also provides that in computing household income households will be entitled to a dependent care deduction for the actual cost of payments necessary for the care of a dependent when such care enables a household member to accept or continue employment, or training or education that is preparatory for employment. The maximum amount for the dependent care deduction for households without an elderly or disabled member is $160 a month. However, if there is an elderly or disabled person in the household, then the maximum amount for the dependent care deduction is the same as the maximum amount for the excess shelter expense deduction for households without an elderly or disabled member. Therefore, since the maximum amount for the excess shelter expense deduction is increasing, the maximum amount for the dependent care deduction for households with an elderly or disabled member is also increasing. These new amounts are shown below.

Dependent Care Deductions/(Elderly or Disabled)—May 1, 1986

48 States and DC	$147
Alaska	256
Hawaii	210
Guam	179
Virgin Islands	109

These amounts will increase when the maximum amounts for the excess shelter expense deduction are increased.

(91 Stat. 958 (7 U.S.C. 2011–2029))

Dated: March 26, 1986.

John W. Bode,

Assistant Secretary.

[FR Doc. 86–7136 Filed 3–31–86; 8:45 am]

BILLING CODE 3410–30–M

DEPARTMENT OF COMMERCE

Agency Form Under Review by the Office of Management and Budget (OMB)

DOC has submitted to OMB for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Agency: Bureau of the Census
Title: 1986 Company Organization Survey
Form Number: Agency—NC–9901, NC–9907; OMB—0607–0444
Type of Request: Revision of a currently approved collection
Burden: 89,000 respondents; 75,092 reporting hours
Needs and uses: The collected data will be used to update and maintain Census' file of company and establishment records, and for continued updating of the Standard Statistical Establishment List.
Affected Public: Farms, businesses or other for-profit institutions; non-profit institutions, and small businesses or organizations
Frequency: Annually
Respondent's Obligation: Mandatory
OMB Desk Officer: Timothy Sprehe, 395–4814

Copies of the above information collection proposal can be obtained by calling or writing DOC Clearance Officer, Edward Michals (202) 377–4217, Department of Commerce, Room 6622, 14th and Constitution Avenue, NW., Washington, DC 20230.

Written comments and recommendations for the proposed information collection should be sent to Timothy Sprehe, OMB Desk Officer, Room 3235, New Executive Office Building, Washington, D.C. 20503.

Dated: March 25, 1986.

Edward Michals

Department Clearance Officer.

[FR Doc. 86–7123 Filed 3–31–86; 8:45 am]

BILLING CODE 3510-07-M

Agency Form Under Review by the Office of Management and Budget (OMB)

DOC has submitted to OMB for clearance the following proposals for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Agency: Bureau of the Census
Title: 1986 Post-Enumeration Survey of East Central Mississippi
Form Number: Agency—DC–1300R, DC1302R; OMB—NA
Type of Request: New Collection
Burden: 3,000 respondents; 825 reporting hours
Needs and Uses: This survey will be used to evaluate housing unit and person coverage for 1986 Rural Census Pretest, to gain experience in rural matching, and to test the Post Enumeration Survey card-approach.
Affected Public: Individuals or households
Frequency: One time
Respondent's Obligation: Mandatory
OMB Desk Officer: Timothy Sprehe, 395–4814

Agency: Bureau of the Census
Title: 1986 Post-Enumeration Survey of Los Angeles, California
Form Number: Agency—DC–1300U, DC1302U; OMB—NA
Type of Request: New collection
Burden: 6,000 respondents; 1,650 reporting hours
Needs and Uses: This survey will be used to test the operational feasibility of conducting a Post-Enumeration Survey (PES). Results will be used to determine if a PES can be completed by December 31, 1986.
Affected Public: Individuals or households
Frequency: One time
Respondent's Obligation: Mandatory
OMB Desk Officer: Timothy Sprehe, 395–4814

Copies of the above information collection proposals can be obtained by calling or writing DOC Clearance Officer, Edward Michals (202) 377–4217, Department of Commerce, Room 6622, 14th and Constitution Avenue, NW., Washington, D.C. 20230.

Written comments and recommendations for the proposed information collection should be sent to Timothy Sprehe, OMB Desk Officer, Room 3235, New Executive Office Building, Washington, D.C. 20503.

Dated: March 24, 1986.

Edward Michals,

Departmental Clearance Officer.

[FR Doc. 86–7124 Filed 3–31–86; 8:45 am]

BILLING CODE 3510-07-M

International Trade Administration

University of Pittsburgh; Decision on Application for Duty-Free Entry of Scientific Instrument

Correction

In FR Doc. 86–6248 appearing on page 9873 in the issue of Friday, March 21, 1986 make the following correction:

In the third column, in the fifth line, the Docket Number should read "86–038".

BILLING CODE 1505-01-M

National Oceanic and Atmospheric Administration

Permits; Pacific Coast Groundfish Fishery

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of receipt of an experimental fishing permit application and request for comments.

SUMMARY: This notice acknowledges receipt of an application for an experimental fishing permit (EFP) to delay until landing the sorting of salmon incidentally taken in a mid-water trawl fishery targeting on Pacific whiting in the fishery conservation zone (FCZ) off the coast of Oregon. If granted, this permit would allow a fishing practice which otherwise would be prohibited by Federal regulations.

DATE: Comments on this application must be received by April 11, 1986.

ADDRESS: Send comments to Rolland A. Schmitten, Director, Northwest Region, National Marine Fisheries Service, 7600 Sand Point Way NE, BIN C15700, Bldg. 1, Seattle, WA 98115.

FOR FURTHER INFORMATION CONTACT: Rolland A. Schmitten, 206–526–6150.

SUPPLEMENTARY INFORMATION: The Pacific Coast Groundfish Fishery Management Plan (FMP) and its implementing regulations at 50 CFR Part 663 specify that EFPs may be issued to authorize fishing that would otherwise be prohibited by the FMP and regulations. The procedures for issuing EFPs are contained in the regulations at § 663.10.

An EFP application to delay until landing the sorting of salmon taken in a mid-water trawl fishery targeting on Pacific whiting in the FCZ off the coast of Oregon was received on March 17, 1985. Current groundfish regulations at § 663.7(i) prohibit the retention of any species of salmonid caught in trawl nets. The normal practice on groundfish trawl vessels is to empty the net on deck and sort the catch from each tow, discarding any prohibited species and unmarketable fish before storing the catch in the vessel's hold. Prohibited species taken in a trawl and placed in the hold are considered to be retained in violation of § 663.7(i).

The applicant intends to target fishing on Pacific whiting using legal mid-water trawl gear subject to all existing regulations, except that upon retrieval of the net after each tow, the applicant proposes to immediately place the entire catch in the vessel's hold under refrigeration without handling or sorting of the catch. As it is possible that fish of a prohibited species may be included in the catch, such action could be a violation of Federal regulations. The purpose of this experiment is to demonstrate that the quality of Pacific whiting can be improved when refrigeration of the catch is not delayed and handling is minimized. Pacific whiting deteriorate rapidly after death and reduced handling and prompt preservation are essential to maintain product quality when shoreside processing is involved. One impediment to further development of the domestic Pacific whiting fishery is the problem of fish quality in shoreside processing.

The applicant proposes to sort the catch at a shoreside processing plant at the conclusion of each trip. Incidentally caught salmon would be sorted from the catch and disposed of by an authorized agent of the Oregon Department of Fish and Wildlife (ODFW) or NMFS. The proposed operation would occur in the FCZ off Oregon from April to October and the catch would be processed in Charleston, Oregon.

An EFP issued to this applicant for the same purpose in 1985. However, only one trip consisting of one tow was made under the EFP. The unsorted landing of approximately 47,000 pounds of Pacific

whiting was monitored by ODFW and only one salmon was found in the catch.

The application will be discussed at the April 8–10, 1986, public meeting of the Pacific Fishery Management Council in Eureka, California. The decision to approve or deny issuance of an EFP will be based on a number of considerations including recommendations made by the Council and comments received from the public. A copy of the application is available for review at the address above.

(16 U.S.C. 1801 *et seq.*)

Dated: March 27, 1986.

Carmen J. Blondin,

Deputy Assistant Administrator for Fisheries Resource Management, National Marine Fisheries Service.

[FR Doc. 86–7134 filed 3–31–86; 8:45 am]

BILLING CODE 3510-22-M

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Import Limits for Certain Cotton and Man-Made Fiber Textile Products Produced or Manufactured in Colombia

March 26, 1986.

The Chairman of the Committee for the Implementation of Textile Agreements (CITA), under the authority contained in E.O. 11651 of March 3, 1972, as amended, has issued the directive published below to the Commissioner of Customs to be effective on April 3, 1986. For further information contact Nathaniel Cohen, Trade Reference Assistant, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 377–4212.

Background

On October 29, 1985 and February 7, 1986, notices were published in the **Federal Register** (50 FR 43764 and 51 FR 4781), which announced the designated consultation levels for Categories 340 (cotton shirts), among others, and 640 (shirts of man-made fibers), produced or manufactured in Colombia and exported during the current agreement year which began on July 1, 1985 and extends through June 30, 1986.

During consultations held under the terms of the Bilateral Cotton, Wool and Man-Made Fiber Textile Agreement of July 1 and August 11, 1982, as amended, the Governments of the United States and Colombia have agreed to further amend their agreement to increase the designated consultation levels from 75,000 dozen to 83,333 dozen for Category 340 and from 29,167 dozen to 54,167 dozen for Category 640, produced or manufactured in Colombia and exported during the twelve-month period which began on July 1, 1985 and extends through June 30, 1986. The two countries also agreed to establish a specific limit for cotton printcloth in Category 315 at 6,000,000 square yards, and designated consultation levels for Categories 335 (cotton coats) at 24,213 dozen, 347/348 (cotton trousers, slacks, and shorts) at 200,000 dozen, and 352 (cotton underwear) at 109,091 dozen, produced and manufactured in Colombia and exported during the period which began on July 1, 1985 and extends through June 30, 1986. The letter to the Commissioner of Customs which follows this notice implements the agreed amendments.

A description of the textile categories in terms of T.S.U.S.A. numbers was published in the **Federal Register** on December 13, 1982 (47 FR 55709), as amended on April 7, 1983 (48 FR 15175), May 3, 1983 (48 FR 19924), December 14, 1983 (48 FR 55607), December 30, 1983 (48 FR 57584), April 4, 1984 (49 FR 13397), June 28, 1984 (49 FR 26622), July 16, 1984 (49 FR 28754), November 9, 1984 (49 FR 44782), and in Statistical Headnote 5, Schedule 3 of the Tariff Schedules of the United States Annotated (1986).

Ronald I. Levin,

Acting Chairman, Committee for the Implementation of Textile Agreements.

March 26, 1986.

Committee for the Implementation of Textile Agreements

Commissioner of Customs,
Department of the Treasury, Washington, D.C. 20229

Dear Mr. Commissioner: This letter further amends, but does not cancel, the letter of June 27, 1985 which directed you to prohibit entry of certain cotton, wool and man-made fiber textile products, produced or manufactured in Colombia and exported during the twelve-month period which began on July 1, 1985 and extends through June 30, 1986.

Effective on April 3, 1986, the letter of June 27, 1985 is hereby further amended to increase the restraint levels for Category 340 to 83,333 dozen [1] and Category 640 to 54,167 dozen.[1]

Also effective on April 3, 1986, the letter of June 27, 1985 is hereby amended to include restraint levels for the following categories:

Categories	Restraint levels [1]
315	6,000,000 Square yards
335	24,213 dozen
347/348	200,000 dozen
352	109,091 dozen

The levels have not been adjusted to account for any imports exported after July 1, 1985.

[1] The levels have not been adjusted to account for any imports exported after July 1, 1985.

Textile products in Categories 315, 335, 347/348 and 352 which have been exported to the United States prior to July 1, 1985 shall not be subject to this directive.

Textile products in Category 315, 335, 347/348 and 352 which have been released from the custody of the U.S. Customs Service under the provisions of 19 U.S.C. 1448(b) or 1484(a)(1)(A) prior to the effective date of this directive shall not be denied entry under this directive.

A description of the textile categories in terms of T.S.U.S.A. numbers was published in the **Federal Register** on December 13, 1982 (47 FR 55709), as amended on April 7, 1983 (48 FR 15175), May 3, 1983 (48 FR 19924), December 14, 1983 (48 FR 55607), December 30, 1983 (48 FR 57584), April 4, 1984 (49 FR 13397), June 28, 1984 (49 FR 26622), July 16, 1984 (49 FR 28754), November 9, 1984 (49 FR 44782), and in Statistical Headnote 5, Schedule 3 of the Tariff Schedules of the United States Annotated (1986).

In carrying out the above directions, the Commissioner of Customs should construe entry into the United States for consumption to include entry for consumption into the Commonwealth of Puerto Rico.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Ronald I. Levin,

Acting Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 86–7126 Filed 3–31–86; 8:45 am]

BILLING CODE 3510-DR-M

Notice of Rescinding Call on Certain Cotton Apparel Products in Category 334 Produced or Manufactured in India

March 26, 1986.

The Chairman of the Committee for the Implementation of Textile Agreements (CITA), under the authority contained in E.O. 11651 of March 3, 1972, as amended, has issued the directive published below to the Commissioner of Customs to be effective on April 3, 1986. For further information contact Claudia Wolfe, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 377–4212.

Background

A CITA directive dated December 20, 1985 (50 FR 52985) established levels for certain specified categories of cotton, wool and man-made fiber textile products, including men's and boys' other cotton coats in Category 334, produced or manufactured in India and exported during the twelve-month period which began January 1, 1986 and extends through December 31, 1986. The purpose of this notice is to announce

that, pursuant to consultations held February 12–14, 1986 under the terms of the Bilateral Cotton, Wool and Man-Made Fiber Textile Agreement of December 21, 1982 between the Governments of the United States and India, the United States Government has rescinded its request for consultations made on January 28, 1984 (see 49 FR 5368) and is withdrawing the level established for Category 334 at this time. Should it become necessary to discuss this category with the Government of India at a later date, further notice will be published in the **Federal Register.** In the letter published below, the Chairman of the Committee of the Committee for the Implementation of Textile Agreements directs the Commissioner of Customs to cancel the import control level previously established for Category 334.

A description of the textile categories in terms of T.S.U.S.A numbers was published in the **Federal Register** on December 13, 1982 (47 FR 55709), as amended on April 7, 1983 (48 FR 15175), May 3, 1983 (48 FR 19924), December 14, 1983 (48 FR 55607), December 30, 1983 (48 FR 57584), April 4, 1984 (49 FR 13397), June 28, 1984 (49 FR 26622), July 16, 1984 (49 FR 28754), November 9, 1984 (49 FR 44782), and in Statistical Headnote 5, Schedule 3 of the Tariff Schedules of the United States Annotated (1986).

Ronald I. Levin,

Acting Chairman, Committee for the Implementation of Textile Agreements.

March 26, 1986.

Committee for the Implementation of Textile Agreements

Commissioner of Customs
Department of the Treasury, Washington, D.C. 20229

Dear Mr. Commissioner: This directive cancels and supersedes that portion of the directive of December 23, 1985 concerning imports of cotton textile products in Category 334, produced or manufactured in India and exported during the twelve-month period which began on January 1, 1986 and extends through December 31, 1986.

The Committee for the Implementation of Textile Agreements has determined that this aciton falls within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Ronald I. Levin,

Acting Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 86–7125 Filed 3–31–86; 8:45 am]

BILLING CODE 3510-DR-M

Request for Public Comment on Bilateral Textile Consultations With the People's Republic of Bulgaria

March 27, 1986.

On March 6, 1986, the United States Government, under section 204 of the Agriculture Act of 1956, as amended, requested consultations with the Government of the People's Republic of Bulgaria concerning exports to the United States of women's, girls' and infants' wool coats in Category 435, produced or manufactured in Bulgaria.

The purpose of this notice is to advise that, if no solution is agreed upon in consultations with Bulgaria, the Committee for the Implementation of Textile Agreements may later establish a limit for entry and withdrawal from warehouse for consumption of such products, produced or manufactured in Bulgaria and exported to the United States during the twelve-month period which began on March 6, 1986 and extends through March 5, 1987 at a level of 11,058 dozen.

A summary market statement concerning this category follows this notice.

Anyone wishing to coment or provide data or information regarding the treatment of Category 435 or on domestic production or availability of textile products include in the category, is invited to submit such comments or information in ten copies to the Acting Chairman, Committee for the Implementation of Textile Agreements, International Trade Administration, U.S. Department of Commerce, Washington, D.C. 20230. Because the exact timing of the consultations is not yet certain, comments should be submitted promptly.

Comments or information submitted in response to this notice will be available for public inspection in the Office of Textiles and Apparel, Room 3100, U.S. Department of Commerce, 14th and Constitution Avenue, NW., Washington, D.C., and may be obtained upon written request.

Further comment may be invited regarding particular comments or information received from the public which the Committee for the Implementation of Textile Agreements considers appropriate for further consideration.

The solicitation of comments regarding any aspect of the agreement or the implementation thereof is not a waiver in any respect to the exemption contained in 5 U.S.C. 553(a)(1) relating to matters which constitute "a foreign affairs function of the United States."

Ronald I. Levin,

Acting Chairman, Committee for the Implementation of Textile Agreements.

Bulgaria—Market Statement

Category 435—Women's, Girls' and Infants Wool Coats

February 1986.

Summary and Conclusions

U.S. imports of Category 435 from Bulgaria were 11,058 dozens in 1985, a 100 percent increase from the 1984 level of 5,522 dozens.

The sharp and substantial increase of low-valued imports of Category 435 from Bulgaria is disrupting the U.S. market for WGI wool coats.

U.S. Production and Market

U.S. production remained relatively flat throughout the last several years. However, in 1984 it dropped 13 percent to 1,103,000 dozens. Between 1982 and 1984, the U.S. market for domestically produced and imported WGI wool coats grew by 119,000 dozens. However, the domestic producers' share declined from 86 to 75 percent.

U.S. Imports and Import Penetration

U.S. imports of Category 435 grew from 186,000 dozens in 1982 to 367,000 dozens in 1984, a 97 percent increase. This upward trend continued in 1985 as imports rose an additional 13 percent to 415,000 dozens. The ratio of imports to domestic production increased from 16 percent in 1982 to 33 percent in 1984.

Duty-Paid Values and U.S. Producers' Price

Approximately 65 percent of Bulgaria's 1985 imports of Category 435 entered under TSUSA Nos. 384.6530 (previously 383.6530)—WGI wool woven coats, not ornament and not over 4 U.S. dollars per pound and TSUSA No. 384.7205 (previoulsy 383.7205)—WGI coats, mostly knit, not ornamented and not over 4 U.S. dollars per pound. These coats enter the U.S. at landed duty-paid values below the U.S. producers' price for comparable garments.

[FR Doc. 86–7140 Filed 3–31–86; 8:45 am]

BILLING CODE 3510-DR-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Defense Policy Advisory Committee for Trade Policy Matters; Renewal

Notice is hereby given that the Secretary of Defense and the United States Trade Representative have renewed the Defense Policy Advisory Committee for Trade Policy Matters.

The Committee provides the Secretary and the USTR with policy advice and information regarding defense trade policy issues and domestic industrial base issues.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

March 27, 1986.

[FR Doc. 86-7201 Filed 3-31-86; 8:45 am]

BILLING CODE 3810-01-M

President's Blue Ribbon Commission on Defense Management; Meeting

ACTION: Notice of Meeting Open to the Public.

SUMMARY: The President's Blue Ribbon Commission on Defense Management announces a forthcoming meeting on April 14, 1986. From 8:30 a.m. until 12:00 Noon on April 14, 1986, the Commission will receive public testimony concerning the defense acquisition process, including application of current laws governing Federal and Department of Defense procurement activities. Specifically, the hearing will address issues related to Department of Defense acquisition of unlimited rights in technical data. The Commission's meeting, which will be open to the public, is scheduled to be held at the Department of Health and Human Services Auditorium, 333 C Street, SW., Washington, DC 20201. All interested persons are invited to attend the meeting and to file written statements on the subjects to be considered by the Commission. Written statements may be mailed to the Commission, 736 Jackson Place, NW., Washington, DC 20503, attention: Paul Stevens (General Counsel). Three (3) copies of all written statements should be received not later than April 11, 1986.

AGENDA: The Commission will meet in open session for public testimony on issues related to acquisition of rights in technical data.

FOR FURTHER INFORMATION CONTACT: Herbert E. Hetu (Public Affairs), 1899 L Street, NW., Suite 400, Washington, DC 20036. Telephone: (202) 466-7080.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

March 27, 1986.

[FR Doc. 86-7200 Filed 3-31-86; 8:45 am]

BILLING CODE 3810-01-M

Department of the Air Force

USAF Scientific Advisory Board; Meeting

March 21, 1986.

The USAF Scientific Advisory Board Ad Hoc Committee to Review the Air Force Science and Technology Programs for Reliability, Maintainability and Logistics will conduct a closed meeting at Rand Corporation, Santa Monica, California on April 16-17, 1986, from 8:30 am to 5:00 pm.

The purpose of the meeting will be to review Air Force Reliability, Maintainability and Logistics technology programs and evaluate their completeness and innovativeness to achieve Air Force goals.

The meeting concerns matters listed in section 552b(c) of Title 5, United States Code, specifically subparagraph (1) thereof, and accordingly, will be closed to the public.

For further information, contact the Scientific Advisory Board Secretariat at 202-697-8404.

Patsy J. Conner,

Air Force Federal Register Liaison Officer.

[FR Doc. 86-7078 Filed 3-31-86; 8:45 am]

BILLING CODE 3910-01-M

USAF Scientific Advisory Board; Meeting

March 21, 1986.

The USAF Scientific Advisory Board Ad Hoc Committee on Appropriate Air Force Technology Efforts to Complement the Strategic Defense Initiative Program will meet at Los Angeles, California on April 17, 1986 and at Headquarters Space Command, Peterson Field, Colorado on April 18, 1986 from 8:30 am to 5:00 pm both days.

The purpose of the meeting will be for the BM/C^3 panel to review Air Force Battle Management/Command, Control and Communications programs for completeness and ability to satisfy AF space requirements.

The meeting concerns matters listed in section 552b(c) of Title 5, United States Code, specifically subparagraph (1) thereof, and accordingly, will be closed to the public.

For further information, contact the Scientific Advisory Board Secretariat at 202-697-8404.

Patsy J. Conner,

Air Force Federal Register Liaison Officer.

[FR Doc. 86-7079 Filed 3-31-86; 8:45 am]

BILLING CODE 3910-01-M

DEPARTMENT OF ENERGY

Bonneville Power Administration

Proposed Allocation Methodologies for Certain Costs and Benefits of the WNP-3 Settlement Agreement, Public Hearings, and Opportunity for Public Review and Comment

AGENCY: Bonneville Power Administration (BPA), DOE.

ACTION: Notice. *BPA File No.*: WN-86. BPA requests that all comments and documents which become part of the Official Record compiled in the process of developing Allocation Methodologies for Certain Costs and Benefits of the WNP-3 Settlement Agreement contain the file number designation WN-86.

SUMMARY: In September 1985, BPA entered into agreements with four Pacific Northwest investor-owned utilities (IOUs) to settle litigation which arose from BPA's request of the Washington Public Power Supply System that construction on Nuclear Project No. 3 (WNP-3) be delayed. BPA is obliged to pay financing costs on bonds sold by the Washington Public Power Supply System (Supply System) for its 70 percent interest in WNP-3. The remaining 30 percent interest in WNP-3 is owned collectively by the four Northwest IOUs, which opposed the construction delay in litigation.

The agreements entered into by BPA and the four Northwest IOUs are referred to collectively as the WNP-3 Settlement Agreement. The WNP-3 Settlement Agreement is founded on an exchange of power. The transactions which implement the exchange of power require payments and receipts of money between BPA and the IOUs under certain specifically defined conditions. To implement the WNP-3 Settlement, BPA will incur certain costs, and receive certain benefits with respect to two aspects of this exchange: (1) Plant related costs and benefits arising from BPA's right to acquire the IOU share of the output of WNP-3, specifically obligations relating to preserving the IOU share of WNP-3 and costs and benefits arising from the IOU share of WNP-3 if that plant is decommissioned prior to completion; and (2) costs and

benefits arising from providing power to the IOUs under the WNP–3 Settlement Exchange Agreement, which is an integral part of the WNP–3 Settlement Agreement package.

The Administrator's Record of Decision (ROD) for entering into the WNP–3 Settlement Agreement was published on September 19, 1985. In a letter to Snohomish County Public Utility District contained in the ROD (Exhibit Q), BPA indicated that it would conduct rate hearings under section 7(i) of the Pacific Northwest Electric Power Planning and Conservation Act (Pacific Northwest Power Act) (16 U.S.C. 838d(c)), to establish which sections of the Pacific Northwest Power Act govern the allocation of certain costs and benefits arising from the above stated provisions of the WNP–3 Settlement Agreement. In that letter BPA indicated that it believed those costs and benefits should be allocated under section 7(g) of the Pacific Northwest Power Act.

BPA is proposing to allocate the plant related costs and benefits arising from provisions of the WNP–3 Settlement Agreement to all BPA loads. BPA is also proposing to allocate the costs and benefits arising from the WNP–3 Settlement Exchange Agreement to all BPA firm loads.

Opportunities will be available for interested persons to review the proposed allocation methodologies and any supporting studies, to participate in hearings, and to submit written comments. A summary of the proposed describing the allocation methodologies for certain WNP–3 Settlement Agreement costs will be available to interested members of the public after March 31, 1986. During the development of the final allocation methodologies, BPA will evaluate all comments received in this process. Consideration of comments and more current data may result in the final proposed allocation methodologies differing from the methodologies proposed in this notice. The final allocation methodologies will be employed in BPA's subsequent rate filings, which will be submitted to the Federal Energy Regulatory Commission (FERC) for confirmation and approval.

Responsible official: Ms. Shirley R. Melton, Director, Division of Rates, is the official responsible for developing allocation methodologies for WNP–3 Settlement Agreement costs and benefits.

DATES: Any person wishing to become a formal "party" to the proceedings must so notify BPA in writing. The notification must be received by April 11, 1986, and should be addressed as follows: Hearing Officer (WN–86)–APR, Bonneville Power Administration, P.O. Box 12999, Portland, Oregon 97212. A copy of this notification must also be served on BPA's Office of General Counsel-APR, P.O. Box 3621, Portland, Oregon 97208.

A prehearing conference, required by the rate procedures, will be held before the Hon. Dean Ratzman, the Hearing Office, in the cafeteria of Jackson High School, 10625 SW. 35th Avenue, Portland, Oregon at 9 a.m. on April 14, 1986. Registration for the prehearing conference will begin at 8:30 a.m. on April 14, 1986.

During the prehearing conference, dates will be set for the presenatation of direct cases, rebuttal cases, cross examination, oral argument, and briefs. A notice of the dates and times of the hearings will be mailed to all parties of record. All formal hearing sessions after the prehearing conference will be held in the cafeteria of Jackson High School, 10625 SW. 35th Avenue, Portland, Oregon.

Individuals other than parties who wish to comment on BPA's proposal may submit written comments until the close of the hearings. The last day for receipt of written comments will be specified in a later **Federal Register** notice.

ADDRESS: Written comments should be submitted to Ms. Donna L. Geiger, Public Involvement Manager, Bonneville Power Administration, P.O. Box 12999, Portland, Oregon 97212.

FOR FURTHER INFORMATION CONTACT: Ms. Kathleen S. Johnson, Public Involvement office, at the address above. Telephone numbers, voice/TTY, for the Public Involvement office are: 503–230–3478 in Portland; toll-free 800–452–8429 for Oregon outside of Portland; 800–547–6048 for Washington, Idaho, Montana, Wyoming, Utah, Nevada, and California.

Information may also be obtained from:

Mr. George Gwinnutt, Lower Columbia Area Manager, Suite 288, 1500 Plaza Building, 1500 NE. Irving Street, Portland, Oregon 97232, 503–230–4551.

Mr. Ladd Sutton, Eugene District Manager, Room 206, 211 East Seventh Avenue, Eugene, Oregon 97401, 503–687–6959.

Mr. Wayne R. Lee, Upper Columbia Area Manager, Room 561, West 920 Riverside Avenue, Spokane, Washington 99201, 509–456–2518.

Mr. George E. Eskridge, Montana District Manager, 800 Kensington, Missoula, Montana 59801, 406–329–3060.

Mr. Ronald K. Rodewald, Wenatchee District Manager, P.O. Box 741, Wenatchee, Washington 98801, 509–662–4377, extension 379.

Mr. Terence G. Esvelt, Puget Sound Area Manager, 415 First Avenue North, Room 250, Seattle, Washington 98109, 206–442–4130.

Mr. Thomas V. Wagenhoffer, Snake River Area Manager, West 101 Poplar, Walla Walla, Washington 99362, 509–522–6226.

Mr. Robert N. Laffel, Idaho Falls District Manager, 531 Lomax Street, Idaho Falls, Idaho 83401, 208–523–2706.

Mr. Frederick D. Rettenmund, Boise District Manager, 550 W. Fort Street, Room 376, Box 035, Boise, Idaho 83724, 208–334–9137.

SUPPLEMENTARY INFORMATION:

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A. General Rate Guidelines
B. Confirmation and Approval
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III. Procedures Governing Rate Adjustments and Public Participation

Background

In developing the proposed WNP–3 Settlement Agreement cost and benefit allocation methodologies, BPA considered revenue and load impacts, cost impacts, environmental impacts, and statutory obligations. BPA published its *Revised Environmental Assessment of the Proposed Settlement of Washington Nuclear Project No. 3 Lawsuits* in August 1985 and a *Finding of No Significant Impact* (FONSI) on the proposed WNP–3 Settlement Agreement in September 1985. BPA does not intend to do any additional environmental analysis.

I. Statutory Provisions

Development of allocation methodologies for costs and benefits arising from the WNP–3 Settlement Agreement must comport with BPA's statutory rate directives contained in applicable legislation.

A. General Rate Guidelines

Guidelines for the development of BPA are found in the Bonneville Project Act (16 U.S.C. 832e), the Federal Columbia River Transmission System Act (Transmission Act) (16 U.S.C. 838), the Flood Control Act of 1944, and the Pacific Northwest Power Act (16 U.S.C. 839e). Section 7(g) of the Pacific Northwest Power Act directs that "Except to the extent that the allocation of costs and benefits is governed by provisions of law in effect on the effective date of this Act, or by other provisions of this section, the Administrator shall equitably allocate to power rates, in accordance with generally accepted ratemaking principles and the provisions of this Act all costs and benefits not otherwise allocated under this section . . .".

B. Confirmation and Approval

The Pacific Northwest Power Act specifies in section 7(a)(2) that rates become effective upon final or interim approval by FERC. FERC must review the rate proposal to determine that (1) rates are sufficient to assure repayment of the Federal investment in the FCRPS over a reasonable number of years after first meeting BPA's other costs; (2) rates are based on BPA's total system costs; and (3) transmission rates equitably allocate the costs of the Federal transmission system between Federal and non-Federal power uses of the system. Pursuant to section 7(i)(6) of the Pacific Northwest Power Act, FERC has promulgated rules found in 18 CFR Part 300 establishing procedures for the approval of BPA rates.

II. Description of Proposed Allocation Methodologies

On September 17, 1985, BPA entered into agreement with four Pacific Northwest-investor owned utilities (IOUs) to settle litigation which arose from BPA's request that construction of the Washington Public Power Supply System Nuclear Project No. 3 (WNP-3) be delayed. BPA is obligated to pay principal and interest on bonds sold by the Supply System to finance 70 percent of that project. The construction delay was opposed in litigation by the four Pacific Northwest IOUs which collectively owned the remaining 30 percent share of WNP-3.

The agreements entered into by BPA and the four Pacific Northwest IOUs are referred to as the WNP-3 Settlement Agreement and are founded on an exchange of power. BPA delivers that is surplus to BPA's present contractual obligations in exchange for a right to acquire power from those companies' resources and from each of the companies' shares of WNP-3.

In certain circumstances, the WNP-3 Settlement Agreement provides for the payment of money by the parties to one another to account for risk, to account for the time value of the power exchange, to avoid an unintended windfall to the companies, to avoid adverse rate impacts to BPA's other customers, and to account for other factors. BPA refers to these payments as 'equalizing the value of the exchange'.

As part of the exchange of power from BPA, each company irrevocably offered to sell its share of WNP-3 capability to BPA. If BPA needs power from the companies' share of WNP-3, BPA will need to complete section 6(c) procedures pursuant to the Pacific Northwest Power Act (16 U.S.C. 838d(c)).

Under the WNP-3 Settlement Agreement, BPA pays only the construction costs to complete the plant and the costs of operating and maintaining the plant. The companies will absorb their investment in construction costs (sunk costs) prior to February 1, 1985. BPA is obligated to reimburse the companies for their share of costs incurred in the preservation of WNP-3 after February 1, 1985, due to the construction delay.

The Record of Decision for the WNP-3 Settlement Agreement, published by BPA on September 19, 1985, included a letter from BPA to Snohomish County Public Utility District, Everett, Washington, (Exhibit Q) which responded to comments made by that utility on several issues, including the ratemaking treatment of costs and benefits of the WNP-3 Settlement Agreement. In that letter BPA agreed to conduct a hearing under Pacific Northwest Power Act section 7(i) to establish two ratemaking principles for allocating certain costs and benefits to BPA of the WNP-3 Settlement Agreement.

The first ratemaking issue to be considered is whether Pacific Northwest Power Act sections 7(b), 7(c), 7(f), or 7(g) should govern the allocation of:

(1) Payments by BPA to the IOUs equal to the operation and maintenance costs of the combustion turbines or the fully distributed costs of less costly resources of the IOUs;

(2) Payments by BPA to other utilities equal to the cost of acquiring less costly resources to displace operation of the IOUs' combustion turbines; and

(3) Payments from the IOUs to BPA which equal the cost of operation and maintenance of four surrogate nuclear plants, or a calculated percentage of the operation and maintenance costs of WNP-3.

These payments relate to the Settlement Exchange Agreement between BPA and the four Pacific Northwest IOUs. BPA believes that these payments should be allocated under section 7(g) of the Pacific Northwest Power Act, which does not specify an allocation methodology. BPA proposes that all net costs and benefits arising from the WNP-3 Settlement Exchange Agreeent be allocated uniformly to all BPA power loads.

This allocation would not require that BPA specifically identify, or assign costs to BPA system resources used to serve the IOU WNP-3 exchange load. To the extent that nonfirm or surplus firm power is used to displace operation of IOU combustion turbines, BPA's Nonfirm and Surplus Firm Power rates will be affected. By allocating all revenues and costs related to the WNP-3 Settlement Exchange Agreement to all BPA firm power loads, this proposed methodology ensures that the net costs or benefits of the settlement exchange are borne by all BPA firm power customers. Moreover, allocation to all BPA firm power loads would not allow the WNP-3 Settlement Exchange Agreement costs and benefits to affect the development of BPA's Nonfirm Power rate. BPA does not believe that these costs and benefits fall within the guidelines established for development of its Nonfirm Power rate.

BPA would perform this allocation in its Wholesale Power Rate Design Study as a separate rate design adjustment, or combine it with other rate design adjustments that have the same effect. The sequence of this rate design adjustment would be prior to the 7(c)(2) adjustment. The effect of this sequencing would be that the rate to BPA's Direct Service Industrial Customers would continue to be determined as the Priority Firm rate plus a margin when the Industrial Power floor rate does not apply. In this way, all costs and benefits affecting the Priority Firm rate would also affect the level of the 7(c)(2) rate. The quantification of IOU payments to BPA, and BPA's cost of resources incidental to the WNP-3 Settlement Exchange Agreement will be made in BPA rate filings after January 1, 1987, when the WNP-3 Settlement Exchange Agreement goes into effect.

The second ratemaking issue to be considered is whether Pacific Northwest Power Act section 7(b), 7(c), 7(f), or 7(g) should govern the allocation of:

(1) Payments of the costs of preserving the IOU's 30 percent share of WNP-3 after February 1, 1985;

(2) Receipt of the proceeds, or payment of excess costs under section 22(a) of the Ownership Agreement (dealing with receipts or disbursals related to decommissioning of WNP-3) of the 20 percent share of WNP-3 owned by the Portland General Electric Company, the Puget Sound Power and Light Company, and the Washington Water Power Company if construction is terminated; and

(3) Receipt of a portion of the proceeds or payment of a portion of excess costs under section 22(a) of the Ownership Agreement for the 10 percent share of WNP-3 owned by the Pacific Power and Light Company if construction is terminated.

These payments and receipts concern WNP-3 plant related costs. BPA believes that these payments and receipts should also be allocated under section 7(g) of the Pacific Northwest

Power Act. BPA proposes to allocate these payments and receipts to all BPA loads.

The costs of preserving, as well as the costs and benefits of decommissioning WNP-3 in the event of termination of construction, should be allocated uniformly to all BPA loads. The plant related costs of the WNP-3 Settlement Agreement fall within the guidelines for determining the Nonfirm Power rate, and therefore should be allowed to affect the Nonfirm Power rate. Allocation of these costs and benefits would be performed in BPA's Cost of Service Analysis in a manner similar to the allocation of BPA-3 generation costs which are not specific to resource pools.

III. Procedures Governing Rate Adjustments and Public Participation

Section 7(i) of the Pacific Northwest Power Act (16 U.S.C. 839e(i)), provides procedures for encouraging participation of the public in the development of BPA's rates. In order to give the public notice of how it may participate in BPA's rate adjustment proceedings and to elaborate on the procedures established in section 7(i), BPA published on March 5, 1986, "Procedures Governing Bonneville Power Administration Rate Adjustments" (51 FR 7611). These procedures were effective on March 7, 1986, and replace procedures found at 47 FR 6240 (February 10, 1982) and 49 FR 10980 (March 23, 1984). BPA has requested public comment on the revised procedures. Section 1010.10, Expedited Rate Proceedings, of BPA's revised procedures will be applicable to the 7(i) hearings on the WNP-3 Settlement Agreement. Under this section, the Administrator's Record of Decision shall be published within 90 days after publication of the notice of proposed rate adjustments.

The Administrator has decided to conduct these proceedings on an expedited basis under section 1010.10 in order to assure completion of this hearing in advance of work on BPA's next general rate case. In reaching his decision, the Administrator has given special consideration to the limited nature of the issues arising under this rate proposal. The Administrator's Record of Decision on this rate case shall be published June 30, 1986.

The Pacific Northwest Power Act prescribes a **Federal Register** notice announcing the proposed methodology; one or more hearings; the opportunity to submit written views, supporting information, questions and arguments outside the hearings; and a decision by the Administrator based on the Official Record developed during the hearing process. BPA's procedures expand these requirements. They provide for publication of a notice of the proposed allocation methodology, a prehearing conference, a hearing, receipt of written comments, preparation of decision documents, a decision, and a transmittal of the decision with supporting documentation to FERC.

The process begins with publication in the **Federal Register** of the notice of the proposed methodology. Following this notice, a prehearing conference is to be conducted. A prehearing conference has been scheduled before the Hearing Officer on April 14, 1986, 9 a.m., in the cafeteria of Jackson High School, 10625 SW. 35th Avenue, Portland, Oregon. Registration will begin at 8:30 a.m. Issues for discussion at the prehearing conference may include disputes concerning status as a party, discovery, the scope of cross-examination, hearing schedules, and other pertinent matters. BPA will prefile the testimony of its witnesses at or before the prehearing conference.

Customers of BPA who provide notice are parties of right. Others may become parties by demonstrating in their notice and at the prehearing conference that they would represent a significant and otherwise unrepresented interest. The notice should contain: (1) The named of the entity claiming status as a party; (2) the person who will be representing the party; (3) whether the person or entity claiming status as a party has a contractual relationship with BPA that could be affected by the proposed allocation methodologies; and (4) if no contractual relationship exists, the interest the person believes would be served by the person or entity being a party. All timely applications will be ruled on by the Hearing Officer. Late intervenors are discouraged by BPA's rules of procedure.

BPA distinguishes between "participants in" and "parties to" the hearings. Apart from the formal hearing process, BPA will receive comments and information from "participants," who are defined in the procedures as interested persons who may express their views, but who may not cross-examine witnesses or participate in the prehearing conference. Participants' written comments will be made part of the Official Record. The "participants" category of interest has been established to give the public the maximum opportunity to participate and have its views considered without assuming the obligations incumbent on "parties." For the benefit of participants, BPA will provide a Summary of the Proposal in non-technical language describing the proposed allocation methodologies for certain WNP-3 Settlement Agreement costs and benefits. This summary will be available after March 31, 1986, and will be mailed to all participants who have previously indicated interest in the WNP-3 Settlement Agreement.

Participants need not attend the hearings in order to have their views included in the record. Written comments may be included in the record if they are submitted before the close of the hearings. Procedures for submitting comments to BPA's Public Involvement Manager are detailed in the Dates and Addresses sections of this notice.

The second category of interest is that of a "party." A party may be considered a party of right because of its legal and/or contractual relationship with BPA, and hence its direct interest, or it may be a peson seeking to represent a significant and otherwise unrepresented interest in the hearings. Parties may participate in the prehearing conference, may call and cross-examine witnesses, and are entitled to service of documents from all other parties. Parties also may be cross-examined and required to serve documents on the other parties. To avoid unnecessary delay, cross-examination by parties may be limited by the Hearing Officer. Where two or more parties have substantially like interest and positions, the Hearing Officer, to expedite the hearing, may order limitations on the number of attorneys (or parties appearing pro se) who will be permitted to cross-examine witnesses and file motions and objections on behalf of such parties. If a party demonstrates that it would not be represented adequately in the joint presentation of an issue or issues, the Hearing Officer may permit separate examination or argument regarding such issue or issues.

To facilitate discovery and promote the efficient use of cross-examination, the Hearing Officer may order BPA, the parties, or both, to make witnesses available for clarifying sessions on technical matters. The prehearing conference will be followed by presentation of the parties' direct cases, the presentation of rebuttal cases, cross examination, and briefing. Oral argument will not be heard in this proceeding unless all parties agree to substitute oral argument for a brief on exceptions. The times for these proceedings will be established by the Hearing Officer at the prehearing conference and will be announced in a subsequent order that will be served upon all parties of record.

After the close of the cross-examination, the Hearing Officer will

extend an opportunity to the parties to file an initial brief to identify separately each legal, factual, and policy issue to be resolved by the Administrator and present all arguments in support of a party's position on each of the issues. The Administrator will publish a Draft Record of Decision (1) identifying each issue BPA will resolve in the pending rate hearing; (2) summarizing the factual, legal and policy arguments presented by BPA and the parties on each issue; and (3) setting forth the Administrator's tentative decision on each issue. Parties may then file briefs on exceptions to (1) raise any alleged legal, policy, or evidentiary errors in the draft Record of Decision, or (2) provide additional support for tentative decisions. Alleged errors not raised in briefs on exceptions shall be deemed waived.

The Official Record will include, among other things, transcripts of the hearings, written material submitted by the parties and participants, documents developed by the BPA staff, and other material accepted into the record by the Hearing Officer. The Hearing Officer then will review the record, will supplement it if necessary, and will certify the record to the BPA Administrator for decision.

The Administrator will develop any final proposed WNP-3 Settlement Agreement allocation methodologies based on the entire Official Record, including the hearing transcripts, exhibits, comments received from participants, and other material and information submitted to or developed by the Administrator. The basis for any final proposal will be expressed in the Administrator's Record of Decision.

Issued in Portland, Oregon on March 19, 1986.

Marvin Klinger,

Acting Administrator.

[FR Doc. 86-7097 Filed 3-31-86; 8:45 am]

BILLING CODE 6450-01-M

Economic Regulatory Administration

Proposed Consent Order; Avant Petroleum, Inc.

AGENCY: Economic Regulatory Administration, Energy.

ACTION: Notice of Proposed Consent Order and Opportunity for Comment.

SUMMARY: The Economic Regulatory Administration (ERA) of the Department of Energy (DOE) announces a proposed Consent Order with Avant Petroleum, Inc. concerning crude oil resales by the firm, and provides an opportunity for public comment on the terms and conditions of the proposed Consent Order.

DATED: Comments by: May 1, 1986.

ADDRESS: Send comments to: Avant Consent Order Comments, Office of Field Operations, U.S. Department of Energy, 1403 Slocum, Second Floor, Dallas, Texas 75207.

FOR FURTHER INFORMATION CONTACT: Ben L. Lemos, Director, Office of Field Operations, Economic Regulatory Administration, U.S. Department of Energy, 1403 Slocum, Second Floor, Dallas, Texas 75207; Tel: (214) 767-4646. (Copies of the Consent Order may be obtained free of charge by writing or calling this office.)

SUPPLEMENTARY INFORMATION: On February 6, 1986, the ERA excuted a proposed Consent Order with Avant Petroleum, Inc. for $1,700,000. Under 10 CFR 205.199(b), a proposed Consent Order which involves the sum of $500,000 or more, excluding interest and penalties, becomes effective no sooner than thirty days after publication of a notice in the Federal Register requesting comments concerning the proposed Consent Order. Although ERA has signed and tentatively accepted the proposed Consent Order, the ERA may, after consideration of the comments it receives, withdraw its acceptance and, if appropriate, attempt to negotiate a modification of the Consent Order or issue the Consent Order as signed.

I. Background

Avant Petroleum, Inc. (Avant) was involved in crude oil reselling activities during the audit period of August 1978 through December 1980. ERA's audit of Avant for this period included a detailed examination of Avant's purchase and sale invoices, purchase, sale and exchange contracts, and Avant's books and records. ERA also examined the Form ERA-69's filed by Avant during this period, as required by the regulations governing crude oil resellers.[1]

ERA's audit found that, during the audit period, Avant engaged in approximately 237 crude oil transactions, 97 percent of which involved crude oil produced outside of the United States.

Because of the complexity of the audit, numerous meetings and exchanges of documentation and information occurred between Avant representatives and ERA personnel after the audit was completed. Several times ERA modified its findings as a result of these further submissions presented by the firm. However, ERA still concluded that Avant had exceeded its permissible average markup in its sales of crude oil in certain months during the audit period resulting in a potential violation of $1,767,296.48 plus interest.

One of the transactions included in the above violation calculation resulted in a profit to Avant of $1.38 million. Avant provided further information demonstrating that this transaction represented only one part of a series of related transactions which also included losses totalling $885,000 (not included in the violation calculation). If Avant's position were accepted and these losses were offset against the profit included in the violation calculation, the violation would be reduced to approximately $800,000, exclusive of interest. The violation together with interest would be approximate $1,850,000.

In light of the above, together with the fact that certain additional controversial interpretative issues would have to be addressed by the agency, it is the opinion of ERA that a payment of $1,700,000, which includes interest, is a satisfactory compromise of the issues raised in this audit.

II. The Consent Order

The proposed Consent Order has been entered into to resolve all civil and administrative disputes, claims, and causes of action by DOE relating to Avant's compliance in its resales of crude oil during the audit period. Although Avant contends that in all respects it correctly construed and applied the applicable regulations, Avant has entered into this proposed Consent Order to avoid the expense of litigation and the disruption of business. DOE believes the Consent Order is in the public interest and provides a satisfactory resolution of the issues raised by its audit.

III. Refunds

Under the Consent Order, Avant will pay the sum of $1,700,000 within thirty days of the effective date of the Consent Order. The Administrator (or his designee) of ERA shall direct that these monies be deposited in a suitable account and ERA will petition DOE's Office of Hearings and Appeals to implement special refund procedures pursuant to 10 CFR Part 205, Subpart V, to distribute the monies.

In consideration for Avant's performance under the Consent Order, the DOE agrees not to pursue any civil claims against Avant that the DOE may have arising out of the matters covered by the Consent Order.

[1] "Avant" refers to both Avant Petroleum, Inc. and Mitsui & Co. (U.S.A.), Inc. (the parent and predecessor of Avant).

The foregoing provisions for payment of the refund amount were established because ERA was unable to readily identify the ultimate injured parties due to the nature of the alleged violations and the complexities of petroleum marketing.

IV. Submission of Written Comments

Interested persons are invited to submit written comments concerning the terms and conditions of this Consent Order to the address given above. Comments should be identified on the outside of the envelope and on the documents submitted with the designation "Comments on Avant Petroleum, Inc. Consent Order." The ERA will consider all comments it receives by 4:40 p.m. CST, thirty (30) days after the date of publication of this notice. Any information or data considered confidential by the person submitting it must be identified as such in accordance with the procedures in 10 CFR 205.9(f).

Issued in Washington, D.C. on the 18th day of February, 1986.

Ben Lemos,

Director, Office of Field Operations, Economic Regulatory Administration.

[FR Doc. 86-7096 Filed 3-31-86; 8:45 am]

BILLING CODE 6450-01-M

Federal Energy Regulatory Commission

[Project No. 4627-005, 2609-005]

Albert R. Hunt and Betty F. Hunt, International Paper Co.; Availability of Environmental Assessment and Finding of No Significant Impact

March 26, 1986.

In accordance with the National Environmental Policy Act of 1969, the Office of Hydropower Licensing, Federal Energy Regulatory Commission (Commission), has reviewed the applications for major and minor licenses (or exemptions) listed below and has assessed the environmental impacts of the proposed developments.

LICENSES

Project No.	Project name	State	Water body	Nearest town	Applicant
4627-005	Baker Creek	CA	Baker Creek	Bridgeville and Dinsmore.	Albert R. Hunt & Betty F. Hunt

AMENDMENTS

Project No.	Project name	State	Water body	Nearest town	Applicant
2609-005	Curtis-Palmer Falls	NY	Hudson River	Corinth, Hadley, and Luzerne.	International Paper Company

Environmental assessments (EA's) were prepared for the above proposed projects. Based on independent analyses of the above actions as set forth in the EA's, the Commission's staff concludes that these projects would not have significant effects on the quality of the human environment. Therefore, environmental impact statements for these projects will not be prepared. Copies of the EA's are available for review in the Commission's Division of Public Information, Room 1000, 825 North Capitol Street, NE., Washington, DC 20426.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7191 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. 8589-001 et al.]

Surrender of Preliminary Permits; Triple Star Hydro Limited et al.

March 26, 1986.

Take notice that the following preliminary permits have been surrendered effective as described in Standard Paragraph I at the end of this notice.

1. Triple Star Hydro Limited

[Project No. 8589-001]

Take notice that Triple Star Hydro Limited, Permittee for the Triple Star Hydroelectric Project, FERC No. 8589, has requested that its preliminary permit be terminated. The preliminary permit for Project No. 8589 was issued on February 14, 1985, and would have expired on July 31, 1986. The project would have been located on Soldier Creek, in Trinity County, California.

The Permittee filed the request on February 24, 1986.

2. Boise Canyon Hydro Limited

[Project No. 8591-001]

Take notice that Boise Canyon Hydro Limited, Permittee for the Boise Canyon Hydroelectric Project, FERC No. 8591, has requested that its preliminary permit be terminated. The preliminary permit for Project No. 8591 was issued on February 12, 1985, and would have expired on July 31, 1986. The project would have been located on Boise Creek, in Humboldt County, California.

The Permittee filed the request on February 24, 1986.

3. Mountain Empire Hydro Ltd.

[Project No. 9337-001]

Take notice that the Mountain Empire Hydro Limited, Permittee for the proposed Mountain Empire Hydroelectric Project No. 9337, has requested that its preliminary permit be terminated. The preliminary permit was issued on November 7, 1985, and would have expired on October 31, 1988. The project would have been located on Leavitt Creek in Mono County, California.

The Permittee filed the request on February 24, 1986.

4. Oglethorpe Power Corporation

[Project No. 8783-001]

Take notice that Oglethorpe Power Corporation, Permittee for the proposed Frosty Mountain Pumped Storage Project No. 8783, has requested that its preliminary permit be terminated. The permit was issued on November 25, 1985, and would have expired October 31, 1988. The project would have been located within the Chattahooche National Forest in Dawson and Lumpkin Counties, Georgia. The Permittee states that other potential sites studied have shown a better overall development potential than the Frosty Mountain site.

The Permittee filed the request on March 3, 1986.

5. Silver Wheel Hydro Limited

[Project No. 8587-001]

Take notice that Silver Wheel Hydro

Limited, Permittee for the Silver Wheel Hydroelectric Project, FERC No. 8587, has requested that its preliminary permit be terminated. The preliminary permit for Project No. 8587 was issued on February 25, 1985, and would have expired on July 31, 1986. The project would have been located on Little North Fork Salmon River, in Siskiyou County, California.

The Permittee filed the request on February 24, 1986.

6. Southwestern Water Conservation District of Colorado

[Project No. 8329-001]

Take notice that the Southwestern Water Conservation District of Colorado, Permittee for the proposed Dolores Pumped-Storage Project No. 8329, has requested that its preliminary permit he terminated. The preliminary permit was issued on October 24, 1985, and would have expired on September 30, 1988. The project would have been located on Plateau Creek, in Montezuma County, Colorado.

The Permittee filed the request on March 3, 1986.

7. St. Vrain Mutual Reservoir & Water Company and Marigold 41 Partnership

[Project No. 8849-001]

Take notice that St. Vrain Mutual Reservoir & Water Company and Marigold 41 Partnership, Permittee for the proposed Dowe Flats Dam Project No. 8849, has requested that its preliminary permit be terminated. The preliminary permit was issued on June 20, 1985, and would have expired on May 31, 1988. The project would have been located near the St. Vrain Supply Canal, in Boulder County, Colorado.

The Permittee filed the request on February 27, 1986.

Standard Paragraphs

I. The preliminary permit shall remain in effect through the thirtieth day after issuance of this notice unless that day is a Saturday, Sunday or holiday as described in 18 CFR 385.2007 in which case the permit shall remain in effect through the first business day following that day. New applications involving this project site, to the extent provided for under 18 CFR Part 4, may be filed on the next business day.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7190 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. GT86-5-000]

Colorado Interstate Gas Co.; Proposed Changes in FERC Gas Tariff

March 26, 1986.

Take notice that Colorado Interstate Gas Company (CIG) on March 17, 1986, tendered for filing certain revisions to its FERC Gas Tariff, Original Volume No. 1 and Original Volume No. 2. CIG states that the propose of this filing is to make miscellaneous update changes to the Table of Contents and other minor changes. No substantive changes are proposed. An effective date of April 18, 1986, is requested for the revised tariff sheets.

Any person desiring to be heard or protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC, 20426, in accordance with Rule 214 or Rule 211 of the Commission's Rules of Practice and Procedure. All such motions or protests should be filed on or before April 3, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7192 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. GT86-4-000]

Columbia Gas Transmission Corp.; Proposed Changes in FERC Gas Tariff

March 26, 1986.

Take notice that Columbia Gas Transmission Corporation (Columbia) on March 19, 1986, tendered for filing the following proposed changes to its FERC Gas Tariff, Original Volume Nos. 1 and 2, to be effective on April 20, 1986:

Original Volume No. 1

Tenth Revised Sheet No. 3
Fourteenth Revised Sheet No. 4
Fourteenth Revised Sheet No. 5
Seventeenth Revised Sheet No. 5A
Sixteenth Revised Sheet No. 5B
Fourteenth Revised Sheet No. 5C
Fifteenth Revised Sheet No. 5D
Second Revised Sheet No. 8
Second Revised Sheet No. 9
Second Revised Sheet No. 10
Second Revised Sheet No. 11
Second Revised Sheet No. 13
Twelfth Revised Sheet No. 76
Ninth Revised Sheet No. 77
Ninth Revised Sheet No. 78
Twelfth Revised Sheet No. 79
Tenth Revised Sheet No. 80
Twelfth Revised Sheet No. 81
Ninth Revised Sheet No. 82
Seventh Revised Sheet No. 83
Sixth Revised Sheet No. 84
Seventeenth Revised Sheet No. 85
Sixteenth Revised Sheet No. 86
First Revised Sheet No. 87
First Revised Sheet No. 87A
Second Revised Sheet No. 87B
Sixth Revised Sheet No. 87C

Original Volume No. 2

Tenth Revised Sheet No. 2
Fourteenth Revised Sheet No. 3
Fourteenth Revised Sheet No. 4
Seventeenth Revised Sheet No. 4A
Sixteenth Revised Sheet No. 4B
Fourteenth Revised Sheet No. 4C
Fifteenth Revised Sheet No. 4D

Columbia states that these proposed revisions are being filed to update the following: (i) Table of Contents; (ii) Maps for Zones 1, 2, 3, 4 and 6; and (iii) Index of Purchasers, to reflect all Service Agreements currently on file with the Commission.

Copies of the filing were served upon the Company's jurisdictional customers and interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, Union Center Plaza Building, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. All such motions or protests should be filed on or before April 3, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to invervene. Copies of Columbia's filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Acting Secretary,

[FR Doc. 86-7193 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA86-2-44-000, 001]

Commercial Pipeline Co., Inc.; PGA Filing

March 26, 1986.

Take notice that on March 21, 1986, Commercial Pipeline Co., Inc. ("Commercial") tendered for filing its 49th Revised Sheet No. 3A, superseding 48th Revised Sheet No. 3A reflecting

Purchased Gas Adjustments and Total Rate as shown below.

	Current adjustment	Cumulative adjustment	Surcharge adjustment	Total rate
(Base)	$.0771	$(.7231)	$(.4910)	$3.2428
(Excess)	$.1007	$(.7011)	$(.4910)	$3.3733

The effective date of Commercial's filing is April 23, 1986.

Commercial states that this filing reflects adjustments in its purchased gas cost to provide for the tracking of a corresponding PGA adjustment by Commercial's sole supplier, Northwest Central Pipeline Corporation. The filing also reflects surcharge adjustments in accordance with Commercial's PGA.

Copies of the filings were served on Commercial's FERC jurisdictional customers, the Kansas Corporation Commission and the Missouri Public Service Commission.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before April 3, 1986. Protestants will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7194 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA86-3-43-000 and 001]

Northwest Central Pipeline Corp.; Proposed Changes in FERC Gas Tariff

March 26, 1986.

Take notice that Northwest Central Pipeline Corporation (Northwest Central) on March 21, 1986, tendered for filing Seventh Revised Sheet Nos. 6, 7 and 8, and Second Revised Sheet Nos. 78, 80, and 81 to its FERC Gas Tariff, Original Volume No. 1. Northwest Central states that pursuant to the Purchased Gas Adjustment in Article 21 and the Incremental Pricing Provisions in Article 24 of its FERC Gas Tariff, it proposes to decrease its rates effective April 23, 1986, to reflect:

(1) 24.69¢ per Mcf decrease in the Cumulative Adjustment due to a decrease in Northwest Central's projected gas purchase costs.

(2) A 19.25¢ per Mcf decrease in the Surcharge Adjustment (to a negative 27.98¢ per Mcf from a negative 8.72¢ per Mcf) to Amortize the Deferred Purchased Gas Cost Subaccount balance.

(3) A .02¢ per Mcf increase in the Advance Payment Rate Adjustment (to a negative 1.46¢ per Mcf from a negative 1.48¢ per Mcf) in compliance with the Stipulation and Agreement in Docket No. RP82-114-000, *et al.*

Northwest Central states that copies of its filing were served on all jurisdictional customers and interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with §§ 385.211 and 385.214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before April 3, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7195 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA86-3-41-002]

Southwest Gas Corp.; Filing

March 26, 1986.

Take notice that on March 21, 1986, Southwest Gas Corporation (Southwest) tendered for filing Substitute Thirtieth Revised Sheet No. 10 to its FERC Gas Tariff, Original Volume No. 1. Southwest states that this tariff sheet reflects the amended rates filed by Northwest Pipeline Corporation (Northwest) proposed to become effective April 1, 1986. Northwest requests that its tariff sheet become effective concurrently with Northwest's approved rates.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 214 and 211 of the Commission's Rules of Practice and Procedure (18 CFR 385.214, 385.211 (1985)). All such motions or protests should be filed on or before April 3 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Lois D. Cashell,

Acting Secretary.

[FR Doc. 86-7196 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CI86-266-000]

Tenneco Oil Co.; Application for Limited-Term Abandonment Authorization

March 26, 1986.

Take notice that on March 14, 1986, Tenneco Oil Company (Applicant), P.O. Box 2511, Houston, Texas 77001, filed an application pursuant to section 7(b) of the Natural Gas Act for authorization to abandon for a limited-term sales made to United Gas Pipe Line Company (United) under certificates issued in Docket Nos. CI64-1043 through CI64-1046, CI64-1065, and CI70-114 as detailed on the attached Appendix. Applicant states there has been a precipitous decline in takes by United amounting to 14% of deliverability for 1985; net deliverability is 12,354 Mcf/d. Applicant proposes to abandon sales of NGPA section 104 and 106(a) gas to United for a limited-term while giving United the monthly right to nominate and take gas it requires for system supply. The term proposed is for one year and thereafter on a month-to-month basis until United begins taking all gas for system supply on a continuous basis. Applicant states United has expressed concurrence and has already released gas no longer subject to the NGA; where requested Applicant states it has agreed to include market-responsive language in certain of the subject contracts or other contracts, to waive accrued take-or-pay obligations, and would waive take-or-pay accruals for the released gas during the abandonment period. Applicant proposes to sell the released gas to others or take the gas for Applicant's own purposes, thereby maintaining production at a maximum efficient rate of flow to avoid shutting-in the wells threatening correlative rights and efficient reserve recovery.

Any person desiring to be heard or to make any protest with reference to said

application should on or before April 10, 1986, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a petition to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211, .214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party in the proceeding herein must file a petition to intervene in accordance with the Commission's Rules. Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicant to appear or to be represented at the hearing.

Lois D. Cashell,

Acting Secretary.

APPENDIX

	TOC GSC # 665/RS # 289	TOC GSC # 666/RS # 89	TOC GSC # 1257/RS # 109	TOC GSC # 1769/RS # 261
Sale Authorized	Docket # CI64-1043/ CI64-1044/CI64-1046.	Docket # CI64-1045	Docket # CI64-1065	Docket # CI70-114
Location of Sale	Bethany Field Harrison & Panola Cos. Texas.	Bethany Field Panola Co., TX.	Normanna, et al., Bee Co., TX.	Bethany Field Panola Co., TX
Date of Basic Contract and Rate Schedule No.	December 12, 1973/ RS # 289.	October 23, 1930/RS # 89.	June 1, 1979/RS # 109.	November 5, 1980/RS # 261
Last Effective Rate	$.927/MMBtu (Sec. 104 Repl. Contract/ Recompletion Gas). $1.644/MMBtu (Sec. 104 '73-'74 Biennium).	$.515/MMBtu (Sec. 104 Flowing Gas $.927/MMBtu (Sec. 104 Repl. Contract/ Recompletion Gas) $1.644/MMBtu (Sec. 104 '73-'74 Biennium).	$.946/MMBtu (Sec. 106(a) Rollover Contract Gas.	$1.644/MMBtu (Sec. 104 '73-'74 Biennium)

[FR Doc. 86-7197 Filed 3-31-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. CI86-254-000 and CI86-265-000]

Tenneco Oil Co., Houston Oil & Minerals, Corp., Tenneco Exploration, Ltd., and Tenneco Exploration II, Ltd.; Application for Limited-Term Abandonment and Blanket Sales Authorization With Pre-Granted Abandonment

March 26, 1986.

Take notice that on March 10, 1986, as supplemented on March 18, 1986, Tenneco Oil Company, Houston Oil & Minerals Corporation, Tenneco Exploration, Ltd., and Tenneco Exploration II, Ltd. (Applicants), P.O. Box 2511, Houston, Texas 77001, filed an application in Docket No. CI86-265-000 pursuant to section 7(b) of the Natural Gas Act for authorization to abandon for a limited-term sales of gas to Tennessee Gas Pipeline Company, a Division of Tenneco Inc. (Tennessee) and on March 12, 1986, Applicants filed an application in Docket No. CI86-254-000 requesting a blanket certificate with pre-granted abandonment authorizing the sale of such gas to others, from specified acreage detailed on the attached Appendix.

Applicants state that due to a precipitous decline in takes from NGPA sections 102(d), 104 post-1974 and 109 wells, located in the Outer Continental Shelf, Gulf of Mexico (OCS), Tennessee has released excess deliverability from the date of Commission approval through December 31, 1987, but retains a call on the gas for its system supply. Applicants state that during the term of the release Tennessee would be accorded a market-out provision in each contract involved in the release which would grant Tennessee the right to impose a price relief measure under certain circumstances; take-or-pay obligations would be waived during the term of the agreement and Tennessee would receive take-or-pay credit for any gas purchased by Tennessee and/or released and resold to an alternate purchaser; Tennessee would have the option of requiring that all released gas be transported in its system where facilities are available and transportation authority is available or obtainable on a timely basis.

Applicant's current abandonment and sales authorization for section 102(d) gas in Docket No. CI85-633-000 expires March 31, 1986. Authorization is therefore requested herein to avoid shutting-in the wells. Applicants state Tennessee's purchases from section 102(d) wells in 1985 was 29% of the contract take obligation and 20% of deliverability. In addition, for section 104 post-1974 and 109 wells, purchases were 49% of contract take requirements and 37% of deliverability. Further, Applicants state that in 1985, approximately 260,000 barrels of crude and condensate were produced in association with gas from the section 102(d) wells and approximately 800,000 barrels from the sections 104 post-1974 and 109 wells. Curtailment of gas production, Applicants state, would severely reduce gas, crude and condensate revenue. Tennessee, or any of its customers, would be eligible spot purchasers of the releasd gas and could compete with other eligible purchasers on a competitive basis. Applicants state that Tennessee will cooperate toward transportation of the released gas on behalf of Applicants, subject to capacity limitations and appropriate authorization, although such action would not obligate Tennessee to become an open access transporter as contemplated under Order No. 436. Applicants estimate deliverability is 477.3 MMcf/d.

Any person desiring to be heard or to make any protest with reference to said applications should on or before April 10, 1986, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a petition to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211, .214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceedings. Any person wishing to become a party to the proceedings herein must file a petition to intervene in accordance with the Commission's Rules. Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicants to appear or to be represented at the hearing.

Lois D. Cashell,

Acting Secretary.

APPENDIX

Docket No.	Rate schedule No.	Seller	OCS block	Purchaser	Contract date	Applicable price(s)
CI71-594	273	Tenneco Oil Company	South Timbalier 169/196	Tennessee Gas Pipeline Co.	1-1-71	§ 102(d)
CI84-398	21	Houston Oil & Minerals Corp.	Vermilion 250	Tennessee Gas Pipeline Co.	1-1-67	§ 104(post-74) § 102(d)
CI81-454	431	Tenneco Oil Company	Vermilion 155/156	Tennessee Gas Pipeline Co.	8-5-81	§ 102(d)
CI68-621	246	Tenneco Oil Company	South Marsh Island 61	Tennessee Gas Pipeline Co.	11-1-67	§ 104(post-74) § 102(d)
CI78-690	339	Tenneco Oil Company	South Marsh Island 60	Tennessee Gas Pipeline Co.	4-25-78	§ 104(post-74) § 102(d)
CI80-447	422	Tenneco Oil Company	Brazos A-17	Tennessee Gas Pipeline Co.	6-19-80	§ 102(d)
CI79-285	8	Tenneco Exploration Ltd	Eugene Island 367	Tenneco Oil Company	8-6-76	§ 109
CI79-283	1	Tenneco Exploration II Ltd	Eugene Island 367	Tenneco Oil Company	8-6-76	§ 109
CI79-286	322	Tenneco Oil Company	Eugene Island 367	Tennessee Gas Pipeline Co.	8-6-76	§ 109
CI76-756	323	Tenneco Oil Company	Eugene Island 367	Tennessee Gas Pipeline Co.	8-6-76	§ 104(post/74)
CI68-1346	303	Tenneco Oil Company	Ship Shoal 198/199	Tennessee Gas Pipeline Co.	5-17-68	§ 104(post-74) § 102(d)
CI79-447	354	Tenneco Oil Company	South Marsh Island 116	Tennessee Gas Pipeline Co.	3-27-79	§ 102(d)
CI84-222	464	Tenneco Oil Company	South Marsh Island 116	Tennessee Gas Pipeline Co.	2-13-84	§ 102(d)
CI84-363	466	Tenneco Oil Company	West Cameron 638	Tennessee Gas Pipeline Co.	4-5-84	§ 102(d)
CI79-262	15	Tenneco Exploration, Ltd	West Cameron 643	Tennessee Gas Pipeline Co.	2-26-76	§ 109 § 102(d)
CI80-39	22	Tenneco Exploration, Ltd	West Cameron 643	Tennessee Gas Pipeline Co.	5-18-77	§ 109

[FR Doc. 86-7198 Filed 3-31-86; 8:45 am]
BILLING CODE 6717-01-M

Office of Hearings and Appeals

Issuance of Proposed Decision and Order; Week of March 3 through March 7, 1986

During the week of March 3 through March 7, 1986, the proposed decision and order summarized below was issued by the Office of Hearings and Appeals of the Department of Energy with regard to applications for exception.

Under the procedural regulations that apply to exception proceedings (10 CFR Part 205, Subpart D), any person who will be aggrieved by the issuance of a proposed decision and order in final form may file a written notice of objection within ten days of service. For purposes of the procedural regulations, the date of service of notice is deemed to be the date of publication of this Notice or the date an aggrieved person receives actual notice, whichever occurs first.

The procedural regulations provide that an aggrieved party who fails to file a Notice of objection within the time period specified in the regulations will be deemed to consent to the issuance of the proposed decision and order in final form. An aggrieved party who wishes to contest a determination made in a proposed decision and order must also file a detailed statement of objections within 30 days of the date of service of the proposed decision and order. In the statement of objections, the aggrieved party must specify each issue of fact or law that it intends to contest in any further proceeeding involving the exception matter.

Copies of the full text of this proposed decision and order area available in the Public Reference Room of the Office of Hearings and Appeals, Room 1E-234, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, Monday through Friday, between the hours of 1:00 p.m. and 5:00 p.m., except federal holidays.

George B. Breznay,

Director, Office of Hearings and Appeals.

March 18, 1986.

Champlain Oil Company, Inc., KEE-0013
E.H. Moorhouse, Inc.; KEE-0015

Champlain Oil Company, Inc. and E.H. Moorhouse, Inc. filed Applications for Exception in which the firms sought relief from their obligations to submit Form EIA-782B, entitled "Reseller/Retailers' Monthly Petroleum Product Sales Report." In considering the applicants' requests, the DOE found that the firms failed to demonstrate that they were particularly adversely affected by the requirement that they file Form EIA-782B. On March 4, 1986, the DOE issued a Proposed Decision and Order which determined that the exception requests be denied.

[FR Doc. 86-7094 Filed 3-31-86; 8:45 am]
BILLING CODE 6450-01-M

Objection To Proposed Remedial Order Filed; Week of February 24 Through February 28, 1986

During the week of February 24 through February 28, 1986, the notice of objection to proposed remedial order listed in the Appendix to this Notice was filed with the Office of Hearings and Appeals of the Department of Energy.

Any person who wishes to participate in the proceeding the Department of Energy will conduct concerning the proposed remedial order described in the Appendix to this Notice must file a request to participate to 10 CFR § 205.194 within 20 days after publication of this Notice. The Office of Hearings and Appeals will then determine those persons who may participate on an active basis in the proceeding and will prepare an official service list, which it will mail to all persons who filed requests to participate. Persons may also be placed on the official service list as non-participants for good cause shown.

All requests to participate in this proceeding should be filed with the Office of Hearings and Appeals, Department of Energy, Washington, DC 20585.

March 17, 1986.

George B. Breznay,

Director, Office of Hearings and Appeals.

Monsanto Oil Co., Houston, TX, KRO-0250, Crude Oil

On February 27, 1986, Monsanto Oil Company (Monsanto), 1300 Post Oak Tower, 5051 Westheimer, Houston, Texas 77056 filed a Notice of Objection to a Proposed Remedial Order which the DOE Houston Office of the Economic Regulatory Administration (ERA) issued to the firm on February 14, 1986. In the PRO the ERA found that during the period June 1979 through December 1980, Monsanto sold crude oil produced from its Horner No. 1 and Gore No. 1 properties at prices which exceeded the applicable upper-tier ceiling prices in violation of 10 CFR 212.74 and 212.79.

According to the PRO, the violation resulted in $336,803.48 of overcharges, plus interest.

[FR Doc. 86-7093 Filed 3-31-86; 8:45 am]
BILLING CODE 6450-01-M

Proposed Refund Procedures; Windsor Gas Corp., Etc.

AGENCY: Office of Hearings and Appeals, Department of Energy.

ACTION: Notice of Implementation of Special Refund Procedures.

SUMMARY: The Office of Hearings and Appeals of the Department of Energy announces the procedures for disbursement of $4,652,548.54 (plus accrued interest) obtained from three crude oil producers: Windsor Gas Corporation, Union Oil Company of California, and Timco Oil Company. The funds will be distributed in accordance with the DOE Policy of Restitution for Crude Oil Overcharges.

DATE AND ADDRESS: Comments must be filed in duplicate by [May 1, 1986 Register] and should be addressed to: Office of Hearings and Appeals, Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585. All comments should display conspicuously a reference to the applicable Case Number(s): KEF–0002 (Windsor), KEF–0004 (Union), and/or KEF–0006 (Timco).

FOR FURTHER INFORMATION CONTACT: Thomas Wieker, Deputy Director or Irene Bleiweiss, Attorney, Office of Hearings and Appeals, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 252–2400.

SUPPLEMENTARY INFORMATION: In accordance with § 205.282(b) of the procedural regulations of the Department of Energy (DOE), notice is hereby given of the issuance of the Proposed Decision and Order set out below. The Proposed Decision and Order sets forth the procedures that the DOE has tentatively formulated to distribute monies obtained from three crude oil producers: Windsor Gas Corporation (Windsor), Union Oil Company of California (Union), and Timco Oil Company (Timco). Each firm remitted monies to the DOE to settle possible pricing violations with respect to its sales of crude oil. Additional information on each firm is contained in the Appendix to the Proposed Decision and Order. The firms' payments are being held in three separate interest-bearing escrow accounts pending distribution by the DOE.

The DOE has tentatively decided that the distribution of the monies received from Windsor, Union, and Timco will be governed by the DOE Policy of Restitution for Crude Oil Overcharges, 50 FR 27400 (1985). That policy states that all overcharge funds associated with crude oil miscertifications should be held in escrow pending Congressional action.

Applications for Refund should not be filed at this time. Appropriate public notice will be given when the submission of claims is authorized.

Any member of the public may submit written comments regarding the proposed refund procedures. Commenting parties are requested to submit two copies of their comments. Comments should be submitted within 30 days of publication of this notice in the **Federal Register**, and should be sent to the address set forth at the beginning of this notice. All comments received will be available for public inspection between the hours of 1:00 p.m. and 5:00 p.m., Monday through Friday, except federal holidays, in the Public Reference Room of the Office of Hearings and Appeals, located in Room 1E–234, 1000 Independence Avenue, SW., Washington, DC 20585.

Dated: March 20, 1986.

George B. Breznay,

Director, Office of Hearings and Appeals.

PROPOSED DECISION AND ORDER OF THE DEPARTMENT OF ENERGY

Special Refund Procedures

Names of Cases:
Windsor Gas Corporation
Union Oil Company of California
Timco Oil Company
Dates of Filings:
October 16, 1985
October 16, 1985
October 18, 1985
Case Numbers:
KEF–0002
KEF–0004
KEF–0006

Under the procedural regulations of the Department of Energy (DOE), the Economic Regulatory Administration (ERA) may request that the Office of Hearings and Appeals (OHA) formulate and implement special refund procedures. *See* 10 CFR Part 205, Subpart V. Such procedures enable the DOE to refund monies to those injured by alleged violations of the DOE pricing regulations.

The ERA has requested that the OHA formulate procedures to distribute a total of $4,652,548.54 plus interest which the DOE received from the following three companies: Windsor Gas Corporation (Windsor); Union Oil Company of California (Union); and Timco Oil Company (Timco) (hereinafter referred to collectively as "the three firms").

I. Background

Each of the three firms is a crude oil producer and was subject to the DOE's Mandatory Petroleum Price Regulations. The ERA's audit of each firm revealed that it may have violated those regulations in its crude oil sales.

The DOE's disputes with Timco and Union were settled when these firms signed separate Consent Orders, agreeing to pay specified sums of money to the DOE. Neither Timco nor Union has admitted to any violations of the regulations.[1] Windsor, however, was found to have violated the regulations in a Decision and Order issued by the OHA. *Windsor Gas Corp.*, 8 DOE ¶ 83,038 (1981), *aff'd*, FERC ¶ 61,254 (1983). Pursuant to the OHA's Decision, Windsor was required to refund its overcharges. The three firms' payments are currently being held in separate interest-bearing escrow accounts pending distribution by the DOE. Additional information about the three firms' payments is set forth in the Appendix to this Decision and Order.

II. Jurisdiction and Authority to Fashion Refund Procedures

The general guidelines which the OHA may use to formulate and implement a plan to distribute funds are set forth in 10 CFR Part 205, Subpart V. The Subpart V process may be used in situations where the DOE cannot readily identify the persons who may have been injured as a result of alleged or adjudicated violations or to ascertain the amount of each person's injuries. For a more detailed discussion of Subpart V and the authority of the OHA to fashion procedures to distribute refunds, see *Office of Enforcement*, 9 DOE ¶ 82,508 (1981), and the Office of Enforcement, 8 DOE ¶ 82,597 (1981).

We have considered the ERA's petitions to implement Subpart V proceedings with respect to the three firms and have determined that such proceedings are appropriate. Accordingly, we will grant the ERA's peitition.

III. DOE Policy Regarding Crude Oil Overcharges

The monies which the three firms remitted to the DOE settle alleged crude oil overcharges. Therefore, we propose that the DOE Policy of Restitution for Crude Oil Overcharges, 50 FR 27400 (1985) (DOE Policy), govern the distribution of the funds.

The DOE Policy is to hold all overcharge funds associated with crude oil miscertifications in escrow, pending Congressional action. The Policy arose out of a report which the OHA issued in the Stripper Well Exemption Litigation. *Report of the Office of Hearings and Appeals, In re: The Department of Energy Stripper Well Exemption Litigation*, MDL No. 378 (D. Kan. filed June 21, 1985), Fed. Energy Guidelines ¶ 90,507 (1985) (the OHA Report). The

[1] In 1983, the OHA issued a Decision and Order ruling that Timco violated the regulations. *Timco Oil Co.*, 10 DOE ¶ 83,025 (1083). Timco appealed this Decision but entered into a Consent Order before the appeal was ruled upon.

OHA Report examined the general effect of crude oil miscertifications on the Entitlements Program.[2]

On the basis of the OHA's findings, the Deputy Secretary of Energy issued a statement establishing the DOE Policy on June 21, 1985. The statement concluded that an indirect means of effectuating restitution was appropriate. 50 FR 27400 (July 2, 1985). Accordingly, the policy statement announced that the DOE would maintain overcharge monies in escrow to afford Congress the opportunity to select the means of making indirect restitution. Should Congress decline to act on the issue by the fall of 1986, the DOE stated that the funds should be paid to the miscellaneous receipts accounts of the United States Treasury in order to benefit all Americans.

In light of the DOE policy, the OHA issued an order announcing that it intended to apply the DOE policy in special refund cases involving crude oil. 50 FR 27402 (July 2, 1985). The OHA solicited comments which were considered and rejected in *Amber Refining, Inc.*, 13 DOE ¶85,217 (1985) (*Amber*). Thus, the OHA has determined that it will apply the DOE policy in implementing special refund procedures in all cases like the present one.

IV. Refund Procedures

In view of the OHA's decision in *Amber*, we propose that the refund monies received from Windsor, Union, and Timco should be pooled with other crude oil settlement funds and distributed in accordance with the DOE policy.

Before taking the action which we have proposed, we intend to publicize our proposal and to solicit comments on it. Comments regarding the tentative distribution process set forth in this Proposed Decision should be filed with the Office of Hearings and Appeals within 30 days of publication of this Proposed Decision and Order in the **Federal Register.**

It Is Therefore Ordered That—

The refund amount obtained from Windsor Gas Corporation pursuant to a Remedial Order issued on October 23, 1981 and the refund amounts obtained from Union Oil Company of California and Timco Oil Company pursuant to Consent Orders entered into with the Department of Energy on June 13, 1985 and October 22, 1984, will be distributed in accordance with the foregoing Proposed Decision.

APPENDIX

Firm: Windsor Gas Corporation
Case Number: KEF–0002
Refund Amount (Principal): $77,558.54
Covered Time Period: September 1, 1974 through December 31, 1977
Violations: Miscertification of crude oil.
Producing Area: Sutton and Duval Counties, Texas.

Firm: Union Oil Company of California.
Case Number: KEF–0004
Consent Order Amount: $4,500,000.00
Consent Order Period: June 1979 through January 1981
Alleged Violations: Regulations concerning marginal and newly discovered crude oil.
Producing Area: Louisiana

Firm: Timco Oil Company
Case Number: KEF–0006
Consent Order Amount: $75,000.00
Consent Order Period: January 1, 1974 through December 31, 1977
Alleged Violations: Miscertification of crude oil.
Producing Area: Signal Hill Area of Long Beach, California

[FR Doc. 86–7095 Filed 3–31 86; 8:45 am]
BILLING CODE 6450–01–M

[2] The Crude Oil Entitlements Program, part of the DOE's system of mandatory petroleum price and allocation controls, was in effect from November 1974 through January 1981. The program was intended to equalize access to the benefits of crude oil price controls among all domestic refiners and their downstream customers. To accomplish this end, refiners were required to make transfer payments among themselves through the purchase and sale of entitlements. Because of the manner in which the program worked, it had the effect of dispersing overcharges resulting from crude oil miscertifications throughout the domestic refining industry. *Amber Refining, Inc.*, 13 DOE ¶ 85,217 (1985).

Western Area Power Administration

Fryingpan-Arkansas Project; Order Confirming and Approving an Extension of Power Rates on an Interim Basis

AGENCY: Western Area Power Administration, Energy.

ACTION: Notice of an Extension of Capacity Rate—Fryingpan-Arkansas Project, Rate Schedule FA–1.

SUMMARY: Notice is given of Rate Order No. WAPA–29 of the Deputy Secretary of Energy extending for a period of 1 year the Rate Schedule FA–1 for capacity without energy marketed by the Western Area Power Administration (Western) from the Fryingpan-Arkansas Project, Colorado.

FOR FURTHER INFORMATION CONTACT: Mr. Mark N. Silverman, Area Manager, Loveland Area Office, Western Area Power Administration, P.O. Box 3700, Loveland, CO 80539, (303) 224–7201.

SUPPLEMENTARY INFORMATION: By Delegation Order No. 0204–108, effective December 14, 1983 (48 FR 55664, December 14, 1983), the Secretary of Energy delegated to the Deputy Secretary of Energy (Deputy Secretary) the authority to develop power and transmission rates, acting by and through the Administrator of the Western Area Power Administration (Western), and to confirm, approve, and place in effect such rates on an interim basis. In accordance with the Procedures for Public Participation in Power and Transmission Rate Adjustments and Extensions (10 CFR Part 903.23(b)), the Deputy Secretary has authority to extend existing rates on a temporary basis.

Pursuant to Delegation Order No. 0204–33, the Federal Energy Regulatory Commission, in the order issued June 24, 1982, in Docket No. EF81–5061–000, confirmed and approved Rate Schedule FA–1 for capacity without energy marketed by the Western's Fryingpan-Arkansas Project. The rate was approved for the period from June 24, 1982, to July 1, 1986.

Western is preparing a power repayment study (PRS) to determine the size of a required rate increase. A proposed time schedule, allowing for a properly scoped PRS, with public involvement and environmental review, extends beyond the termination date of the present rate schedule.

The purpose of Rate Order No. WAPA–29 is to extend the Rate Schedule FA–1 for 1 year to allow for a properly scoped PRS, environmental review, and full public involvement.

Issued in Washington, DC, March 24, 1986.

Danny J. Boggs,
Deputy Secretary.

Deputy Secretary,
Department of Energy

[Rate Order No. WAPA–29]

Order Confirming and Approving an Extension of Power Rate Schedule FA–1

March 24, 1986.

In the Matter of: Western Area Power Administration—Fryingpan-Arkansas Project Power Rate

Pursuant to section 302(a) of the Department of Energy Organization Act, 42 U.S.C. 71.1 *et seq.*, the power marketing functions of the Secretary of the Interior under the Reclamation Act of 1902, 43 U.S.C. 372 *et seq.*, as amended and supplemented by subsequent enactments, particularly by section 9(c) of the Reclamation Project

Act of 1939, 43 U.S.C. 485h(c), for the Bureau of Reclamation were transferred to and vested in the Secretary of Energy. By Delegation Order No. 0204–108 effective December 14, 1983 (48 FR 55664, December 14, 1983), the Secretary of Energy delegated to the Deputy Secretary of Energy (Deputy Secretary) the authority to develop power and transmission rates, acting by and through the Administrator of the Western Area Power Administration (Western), and to confirm, approve, and place in effect such rates on an interim basis. In accordance with the Procedures for Public Participation in Power and Transmission Rate Adjustments and Extensions (10 CFR Part 903.23(b)), the Deputy Secretary has authority to extend existing rates on a temporary basis. This rate order is issued pursuant to the delegation to the Deputy Secretary.

Background

Pursuant to Delegation Order No. 0204–33, Federal Energy Regulatory Commission (FERC), in the order issued June 24, 1982, in Docket No. EF81–5061–000, confirmed and approved Rate Schedule FA–1 for capacity without energy marketed by Western's Fryingpan-Arkansas Project (Fry-Ark). The rate was approved for the period from June 24, 1982, to July 1, 1986.

Discussion

Western is preparing a Fry-Ark power repayment study (PRS) to determine the size of a required rate increase. A proposed time schedule, allowing for a properly scoped PRS, with public involvement and environmental review, extends beyond the termiantion date of the FERC approval for the present rate schedule.

Order

In view of the foregoing and pursuant to the authority delegated to me by the Secretary of Energy, I hereby confirm and approve for a period effective July 1, 1986, a 1-year extension of existing Rate Schedule FA–1 for sales of capacity without energy by Western's Fryingpan-Arkansas Project.

Issued in Washington, DC, March 24, 1986.

Danny J. Boggs,

Deputy Secretary.

[FR Doc. 86–7098 Filed 3–31–86; 8:45 am]

BILLING CODE 6450–01–M

ENVIRONMENTAL PROTECTION AGENCY

[AD–FRL–2987–5]

Extension of the Public Comment Periods on the Notices of Intent To List Trichloroethylene and Perchloroethylene as Potentially Toxic Air Pollutants.

Correction

In FR Doc. 86–5974 appearing on page 9510 in the issue of Wednesday, March 19, 1986, make the following correction in the next to the last line under SUMMARY:

The first word "not" should read "now".

BILLING CODE 1505–01–M

[AAA–FL–2995–7]

EPA Master List of Debarred, Suspended or Voluntarily Excluded Persons

AGENCY: Environmental Protection Agency.

ACTION: EPA Master List of Debarred, Suspended, or Voluntarily Excluded Persons.

SUMMARY: 40 CFR 32.400 requires the Director, Grants Administration Division, to publish in the **Federal Register** each calendar quarter the names of, and other information concerning, those parties debarred, suspended, or voluntarily excluded from participation in EPA assisted programs by EPA action under Part 32. Assistance (grant and cooperative agreement) recipients and contractors under EPA assistance awards may not initiate new business with these firms or individuals on any EPA funded activity during the period of suspension, debarment, or voluntary exclusion.

This short list contains the names of those persons who have been listed as a result of EPA actions only. It is provided for general informational purposes only and is not to be relied on in determining a person's current eligibility status. A comprehensive list, updated weekly, is available in each Regional Office. Inquiries concerning the status of any individual, organization, or firm should be directed to EPA's Regional or Headquarters office for grants administration that normally serves you.

DATE: This short list is current as of March 21, 1986.

FOR FURTHER INFORMATION CONTACT: Frank Dawkins, of the EPA Compliance Staff, Grants Administration Division, at (202) 475–8025.

Dated: March 21, 1986.

Harvey G. Pippen, Jr.,

Director, Grants Administration Division (PM–216)

EPA MASTER LIST OF DEBARRED, SUSPENDED AND VOLUNTARILY EXCLUDED PERSONS

Name and jurisdiction	File No.	Status [1]	From	To	Grounds
A.C. Lawrence Leather Company, Inc. (Danvers, MA)	83–0007–00	D	04–12–84	04–11–87	§ 32.200(a) (c)(i).
A.F. Bell Electric Company, Inc. (Youngstown, OH)	85–0014–00	D	06–27–85	06–26–88	§ 32.200(a).
Altman, Larry L. (Charleston, SC)	85–0063–03	S	07–29–85	Open	§ 32.300(b).
Anderson, Scott (Walnut Creek, CA)	83–0004–01	D	06–17–83	06–16–86	§ 32.200(a) (b) (e) (f).
Atlas Prestressing Corp. (Panorama City, CA)	83–0050–00	D	08–02–83	08–01–86	§ 32.200(a).
Averill, Ernest, Jr. (Fort Myers, FL)	83–0066–06	D	12–02–83	10–29–88	§ 32.200(b).
Barber, Lawrence (Hazelwood, NC)	83–0007–05	D	04–12–84	04–11–87	§ 32.200(a) (c)(i).
Barnum, James Charles (Utica, MI)	86–0010–01	D	12–10–85	12–09–88	§ 32.200(a).
Batzer Construction Co., Inc. (St. Cloud, MN)	85–0052–00	S	03–07–86	Open	§ 32.300(b).
Batzer, Bruce (St. Cloud, MN)	85–0052–01	S	03–07–86	Open	§ 32.300(b).
Batzer, Robert (St. Cloud, MN)	85–0052–02	S	03–07–86	Open	§ 32.300(b).
Beckham, Charles (Detroit, MI)	84–0030–02	S	02–24–86	Open	§ 32.200(a) (b).
BECO, Inc. (High Point, NC)	85–0017–01	VE	12–10–85	12–09–88	§ 32.200(a)(3).
Bell, Edwin (Surphur, LA)	85–0071–01	D	03–06–86	03–05–89	§ 32.200(a) (b).
Bell, Bobby (Sulphur, LA)	85–0071–02	D	03–06–86	03–05–89	§ 32.200(a) (b).
Blackwelder, Ray Martin (Concord, NC)	84–0011–01	D	06–27–85	06–26–88	§ 32.200(a).
Bowe, Walsh and Associates, Inc. (Melville, NY)	83–0040–00	D	04–14–83	04–13–86	§ 32.200(a) (e).
Bowers, Darralyn (Detroit, MI)	84–0030–01	S	02–24–86	Open	§ 32.200(a) (b).
Boyette, Willie Eugene (Wilson, NC)	83–0044–01	D	04–15–85	04–14–87	§ 32.200(a).
Cannady, Nathaniel Ellis (Asheville, NC)	86–0047–01	S	03–18–86	Open	§ 32.200(a)(i).
Carson, Charles (Grosse Point Woods, MI)	85–0066–00	S	03–18–86	Open	§ 32.200(b).
Carson, E. Eugene (Statesville, NC)	85–0004–01	D	01–06–86	01–05–89	§ 32.200(a).
Cooney Construction Co., Inc. (Waucon, IA)	86–0062–00	S	03–18–86	Open	§ 32.300(b).

EPA Master List of Debarred, Suspended and Voluntarily Excluded Persons—Continued

Name and jurisdiction	File No.	Status [1]	From	To	Grounds
Croft, William A. (Madison, WI)	83-0047-00	D	08-20-84	08-19-87	§ 32.200(a).
Cryer, John P. (Baton Rouge, LA)	85-0062-03	S	07-29-85	Open	§ 32.300(b).
Cusenza, Sam (Ypsilanti, MI)	85-0024-02	S	02-24-86	Open	§ 32.200(a) (b).
Cuti, Vincent J., Jr. (Huntington, NY)	83-0040-03	D	04-30-85	04-29-88	§ 32.200(a).
Dellinger, Theodore C. (Monroe, NC)	84-0012-01	VE	03-12-85	03-11-88	§ 32.200(a).
Dobson, Arthur A. (Lincoln, NE)	83-0030-01	D	08-30-85	04-16-87	§ 32.200(f).
Domanski, Gary Henry (Utica, MI)	86-0010-02	D	12-10-85	12-09-88	§ 32.200(a).
Drown, William Eugene (Marshall, MN)	85-0049-02	S	01-17-86	Open	§ 32.300(b).
Dykes, Lamar D. (Nederland, TX)	85-0071-03	D	03-06-86	03-05-89	§ 32.200(a) (b).
Enamanco (Utica, MI)	86-0010-00	D	12-10-85	12-09-88	§ 32.200 (a).
Environment Management Corporation (Utica, MI)	86-0010-00	D	12-10-85	12-09-88	§ 32.200 (a).
Errichetti, Angelo J. (Camden, NJ)	83-0040-04	D	04-14-83	04-13-86	§ 32.200 (a)(b).
Fischback & Moore, Inc. (Dallas, TX)	84-0023-00	S	01-15-86	Open	§ 32.200 (a).
Floyd D. Stuckey & Associate (Winfield, KS)	84-0028-00	D	08-26-85	08-25-88	§ 32.200 (a).
Foley, Bancroft T. (Washington, DC)	86-0004-03	D	03-07-86	03-06-89	§ 32.200 (a).
Franklin Wiring Co. (Youngstown, OH)	85-0044-00	D	09-04-85	09-03-88	§ 32.200 (a)(3).
FSA Engineering Consultants (Winfield, KS)	84-0028-00	D	08-26-85	08-25-88	§ 32.200 (a).
Gabey, Martin (Northport, NY)	83-0040-02	D	12-16-83	12-15-86	§ 32.200 (a).
G.E. Moore Company, Inc. (Greenwood, SC)	85-0031-00	D	12-19-85	12-18-88	§ 32.200 (a)(3).
Geuther, Herbert G. (Philadelphia, PA)	86-0004-04	D	03-07-86	03-06-89	§ 32.200 (a).
Gillespie Contracting Company, Inc. (Franklin, TN)	85-0060-00	D	02-25-86	05-24-86	§ 32.200 (i).
Gillespie Wallace (Franklin, TN)	85-0060-01	D	02-25-86	05-24-86	§ 32.200 (e)(i).
Goodspeed, Robert (North Hampton, NH)	83-0007-02	D	04-12-84	04-11-87	§ 32.200 (c)(i).
Graves Electric Company (Wilmington, NC)	85-0069-00	D	03-05-86	03-04-89	§ 32.200 (a).
Graves, George William (Wilmington, NC)	85-0069-02	D	03-05-86	03-04-89	§ 32.200 (a).
Hansen, Leonard A. (St. Peter, MN)	85-0019-02	D	09-26-85	09-25-88	§ 32.200 (a)(3).
Harry Johnson Plumbing Company, Inc. (Walla Walla, WA)	83-0060-00	D	07-22-83	07-21-86	§ 32.200 (b)(c)(e)(i).
Hector Construction Co., Inc. (Caledonia, MN)	85-0056-00	S	03-18-86	Open	§ 32.300 (b).
Herring, Donald W. (Wilson, NC)	83-0044-01	D	10-11-84	10-10-87	§ 32.200 (a).
Hi-Way Surfacing, Inc. (Marshall, MN)	85-0053-00	D	12-17-85	12-16-88	§ 32.200 (a)(3).
Howard P. Foley Company (Washington, DC)	86-0004-00	D	03-07-86	03-06-89	§ 32.200 (a).
Hunter, James C. (Gardena, CA)	83-0002-02	D	07-07-83	07-06-86	§ 32.200 (a).
Insulation Speciality and Supply, Inc. (Cleveland, OH)	84-0025-00	D	10-04-84	10-03-87	§ 32.200 (c)(i).
Jackson, Manly (San Jose, CA)	83-0048-02	D	06-27-83	06-26-86	§ 32.200 (a).
Johnson, C. Theodore (Indianapolis, IN)	84-0023-04	D	03-04-86	03-03-89	§ 32.200 (a)(f).
Johnson, Mark (Walla Walla, WA)	83-0060-01	D	07-22-83	07-21-86	§ 32.200 (b)(c).
Johnson, Richard (Hinsdale, NH)	83-0007-03	D	04-12-84	04-11-87	§ 32.200 (c)(i).
Jopel Contracting & Trucking Corporation (Bronx, NY)	85-0022-00	S	07-30-85	Open	§ 32.300 (b).
Komatz Construction Co., Inc. (St. Peter, MN)	85-0019-00	D	09-26-85	09-25-88	§ 32.200 (a)(3).
Komatz, Thomas P. (St. Peter, MN)	85-0019-01	D	09-26-85	09-25-88	§ 32.200 (a)(3).
Krueger, Joseph (Cleveland, OH)	84-0025-01	D	10-04-85	10-03-87	§ 32.200 (c)(i).
L.A. Reynolds Company (Winston Salem, NC)	83-0036-00	D	07-01-83	06-30-86	§ 32.200 (a).
Law, David P. (Greenwell Springs, LA)	85-0064-00	S	07-29-85	Open	§ 32.300 (b).
Law, Theresa McBeth (Greenwell Springs, LA)	85-0064-01	S	07-29-85	Open	§ 32.300(b).
Lee, Herbert P., III. (Sumter, SC)	84-0013-01	VE	02-14-85	12-31-87	§ 32.200(a).
Lench, Frank P. (Lafayette, CA)	86-0004-01	D	03-07-86	03-06-89	§ 32.200(a).
Long, Harold Delmar (Los Gatos, CA)	83-0050-01	D	07-07-83	07-06-86	§ 32.200(a).
Lundin Construction Co., Inc. (Mankato, MN)	85-0018-00	D	01-22-86	08-31-86	§ 32.200(a).
Lundin, Richard C. (Mankato, MN)	85-0018-01	D	01-22-86	08-31-86	§ 32.200(a).
Marshall, Weymouth (Gloucester, MA)	83-0007-01	D	04-12-84	04-11-87	§ 32.200(c)(i).
Masselli, William P. (Bronx, NY)	85-0022-02	S	07-30-85	Open	§ 32.300(b).
Mattlin, Thomas B. (Delta, PA)	84-0007-01	VE	10-24-85	04-23-86	§ 32.200(a).
M.B. Hayes Electric Corporation (Asheville, NC)	86-0047-00	S	03-18-86	Open	§ 32.200(a).
McDowell Contractors, Inc. (Nashville, TN)	84-0014-00	VE	12-23-85	12-22-88	§ 32.200(a).
McLaughlin & Schulz, Inc. (Marshall, MN)	85-0049-00	D	03-07-86	03-06-89	§ 32.200(a).
Modern Electric Co. (Statesville, NC)	85-0004-00	D	01-06-86	01-05-89	§ 32.200(a).
Moorehead, Dennis L. (Graniteville, SC)	84-0006-01	D	01-11-85	01-10-88	§ 32.200(a).
Moorse, Lawrence (Marshall, MN)	85-0053-01	D	12-17-85	12-16-88	§ 32.200(a)(3).
Municipal & Industrial Pipe Services, Ltd. (Douglasville, GA)	82-0601 82-0408	D	10-07-82	02-16-87	§ 32.200(b)(c)(e)(i).
Murray Paving Company, Inc. (Whitesboro, NY)	84-0032-00	D	08-19-85	10-18-86	§ 32.200(a).
Murray, Harry (Whitesboro, NY)	84-0032-01	D	08-19-85	10-18-86	§ 32.200(a).
Newman, Fred M. (Vienna, VA)	83-0072-01	D	09-30-83	09-29-86	§ 32.200(i).
Newman, Richard Gordon (Pierre, SD)	83-0041-00	D	11-29-83	11-28-86	§ 32.200(a).
Newt Solomon, Inc. (Nashville, TN)	85-0058-00	D	10-10-85	10-09-88	§ 32.200(e)(i).
Nurre, Larry V. (Mankato, MN)	85-0018-02	VE	01-22-86	08-31-86	§ 32.200(a).
Odland, Kenneth Gabriel (Marshall, MN)	85-0049-01	S	01-17-86	Open	§ 32.300(b).
Owens, Jerry B. (Southfield, MI)	85-0065-00	S	02-24-86	Open	§ 32.200(b).
Peterson, Roger A. (Cloquet, MN)	85-0054-02	D	02-25-86	01-31-87	§ 32.200(a).
Pinney, J.A. Bruce (Bala Cynwyd, PA)	84-0023-06	D	01-15-86	03-03-89	§ 32.200(a)(f).
Post-Tensioning Service Corporation (Saratoga, CA)	83-0001-00	D	07-08-83	07-07-86	§ 32.200(a).
Regenscheid, Charles E. (St. Peter, MN)	85-0019-03	VE	12-19-85	12-18-87	§ 32.200(a)(3).
Reynolds, Jon R. (Winston Salem, NC)	83-0036-01	D	07-01-83	06-30-86	§ 32.200(a).
Richmond, Elwood P. (Grand Forks, ND)	83-0006-01	D	06-06-83	06-05-86	§ 32.200(a)(f).
Richmond Engineering, Inc. (Grand Forks, ND)	83-0006-00	D	06-06-83	06-05-86	§ 32.200(a)(f).
Richmond, Lloyde W., Jr. (Grand Forks, ND)	83-0006-02	D	06-06-83	06-05-86	§ 32.200(a)(f).
Rio Grande Construction Company (Bunkie, LA)	85-0063-00	S	07-29-85	Open	§ 32.300(b).
Rogers, Joseph J. (Pittsburgh, PA	86-0004-02	D	03-07-86	03-06-89	§ 32.200(a).
Rothrock Construction, Inc. (Murrells Inlet, NC)	83-0064-00	D	05-17-84	05-16-87	§ 32.200(a).
Rothrock, Steve D. (Murrells Inlet, NC)	83-0064-01	D	05-18-84	05-17-87	§ 32.200(a).
Sargent, Frederic B. (Pittsburgh, PA)	85-0020-01	VE	07-26-85	02-13-87	§ 32.200(a)(3).
SDaunders, George F. (High Point, NC)	85-0017-02	VE	12-10-85	12-09-88	§ 32.200(a)(3).
Sauseda, Roy (Bunkie, LA)	85-0063-02	S	07-29-85	Open	§ 32.300(b).
Schulze, Leland (Caledonia, MN)	85-0056-01	S	03-18-86	Open	§ 32.300(b).
Slattery, Edward J. (Youngstown, OH)	85-0015-01	D	09-15-85	03-14-87	§ 32.200(a)(3).
Solomon, Newt (Nashville, TN)	85-0058-01	D	10-07-85	10-06-88	§ 32.200(e)(i).
Stone, Francis (Swanzey, NH)	83-0007-04	D	04-12-84	04-11-87	§ 32.200(a)(c)(i).
Stuckey, Floyd D. (Winfield, KS)	84-0028-01	D	08-26-85	08-26-88	§ 32.200(a).
Tow Brothers Const. Company (Fairmont, MN)	85-0054-00	D	01-22-86	01-21-89	§ 32.200(a).
Tow, James (Fairmont, MN)	85-0054-01	D	01-22-86	01-21-89	§ 32.200(a).
Toy, Daniel Lee (Utica, MI)	86-0010-03	D	12-10-85	12-09-88	§ 32.200(a).
Tubre Enterprises (Bunkie, LA)	85-0062-01	S	07-29-85	Open	§ 32.300(b).

EPA MASTER LIST OF DEBARRED, SUSPENDED AND VOLUNTARILY EXCLUDED PERSONS—Continued

Name and jurisdiction	File No.	Status [1]	From	To	Grounds
Tubre Enterprises, Inc. (Bunkie, LA)	85-0062-00	S	07-29-85	Open	§ 32.300(b).
Tubre, Charles (Baton Rouge, LA)	85-0062-02	S	07-29-85	Open	§ 32.300(b).
Tubre, Thomas (Bunkie, LA)	85-0063-01	S	07-29-85	Open	§ 32.300(b).
Tucker Brothers Contracting Co. (Pell City, AL)	83-0061-00	D	11-26-84	11-25-87	§ 32.200(a).
Tucker, Harold Ray (Pell City, AL)	83-0061-02	D	11-26-84	11-25-87	§ 32.200(a).
Tucker, Kenneth W. (Pell City, AL)	83-0061-01	D	11-26-84	11-25-87	§ 32.200(a).
Twedell, David Bruce (Gainesville, FL)	83-0020-01	D	08-30-85	08-29-87	§ 32.200(a).
Ulland Brothers, Inc. (Cloquet, MN)	85-0054-00	D	02-25-86	01-31-87	§ 32.200(a).
Ulland, Robert O. (Cloquet, MN)	85-0054-01	D	02-25-86	01-31-87	§ 32.200(a).
Universal Engineering & Supply, Inc. (Sulphur, LA)	85-0071-00	D	03-06-86	03-05-89	§ 32.200(a)(b).
Universal Engineering (Sulphur, LA)	85-0071-05	D	03-06-86	03-05-89	§ 32.200(a)(b).
Universal Wheels (Sulphur, LA)	85-0071-06	D	03-06-86	03-05-89	§ 32.200(a)(b).
Valentini, Joseph (Ypsilanti, MI)	85-0024-01	S	02-24-86	Open	§ 32.200(a)(b).
Vanderhurst, William (Saratoga, CA)	83-0001-01	D	07-08-83	07-07-86	§ 32.200(a).
Vryenhoek, Ralph D. (Pittsburgh, PA)	85-0020-02	VE	07-26-85	02-13-87	§ 32.200(a)(3).
W.V. Pangborne & Co., Inc. (Bala Cynwyd, PA	84-0023-05	S	01-15-86	Open	§ 32.200(a)(f).
Walker, Kenneth (Clifton, TN)	85-0059-00	VE	01-07-86	04-06-86	§ 32.200(e)(i).
Walsh, Charles T. (Huntington Bay, NY)	83-0040-01	D	04-14-83	04-13-86	§ 32.200(a).
Walstad, Merrill (Huntington Beach, CA)	83-0003-03	D	06-27-83	06-26-86	§ 32.200(a).
Watson Electrical Construction Co. (Wilson, NC)	83-0044-00	D	04-15-85	04-14-87	§ 32.200(a).
Williams, G. Marvin (Asheville, NC)	86-0047-02	S	03-18-86	Open	§ 32.200(j).
Wilson, John Bruff (Lebanon, TN)	84-0014-01	VE	10-16-85	10-15-86	§ 32.200(a).
Wirt, David (Douglasville, GA)	82-0601	D	10-07-82	02-16-87	§ 32.200(b)(c)(e)(i).
	82-0408				
Wirt, Gordon D. (Douglasville, GA)	82-0408	D	12-07-82	02-16-87	§ 32.200(c)(e).
Wirt, Judith C. (Douglasville, GA)	82-0408	D	12-07-82	02-16-87	§ 32.200(c)(e)(i).
Wolverine Disposal, Inc. (Ypsilanti, MI)	85-0024-00	S	02-24-86	Open	§ 32.200(a)(b).
Zeigler, Beaty Stevens (Sumter, SC)	83-0045-01	VE	07-15-83	08-31-86	§ 32.200(a).
Zeigler Construction Co. (Sumter, SC)	86-0073-00	S	03-19-86	Open	§ 32.300(b).

[1] D = Debarred; S = Suspended; VE = Voluntarily Excluded.

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FEDERAL COMMUNICATIONS COMMISSION

[CC Docket No. 86-81; Tariff FCC No. 2]

Common Carrier Service, AT&T's WATS Rates; Order Designating Issues for Investigation

Adopted: March 13, 1986.
Released: March 14, 1986.

By the Chief, Common Carrier Bureau.

I. Introduction

1. By an Order adopted March 13, 1986,[1] the Commission has amended its access charge rules,[2] effective June 1, 1986, to move closed end Wide Area Telecommunications Service (WATS) access lines from the common line category to the special access category. By this Order, pursuant to the Commission's direction in the *WATS Access Order*, under the authority of section 205(a) of the Communications Act, 47 U.S.C. 205(a),[3] the Common Carrier Bureau initiates an investigation into the reasonableness of American Telephone and Telegraph Company's (AT&T's) current rates for its WATS service in light of the revised access charge treatment of WATS closed ends. This Order also establishes a schedule for the filing of submissions by AT&T, and other interested parties, addressing the specific rates and issues herein discussed and designated for investigation.

II. Background

2. As more fully explained in the *WATS Access Notice*, WATS is a bulk-rated offering of switched long-distance services. Outward WATS or "OUTWATS" allows customers to place calls to preselected service areas, while "INWATS" or "800" Service, permits customers to receive calls from selected service areas without a charge to the calling party. For OUTWATS, the originating end of the service—a dedicated access line from the subscriber's premises to the WATS screening office—is referred to as the "closed end." The terminating end, where the call is delivered to an ordinary telephone subscriber, uses local exchange facilities in the same fashion as an ordinary Message Telephone Service (MTS) long-distance call, and is referred to as the "open end." Conversely, INWATS calls are originated by telephone subscribers over regular local loops and terminated over a dedicated access line to the INWATS customer's premises; the originating end of the service is the "open end" and the terminating end is the "closed end" of the service.[4] While both interstate and intrastate WATS services are available, separate access lines, dedicated to one or the other service, are utilized.

3. The separations rules [5] apportion the investment in the intrastate and interstate WATS lines between the state and federal jurisdictions: historically the line portion has been allocated on the same basis as ordinary subscriber access lines (*i.e.*, according to the Subscriber Plant Factor (SPF)) and the trunk portion on the basis of relative minutes of use. The Commission's access charge rules, absent substantial countervailing policy considerations, generally treat carrier expenses in a manner that parallels their treatment under the separations rules. Accordingly, the line portion of closed-

[1] In the Matter of WATS-Related and Other Amendments of Part 69, Report and Order and Supplemental Notice of Proposed Rulemaking, CC Docket No. 86-1 (adopted March 13, 1986) (*WATS Access Order*). *See also* the Notice of Proposed Rulemaking in this proceeding, 51 FR 633 (1986) (*WATS Access Notice*).

[2] 47 CFR Part 69.

[3] Section 205(a) provides, in part, that, "Whenever, after full opportunity for hearing, upon a complaint or under an order for investigation and hearing made by the Commission on its own initiative, the Commission shall be of the opinion that any charge, classification, regulation, or practice of any carrier or carriers is or will be in violation of any of the provisions of this Act, the Commission is authorized and empowered to determine and prescribe what will be the just and reasonable charge or the maximum or minimum, or maximum and minimum, charge or charges to be thereafter observed . . . ."

[4] The WATS closed-end is generally comprised of a dedicated "line" portion (extending from the customer's premises to the serving local exchange central office) and a dedicated "trunk" portion (extending from that central office to the WATS serving office). Additionally, the connection between the WATS serving office and AT&T's Point of Presence is completed by means of central office switching and other switched access functions. The traffic-sensitive switched access elements will continue to apply to WATS at the closed end to the extent switched access functions, such as local switching and transport are performed there.

[5] 47 CFR Part 67.

end WATS access lines has been included in the common line category along with regular subscriber lines, and the trunk portion has been included in the switched access transport element.[6] Pursuant to a recent Joint Board Recommendation adopted by the Commission, however, those separation rules have been changed so that, as with the special access lines used for private line service, the full costs associated with both the line and trunk portions of closed end WATS access lines will be directly assigned on a jurisdictional basis, effective June 1, 1986.[7]

4. Under the existing access charge rules, consistent with the separation rules, the investment in closed end WATS lines has been included in the carrier common line ("CCL") revenue requirement, and closed end WATS minutes are subject to the same per minute carrier common line charges as MTS and open end WATS access minutes.[8] As a consequence of the Commission's decision in the *WATS Access Order* to include these WATS lines in the special access category, beginning June 1, 1986, WATS closed end costs will no longer be included in the common line revenue requirement and closed end WATS minutes will no longer be subject to the carrier line charge. The local exchange carriers (LECs) will instead recover the costs of WATS closed end access lines through the imposition of flat, non-traffic sensitive charges.[9] Closed end WATS lines would also be subject to the special access surcharge, as well as to any applicable traffic sensitive switched elements for the local switching and transport performed at the closed end.

4. Because WATS lines tend to have heavy interstate usage levels, the move from a usage-based to a flat rate method of recovering the fixed costs of the closed ends should substantially reduce the local access rates imposed on WATS closed ends, and thus AT&T's costs of providing WATS to its customers. While we recognize that the flat per line special access charge, the special access surcharge and other new costs associated with providing the WATS closed end under the special access structure [10] will to some degree offset these switched access cost savings, it nonetheless appears that the net result will be that AT&T's cost of providing WATS service under the new rules will be substantially reduced. A number of commenters in the *WATS Access Order* proceeding debated the possible effects of the proposed access charge changes of WATS rates. For its part, AT&T indicated that it did not intend to alter the current WATS structure or the price relationship between MTS and WATS as a consequence of the new access charge treatment of closed end WATS lines.[11] Many other parties urged the Commission to direct AT&T to flow through its resulting cost savings to end users in the form of lower WATS rates. While the Commission declined to consider the WATS rate issue in the context of CC Docket No. 86-1, in the *WATS Access Order* the Commission directed the Common Carrier Bureau to initiate an investigation of AT&T's WATS rates in light of the special access treatment of WATS closed ends.

III. Discussion

5. Since AT&T's current WATS rates are presumably cost-based and earning at or above the authorized rate of return,[12] the Bureau would expect, as many commenters suggest, that a failure by AT&T to reduce its WATS rates to flow through its savings in access costs is likely to result in unjust and unreasonably excessive and discriminatory prices to WATS customers in violation of sections 201(b) and 202(a) of the Communications Act, 47 U.S.C. 201(b) and (202)(a).[13] It would also undermine the Commission's cost-based pricing policies intended to foster the development of competition in the interexchange marketplace.

6. Of particular concern is the impact AT&T's WATS rates will have on WATS resellers. After direct assignment takes effect, WATS resellers will be subject to both traffic and non-traffic sensitive switched access charges on the closed end instead of the local business line charges. This change is premised on the fact that WATS resellers formerly paid a CCL-type contribution to the local exchange carrier as part of the WATS rate for use of local common lines. Under the principle that the local exchange company was entitled to only one such payment, the local business rate was applied rather than an access-type charge. As a result of the special access treatment of WATS closed ends, WATS resellers will no longer be receiving a service for which CCL charges have already been assessed, thus the generally higher switched access rates will apply at the closed end. Unless AT&T's WATS rates are reduced to reflect the switched access cost savings, the result would appear to unfairly burden WATS resellers: AT&T will be charging WATS resellers rates which reflect carrier common line access costs not actually incurred, while those resellers will at the same time be obligated to pay carrier common line charges directly to the exchange carrier for the same service.[14] We are also concerned about AT&T's monopoly "800" Service and the potential that AT&T will both charge excessive rates to those customers and use the revenues derived from those rates to cross-subsidize its more competitive services.

7. In this investigation we seek information from all parties on the reasonableness of the current WATS rates under general ratemaking principles as well as their effect on these broader policy issues. In particular, we ask that AT&T explain why, in light of the issues discussed above, the existing WATS rates, or any WATS rates which do not reflect the direct assignment of WATS closed ends would be just and reasonable, or, in the alternative, why the Commission should not direct AT&T to reduce its WATS rates from their current levels when the

[6] For a history of the treatment of WATS line costs under the access charge plan, see *WATS Access Notice* at paras. 5-7.

[7] *See* MTS/WATS Market Structure and Amendment of Part 67, Recommended Decision and Order, CC Docket No. 78-72 and 80-286, Mimeo No. 139 (released Oct. 8, 1985); Amendment of Part 67 and MTS/WATS Market Structure, Decision and Order, CC Docket Nos. 80-286 and 78-72, FCC 85-655 (adopted Dec. 18, 1985).

[8] Both interstate and intrastate WATS subscribers have also been subject to end user subscriber line charges. 47 CFR 69.202(g).

[9] The LECs will be filing revisions to their special and switched access tariffs on April 1, 1986, to be effective June 1, 1986, to, among other things, reflect the changes resulting from the Commission's direct assignment of WATS decisions. These access tariff changes will also reflect the reduction in the CCL rate attributable to the increase of the residential subscriber line charge to $2.00 as of June 1, 1986.

[10] We also recognize that as a result of the *WATS Access Order* decision to load more CCL costs onto terminating minutes and to treat all open end WATS minutes as terminating minutes for purposes of applying the CCL charge, AT&T's WATS service will in the future be making a larger contribution to carrier common line than it would have if terminating and originating carrier common line rates had remained equal.

[11] *See* AT&T Comments at 8-9 and their Reply Comments at 7-8 filed on January 27, 1986 and February 10, 1986, respectively, in CC Docket No. 86-1.

[12] For instance, the WATS rate of return for 1984 was 15.644 percent. *See* Annual FDC Report, submitted June 28, 1985.

[13] To the extent that the AT&T's April 15 tariff revisions to effect the flow through of reduced carrier common line charges due to the subscriber line charge increase also adjust WATS rates to take account of direct assignment changes, the issues designated for investigation in this Order may be mooted.

[14] Under the phased-in approach adopted for the revised WATS reseller access rules, the changes will apply in full to all resold WATS lines put in service after the date the *WATS Access Order* is adopted. For those WATS lines already in place as of that date, resellers will be subject to all traffic sensitive access charges as of June 1, 1986, but relieved from payment of carrier common line charges until January 1, 1987.

revised access rules for WATS closed ends take effect. Commenting parties should indicate whether they believe the Commission should, in the event AT&T does not voluntarily reduce the WATS rates, prescribe rates for this service and what rate levels they would consider to be reasonable. These parties should discuss all factors which bear upon these determinations, including those relating to rate of return issues. We will consider issuing a further information request specifying more precisely the information AT&T should submit as part of its direct case. In the event that this investigation is not concluded by June 1, we will issue an accounting order to permit refunds if rates are subsequently found to be excessive.

III. Procedural Requirements

8. For the reasons discussed above, and pursuant to Section 205(a) of the Communications Act, 47 U.S.C. 205(a), the Bureau designates AT&T's current WATS rates for investigation and designates the American Telephone and Telegraph Company as a party. This investigation will be conducted as a notice and comment proceeding. AT&T shall file its "Direct Case" on April 15, 1986, addressing those rates and issues as discussed above. AT&T's "Direct Case" must present all the arguments and data supporting its position. Other parties commenting on AT&T's "Direct Case" may file "Oppositions to Direct Case" or "Comments on Direct Case" by April 30, 1986. Finally, AT&T's "Rebuttal" to those oppositions and comments will be due on May 12, 1986. All submissions should include in their heading the title and docket number of this proceeding.

9. An original and seven copies of all pleadings shall be filed with the Secretary of the Commission. In addition, one copy shall be delivered to the Commission's commercial copying firm, International Transcription Services, Inc. (ITS), located in Room 246, 1919 M Street, NW., Washington, DC. Parties commenting on AT&T's "Direct Case" should also serve copies on AT&T. Interested persons may obtain copies of the pleadings from ITS. A complete set will also be made available for review or photocopying at the Commission's docket library in Room 239, 1919 M Street, NW., Washington, DC 20554.

10. Members of the general public who wish to express their views on the rates included in this investigation in an informal manner may do so by submitting one copy of their comments to the Secretary, Federal Communications Commission, Washington, DC 20554. The only requirement for such informal submissions is that they include the title of the proceeding in the heading.

11. *Ex parte* contacts (*i.e.*, written or oral communications with a Commissioner or Commission staff members which address the merits of a proceeding, both procedural and substantive) are permitted in this proceeding until a public notice of scheduled Commission consideration of a final Order is released or the final Order itself is issued. Written *ex parte* contacts must be filed with the Secretary for inclusion in the public file. A written summary of oral *ex parte* presentations must be served on the Secretary and the Commission officials receiving each presentation. For other requirements, see generally § 1.1231 of the Commission's Rules, 47 CFR 1.1231.

Federal Communications Commission.
Albert Halprin,
Chief, Common Carrier Bureau.
[FR Doc. 86-7154 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

Federal Advisory Committee for the 1987 ITU World Administrative Radio Conference for the Mobile Services; Meeting Notice

March 26, 1986.

The Seventh meeting of the Federal Advisory Committee for the 1987 Mobile World Administrative Radio Conference will be held on Friday, May 9, 1986, at 9:30 A.M. in the Commission Meeting Room 856, 1919 M Street, NW., Washington, DC.

The meeting agenda is:

1. Approval of meeting agenda.
2. Approval of the summary record of the
3. Report on administrative matters from designated federal employee.
4. Progress reports and consideration of draft proposals from Ad Hoc Group Chairmen:

(a) Aeronautical
(b) Land Mobile
(c) Maritime
(d) Satellite
(e) Steering

5. Report on technical matters under consideration in the U.S. CCIR organization relevant to the Mobile WARC.
6. Reports on international meetings bearing on the Moblie WARC.
7. Other business.
8. Selection of next meeting date.

Anyone desiring further information should contact Gordon Hempton, FCC/PRB at (202) 632-7175. These meetings are open to the public.

Federal Communications Commission.
William J. Tricarico,
Secretary.
[FR Doc. 86-7166 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

[Report No. 1577]

Petitions for Reconsideration of Actions in Rulemaking Proceedings

March 27, 1986.

Petitions for reconsideration have been filed in the Commission rule making proceeding listed in this Public Notice and published pursuant to 47 CFR 1.429(e). The full text of these documents are available for viewing and copying in Room 239, 1919 M Street, NW., Washington, DC, or may be purchased from the Commission's copy contractor, International Transcription Service (202-857-3800). Oppositions to these petitions must be filed within 15 days after publication of this Public Notice in the Federal Register. Replies to an opposition must be filed within 10 days after the time for filing oppositions has expired.

SUBJECT: Preemption of Local Zoning or Other Regulation of Receive-Only Satellite Earth Stations. (CC Docket No. 85-87) Number of Petitions received: 1

SUBJECT: Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations. (Santa Isabel, Puerto Rico and Christiansted, Virgin Islands) (MM Docket No. 85-211, RM-4740) Number of Petitions received: 2

Federal Communications Commission.
William J. Tricarico,
Secretary.
[FR Doc. 86-7149 Filed 3-31-86; 8:45 am]
BILLING CODE 6712-01-M

Window Notice for the Filing of FM Broadcast Applications

Report No. W-7
Released: March 25, 1986

Notice is hereby given that applications for vacant FM broadcast allotment(s) listed below may be submitted for filing during the period beginning April 7, 1986 and ending May 7, 1986 inclusive. Selection of a permittee from a group of acceptable applicants will be by the Comparative Hearing process.

Channel—238 A

Lafayette—LA
Topsham—ME
New Praque—MN
Broadway—VA

Channel—252 A

Oraibi—AZ

Channel—255A

Orlando—FL
Jefferson—IA
Dwight—IL
Salisbury—MD
Grand Rapids—MI
Kingsford—MI
Vassar—MI
Windsor—NC
Upper Arlington—OH
Millersburg—PA
Lawrenceville—VA

Federal Communications Commission.

William J. Tricarico,

Secretary.

[FR Doc. 86-7167 Filed 3-31-86; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL RESERVE SYSTEM

Bankvest, Inc., et al.; Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C 1842) and §225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Unless otherwise noted, comments regarding each of these applications must be received not later than April 21, 1986.

A. **Federal Reserve Bank of Philadelphia** (Thomas K. Desch, Vice President) 100 North 6th Street, Philadelphia, Pennsylvania 19105:

1. *Bankvest, Inc.*, Wilkes-Barre, Pennsylvania; to acquire 51.01 percent of the voting shares of Peoples National Bank of Edwardsville, Edwardsville, Pennsylvania.

B. **Federal Reserve Bank of Cleveland** (Lee S. Adams, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101:

1. *Banc One Corporation*, Columbus, Ohio; to merge with KYNB Bancshares, Inc., Lexington, Kentucky, thereby indirectly acquiring Citizens Union National Bank & Trust Company, Lexington, Kentucky.

C. **Federal Reserve Bank of Atlanta** (Robert E. Heck, Vice President) 104 Marietta Street NW., Atlanta, Georgia 30303:

1. *ABC Holding Company*, Moultrie, Georgia; to acquire 100 percent of the voting shares of Farmers and Merchants Bank of Thomas County, Coolidge, Georgia. The comment period on this application ends April 23, 1986.

2. *Leeds Bancgroup, Inc.*, Birmingham, Alabama; to acquire 52.35 percent of the voting shares of The Fort Deposit Bank, Fort Deposit, Alabama.

D. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Tri-County Financial Group, Inc.*, Mendota, Illinois; to become a bank holding company by acquiring 100 percent of the voting shares of First State Bank, Mendota, Illinois. The comment period on this application ends April 23, 1986.

E. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *First Kansas Bancshares, Inc.*, Hutchinson, Kansas; to become a bank holding company by acquiring 100 percent of the voting shares of The First National Bank of Hutchinson, Hutchinson, Kansas.

2. *Manhattan Banking Corporation*, Manhattan, Kansas; to become a bank holding company by acquiring 99.67 percent of the voting shares of Kansas State Bank, Manhattan, Kansas.

Board of Governors of the Federal Reserve System, March 26, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-7073 Filed 3-31-86; 8:45 am]

BILLING CODE 6210-01-M

Illinois Neighborhood Development Corp. et al.; Filing of Applications To Engage de Novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than April 23, 1986.

A. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Illinois Neighborhood Development Corporation*, Chicago, Illinois; to engage *de novo* through its subsidiary TNI Development Corporation, Chicago, Illinois, in the organization, development and investment in low to middle income housing development projects pursuant to section 225.25(b)(6) of the Board's Regulation Y. The activities will be conducted in the State of Illinois. The comment period on this application ends April 21, 1986.

2. *Mahaska Investment Company*, Oskaloosa, Iowa; to engage *de novo* in providing data processing services pursuant to § 225.25(b)(7) of the Board's Regulation Y.

Board of Governors of the Federal Reserve System, March 26, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-7072 Filed 3-31-86; 8:45 am]

BILLING CODE 6210-01-M

Ventura County National Bancorp, Oxnard, CA; Acquisition of Company Engaged in Permissible Nonbanking Activities

The organziation listed in this notice has applied under § 225.23 (a)(2) or (f) of the Board's Regulation Y (12 CFR 225.23 (a)(2) or (f) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to acquire or control voting securities or assets of a company engaged in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than April 21, 1986.

A. **Federal Reserve Bank of San Francisco** (Harry W. Green, Vice President) 101 Market Street, San Francisco, California 94105:

1. *Ventura County National Bancorp,* Oxnard, California; to retain Strathearn Cattle Company, Simi Valley, California, and thereby engage in making and servicing loans, pursuant to section 225.25(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, March 26, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-7064 Filed 3-31-86; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control

National Institute for Occupational Safety and Health, Center for Excellence in Construction Safety; Program Announcement and Notice of Availability of Funds for Fiscal Year 1986

The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control, announces that competitive applications are being accepted to establish a Center for Excellence in Construction Safety. The Catalog of Federal Domestic Assistance number is 13.262.

Authority

This program is authorized under section 21(a) of the Occupational Safety and Health Act of 1970. Program regulations applicable to this cooperative agreement are set forth in Title 42, Part 87, of the U.S. Code of Federal Regulations entitled "National Institute for Occupational Safety and Health, Research and Demonstration Grants."

Availability of Funds

It is expected that approximately $50,000 will be available in Fiscal Year 1986 to fund one award. The award will be funded with a 12-month budget period and a 3-year project period. It is planned that $100,000 will be available each year in the second and third years. Continuation awards within the project period will be made on the basis of satisfactory progress in meeting project objectives and availability of funds. The funding estimate outlined above may vary and is subject to change.

Eligible Applicants

Eligible applicants are public and private non-profit universities and colleges which have a Department of Civil Engineering in an accredited College of Engineering.

Type of Assistance

Award resulting from this announcement will be a cooperative agreement.

Objectives and Collaborative Activities

A. Objectives

1. Introduce hazard control components into engineering curricula by drawing engineering expertise into the study of traumatic injury hazards.

2. Promote hazard awareness and safety-related knowledge and skills specific to the construction industry.

3. Promote consideration of safety issues during project design for the purpose of reducing injury during construction.

B. Cooperative Activities

1. Recipient Activities

a. Develop course materials and teach undergraduate and graduate construction safety courses specifically tailored to the civil engineering student.

b. Promote the adoption of the course materials by other civil engineering academic institutions and the American Society of Civil Engineering Education.

c. Design and conduct projects related to the improvement of current construction practices that would develop design parameters to reduce trauma during the construction phase; i.e., safety design in the construction of multistory structures.

d. Facilitate adoption of safety design principles and practices by designers and architects.

e. Facilitate and support interaction with major construction firms, trade associations, and labor unions to adopt trauma intervention techniques.

f. Conduct continuing education seminars and training programs for current civil engineering and architectural practitioners, focusing on construction trauma intervention techniques and practices.

g. Provide for participation of civil engineering students in construction research projects and safety construction activities.

h. Develop a plan which describes methods to publish study results.

2. NIOSH Activities

a. Provide construction industry surveillance data and results of NIOSH construction, related and specific projects.

b. Provide assistance in the preparation and review of construction safety course materials at the undergraduate and graduate levels.

c. Provides assistance in conducting construction safety seminars, training programs, meetings with construction safety-related constituencies, etc.

d. Provide assistance with protocol development and design of projects, experiments, and demonstrations that

would improve safety construction practices.

e. Provide opportunities for civil engineering students to participate in construction projects, experiments, and demonstrations.

f. Assist in development of a plan to present study results.

Reports

Progress reports will be submitted on a quarterly basis for the first year, due 30 days after each quarter; semiannually for the second and third year, due 30 days after the semiannual period. Financial status reports are required no later than 90 days after the end of each budget period. Final financial status and progress reports are required 90 days after the end of the project period.

Applications

A. Copies—Place of Submission

The original and two copies of the application should be submitted on Form PHS 5161–1 by May 23, 1986, to: Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, Room 321, 255 East Paces Ferry Road NE. Atlanta, Georgia 30305.

Application forms should be available from your business office or may be obtained from the above address.

B. Deadlines

Applications shall be considered as meeting the deadline if they are either:

1. Received on or before the deadline date, or

2. Sent on or before the deadline date and received in time for submission to the independent review group. (Applicants should request a legibly-dated U.S. Postal Service postmark or obtain a legibly-dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.)

C. Late Applications

Applications which do not meet the criteria in either paragraph 1 or 2 immediately above are considered late applications and will not be considered in the current competition and will be returned to the applicant.

D. Reviews

Applications are not subject to review as governed by Executive Order 12372, Intergovernmental Review of Federal Programs, and are not subject to review under regulations (42 CFR Part 122, as amended, and Part 123) implementing the National Health Planning and Resources Development Act of 1974.

Review Criteria

Applications will be reviewed and evaluated based on the evidence submitted which specifically describes the applicant's ability to meet the following criteria:

A. Adequacy and completeness of the project plan and methodology, including a proposed schedule for accomplishing the activities and objectives.

B. The qualifications and time allocation of the applicant's staff and the type and quality of facilities, equipment, and administrative support for the Center.

C. How closely the project's objective fits the objective for which applications were invited.

D. The cost-effectiveness of the project.

Content of Application

Applicants must include a narrative which details the following:

A. A description of the applicant's understanding of the problem and purpose of the cooperative agreement.

B. A plan describing how the applicant will establish a Center for Excellence in Construction Safety. The plan should include a schedule with time frames for accomplishing the activities and objectives of the cooperative agreement; a dissemination plan which describes methods to publish results, designates responsibilities for scientific publications, authors, summary documents, news releases, etc.; details as to how the applicant will interact with external constituencies; documentation of accreditation.

C. The qualifications and time allocations of the faculty and staff, facilities, equipment, and administrative support for the Center for Excellence.

Information

Information on application procedures, copies of application forms, and other material may be obtained from: Mr. Luther Deweese, Grants Management Specialist, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road NE., Room 321, Atlanta, Georgia 30305, (404) 262–6575 or FTS 236–6575.

Technical assistance may be obtained from the sponsoring NIOSH Division in Morgantown, West Virginia:

John B. Morgan, Director, Division of Safety Research, NIOSH, 944 Chestnut Ridge Road, Morgantown, West Virginia 26505, (304) 291–4595 or FTS 923–4595.

Ronald L. Stanevich, Safety Engineer, Division of Safety Research, NIOSH, 944 Chestnut Ridge Road, Morgantown, West Virginia 26505, (304) 291–4531 or FTS 923–4531

Dated: March 24, 1986.

L.W. Sparks,

Executive Officer, National Institute for Occupational Safety & Health.

[FR Doc. 86–7108 filed 3–31–86; 8:45 am]

BILLING CODE 4160–19–M

Food and Drug Administration

[Docket No. 85M–0419]

Premarket Approval of DEY–VIAL® Sterile Saline Solution

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing its approval of the application by Dey Laboratories, Inc., Concord, CA, for premarket aproval, under the Medical Device Amendments of 1976, of the DEY–VIAL® Sterile Saline Solution for use in rinsing, heat disinfection, and storage of soft (hydrophilic) contact lenses. After reviewing the recommendation of the Ophthalmic Devices Panel, FDA's Center for Devices and Radiological Health (CDHR) notified the applicant of the approval of the application.

DATE: Petitions for administrative review by May 1, 1986.

ADDRESS: Written requests for copies of the summary of safety and effectiveness data and petitions for administrative review to the Dockets Management Branch (HFA–305), Food and Drug Administration, Rm. 4–62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Richard E. Lippman, Center for Devices and Radiological Health (HFZ–460), Food and Drug Administration, 8757 Georgia Ave., Silver Spring, MD 20910, 301–427–7940.

SUPPLEMENTARY INFORMATION: On November 20, 1984, Dey Laboratories, Inc., Concord, CA 94518, submitted to CDRH an application for premarket approval of the DEY–VIAL® Sterile Saline Solution. The device is intended for use in the rinsing, heat disinfection, and storage of soft (hydrophilic) contact lenses.

On July 15, 1985, the Ophthalmic Devices Panel, an FDA advisory committee, reviewed and recommended approval of the application. On August 16, 1985, CDRH approved the application by a letter to the applicant from the Director of the Office of Device Evaluation, CDRH.

A summary of the safety and effectiveness data on which CDRH based its approval is on file in the Dockets Management Branch (address above) and is available from that office upon written request. Requests should be identifed with the name of the device and the docket number found in brackets in the heading of this document.

A copy of all approved labeling is available for public inspection at CDRH—contact Richard E. Lippman (HFZ–460), address above.

The labeling of the DEY–VIAL® Sterile Saline Solution states that the solution is indicated for use in the rinsing, heat disinfection, and storage of soft (hydrophilic) contact lenses. Manufacturers of soft (hydrophilic) contact lenses that have been approved for marketing are advised that whenever CDRH publishes a notice in the **Federal Register** of CRRH's approval of a new solution for use with an approved soft contact lens, the manufacturer of each lens shall correct its labeling to refer to the new solution at the next printing or at any other time CDRH prescribes by letter to the contact lens manufacturer or PMA holder. Such notice informs new users of soft contact lenses of appropriate solutions for use in the care of soft contact lenses, and avoids use of inappropriate proudcts, such as solutions intended for use with hard contact lenses only. The restrictive labeling needs to be updated periodically, however, to comply with the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 301 et seq.), and regulations thereunder, and with the Federal Trade Commission Act (15 U.S.C. 41–58), as amended.

Opportunity for Administrative Review

Section 515(d)(3) of the act (21 U.S.C. 360e(d)(3)) authorizes any interested person to peitition, under section 515(g) of the act (21 U.S.C. 360e(g)), for administrative review of CDRH's decision to approve this application. A petitioner may request either a formal hearing under Part 12 (21 CFR Part 12) of FDA's administrative practices and procedures regulations or a review of the application and CDRH's action by an independent advisory committee of experts. A peitition is to be in the form of a petition for reconsideration under § 10.33(b) (21 CFR 10.33(b)). A petitioner shall identify the form of review requested (hearing or independent advisory committee) and shall submit with the petition supporting data and information showing that there is a genuine and substantial issue of material fact for resolution through administrative review. After reviewing the petition, FDA will decide whether to grant or deny the petition and will publish a notice of its decision in the **Federal Register**. If FDA grants the petition, the notice will state the issue to be reviewed, the form of review to be used, the persons who may participate in the review, the time and place where the review will occur, and other details.

Petitioners may, at any time on or before May 1, 1986, file with the Dockets Management Branch (address above) two copies of each petition and supporting data and information, identified with the name of the device and the docket number found in brackets in the heading of this document. Received petitions may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

This notice is issued under the Federal Food, Drug, and Cosmetic Act (secs. 515(d), 520(h), 90 Stat. 554–555, 571 (21 U.S.C. 360e(d), 360(h))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director, Center for Devices and Radiological Health (21 CFR 5.53).

Dated: March 25, 1986.

John C. Villforth,

Director, Center for Devices and Radiological Health.

[FR Doc. 86–7082 Filed 3–31–86; 8:45 am]

BILLING CODE 4160–01–M

Health Resources and Services Administration

Task Force on Organ Transplantation; Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), announcement is made of the following national advisory body scheduled to meet during the month of April 1986:

Name: Task Force on Organ Transplantation

Date and Time: April 18, 1986 10:00 a.m.

Place: Holiday Inn, O'Hare Airport, Chicago, Illinois 60018

The entire meeting is open to the public.

Purpose: The Task Force on Organ Transplantation is required to conduct comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation; including an assessment of immunosuppressive medications used to prevent organ rejection in transplant patients. Reports on these issues are required to be submitted to the Department of Health and Human Services and the Congress later this year.

Agenda: The Task Force will conclude discussions of its year-long examination of issues in organ transplantation and will consider its final report and recommendations that will be submitted to the Secretary of the Department of Health and Human Services and to the Congress.

Anyone wishing to obtain a roster of members, minutes of meetings, or other relevant information should write to or contact Ms. Linda D. Sheaffer, Executive Director, Office of Organ Procurement and Transplantation, Office of the Administrator, Health Resources and Services Administration, Room 17–60, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857, telephone (301) 443–5911.

Agenda items are subject to change as priorities dictate.

Dated: March 26, 1986.

Jackie E. Baum,

Advisory Committee Management Officer, HRSA.

[FR Doc. 86–7081 Filed 3–31–86; 8:45 am]

BILLING CODE 4160–16–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[F–14882–B]

Alaska Native Claims Selection; Gana-a 'Yoo, Ltd.

In accordance with Departmental regulation 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of Sec. 14(a) of the Alaska Native Claims Settlement Act of December 18, 1971 (ANCSA), 43 U.S.C. 1601, 1613(a), will be issued to Gana-a 'Yoo, Limited for approximately 225 acres. The lands involved are in the vicinity of Koyukuk, within T. 7 S., R. 5 E., Kateel River Meridian, Alaska.

A notice of the decision will be published once a week for four (4) consecutive weeks, in the FAIRBANKS DAILY NEWS-MINER. Copies of the decision may be obtained by contacting the Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513. ([907] 271–5960).

Any party claiming a property interest which is adversely affected by the decision shall have until May 1, 1986 to file an appeal. However, parties receiving service by certified mail shall have 30 days from the date of receipt to file an appeal. Appeals must be filed in

the Bureau of Land Management, Division of Conveyance Management (960), address identified above, where the requirements for filing an appeal can be obtained. Parties who do not file an appeal in accordance with the requirements of 43 CFR Part 4, Subpart E shall be deemed to have waived their rights.

Helen Burleson,

Section Chief, Branch of ANCSA Adjudication.

[FR Doc. 86-7090 Filed 3-31-86; 8:45 am]

BILLING CODE 4310-JA-M

[AA-6701-D]

Alaska Native Claims Selection; Seldovia Native Association, Inc.

In accordance with Departmental regulations 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of sec. 14(a) of the Alaska Native Claims Settlement Act of December 18, 1971 (ANCSA), 43 U.S.C. 1601, 1613(a), will be issued to Seldovia Native Association, Inc., for approximately 2 acres. The lands involved are in the vicinity of Homer, Alaska.

Gull Island, T. 7 S., R. 12 W., Seward Meridian, Alaska

A notice of the decision will be published once a week for four (4) consecutive weeks, in the KODIAK DAILY MIRROR. Copies of the decision may be obtained by contacting the Bureau of Land Management, Alaska State Office, 701 C Street, Box 13, Anchorage, Alaska 99513 ((907) 271-5960).

Any party claiming a property interest which is adversely affected by the decision shall have until May 1, 1986 to file an appeal. However, parties receiving service by certified mail shall have 30 days from the date of receipt to file an appeal.

Appeals must be filed in the Bureau of Land Management, Division of Conveyance Managment (960), address identified above, where the requirements for filing an appeal can be obtained. Parties who do not file an appeal in accordance with the requirements of 43 CFR Part 4, Subpart E, shall be deemed to have waived their rights.

Olivia Short,

Section Chief, Branch of ANCSA Adjudication.

[FR Doc. 86-7091 Filed 3-31-86; 8:45 am]

BILLING CODE 4310-JA-M

Request for Public Comment on Environmental Analysis, Fair Market Value and Maximum Economic Recovery; North Dakota Emergency Coal Lease Application M 68608(ND)—the Coteau Properties Co.

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Land Management requests public comment on the fair market value of certain coal resources it proposes to offer for competitive lease sale.

The land included in Coal Lease Application M 68608(ND) is located approximately 7 miles north of Beulah, Mercer County, North Dakota, described as follows:

T. 145 N., R. 87 W., 5th P.M.
Sec. 20, NW¼.
160 acres.

The economically recoverable coal seam in this tract is the Beulah-Zap seam. This seam ranges from 5 to 20 feet in thickness and averages 17.2 feet. The tract contains an estimated 2.895 million tons of recoverable lignite. The Beulah-Zap seam averages (as-received) 6,800 BTU/lb. with 38.1 percent moisture, 0.7 percent sulfur, and 5.6 percent ash.

The public is invited to submit written comments on the environmental analysis, fair market value and the maximum economic recovery of the tract.

In addition, notice is also given that a public hearing will be held on Wednesday, April 30, 1986, on the environmental assessment, the proposed lease sale, fair market value and maximum economic recovery on the above least tract.

DATES: Comments must be received on or before April 30, 1986. The public hearing will be held at 1:00 p.m. on the same date, at the Bureau of Land Management, Gate City Building, Community Room, 204 Sims Street, Dickinson, North Dakota.

ADDRESSES: For more complete data on this tract, please contact Jeanette Bejot (telephone 406-657-6875), Bureau of Land Management, Montana State Office, 222 North 32nd Street, P.O. Box 36800, Billings, Montana 59107. Copies of the environmental assessment are available at this address or at the BLM Dickinson District Office, 204 Sims Street, P.O. Box 1229, Dickinson, North Dakota 58602.

SUPPLEMENTARY INFORMATION: In accordance with the Federal Coal Management regulations 43 CFR Parts 3422 and 3425, not less than 30 days prior to the publication of a notice of sale, the Secretary shall solicit public comments on fair market value appraisal and maximum economic recovery and on factors that may affect these two determinations. Proprietary data marked as confidential may be submitted to the Bureau of Land Management in response to this solicitation of public comments. Data so marked shall be treated in accordance with the laws and regulations governing the confidentialtiy of such information. A copy of the comments submitted by the public on fair market value and maximum economic recovery, except those portions identified as proprietary by the author and meeting exemptions stated in the Freedom of Information Act, will be available for public inspection at the Bureau of Land Management, 222 North 32nd Street, Billings, Montana during regular business hours (9:00 a.m. to 4:00 p.m.) Monday through Friday.

Comments should be sent to the Bureau of Land Management at P.O. Box 36800, Billings, Montana 59107 and should address, but not necessarily be limited to, the following information:

1. The quality and extent of the coal resource;
2. The mining method or methods which would achieve maximum economic recovery of the coal, including specification of seams to be mined and the most desirable timing and rate of production;
3. The quantity of coal;
4. If this tract should be evaluated as part of a larger mining unit (i.e., a tract which does not in itself form a logical mining unit);
5. The configuration of any larger mining unit of which the tract may be a part;
6. Restrictions to mining which may affect coal recovery;
7. The price that the mined coal would bring in the market place;
8. Costs, including mining and reclamation, of producing the coal;
9. The interest rate at which anticipated income streams should be discounted, either in the absence of inflation or with inflation, in which case the anticipated rate of inflation should be given;
10. Depreciation and other accounting factors;
11. The value of any surface estate where held privately;
12. Documented information on the terms and conditions of recent and similar coal land transactions in the lease sale area; and
13. Any comparable sales data of similar coal lands.

The values given above may or may not change as a result of comments received from the public and changes in market conditions between now and when final economic evaluations are completed.

Dated: March 21, 1986.

Marvin LeNoue,

Acting State Director.

[FR Doc. 86-7107 Filed 3-31-86; 8:45 am]

BILLING CODE 4310-DN-M

Proposed Devers-Palo Verde Transmission Project: Scoping Meetings

AGENCY: Bureau of Land Management, Interior.

ACTION: Scoping meetings scheduled for EIS and EIR covering proposed project.

SUMMARY: Pursuant to section 102(c) of the National Environmental Policy Act of 1969 (NEPA), a series of scoping meetings will be conducted jointly by the Bureau of Land Management, California Desert District, and the California Public Utilities Commission to provide and receive public information relative to the Devers-Palo Verde Transmission project proposed by Southern California Edison.

SUPPLEMENTARY INFORMATION: The Bureau of Land Management, California Desert District (BLM), and the California Public Utilities Commission (CPUC) will jointly conduct public scoping meetings in advance of preparing both an Environmental Impact Statement (EIS) and an Environmental Impact Report (EIR) covering the Southern California Edison proposal to construct and operate the Devers-Palo Verde Transmission Project.

The public meetings will be conducted at the following locations and times in California and Arizona:

Wednesday, April 16, 1986 1 p.m.—3 p.m.
City Council Chambers—3900 Main Street—Riverside, California

Thursday, April 17, 1986 7:30 p.m.—9 p.m.
Multi-Purpose Room—11711 West Drive—Desert Hot Springs, California

Tuesday, April 22, 1986 7 p.m.—9 p.m.
Ruth Brown Auditorium—241 N. Seventh Street—Blythe, California

Wednesday, April 23, 1986 7 p.m.—9 p.m.
Ruth Fisher Elementary School Community Building—38201 W. Indian School Road—Tonopah, Arizona

Southern California Edison (SCE) is proposing to build a second Devers-Palo Verde 500 KV transmission line from the Devers substation north of Palm Springs, CA, to the Palo Verde Nuclear Energy Generating Station, about 40 miles southeast of Phoenix, AZ. Additionally, SCE will be reconducting its existing 220 KV transmission line between the Devers substation and the San Bernardino substation in San Bernadino, CA and its Vista substation in Grand Terrace, CA.

FOR FURTHER INFORMATION AND MEETING CONFIRMATION CONTACT:

Bill Collins, Bureau of Land Management, California Desert District, 1695 Spruce Street, Riverside, CA 92507 (714) 351-6373

Mike Burke, California Public Utilities Commission, 926 J Street, Suite 1400, Sacramento, CA 958-4 (916) 322-7316

Dated: March 25, 1986.

William A. Kennedy,

Acting District Manager.

[FR Doc. 86-7219 Filed 3-31-86; 8:45 am]

BILLING CODE 4310-40-M

Utah; Availability of Record of Decision for PR Spring Combined Hydrocarbon Lease Conversions

AGENCY: Bureau of Land Management (BLM), Interior.

ACTION: Notice of Availability, PR Spring Combined Hydrocarbon Lease Conversion Record of Decision.

SUMMARY: In accordance with 40 CFR 1506.6(b), notice is hereby given of the availability of the Record of Decision for proposed lease conversions as discussed in the PR Spring Combined Hydrocarbon Lease Conversions Environmental Impact Statement (EIS).

Proponents of ten tar sand projects have filed applications with the Bureau of Land Management (BLM) to convert existing oil and gas leases within the PR Spring and Hill Creek Special Tar Sand Areas (STSA's) to combined hydrocarbon leases in accordance with the Combined Hydrocarbon Leasing Act of 1981. The application area is located in Uintah County south of Vernal, Utah. In-situ and surface mining methods would be employed. Nearly 35,500 acres of public land are involved in the lease coversion process. The final EIS (published in October, 1985) analyzed the possible invironmental impacts that would result from the development of these ten projects on both a site specific and cumulative basis. The Record of Decision documents the decisions made concerning the lease conversion applications.

DATE: Copies will be available for public inspectiom beginning on March 31, 1986 in the Public Room at the Utah State Office in Salt Lake City, Utah and at the Vernal District Office in Vernal, Utah.

ADDRESSES:

Utah State Office, Bureau of Land Management, 324 South State Street, CFS Financial Center, Salt Lake City, Utah 84111-2303.

Vernal District, Bureau of Land Management, 170 South 500 East, Vernal, Utah 84078.

FOR FURTHER INFORMATION CONTACT:

Ronald Bolander, Utah State Office, Telephone (801) 524-3133 or

Lloyd Ferguson, Vernal District Manager, Telephone (801) 789-1362.

SUPPLEMENTARY INFORMATION: A limited number of single copies of the Record of Decision are available upon request from Mr. Bolander at the Utah State Office.

Dated: March 25, 1986.

James A. Moorhouse,

Acting State Director.

[FR Doc. 86-7112 Filed 3-31-86; 8:45 am]

BILLING CODE 4320-DQ-M

Request for Expressions of Interests for Oil Shale Lands; Utah

AGENCY: Bureau of Land Management, Interior.

ACTION: Request for Expressions of Interest for Oil Shale Lands Near Vernal, Utah.

SUMMARY: On December 30, 1985, companies holding interest in oil shale leases on public land in Utah commonly known as U-A and U-B relinquished those interests back to the Federal government. With the relinquishment of U-A and U-B several options are available to the Bureau of Land Management regarding disposition of these properties. Options currently being explored include the issuance of new oil shale leases or use of the facilities for purposes other than oil shale. BLM's Utah State Office is seeking persons or companies interested in these properties for appropriate beneficial uses, subject to applicable legal requirements.

SUPPLEMENTARY INFORMATION: A limited number of draft option papers and listings of surface facilities on the properties are available at the Utah State Office.

DATE: Expressions of interest must be received at the Utah State Office by May 2, 1986.

ADDRESS: Written expressions of interest should be sent to: Roland G. Robison, State Director, Utah, Bureau of Land Management, CFS Financial

Center, 324 South State Street, Suite 301, Salt Lake City, Utah 84111–2303.

FOR FURTHER INFORMATION CONTACT: Ronald Bolander, Bureau of Land Management, Utah State Office, CFS Financial Center, 324 South State Street, Suite 301, Salt Lake City, Utah 84111–2302, (801) 524–3133.

Date: March 25, 1986.

James A. Moorhouse,

Acting State Director.

[FR Doc. 86–7113 Filed 3–31–86; 8:45 am]

BILLING CODE 4320-DQ-M

Filing of Plats of Survey: Oregon/ Washington

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The plats of survey of the following described lands have been officially filed in the Oregon State Office, Portland, Oregon, on February 27, 1986.

Willamette Meridian

OR T. 4 N., R. 3 W.
WA T. 8 N., R. 16 E.

All of the above listed plats represent dependent resurveys, and subdivisional lines.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 825 N.E. Multnomah Street, P.O. Box 2965, Portland, Oregon 97208.

Dated: March 21, 1986.

B. LaVelle Black,

Chief, Branch of Lands and Minerals Operations.

[FR Doc. 86–7109 Filed 3–31–86; 8:45 am]

BILLING CODE 4310-33-M

Wyoming: Filing of Plats of Survey

AGENCY: Bureau of Land Management, Interior.

ACTION: Filing of Plats of Survey.

SUMMARY: The plats of survey of the following described lands were officially filed in the Wyoming State Office, Bureau of Land Management, Cheyenne, Wyoming, effective 10:00 A.M., March 20, 1986.

Sixth Principal Meridian

T. 45 N., R. 69 W.

The plat representing the dependent resurvey of the east and north boundaries, and the subdivisional lines, T. 45 N., R. 69 W., Sixth Principal Meridian, Wyoming, Group No. 420, was accepted March 14, 1986.

T. 46 N., R. 69 W.

The plat representing the dependent resurvey of the east and north boundaries, and the subdivisional lines, T. 46 N., R. 69 W., Sixth Principal Meridian, Wyoming, Group No. 420, was accepted March 14, 1986.

T. 45 N., R. 70 W.

The plat representing the corrective dependent resurvey of a portion of the Eleventh Standard Parallel North, and the dependent resurvey of a portion of the north boundary, the east and west boundaries, and the subdivisional lines, T. 45 N., R. 70 W., Sixth Principal Meridian, Wyoming, Group No. 420, was accepted March 14, 1986.

T. 47 N., R. 70 W.

The plat representing the dependent resurvey of a portion of the south boundary, the east, west and north boundaries, and the subdivisional lines, T. 47 N., R. 70 W., Sixth Principal Meridian, Wyoming, Group No. 420, was accepted March 14, 1986.

T. 52 N., R. 104 W.

The plat representing the dependent resurvey of portions of Tract Nos. 43 and 44, and the metes and bounds survey of Tracts 83, 84 and 85, T. 52 N., R. 104 W., Sixth Principal Meridian, Wyoming, Group No. 471, was accepted March 14, 1986.

These surveys were executed to meet certain administrative needs of this Bureau.

ADDRESS: All inquiries concerning these lands should be sent to the Wyoming State Office, Bureau of Land Management, P.O. Box 1828, 2515 Warren Avenue, Cheyenne, Wyoming 82003.

Dated: March 20, 1986.

Richard L. Oakes,

Chief Gadastral Surveyor for Wyoming.

[FR Doc. 86–7105 Filed 3–31–86; 8:45 am]

BILLING CODE 4310-22-M

National Park Service

National Register of Historic Places; Notification of Pending Nominations

Nominations for the following properties being considered for listing in the National Register were received by the National Park Service before March 22, 1986. Pursuant to § 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded to the National Register, National Park Service, U.S. Department of the Interior, Washington, DC 20243. Written comments should be submitted by April 16, 1986.

Carol D. Shull,

Chief of Registration, National Register.

ARIZONA

Coconino County

Flagstaff, *Arizona Lumber and Timber Company Office (Flagstaff MRA)*, 1 Riordan Rd.
Flagstaff, *Brannen—Devine House (Flagstaff MRA)*, 209 E. Cottage
Flagstaff, *C & M Garage (Flagstaff MRA)*, 204 S. Milton Rd.
Flagstaff, *Campbell, H. E., House (Flagstaff MRA)*, 215 N. Leroux
Flagstaff, *Coconino County Hospital Complex (Flagstaff MRA)*, Fort Valley Rd.
Flagstaff, *Flagstaff Armory (Flagstaff MRA)*, 503 S. Milton
Flagstaff, *Flagstaff Townsite Historic Residential District (Flagstaff MRA)*, Roughly bounded by Toltec, Humphreys, and Cherry Sts. and Sante Fe Ave.
Flagstaff, *Francis, D. M., House (Flagstaff MRA)*, 1456 Meade Ln.
Flagstaff, *House at 310 S. Beaver (Flagstaff MRA)*, 310 S. Beaver
Flagstaff, *House at 607 Grand Canyon Avenue (Flagstaff MRA)*, 607 Grand Canyon Ave.
Flagstaff, *House at 720 Grand Canyon Avenue (Flagstaff MRA)*, 720 Grand Canyon Ave.
Flagstaff, *Koch, I. B., House (Flagstaff MRA)*, 7 Riordan Rd.
Flagstaff, *La Ciudad de Mexico Grocery (Flagstaff MRA)*, 217 S. San Francisco
Flagstaff, *North End Historic Residential District (Flagstaff MRA)*, Roughly bounded by Humphreys, Verde, Hunt, Cherry, and Elm Sts.
Flagstaff, *Our Lady of Guadalupe Church (Flagstaff MRA)*, 302 S. Kendrick
Flagstaff, *Presbyterian Church Parsonage (Flagstaff MRA)*, 15 E. Cherry
Flagstaff, *Prochnow House (Flagstaff MRA)*, 304 S. Elden
Flagstaff, *Railroad Addition Historic District (Boundary Increase) (Flagstaff MRA)*, Roughly bounded by Santa Fe RR tracks, San Francisco and Beaver Sts., and alley S. of Phoenix Ave.
Flagstaff, *Wilson, Charles, Jr., House (Flagstaff MRA)*, 100 Wilson Dr.

DISTRICT OF COLUMBIA

Washington, *Banneker Recreation Center, 2500 Georgia Ave. NW*

FLORIDA

Pinellas County

St. Petersburg, *Dennis Hotel*, 226 First Ave. N.

GEORGIA

Barrow County

Winder, *Athens—Candler—Church Street Historic District*, Roughly bounded by Athens, Betts, Church, and Candler Sts.

Harris County

Pine Mountain, *Chipley—Pine Mountain City Hall*, McDougal Ave.

Lamar County

Barnesville, *Barnesville Depot*, Plaza Way and Main St.

Troup County

Hogansville vicinity, *Phillips—Sims House*, GA 54

Ware County

Waycross, *Phoenix Hotel*, 201-222 Pendleton St.

KENTUCKY

Jefferson County

Louisville, *Schneikert, Valentine, House*, 1234 Lexington Rd.

Kenton County

Covington, *Holy Cross Church and School Complex—Latonia*, Church St.

MAINE

Androscoggin County

Lewiston, *U.S. Post Office—Lewiston Main*, 49 Ash St.

Hancock County

Bar Harbor, *U.S. Post Office—Bar Harbor Main*, Cottage St.

Kennebec County

Augusta, *Adams, D.V., Co.—Bussell & Weston (Augusta Central Business District MRA)*, 190 Water St.
Augusta, *Doughty Block (Augusta Central Business District MRA)*, 265 Water St.
Augusta, *Journal Building (Augusta Central Business District MRA)*, 325—331 Water St.
Augusta, *Kresge Building (Augusta Central Business District MRA)*, 241—249 Water St.
Augusta, *Libby—Hill Block (Augusta Central Business District MRA)*, 227—233 Water St.
Augusta, *Masonic Hall (Augusta Central Business District MRA)*, 313—321 Water St.
Augusta, *Noble Block (Augusta Central Business District MRA)*, 186 Water St.
Augusta, *Sturgis & Haskell Block (Augusta Central Business District MRA)*, 180—182 Water St.
Augusta, *Whitehouse Block (Augusta Central Business District MRA)*, 188 Water St.
Augusta, *Williams Block (Augusta Central Business District MRA)*, 183—187 Water St.

Penobscot County

Orono, *U.S. Post Office—Orono Main*, Forest and Bennoch Sts.

Waldo County

Belfast, *Belfast Historic District*, Roughly bounded by Congress, Main, Market, High, Franklin, Church, Court, Cedar and Grove Sts.

York County

Sanford, *U.S. Post Office—Sanford Main*, 28 School St.

MICHIGAN

Lenawee County

Adrian, *Downtown Adrian Commercial Historic District*, Roughly bounded by Toledo, N. Broad, E. Church, S.& N. Winter, and W. Maumee Sts. and the Raisin River
Tecumseh, *Tecumseh Downtown Historic District*, E. and W. Chicago Blvd. and S. Evans St.

Livingston County

Brighton, *Western House*, 500 W. Main St.

Wayne County

Detroit, *Cass Motor Sales (University—Cultural Center Phase I MRA)*, 5800 Cass Ave.
Detroit, *Chatsworth Apartments (University—Cultural Center Phase II MRA)*, 630 Merrick
Detroit, *Jacob, Max, House (University—Cultural Center Phase I MRA)*, 451 W. Kirby
Detroit, *Joy, James, House (University—Cultural Center Phase I MRA)*, 100 W. Kirby
Detroit, *Linsell, Frederick, House (University—Cultural Center Phase I MRA)*, 5104 Second Ave.
Detroit, *Rands, William C., House (University—Cultural Center Phase I MRA)*, 5229 Cass
Detroit, *Santa Fe Apartments (University—Cultural Center Phase II MRA)*, 681 Merrick
Detroit, *Smith, Samuel L., House (University—Cultural Center Phase I MRA)*, 5035 Woodward
Detroit, *Sprague, Thomas S., House (University—Cultural Center Phase I MRA)*, 80 W. Palmer
Detroit, *St. Andrew's Memorial Episcopal Church (University—Cultural Center Phase II MRA)*, 5105 Anthony Wayne Dr.
Detroit, *Strasburg, Herman, House (University—Cultural Center Phase I MRA)*, 5415 Cass
Detroit, *Verona Apartments (University—Cultural Center Phase I MRA)*, 92 W. Ferry
Detroit, *Webster Hall (University—Cultural Center Phase I MRA)*, 5050 Cass Ave.

MINNESOTA

St. Louis County

Duluth, *Endion Passenger Depot (Proposed Move)*, 1504 South St.

MONTANA

Rosebud County

Forsyth, *Rosebud County Courthouse*, 1250 Main St.

Yellowstone County

Billings, *Masonic Temple*, 2806 Third Ave. N

NORTH CAROLINA

Cabarrus County

Mount Pleasant, *Mount Pleasant Historic District*, Roughly W. Franklin, NC 73, E. Franklin, and N. & S. Main between Boston and Broad Sts.

PUERTO RICO

Ponce County

Ponce, *Casa Miguel C. Godreau*, Calle Reina No. 146

SOUTH DAKOTA

Butte County

Belle Fourche vicinity, *Belle Fourche River Bridge (Rural Butte and Meade Counties MRA)*, NE of Belle Fourche off US 212
Belle Fourche vicinity, *Fishel Ranch (Rural Butte and Meade Counties MRA)*, SD 34
Belle Fourche vicinity, *Olson Bridge (Rural Butte and Meade Counties MRA)*, NE of Belle Fourche
Fruitdale vicinity, *Fruitdale Bridge (Rural Butte and Meade Counties MRA)*, ½ mile S of Fruitdale
Fruitdale, *Fruitdale School (Rural Butte and Meade Counties MRA)*, High St.
Fruitdale, *Fruitdale Store (Rural Butte and Meade Counties MRA)*, Water and Main Sts.
Fruitdale, *Johnston, William, House (Rural Butte and Meade Counties MRA)*, High St.
Hoover, *Hoover Store (Rural Butte and Meade Counties MRA)*, SD 79
Hoover, *Hoover, Alexander, House (Rural Butte and Meade Counties MRA)*, SD 79
Newell vicinity, *Gartner, Carl Friederick, Homestead (Rural Butte and Meade Counties MRA)*, W of SD 79
Newell vicinity, *Stonelake Bridge (Rural Butte and Meade Counties MRA)*, Winkler Rd.
Newell vicinity, *Viken, Nicholas Augustus, Homestead (Rural Butte and Meade Counties MRA)*, N of Hope Cemetery Rd.
Nisland vicinity, *Butte—Lawerence County Fairgrounds (Rural Butte and Meade Counties MRA)*, SW of Nisland
Nisland vicinity, *Langdon School (Rural Butte and Meade Counties MRA)*, Snoma Rd.
Nisland vicinity, *Nisland Bridge (Rural Butte and Meade Counties MRA)*, S. of Nisland on section rd.

Meade County

Black Hawk vicinity, *Johnson, Ole and Carrie, Ranch (Rural Butte and Meade Counties MRA)*, CR 7
Black Hawk, *Black Hawk Elementary School (Rural Butte and Meade Counties MRA)*, Main and Elm Sts.
Elm Springs vicinity, *Olsen, Elias B., Ranch (Rural Butte and Meade Counties MRA)*, CR 6
Faith, *Bethel Lutheran Church (Rural Butte and Meade Counties MRA)*, Main and Fifth Sts.
Hereford vicinity, *Baker, Joseph, House (Rural Butte and Meade Counties MRA)*, CR 19–A
Piedmont vicinity, *Evans, John and Coralin, Ranch (Rural Butte and Meade Counties MRA)*, CR 4
Piedmont vicinity, *Stevens Ranch (Rural Butte and Meade Counties MRA)*, CR 4
Stoneville vicinity, *Bartlett, L. L., House (Rural Butte and Meade Counties MRA)*, CR 26

Sturgis vicinity, *Raskob, Jacob and Elizabeth, Ranch (Rural Butte and Meade Counties MRA)*, SD 34

TEXAS

Harris County

Houston, *Houston Fire Station No. 7*, 2304 Milam St.

VERMONT

Grand Isle County

Grand Isle, *Gordon—Center House*, West Shore Rd.

WEST VIRGINIA

Morgan County

Berkeley Springs, *Wright, Judge John W., Cottage*, 305 S. Green St.

[FR Doc. 86-7005 Filed 3-31-86; 8:45 am]

BILLING CODE 4310-70-M

DEPARTMENT OF JUSTICE

Pollution Control, Greenville, TX, Lodging of Consent Decree

In accordance with the policy of the Department of Justice, 28 CFR 50.7, notice is hereby given that on March 20, 1986 a proposed consent decree in *United States* v. *City of Greenville, Texas, et al.*, Civil Action No. 3-85-1295 T, was lodged with the United States District Court for the Northern District of Texas, Dallas Division. This consent decree settles a lawsuit filed July 3, 1985, pursuant to section 309 of the Clean Water Act ("the Act"), 33 U.S.C. 1319, for injunctive relief and for assessment of a civil penalty against the City of Greenville, Texas ("the City"). The complaint alleged, among other things, that the City: discharged pollutants from its sewage treatment plant into navigable waters in excess of the authorization in the City's National Pollutant Discharge Elimination System ("NPDES") permit; discharged pollutants into navigable waters in a manner that bypassed the City's treatment plant on numerous occasions; failed to operate and maintain the sewage treatment plant in an adequate manner; failed to monitor effluent discharges as required by the permit; failed to report monitoring results properly; and failed to notify the Environmental Protection Agency of permit violations as required by the permit. The complaint alleged that these acts and omissions constituted violations of Section 301 of the Act, U.S.C. 1311, and the NPDES permit issued to the City for its sewage treatment plant pursuant to Section 402 of the Act, 33 U.S.C. 1342.

The State of Texas was named as a Defendant pursuant to Section 309(e) of the Act, which states that a State shall be liable for payment of a judgment, or any expenses incurred as a result of complying with any judgment, entered against a municipality to the extent that State laws prevent the municipality from raising revenues needed to comply with the judgment.

Under the terms of the proposed consent decree, the City will undertake a two-phase program to attain and thereafter maintain compliance with its NPDES permit and the Clean Water Act, consisting of an upgrade and modification of the plant. The upgrade and modification will be completed no later than May 1, 1988, and the City is to attain compliance with its permit and the Act by no later than July 1, 1988. The proposed consent decree also calls for stipulated penalties against the City for failure to meet any of the deadlines set by the decree or failure to meet any of the interim effluent limitations set by the decree. Also, the proposed decree calls for the City to pay a civil penalty of $30,000 with respect to the violations of the Clean Water Act alleged in the complaint.

The Department of Justice will receive comments relating to the proposed consent decree for a period of thirty (30) days from the date of this publication. Comments should be addressed to the Assistant Attorney General of the Land and Natural Resources Division, Department of Justice, Washington, DC 20530. All comments should refer to *United States* v. *Greenville, Texas, et al.*, D.J. Ref. 90-5-1-2404.

The proposed consent decree may be examined at the following offices of the United States Attorney and the Environmental Protection Agency ("EPA"):

EPA Region VI

Contact: Ralph Corley, Office of Regional Counsel, U.S. Environmental Protection Agency, Region VI, 1201 Elm Street, Dallas, Texas 75270, (214) 767-9970.

United States Attorney's Office

Contact: John M. Nevins, Assistant United States Attorney, Northern District of Texas, 1100 Commerce Street, Room 16G28, Dallas, Texas 75242 (214) 767-0975.

Copies of the proposed consent decree may also be examined at the Environmental Enforcement Section, Land and Natural Resources Division, United States Department of Justice, Room 1515, Ninth Street and Pennsylvania Avenue, NW., Washington, DC 20530. A copy of the proposed consent decree may be obtained by mail from the Environmental Enforcement Section, Land and Natural Resources Division of the Department of Justice. In requesting a copy of the decree, please enclose a check for copying costs in the amount of $1.60 payable to Treasurer of the United States.

F. Henry Habicht II,

Assistant Attorney General, Land and Natural Resources Division.

[FR Doc. 86-7075 Filed 3-31-86; 8:45 am]

BILLING CODE 4410-01-M

Pollution Control, New York; Consent Decree in Action To Enjoin Violation of the Resource Conservation and Recovery Act ("RCRA")

In accordance with Departmental Policy, 28 CFR 50.7, 38 FR 19029, notice is hereby given that a consent decree in *United States* v. *PLC Enterprises, Inc., and its Division, The Debevoise Company*, Civil Action No. 84-1044, was lodged with the United States District Court for the Eastern District of New York on March 20, 1986. The consent decree establishes a compliance program for the Brooklyn, New York facility owned and operated by PLC Enterprises, Inc. and its Division, The Debevoise Company, to bring the facility into compliance with the Resource Conservation and Recovery Act ("RCRA"), 42 U.S.C. 6901 *et seq.* and the applicable hazardous waste management regulations and requires payment of a civil penalty in the amount of $22,500.00

The Department of Justice will receive for thirty (30) days from the date of publication of this notice, written comments relating to the consent decree. Comments should be addressed to the Assistant Attorney General, Land and Natural Resources Division, Department of Justice, Washington, DC 20530 and should refer to *United States* v. *PLC Enterprises, Inc., and its Division, The Debevoise Company*, D.J. Ref. No. 90-7-1-247.

The consent decree may be examined at the Office of the United States Attorney, Eastern District of New York, U.S. Courthouse, 225 Cadman Plaza East, Brooklyn, New York 11201; at the Region II office of the Environmental Protection Agency, 26 Federal Plaza, New York, New York 10278; and the Environmental Enforcement Section, Land and Natural Resources Division of the Department of Justice, Room 1515, Ninth Street and Pennsylvania Avenue NW., Washington, DC 20530. A copy of the consent decree may be obtained in person or by mail from the Environmental Enforcement Section, Land and Natural Resources Division of

the Department of Justice. In requesting a copy, please enclose a check in the amount of $4.90 (10 cents per page reproduction charge) payable to the Treasurer of the United States.

F. Henry Habicht II,

Assistant Attorney General, Land and Natural Resources Division.

[FR Doc. 86-7077 Filed 3-31-86; 8:45 am]

BILLING CODE 4410-01-M

Lodging of Consent Judgment Pursuant to the Clean Air Act; Florida

In accordance with Departmental policy, 28 CFR § 50.7, notice is hereby given that on December 13, 1985 a proposed Consent Judgment in *United States* v. *Thoni Oil Magic Benzol Gasoline Stations of Florida, Inc. ("Thoni Oil")* was lodged with the United States District Court for the Middle District of Florida. The complaint filed by the United States alleged violations of the Clean Air Act by Thoni Oil at one of the company's gasoline retail outlets due to the introduction of leaded gasoline into a motor vehicle labeled "unleaded gasoline only" by a company employee." The complaint sought civil penalties for past violation and injunctive relief to require compliance. The Consent Judgment requires Thoni Oil to pay a civil penalty of $4,000 in settlement of the government's civil penalty claims. It further provides that Thoni Oil shall institute a preventive action program at each of its retail outlets.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General, of the Land and Natural Resources Division, Department of Justice, Washington, DC 20530 and should refer to *U.S.* v. *Thoni Oil*, D.J. Ref. 90-5-2-1-144.

The proposed Consent Judgment may be examined at the Office of the United States Attorney, 410 Robert L. Timberlake Bldg., 500 Zack Street, Tampa, Florida 33602 and at the Office of the Environmental Protection Agency, 401 M Street SW, Washington, DC 20460. Copies of the Consent Judgment may be examined at the Environmental Enforcement Section, Land and Natural Resources Division, Department of Justice, Room 1517, 9th & Pennsylvania Avenue NW., Washington, DC 20530. A copy of the proposed Consent Judgment may be obtained in person or by mail from the Environmental Enforcement Section. In requesting a copy, please enclose a check in the amount of $1.90 (10 cents per page reproduction cost) payable to the Treasurer of the United States.

F. Henry Habicht II,

Assistant Attorney General, Land and Natural Resources Division.

[FR Doc. 86-7076 Filed 3-31-86; 8:45 am]

BILLING CODE 4410-01-M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance; American Cyanamid Co. et. al.

Petitions have been filed with the Secretary of Labor under section 221 (a) of the Trade Act of 1974 ("the Act") and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Office of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221 (a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than April 11, 1986.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than April 11, 1986.

The petitions filed in this case are available for inspection at the Office of the Director, Office of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, 601 D Street, NW., Washington, DC, 20213.

Signed at Washington, DC this 24th day of March 1986.

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

APPENDIX

Petitioner (Union/workers or former workers of—	Location	Date received	Date of petition	Petition No.	Articles produced
American Cyanamid Co. (USWA)	Linden, NJ	3/17/86	3/13/86	TA-W-17,290	Chemicals—mining, paper, pesticides
ASARCO, Inc. (workers)	Salt Lake City, UT	3/10/86	3/5/86	TA-W-17,291	Exploration, copper, lead, zinc
Formica Corp. (company)	Hialeah, FL	3/20/86	3/15/86	TA-W-17,292	High pressure decorative plastic laminate
General Radiator Div. (company)	Mt. Vernon IL (2 plts)	3/17/86	2/25/86	TA-W-17,293	Heat transfer products (primarily radiators) and office workers
Keystone Fireworks Mfg Co Inc. (USWA)	Dunbar, PA	3/17/86	3/10/86	TA-W-17,294	Class C fireworks
LTV Steel Co. (USWA)	Massillon, OH	3/20/86	3/13/86	TA-W-17,295	Carbon steel products
Miller Printing Equipment Corp. (IAMAW)	Pittsburgh, PA	3/18/86	3/14/86	TA-W-17,296	Sheet fed printing presses
Ohio Knife Corp. (USWA)	Cincinnati, OH	3/17/86	3/13/86	TA-W-17,297	Industrial knives
Raymond Schall Coal Co. (workers)	Kittanning, PA	3/20/86	3/7/86	TA-W-17,298	Coal mining
Summitville Tiles, Inc. (workers)	Summitville, OH	3/20/86	3/14/86	TA-W-17,299	Ceramic tile and office workers
Summitville Tiles, Inc. (workers)	Minerva, OH	3/20/86	3/14/86	TA-W-17,300	Ceramic tile
Tennessee Zinc Div. Inspiration Mines Inc. (workers)	Jefferson City, TN	3/18/86	3/11/86	TA-W-17,301	Zinc mining
W-I Forest Products, L.P Sandpoint Div., Planer Operation (IWA).	Sandpoint, ID	3/20/86	3/17/86	TA-W-17,302	Surfaces lumber products

[FR Doc. 86-7181 Filed 3-31-86; 8:45 am]

BILLING CODE 4510-30-M

TA-W-16,115 and TA-W-16,119]

Commonwealth Aluminum Corp. and Martin Marietta Aluminum; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974, the Department of Labor issued the above mentioned two certifications regarding eligibility to apply for worker adjustment assistance which were published in the Federal Register on January 10, 1986 (51 FR 1310).

Based on additional information furnished to the Department of Labor by the United Steelworkers of America subsequent to issuing separate certifications for worker groups at the subject plants, the Department has determined to combine the certifications for workers at the two plants into one notice. Both plants produced aluminum ingots. While the Dalles plant closed in December 1984 and the Goldendale plant was sold to Commonwealth Aluminum Corporation in January 1985, both plants were owned by Martin Marietta Aluminum when import competition first resulted in worker separations. This action will permit workers separated from employment at The Dalles plant who were recalled at the Goldendale Plant under a common labor-management agreement to establish individual eligibility for certain benefits. Those workers separated from employment at the Goldendale plant after the plant was sold to Commonwealth Aluminum in January 1985 would be covered since Commonwealth Aluminum is a successor-in-interest under the definition of "firm" in 20 CFR 90.2.

The intent of this amended certification is to cover all workers at both plants who were adversely affected by import competition of aluminum ingots. The prior Notices of Certification, therefore, are amended by combining both certifications under this single Notice of Certification to include all workers at both plants.

The certifications applicable to TA-W-16, 115 and TA-W-16,119 are hereby amended as follows:

All workers of the Commonwealth Aluminum Corporation (or its predecessor-in-interest Martin Marietta Aluminum), Goldendale, Washington (TA-W-16,115) and Martin Marietta Aluminum, The Dalles, Oregon (TA-W-16,119) who became totally or partially separated from employment on or after June 7, 1984 are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974.

Signed at Washington, DC, this 25th day of March 1986.

James D. Van Erden,

Acting Deputy Director, Office of Program Management, UIS.

[FR Doc. 86-7182 Filed 3-31-86; 8:45 am]

BILLING CODE 4510-30-M

Determinations Regarding Eligibility To Apply for Worker Adjustment Assistance; SGA Scientific, Inc., et al.

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor herein presents summaries of determinations regarding eligibility to apply for adjustment assistance issued during the period March 17, 1986-March 21, 1986.

In order for an affirmative determination to be made and a certification of eligibility to apply for adjustment assistance to be issued, each of the group eligibility requirements of section 222 of the Act must be met.

(1) That a significant number or proportion of the workers in the workers' firm, or an appropriate subdivision thereof, have become totally or partially separated,

(2) That sales or production, or both, of the firm or subdivision have decreased absolutely, and

(3) That increases of imports of articles like or directly competitive with articles produced by the firm or appropriate subdivision have contributed importantly to the separations, or threat thereof, and to the absolute decline in sales or production.

Negative Determinations

In each of the following cases the investigation revealed that criterion (3) has not been met. A survey of customers indicated that increased imports did not contribute importantly to worker separations at the firm.

TA-W-16,512; SGA Scientific, Inc., Bloomfield, NJ

TA-W-16,628; Crescent Hills Coal Co., Ocean #5 Mine, Washington, PA

TA-W-16,517; West Point Pepperell, Columbus, GA

TA-W-16,577; Chase Bag Co., Dallas, TX

TA-W-16,546; Ruff Mould & Machine Shop, Inc., Lancaster, OH

TA-W-16,525; J.P. Stevens Co., Inc., Anderson, SC

TA-W-16,532; Eastern Associated Coal Corp., Harris Mines, Bald Knob, WV

TA-W-16,526; Kramer Body and Equipment Co., Inc., Hillside, NJ

TA-W-16,509; AT&T Technology Systems, Radford, VA

TA-W-16,508; AT&T Technology Systems, Winston-Salem, NC

In the following cases the investigation revealed that criterion (3) has not been met for the reasons specified.

TA-W-16,574; The West Co., Pharma-Packaging Div., Phoenixville, PA

Separations from the subject firm were due to the transfer of functions to other domestic facilities.

TA-W-16,756; PMDR Enterprise, Boise, ID

Firm operating only 4 months. No basis to measure year to year change in sales/production or import impact.

TA-W-16,439; Albany Industrial Maintenance, Albany, GA

The workers' firm does not produce an article as required for certification under Section 222 of the Trade Act of 1974.

Affirmative Determinations

TA-W-16,344; Storage Technology Corp., Louisville, CO

A certification was issued covering all workers of the firm separated on or after October 1, 1984.

TA-W-16,401; Calhio Chemicals, Perry OH

A certification was issued covering all workers of the firm separated on or after June 1, 1985 and before December 31, 1985.

TA-W-16,417; Ciba-Geigy Corp., Glens Falls, NY

A certification was issued covering all workers of the firm separated on or after January 1, 1985.

TA-W-16,521; Fashions By Surf, Newark, NJ

A certification was issued covering all workers of the firm separated on or after January 1, 1985 and before December 31, 1985.

TA-W-16,587; Westinghouse Electric Corp., LaGrange, GA

A certification was issued covering all workers of the firm separated on or after October 14, 1984.

TA-W-16,594; Sylvania Shoe Manufacturing Co., McSherrystown, PA

A certification was issued covering all workers of the firm separated on or after October 15, 1984.

TA-W-16,593; Sylvania Shoe Manufacturing Co., Mt. Holly Springs, PA

A certification was issued covering all workers of the firm separated on or after October 15, 1984 and before October 30, 1985.

TA-W-16,566; Union Apparel, Inc., Norvelt, PA
A certification was issued covering all workers of the firm separated on or after October 8, 1984.
TA-W-16,578; Debra Fashions, Northport, AL
A certification was issued covering all workers of the firm separated on or after September 22, 1984 and before November 11, 1985.
TA-W-16,615; Ladish Co., Inc., Cudahy, WI
A certification was issued covering all workers of the firm separated on or after October 30, 1984.
TA-W-16,448; Ratner California Clothing Corp., Chula Vista, CA
A certification was issued covering all workers of the firm separated on or after September 23, 1984.
TA-W-16,506; Weyerhaeuser Co., Klamath Falls, OR
A certification was issued covering all workers producing logs and soft wood lumber separate on or after January 1, 1985.
TA-W-16,550; Charland Sportswear, Charleroi, PA
A certification was issued covering all workers of the firm separated on or after July 1, 1985.
TA-W-16,505A; Jensports, Inc., New Kensington, PA
A certification was issued covering all workers of the firm separated on or after July 1, 1985.
TA-W-16,550B; Gateway Sportswear, Masontown, PA
A certification was issued covering all workers of the firm separated on or after July 1, 1985.
TA-W-16,550C; Faymore Manufacturing Co., Confluence, PA
A certification was issued covering all workers of the firm separated on or after July 1, 1985.
TA-W-16,547; Columbian Cutlery Co., Inc., Reading, PA
A certification was issued covering all workers of the firm separated on or after September 27, 1984.
TA-W-16,507; AT&T Technology Systems, Richmond, VA
A certification was issued covering all workers of the firm separated on or after June 1, 1985.
TA-W-16,510; AT&T Technology Systems, Kansas City, MO
A certification was issued covering all workers of the firm separated on or after July 1, 1985.
TA-W-16,511; AT&T Technology Systems, Dallas, TX
A certification was issued covering all workers of the firm separated on or after January 1, 1985.
TA-W-16,548; AT&T Technology Systems, Reading, PA
A certification was issued covering all workers of the firm separated on or after January 1, 1985.
TA-W-16,549; AT&T Technology Systems, Allentown, PA
A certification was issued covering all workers of the firm separated on or after July 1, 1985.

I hereby certify that the aforementioned determinations were issued during the period March 17, 1986–March 21, 1986. Copies of these determinations are available for inspection in Room 6434, U.S. Department of Labor, 601 D Street, NW., Washington, DC during normal business hours or will be mailed to persons who write to the above address.

Dated: March 25, 1986.

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

[FR doc. 86-7183 Filed 3-31-86; 8:45 am]

BILLING CODE 4510-30-M

Occupational Safety and Health Administration

Oregon State Standards; Approval

1. *Background.* Part 1953 of Title 29, Code of Federal Regulations prescribes procedures under section 18 of the Occupational Safety and Health Act of 1970 (hereinafter called the Act) by which the Regional Administrator for Occupational Safety and Health (hereinafter called Regional Administrator) under a delegation of authority from the Assistant Secretary of Labor for Occupational Safety and Health (hereinafter called the Assistant Secretary) (29 CFR 1953.4) will review and approve standards promulgated pursuant to a State plan which has been approved in accordance with section 18(c) of the Act and 29 CFR Part 1902. On December 28, 1972, notice was published in the **Federal Register** (37 FR 28628) of the approval of the Oregon plan and the adoption of Subpart D to Part 1952 containing the decision. The Notice of Approval of Revised Developmental Schedule was further published on April 1, 1974 in the **Federal Register**.

The Oregon plan provides for the adoption of Federal standards as State standards after comments and/or public hearing. Section 1952.108 of Subpart D sets forth the State's schedule for the adoption of Federal standards.

By letter dated April 8, 1983, from Darrel D. Douglas, Administrator, Accident Prevention Division, Workers' Compensation Department, to James W. Lake, Regional Administrator, and incorporated as part of the plan, the State submitted standard amendments identical to 29 CFR 1910.401 and .402, Commercial Diving (Amended) as published in the **Federal Register** (47 FR 53365) on November 26, 1982.

These standards amendments which are contained in OAR 437, Division 86, Oregon Occupational Safety and Health Code, were promulgated by the State after a notice was published in the Secretary of State's Administrative Rules Bulletin on February 1, 1983 pursuant to ORS Chapter 183.335. No written comments or requests for a public hearing were received. The original Oregon Commercial Diving standard was adopted May 30, 1978 and became effective June 15, 1978, while the amendments were adopted March 30, 1983 and became effective April 15, 1983.

2. *Decision.* Having reviewed the State submission in comparison with the Federal standard, it has been determined that the State standard is identical to the Federal standard.

3. *Location of supplement for inspection and copying.* A copy of the standard supplement, along with the approved plan, may be inspected and copied during normal business hours at the following locations: Office of the Regional Administrator, Occupational Safety and Health Administration, Room 6003, Federal Office Building, 909 First Avenue, Seattle, Washington 98174; Workers' Compensation Department, Labor and Industries Building, Salem, Oregon 97310; and the Office of State Programs, Room N-3613, 200 Constitution Avenue NW. Washington, DC 20210.

4. *Public participation.* Under 29 CFR 1953.2(c), the Assistant Secretary may prescribe alternative procedures to expedite the review process or for other good cause which may be consistent with applicable laws. The Assistant Secretary finds that good cause exists for not publishing the supplement to the Oregon plan as a proposed change and making the Regional Administrator's approval effective upon publication for the following reasons:

1. The standards are identical to the Federal standards which were promulgated in accordance with Federal law including meeting requirements for public participation.

2. The standards were adopted in accordance with the procedural requirements of State law and further participation would be unnecessary.

This decision is effective April 1, 1986.

(Sec. 18, Pub. L. 91-596, 84 Stat. 1608 (29 U.S.C. 667))

Signed at Seattle, Washington this 31st day of May 1983.

James W. Lake,

Regional Administrator.

[FR Doc. 86-6921 Filed 3-31-86; 8:45 am]

BILLING CODE 4510-26-M

NUCLEAR REGULATORY COMMISSION

Abnormal Occurrence Report; Section 208 Report Submitted to the Congress

Notice is hereby given that pursuant to the requirements of Section 208 of the Energy Reorganization Act of 1974, as amended, the Nuclear Regulatory Commission (NRC) has published and issued the periodic report to Congress on abnormal occurrences (NUREG-0090, Vol. 8, No. 3).

Under the Energy Reorganization Act of 1974, which created the NRC, an abnormal occurrence is defined as "an unscheduled incident or event which the Commission (NRC) determines is significant from the standpoint of public health or safety." The NRC has made a determination, based on criteria published in the **Federal Register** (42 FR 10950) on February 24, 1977, that events involving an actual loss or significant reduction in the degree of protection against radioactive properties of source, special nuclear, and byproduct materials are abnormal occurrences.

This report to Congress is for the third calendar quarter of 1985. The report identifies the occurrences or events that the Commission determined to be significant and reportable; the remedial actions that were undertaken are also described. During the report period, there were three abnormal occurrences at the nuclear power plants licensed to operate. These events involved, respectively: (1) Management control dificiencies, (2) inoperable steam generator low pressure trip, and (3) management deficiencies at Tennessee Valley Authority. There were four abnormal occurrences at the other NRC licensees. Three of the events involved medical misadministrations—two therapeutic and one diagnostic. The other event involved exposure of radiographic personnel due to management and procedure control deficiencies. There were no abnormal occurrences reported by the Agreement States.

The report also contains information updating some previously reported abnormal occurrences.

Interested persons may review the report at the NRC's Public Document Room, 1717 H Street, NW, Washington, DC or at any of the nuclear power plant Local Public Document Rooms throughout the country.

Copies or microfiche of NUREG-0090, Vol. 8, No. 3 (or any of the previous reports in this series), may be purchased by calling (202) 275-275-2060 or (202) 275-2171, or by writing to the Superintendent of Documents, U.S. Government Printing Office, Post Office Box 37082, Washington, DC 20012-7982. A year's subscription to the NUREG-0090 series publication, which consists of four issues, is also available. Documents may be purchased by check, money order, Visa, MasterCard, or charged to a GPO Deposit Account.

Copies of the report may also be purchased from the National Technical Information Service, Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161.

Dated at Washington, DC, this 20th day of March 1986.

For the Nuclear Regulatory Commission.

Samuel J. Chilk,

Secretary of the Commission.

[FR Doc. 86-7175 Filed 3-31-86; 8:45 am]

BILLING CODE 7590-01-M

Advisory Committee on Reactor Safeguards Subcommittee on Davis-Besse; Postponement

The notice previously published on Friday, March 21, 1986 (51 FR 9904) concerning the ACRS Subcommittee on Davis-Besse scheduled for April 9, 1986, Washington, DC has been postponed indefinitely.

Dated: March 25, 1986.

Morton W. Libarkin,

Assistant Executive Director for Project Review.

[FR Doc. 86-7174 Filed 3-31-86; 8:45 am]

BILLING CODE 7590-01

Bi-Weekly Notice; Applications and Amendments to Operating Licenses Involving No Significant Hazards Considerations

Correction

In FR Doc. 86-5386, beginning on page 8584 in the issue of Wednesday, March 12, 1986, make the following correction:

On page 8603, in the second column, in the twentieth line of paragraph (b), "not" should read "now".

BILLING CODE 1505-01-M

[Docket No. 70-364; ASLBP No. 85-511-01-ML]

Babcock & Wilcox; Substitution of Presiding Officer Appointed to Conduct Informal Proceeding

Pursuant to the authority contained in 10 CFR 2.721 and 2.721(b), Administrative Judge Oscar H. Paris is hereby appointed Presiding Officer in the Babcock & Wilcox, Parks Township, Pennsylvania Volume Reduction Facility proceeding in place of Administrative Judge Peter A. Morris, who became of schedule conflict is unable to serve.

The name and address of the new Presiding Officer is: Dr. Oscar H. Paris, Administrative Judge, Atomic Safety and Licensing Board Panel, U.S. Nuclear Regulatory Commission, Washington, DC 20555.

All correspondence, documents and other material shall be filed with the Presiding Officer in accordance with 10 CFR 2.701 (1980).

Issued at Bethesda, Maryland, this 25th day of March, 1986.

Robert M. Lazo,

Acting Chief Administrative Judge, Atomic Safety and Licensing Board Panel.

[FR Doc. 86-7173 Filed 3-31-86; 8:45am]

BILLING CODE 7590-01-M

PRESIDENTIAL COMMISSION ON THE SPACE SHUTTLE CHALLENGER ACCIDENT

[Notice 86-25]

Meeting

AGENCY: Presidential Commission on the Space Shuttle Challenger Accident.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Pub. L. 92-463, as amended, the Commission announces a forthcoming meeting.

DATE AND TIME: April 3, 1986, beginning at 9:30 a.m.

ADDRESS: Dean Atchison Auditorium, State Department, 2201 C Street NW, Washington, DC 20520.

FOR FURTHER INFORMATION CONTACT: Dr. Alton G. Keel, Executive Director, Presidential Commission on the Space Shuttle Challenger Accident, (202/453-1797).

Purpose of Meeting: The Commission will discuss safety matters with astronauts and NASA officials.

SUPPLEMENTARY INFORMATION: The Presidential Commission on the Space Shuttle Challenger Accident was established as a group of distinguished leaders of the government and the

scientific, technical and management communities to investigate the accident of the Space Shuttle Challenger which occurred on January 28, 1986.

Exceptional circumstances requiring less than 15 days notice: the meeting is required to be held promptly due to the Presidential direction that the Commission investigate the January 28, 1986, Space Shuttle Challenger accident and submit a final report to the President and the Administrator of the National Aeronautics and Space Administration within 120 days of issuance of Executive Order 12546, dated February 3, 1986.

Type of Meeting: Open.

Richard L. Daniels,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 86-7328 Filed 3-31-86; 10:17 am]

BILLING CODE 7510-01-M

RAILROAD RETIREMENT BOARD

Agency Forms Submitted for OMB Review

AGENCY: Railroad Retirement Board.

ACTION: In accordance with the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35), the Board has submitted the following proposal(s) for the collection of information to the Office of Management and Budget for review and approval.

Summary of Proposal(s):

(1) Collection title: Medical Reports
(2) Form(s) submitted: G-3EMP, G-250, RL-11b, and RL-11d
(3) Type of request: Extension of the expiration date of a currently approved collection without any change in the substance or in the method of collection.
(4) Frequency of use: On occasion
(5) Respondents: Individuals or households
(6) Annual responses: 28,050
(7) Annual reporting hours: 11,050
(8) Collection description: The Railroad Retirement Act provides disability annuities for qualified railroad employees whose physical or mental condition renders them incapable of working in their regular occupation (occupational disability) or any occupation (total disability). The medical reports obtain information needed for determining the nature and severity of the impairment.

Summary of Proposal(s):

(1) Collection title: Pay Rate Reports
(2) Form(s) submitted: UI-lg, UI-lg
(3) Type of request: Extension of the expiration date of a currently approved collection without any change in the substance or in the method of collection.
(4) Frequency of use: On occasion
(5) Respondents: Individuals or households
(6) Annual responses: 2,600
(7) Annual reporting hours: 367
(8) Collection description: Under the RUIA, the daily benefit rate for unemployment and sickness benefits depends on the employee's last daily rate of pay. The reports obtain information from the employee and verification from the employer of the claimed rate of pay for use in determining whether an increase in the benefit rate is due.

Additional Information or Comments:

Copies of the proposed forms and supporting documents may be obtained from Pauline Lohens, the agency clearance officer (312-751-4692). Comments regarding the information collection should be addressed to Pauline Lohens, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611 and the OMB reviewer, Judy McIntosh (202-395-6880), Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503.

Pauline Lohens,

Director of Information and Data Management.

[FR Doc. 86-7110 Filed 3-31-86; 8:45 am]

BILLING CODE 7905-01-M

Agency Forms Submitted for OMB Review

AGENCY: Railroad Retirement Board.

ACTION: In accordance with the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35), the Board has submitted the following proposal(s) for the collection of information to the Office of Mangement and Budget for review and approval.

Summary of Proposal(s):

(1) Collection title: Supplement to Claim of Person Outside the United States
(2) Form(s) submitted: G-45
(3) Type of request: New collection
(4) Frequency of use: On occasion, Semi-annually
(5) Respondents: Individual households
(6) Annual responses: 50
(7) Annual reporting hours: 8
(8) Collection description: Under Public Law 98-21 railroad retirement beneficiaries' Tier 1, or overall minimum portion of an annuity and Medicare benefits payable under the Railroad Retirement Act may be withheld effective January 1, 1985. The collection obtains the information needed by the Board to implement the benefit withholding provisions of Pub. L. 98-21.

Additional Information or Comments:

Copies of the proposed forms and supporting documents may be obtained from Pauline Lohens, the agency clearance officer (312-751-4692). Comments regarding the information collection should be addressed to Pauline Lohens, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611 and the OMB reviewer, Judy McIntosh (202-395-6880), Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503.

Pauline Lohens,

Director of Information and Data Management.

[FR Doc. 86-7111 Filed 3-31-86; 8:45 am]

BILLING CODE 7905-01-M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-23063; File No. SR-Amex-86-8]

Self-Regulatory Organizations; Filing and Order Granting Accelerated Approval of Proposed Rule Change by the American Stock Exchange, Inc.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on March 6, 1986, the American Stock Exchange, Inc. filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II, and III below, which items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The American Stock Exchange, Inc. ("Amex" or "Exchange") proposes to extend the pilot program for the automatic execution of certain Major Market Index (XMI) Options for an additional three-month period. In addition, the Amex proposes to increase the number of series from four to six (three puts and three calls) that will be included in the automatic execution system.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in section (A), (B), and (C) below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In November 1985, the Securities and Exchange Commission approved the implementation of a three-month pilot program for the automatic execution of certain XMI options contracts. (*See* Release No. 34–22610, dated November 8, 1985, approving SR–Amex–85–29). The Exchange implemented the pilot program on December 6, 1985, and the three-month period expires on March 6, 1986. In view of the favorable response to the program, the Exchange proposes to extend it for an additional three-month period on an uninterrupted basis.[1]

The proposed change is consistent with the requirements of the Securities Exchange Act of 1934 ("1934 Act") and the rules and regulations thereunder applicable to the Exchange by continuing to provide the means to reduce operational burdens in executing and reporting XMI AUTOAMOS orders while maintaining the trading primacy of orders on the limit order book. Therefore, the proposed rule change is consistent with section 6(b)(5) of the 1934 Act, which provides in pertinent part, that the rules of the Exchange be designed to promote just and equitable principles of trade and to protect the investing public.

B. Self-Regulatory Organization's Statement of Burden on Competition

The Amex believes that the proposed rule change will not impose a burden on competition.

[1] In addition, the Exchange subsequently amended the filing to indicate that the Exchange would "expand the pilot program to include two additional XMI series in the most recent expiration month." Letter from Heidi Litt Spitzer, Senior Attorney, Options Division, Amex, to Eneida Rosa, Branch Chief, Branch of Options Regulation, Division of Market Regulation, dated March 19, 1986.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a self-regulatory organization and in particular, the requirements of section 6 and the rules and regulations thereunder. The Commission finds good cause for approving the proposed rule change prior to the thirtieth day after the date of publication of notice of filing thereof, in that the pilot has operated to date without technical or other difficulty, and provides a benefit to public customers by reducing the time needed to execute and report certain XMI AUTOMAMOS orders.

IV. Solicitation Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street NW., Washington DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by April 22, 1986.

It is therefore ordered, pursuant to section 19(b)(2) of the Act, that the proposed rule change referenced above be, and hereby is approved.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.

Dated: March 25, 1986.

John Wheeler,

Secretary.

[FR Doc. 86–7115 Filed 3–31–86; 8:45 am]

BILLING CODE 8010–01–M

[Release No. 34–23052; File No. SR–CBOE–86–08]

Self-Regulatory Organizations; Proposed Rule Change by Chicago Board Options Exchange, Inc., Relating to Currency Options Trading Rights Proposal

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on March 10, 1986 the Chicago Board Options Exchange, Incorporated filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange files as a rule change the following currency options trading rights proposal.

The Exchange would issue fifty one-year trading rights. Members and nonmembers would be able to purchase these rights for a $500 registration fee. The rights can be used only for trading currency option contracts as principal or agent on the Exchange's trading floor. The rights will not convey any other benefit to rights holders, who will be subject to Exchange rules and, unless waived, to dues, fees and other charges. Currency options rights applicants who are nonmembers will go through the Exchange's usual application process. If there are more than 50 applicants, the Exchange's Membership Committee will select the most qualified. If these rights are approved, the 22 existing three-year currency permits will become free permits, and the $10,000 first-year fee will be refunded.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at

the places specified in Item IV below and is set forth in sections (A), (B), and (C) below.

(A) Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

The purpose of this proposed currency options trading rights program is to attempt to attract additional market makers to the currency options trading crowds. Inexpensive access is one way to achieve this objective. Additional market makers available to trade currency options will increase competition among market makers and will provide increased capacity for trading with public customer and firm proprietary currency option orders. The statutory basis for the proposed rule change is section 6(b)(5) of the Securities Exchange Act of 1934 (the Act), in that the program is designed to facilitate the trading of currency options.

(B) Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed currency option rights access program will impose a burden on competition. The program is designed to encourage competition both on the Exchange and among exchanges by adding additional market makers to the currency options trading crowds.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Comments were neither solicited nor received:

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submission should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Section, 450 Fifth Street NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by April 22, 1986.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

March 24, 1986.

[FR Doc. 86-7117 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-23051; File No. SR-CBOE-86-07]

Self-Regulatory Organizations; Proposed Rule Change by Chicago Board Options Exchange, Inc., Relating to Proposed Currency Options Incentive Program

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on March 6, 1986 the Chicago Board Options Exchange, Incorporated filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange files as a rule change the following proposed six-month currency options incentive program. For each market-maker the Exchange will compute from trade match data in each currency option class the total numer of in-person, market-maker trades made with off-floor orders ("accommodation volume"). No order from a market maker can be an off-floor order.

For each currency option class, incentive credits will be allocated among market-makers. The monthly allocation will be according to the ratio of each market-maker's accommodation volume per currency option class to the total accommodation volume per currency option class. If a market-maker handles 10 percent of the accommodation volume, he gets 10 percent of the bonus for that month. However, there is a $50 cap per contract, so that if a market-maker trades only one contract, the maximum incentive credit is $50. For the first three months of the program, the monthly totals per currency option class will be $30,000 each for Japanese yen and Swiss francs, $20,000 each for British pounds and West German marks, and $10,000 each for Canadian dollars and French francs. During this six-month program, the monthly total of incentive credits will not be more than $120,000 for all currency option classes.

These incentive credits can be applied, by the market-maker who earned them, toward the payment of his Exchange dues, fees and open-market seat purchases; they may also be sold to the market-maker's clearing firm, which may apply them to its Exchange dues, fees and open-market seat purchases. The Exchange will begin to compute market-maker accommodation volume in connection with this program on Monday, March 3, 1986, though no credits will be applied unless SEC approval is received.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below and is set forth in sections (A), (B), and (C) below.

(A) Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

The purpose of this proposed currency incentive program is (1) to assure the continued presence of those market-makers who have already demonstrated the ability and willingness to fill outside order flow and (2) to attract new market-makers to the currency trading crowds. By providing a guaranteed level of incentive payment in each currency

option class, the program encourages market-makers to support these products. The Exchange will monitor the currency option trading of market makers doing a large accommodation volume to make sure that this volume consists of accommodations.

This program is expected to attract a limited number of market-makers because of the volatility of, and the capital needed for, currency options. Therefore, little, if any, impact is expected on the number of market-makers available at trading posts where lower volume equity option classes are traded. In addition, the program is only for a six-month period, during which the Exchange will monitor which trading crowds participating market-makers are coming from, in order to insure that the currency incentive program does not decrease liquidity in lower volume equity option classes.

The statutory basis for the proposed rule change is Section 6(b)(5) of the Securities Exchange Act of 1934 (the Act), in that the program will facilitate the trading of currency options.

(B) Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed program will impose a burden on competition. The incentive program is designed to foster competition by encouraging those market-makers now trading currency options to remain there and to encourage additional market-makers to commit to trade currency options. The Exchange believes these incentives will result in greater competition among market-makers on the Exchange as well as increased competition among currency options markets.

To the extent a market-maker commits to trading in a new product like currency options, he foregoes the more predictable revenues in more established markets for other options classes. The six-month incentive credit program is an attempt to defray the costs borne by market-makers as they attempt to establish this new market. The credits also help to offset the competitive advantage enjoyed by specialists at competing exchanges who have a guaranteed source of revenue in agency commissions.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submission should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Section, 450 Fifth Street NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by April 22, 1986.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

March 24, 1986.

[FR Doc. 86-7116 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-23061; File No. SR-PSE-86-03]

Self-Regulatory Organizations, Pacific Stock Exchange, Inc.

Proposed rule change by the Pacific Stock Exchange Incorporated relating to the Adoption by the Board of Governors of the Pacific Stock Exchange of a rule fixing the effective date of a suspension of trading in a dually listed security on the PSE when the primary market has suspended trading in the security due to a buyout or a merger.

Pursuant to section 19(b)(1), of the Securities Exchange Act of 1934, 15 U.S.C. 78s(L)(1), notice is hereby given that on March 18, 1986, the Pacific Stock Exchange Incorporated, filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II and III below, which items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule filing from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule (i.e. Rule I, Section 3(f), of the Rules of the Board of Governors) that has been approved by the Board of Governors of the Pacific Stock Exchange Incorporated ("PSE" or "Exchange") specifies that when trading in a dually listed security is suspended by the primary market due to a merger or buyout, the PSE will suspend trading effective at the close of trading of the primary market on the day designated by the primary market as the day of suspension. The rule also allows for flexibility in unforeseen situations by allowing the Joint Equity Floor Trading Committee ("JEFTC") to institute the suspension at another time.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in Sections (A), (B), (C) below, of the most signficiant aspects of such statements.

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The proposed rule has been adopted in response to the desire of the members of the PSE to fix a specific time for suspension of trading in a dually listed security when the primary market has announced such a suspension due to a buyout or a merger. It was felt that without such a procedure, disputes over

PSE trades in the effected security could develop. This proposed rule is consistent with sections 6 and 11 of the Securities Exchange Act of 1934, in that it will help to maintain a fair and orderly market in the trading of dually listed securities that have been so effected, by coordinating the suspension of trading. This will also comply with the goal of a national market system by coordinating the suspension between the PSE and the primary market, thus, helping to eliminate potential confusion and questions about the effectiveness of any PSE trades in such securities. In this manner, it will also act to protect investors and the public interest.

(B) Self-Regulatory Organization's Statement on Burden on Competition

The proposed rule change will not impose any burden on competition that is not necessary or appropriate in furtherance of the Act.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No comments were received or solicited concerning the proposal to set a fixed time for the suspension of a dually listed security when the primary market has announced a suspension due to a buyout or a merger in the effected security.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five (35) days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to ninety (90) days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents the Commission will:

(a) By order approve such proposed rule change; or

(b) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, at 450 Fifth Street NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by April 22, 1986.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.

Dated: March 25, 1986.

John Wheeler,

Secretary.

[FR Doc. 86-7118 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-23064; File No. SR-Amex-86-6]

Self-Regulatory Organizations; Proposed Rule Change by American Stock Exchange Amending Section 110 of the Amex Company Guide To Modify Foreign Listing Guidelines

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on March 17, 1986, the American Stock Exchange, Inc. filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization.[1] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The American Stock Exchange is proposing to amend Section 110 of the Amex Company Guide to modify Exchange listing requirements for foreign issuers.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

(1) Purpose

The Amex believes that the benefits of an auction market, including its regulatory framework, should be available to U.S. investors in foreign securities as an alternative both to foreign trading markets and dealer markets in this country. In order for investors to have this choice, however, U.S. exchange markets must be able to attract foreign issuers. Experience has shown that foreign companies have been reluctant to list on an exchange because they find it difficult or impossible to comply with certain exchange standards that are either inconsistent with, or contrary to, their own country's laws and practices. The Exchange believes that modification of its listing requirements for foreign issuers through recognition of their domestic customs and practices, may eliminate some of the disincentives to listing, and has identified the following areas in which it believes modifications can be safely made without any lessening of fundamental investor protections.

Voting and Independent Directors

Due to the broad range of political and economic systems found world-wide, many foreign issuers are incorporated in nations which lack a history of providing shareholders with the same degree of participation in the choice of management, and in voting on stock issuances, as is the norm in this country. In a number of instances, other means of corporate accountability and discipline are favored over shareholder voting as a check on managment.[2] In addition, some countries restrict foreign ownership, in whole or in part, to shares in which the right to vote is constrained.

The Exchange therefore, proposes to modify its listing guidelines to allow consideration of custom and practice in the issuer's country of domicile with

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[1] The full text of the proposed rule change is contained in *Exhibit A*.

[2] One such example is found in Scandinavian countries, where many companies are required to afford significant Board level representation to their employees.

respect to shareholder voting rights, including shareholder approval of certain corporate actions (Sections 710 to 713 of the Company Guide) and independent directors (Section 121).

Quorum Requirement

The corporate charters of foreign companies seldom provide a minimum quorum for holding annual meetings reflecting a tradition of investor non-participation in corporate governance. In cases where there is a quorum requirement, it often is much lower than the requirements found in the U.S. A foreign company attempting to meet Amex standards (Section 123)—which specify a minimum quorum requirement of at least one-third of the outstanding shares—could very well find itself unable to obtain the votes necessary to hold an annual meeting.

The Exchange proposes to amend its listing guidelines for foreign issuers to permit the Exchange to evaluate the adequacy of a foreign company's quorum requirements viewed in light of the corporate law and practice of its country of domicile.

Reporting

Foreign issuers have frequently voiced objections to the exchange requirement for quarterly reporting (Section 620). Such a practice is not observed in most countries and it is argued that its adoption solely for the benefit of U.S. shareholders would cause domestic complications. The Exchange, therefore proposes to allow foreign issuers to publish, at least semi-annually, an English language version of an interim financial statement.[3]

(2) Basis

The proposed rule change is consistent with sections 6(b)5 and 11A(a)(i)(c)(ii) of the Act, in that it is designed to remove impediments to and perfect the mechanism of a free and open market and enhance competition between markets. While the proposed revision will afford the Exchange greater latitude in evaluating the listing eligibility of ceratin foreign issuers, this is intended solely to eliminate barriers to foreign listings, thereby fostering competition. In this regard, it should be noted that foreign issuers traded through the facilities of NASDAQ are not required to adhere to any standards of corporate governance. Moreover, the NASD is seeking broad exemptive authority for foreign issuers with respect to those governance standards for which it is now seeking SEC approval (see SR-NASD-85-20).

The proposed rule would also parallel the Commission's own treatment of foreign issuers. Foreign issuers which register securities on Form 20-F or are exempt from registration pursuant to Rule 12g3-2 are permitted to provide less extensive disclosure and are not subject to the proxy, quarterly reporting or insider trading provisions of the Exchange Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The proposed rule change will act to reduce existing competitive disparities between the Exchange and the over-the-counter market with regard to the ability to attract foreign listings.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants or Others

While no written comments were solicited with respect to the proposed rule change, such comments were received from Senator Alfonse D'Amato and Congressman John Dingell.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriated and publishes its reasons for so finding or (ii) as to which the self-regulatory organizations consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 5th Street, NW, Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 5th Street, NW., Washington, DC. copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization.

All submissions should refer to the file number in the caption above and should be submitted by April 22, 1986.

For the Commission by the Division of Market Regulations, pursuant to delegate authority.

Dated: March 25, 1986.

John Wheeler,

Secretary.

Exhibit A

American Stock Exchange, Inc. Proposed Rule Change

It is proposed that Section 110 of the Company Guide be amended as follows:[1]

Section 110 Securities of Foreign Companies.—The Exchange recognizes that every corporate entity must operate in accordance with the laws and customary practices of its country of origin or incorporation. Therefore, in evaluating the eligibility for listing of a foreign based entity, the Exchange will consider the laws, customs and practices of the applicant's country of domicile regarding such matters as: (i) The election and composition of the Board of Directors; (ii) the issuance of quarterly earnings statements; (iii) shareholder approval requirements; and (iv) quorum requirements for shareholder meetings.

Since business practices may vary among foreign companies, the following information is presented solely as a guide rather than a set of inflexible rules:

Paragraphs (a) Listing Requirements, (b) Form of Security and (c) Citizenship Restrictions remain unchanged.

(d) Disclosure.—The Exchange will require the company to: (i) Furnish to American shareholders an English language version of its annual financial statements and all other materials regularly provided to other shareholders, and (ii) publish, at least semi-annually, an English version of its interim financial statements.

(e) Form of Listing Application.—Sections 220-222.

[FR Doc. 86-6622 Filed 3-31-86; 8:45am]

BILLING CODE 8010-01-M

[3] This proposed change in the Exchange's quarterly reporting requirement will not alter the company's obligation to comply with the Exchange's timely disclosure policies (Sections 401 to 405 of the Company Guide), nor will it have any effect on the issuer's obligation to make periodic disclosure pursuant to SEC rules.

[1] All added material is italicized, all deleted material is [bracketed].

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Midwest Stock Exchange, Incorporated

March 24, 1986.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f–1 thereunder, for unlisted trading privileges in the following stocks:

Wherehouse Entertainment, Inc.
Common Stock, $.10 Par Value (File No. 8884)
Growth Stock Outlook Trust Inc.
Common Stock, $.10 Par Value (File No. 8885)
Italy Fund, Inc. (The)
Common Stock, $.01 Par Value (File No. 8886)
Sun Energy Partners
Depository Receipt for Limited Partnership (File No. 8887)
L F Rothschild Unterderg Towbin Holdings
Common Stock, $1.00 Par Value (File No. 8888)
California Real Estate Investment Trust
Shares of Beneficial Interest (File No. 8889)
Beneguity Holdings
Units of LTD Partners Interest, No Par Value (File No. 8890)
Weingerten Realty
Common Stock, $.03 Par Value (File No. 8891)
CNW Corporation
$2.125 Cumulative Convertible Exchangeable Preferred (File No. 8892)
Times Mirror Co., (Delaware)
Common Stock, No Par Value (File No. 8893)
Clenfed Inc. (Holding Company)
Common Stock, $.01 Par Value (File No. 8894)

These securities ar listed and registered on one or more other natinal securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before April 14, 1985, written data, views and arguments concerning the above-referenced applications. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, D.C. 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86–7122 Filed 3–31–86; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing; Pacific Stock Exchange, Inc.

March 24, 1986.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to Section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f–1 thereunder, for unlisted trading privileges in the following securities:

Eli Lilly & Company
Warrants to Purchase Common Stock (File No. 7–8882)
Eli Lilly & Company
Contingent Payment Obligation Units (File No. 7–8883)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before April 14, 1986, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, D.C. 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such application is consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86–7121 Filed 3–31–86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. IC–15012; (File No. 812–6012)]

Guaranteed Mortgage Corporation III (Formerly Guaranteed Mortgage Corporation I); Application

March 25, 1986.

Notice is hereby given that Guaranteed Mortgage Corporation III (formerly Guaranteed Mortgage Corporation I) ("Applicant"), 6251 South Ulser Street, Englewood, Colorado 80111, filed an application on December 26, 1984, and amendments thereto on November 5, 1985, February 5, 1986 and March 21, 1986, for an order, pursuant to section 6(c) of the Investment Company Act of 1940 ("Act"), amending an order dated January 11, 1983 (Investment Company Act Release No. 12955, "1983 Order"), to permit Applicant to modify the manner in which it conducts its business. All interested persons are referred to the application on file with the Commission for a complete statement of the representations contained therein, which are summarized below, and to the Act for the relevant provisons thereof.

Applicant, an indirect wholly-owned subsidiary of Pulte Home Corporation, states that it was incorporated for the limited purpose of facilitating the financing of long-term residential mortgage loans. The 1983 Order exempted Applicant from all provisions of the Act to permit it to issue bonds backed by obligations secured by GNMA Certificates (defined below). Applicant now proposes to expand the types of collateral it may use to secure its bonds and to substitute collateral under limited circumstances.

Applicant proposes to issue, in series, collaterialized mortgage bonds (the "bonds"). Each series will be separately secured, primarily by collateral consisting of Mortgages,[1] Private Certificates [2] and/or Federal Certificates [3] representating undivided interests in first-lien residential mortgages (without regard to whether such mortgage certificates represent all or part of a particular pool of mortgages), or Collateralized Obligations,[4] and by one or more

[1] First liens on single (one-to-four) family residences.

[2] An undivided interest in pools of mortgages that are first liens on single (one-to-four) family residences.

[3] Mortgage certificates guaranteed by the Government National Mortgage Association ("GNMA") the Federal National Mortgage Association ("FNMA") or the Federal Home Loan Mortgage Corporation ("FHLMC") ("Federal Certificates").

[4] Collateralized Obligations are notes, bonds or other evidences of indebtedness issued by owners of Mortgages, Private Certificates and Federal Certificates and secured by such Mortgages, Private Certificates and Federal Certificates. Such owners would include, among others, builders and affiliates of builders, savings and loan associations, banks and mortgage bankers, with whom Applicant has agreed respecting the purchase of Collateralized Obligations. Collateralized Obligations are the substantive equivalent of so called "funding agreements" utilized by other applicants.

reserve funds and/or mortgage insurance polices. Mortgages, mortgage certificates or Collateralized Obligations securing each series will be acquired by Applicant using the proceeds of sale of the bonds (or funds provided by its parent companies). Until such bonds are paid, the trustee will not be permitted to release any pledged Mortgages, mortgage certificates or Collateralized Obligations which are required to collateralize Applicant's bonds. However, Applicant will be permitted to substitute other Mortgages, mortgage certificates or Collateralized Obligations for Mortgages, mortgage certificates or Collateralized Obligations originally pledged as collateral for a series of bonds under the limited circumstances described below.

Applicant states that collateral held by the trustee for each series of bonds will be registered in the name of the trustee for collateral purposes and the trustee will have a first-priority perfected security interest in all the collateral pledged to secure each such series of bonds. Also, collateral security for a series of bonds will not secure any other series of bonds or any other obligations of the Applicant. In addition, all of the collateral for the Collateralized Obligations will be held in trust by the trustee for the series of bonds secured by such Collateralized Obligations.

According to the application, reserve funds required by the rating agencies rating the bonds and other cash held by the trustee from time to time as collateral for bonds (including proceeds of collateral) may only be invested in short-term investments approved for bonds rated in one of the two highest rating categories by the rating agencies rating the bonds ("Eligible Investments"). Eligible Investments must mature prior to the date on which any amount payable out of the proceeds thereof is due and will be paid. Such reserves are small in comparison to the total pool of collateral and earnings on such funds are, absent default, generally released to Applicant on each bond payment date. Unless or until released to Applicant or paid to bondholders all such funds will be maintained with the trustee. Proceeds of the collateral securing a series of bonds will, absent default by FHLMC, FNMA, GNMA or mortgage insurers, as the case may be, be calculated to be sufficient to pay the principal of and interest on the bonds of such series when and as the same become due.

Certain series of bonds or classes within a series may provide for some or all of the payments on the collateral of amounts in excess of current interest payments on bonds to be deposited in a redemption fund or for all proceeds of the collateral (including principal and interest) to be deposited in a proceeds account which the trustee will invest in Eligible Investments. These funds or accounts will be available for redemptions or prepayments of bonds on the next bond payment date on terms specified in each bond offering after payment of all other principal and interest due on such date. The terms of each offering may provide bondholders the right to request redemption of bonds, but only to the extent that payments on the Mortgages, Private Certificates or Federal Certificates are available in the redemption fund for such offering. However, under no circumstances will bondholders be permitted to compel the liquidation of Mortgages, Private Certificates, Federal Certificates, Collateralized Obligations or reserve funds in order to redeem bonds at bondholder request prior to maturity. It is the position of Applicant that such redemption procedures do not create a "redeemable security" within the meaning of that term in the Act.

Applicant represents that its future securities offerings will be limited to bond offerings meeting the following conditions:

(1) Each series of bonds will be registered under the Securities Act of 1933 ("Securities Act"), unless offered in a transaction exempt from registration pursuant to Section 4(2) of the Securities Act.

(2) The bonds will be "mortgage related securities" within the meaning of section 3(a)(41) of the Securities Exchange Act of 1934. However, the mortgage collateral underlying the bonds (and underlying Collateralized Obligations) will be limited to: (i) Mortgages that are first liens on single (one-to-four) family residences ("Mortgages"); (ii) mortgage certificates evidencing an undivided interest in pools of mortgages that are first liens on (one-to-four) family residences ("Private Certificates"); and (iii) mortgage certificates guaranteed by the Government National Mortgage Association ("GNMA"), the Federal National Mortgage Association ("FNMA") or the Federal Home Loan Mortgage Corporation ("FHLMC") ("Federal Certificates") (collectively, "mortgage collateral").

(3) If new mortgage collateral owned by Applicant or pledged pursuant to Collateralized Obligations is substituted, the substitute collateral must: (i) Be of equal or better quality than the collateral replaced; (ii) have similar payment terms and cash flow as the collateral replaced; (iii) be insured or guaranteed to the same extent as the collateral replaced; and (iv) meet the conditions set forth in paragraphs (2), (4) and (6). In addition, new collateral may not be substituted for more than 20% of the aggregate face amount of the Mortgages initially pledged as mortgage collateral or for more than 40% of the aggregate face amount of the mortgage certificates initially pledged as mortgage collateral. New Mortgages may be substituted for Mortgages initially pledged as mortgage collateral only in the event of default, late payments or defect in the collateral being replaced. New Private Certificates may be substituted for Private Certificates initially pledged as mortgage collateral only in the event of default, later payments or defect in the collateral being replaced. In no event would any new mortgage collateral be substituted for any substitute mortgage collateral.[5]

(4) All Mortgages, mortgage certificates, funds, accounts or other collateral securing a series of bonds ("bond collateral") will be held by the trustee or on behalf of the trustee by an independent custodian. The custodian shall not be an affiliate (as the term "affiliate" is defined in Securities Act Rule 405, 17 CFR 230.405) of the Applicant, or of the master servicer or originating lender of any Mortgages that are pledged as mortgage collateral. If there is no master service, no servicer of those Mortgages shall be an affiliate of the custodian. The trustee will be provided with a first priority perfected security or lien interest in and to all bond collateral.

(5) Each series of bonds will be rated in one of the two highest bond rating categories by at least one nationally recognized statistical rating organization that is not affiliated with the Applicant. The bonds will not be considered redeemable securities within the meaning of section 2(a)(32) of the Act.

(6) The master servicer of any Mortgages (including, for purposes of this paragraph, mortgages underlying Private Certificates) that are pledged as mortgage collateral may not be an affiliate of the trustee. If there is no master servicer, no servicer of such Mortgages may be an affiliate of the trustee. Any master servicer and servicer of any such Mortgage will be approved by FNMA or FHLMC as an "eligible seller/servicer" of

[5] New Collateralized Obligations may be substituted for Collateralized Obligations initially pledged only if the substitution of mortgage collateral underlying those instruments would be permitted under this condition.

conventional, residential mortgage loans. The agreement governing the servicing of such Mortgages shall obligate the servicer to provide substantially the same services with respect to those Mortgages as it is then currently required to provide in connection with the servicing of mortgages insured by FHA, guaranteed by VA or eligible for purchase by FNMA or FHLMC.

(7) No less often than annually, an independent public accountant will audit the books and records of Applicant and in addition will report on whether the anticipated payments of principal and interest on the mortgage collateral for each series of bonds continue to be adequate to pay the principal and interest on the bonds in accordance with their terms. Upon completion, copies of the auditor's report(s) will be provided to the trustee.

Substitution of Collateralized Obligations will be used by Applicant in circumstances where it would be desirable or appropriate to substitute underlying mortgage collateral but the issuer of the Collateralized Obligation is unable or unwilling to do so. These circumstances would occur, for example, where defects are discovered in a mortgage certificate that underlies a Collateralized Obligation but the issuer is unable to deliver a new mortgage certificate meeting the prescribed conditions for substitution. Applicant asserts that, in such cases, bondholders would prefer that Applicant replace the defective Collateralized Obligation, rather than jeopardize payments to bondholders.

According to Applicant the public interest served by its activities was recognized and approved by Congress and the Administration through enactment of the Secondary Mortgage Market Enhancement Act of 1984 ("1984 Act"). The goal of this new act is to increase funds available for housing by facilitating participation of the private sector in the secondary market for mortgages. Applicant asserts that the 1984 Act places Applicant's bonds on a more equal basis with direct obligations of governmental housing finance agencies by granting Applicant's bonds the same exemptions from state securities acts and legal investment statutes as are presently available to the United States Government and its agencies. Applicant states that it cannot, however, issue bonds in series which are large enough to compete effectively with such agencies in the capital markets unless it is permitted to issue bonds backed by "partial pool" mortgage certificates.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than April 16, 1986, at 5:30 p.m., do so by submitting a written request setting forth the nature of his interest, the reasons for his request, and the specific issues, if any, of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personally or by mail upon Applicant at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86-7188 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-10-M

Filing of Application To Withdraw from Listing and Registration by MacMillan Bloedel Limited; Common Stock, No Par Value (File No. 1-7902)

March 25, 1986.

The above named issuer has filed an application with the Securities and Exchange Commission pursuant to Section 12(d) of the Securities Exchange Act of 1934 ("Act") and Rule 12d2-2(d) promulgated thereunder, to withdraw the specified security from listing and registration on the New York Stock Exchange, Inc. ("Exchange" or "NYSE").

The reasons alleged in the application for withdrawing this security from listing and registration include the following:

The Board of Directors of the issuer decided to withdraw its shares from listing on the NYSE because in the Board's judgment continuation of the listing is not justified in light of the costs and other potential burdens involved. Further, the issuer states that it is applying to the NYSE for withdrawal of the shares from listing, pursuant to NYSE Rule 500. NYSE Rule 500 states in part that:

"In the absence of special circumstances, a security considered by the Exchange to be eligible for continued listing will not be removed from the list upon request or application of the issuer, unless the proposed withdrawal from listing is approved by the security holders at a meeting at which a substantial percentage of the outstanding amount of the particular security is represented, without objection to the proposed withdrawal from a substantial number of individual holders of the particular security; provided, however, that the Exchange will not oppose delisting action by the issuer of a security listed on the Exchange if

(1) The Exchange shall have denied the listing of an additional amount of such security within the preceding 30 days, and

(2) following such action by the Exchange, delisting has been approved by a majority of the company's directors then in office and the company has notified stockholders, in form satisfactory to the Exchange of the proposed delisting prior to the filing of the delisting application and at least 30 days in advance of the date delisting is affected.

.10 *Minimum requirement*—In applying the provisions of Rule 500, above, relating to approval by security holders, the Exchange, in the absence of special circumstances, will consider approval of the proposed withdrawal from listing by 66⅔% of the outstanding security, together with a failure of 10% of the individual holders thereof to object, as the minimum requirement."

The Commission, by order, dated March 14, 1986, approved the issuer's application for delisting and deregistration of the specified security, effective at the opening of business March 17, 1986. The issuer, however, has scheduled a vote of its stockholders on the question of whether to delist and deregister from the NYSE, in order to comply with the requirements of NYSE Rule 500. Accordingly, the Commission orders *nunc pro tunc* the postponement of the said Commission order, dated March 14, 1986, from the opening of business on March 17, 1986 until such time following the scheduled March 27, 1986 meeting as the Commission will have an opportunity to reconsider the issuer's delisting application following the meeting. The Commission notes that NYSE trading in the specified security shall continue pending resolution of these matters.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86-7186 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 15009; (File No. 812-6266)]

M.D.C. Mortgage Funding Corporation; Mortgage-Backed Securities Application

March 24, 1986.

Notice is hereby given that M.D.C. Mortgage Funding Corporation ("Applicant"), 3600 South Yosemite Street, Suite 900, Denver, CO 80237, filed

an application on December 23, 1985, and amendments thereto on March 7, 21 and 24, 1986, for a Commission order pursuant to section 6(c) of the Investment Company Act of 1940 ("Act"), exempting it from all provisions of the Act in connection with the proposed issuance of mortgage-backed securities. All interested persons are referred to the application on file with the Commission for a statement of the representations contained therein, which are summarized below, and to the Act and the rules thereunder for the text of the applicable provisions.

Applicant states that it is a Delaware corporation organized in October 1985 for the purpose of investing in certain mortgage-backed certificates to be purchased with the proceeds of bonds collateralized by such certificates. Applicant also states that it will not engage in any business or investment activities other than issuing and selling bonds under one or more indentures, acquiring, owning, holding and pledging mortgage certificates, investing cash balances on an interim basis in certain short-term investments and engaging in any activities incidental to and necessary for such purposes. Further, Applicant states that it is a wholly-owned subsidiary of Yosemite Financial, Inc., which is a wholly-owned subsidiary of M.D.C. Holdings, Inc.

According to the application, Applicant proposes to issue and sell bonds ("Bonds") in series ("Series"). Each Series will be issued pursuant to an indenture ("Indenture"), qualified under the Trust Indenture Act of 1939, between Applicant and an independent trustee ("Trustee"). Applicant states that each Series will be secured separately by assignments to the Trustee of any combination of mortgage-backed certificates guaranteed by the Government National Mortgage Association ("GNMA Certificates"), mortgage participation certificates issued by the Federal Home Loan Mortgage Corporation ("FHLMC Certificates") and guaranteed mortgage pass-through securities issued by the Federal National Mortgage Association ("FNMA Certificates"). (As used herein, "Mortgage Certificates" includes GNMA, FHLMC and FNMA Certificates.) Applicant represents that each Series will be registered under the Securities Act of 1933 ("1933 Act") and sold pursuant to a prospectus and prospectus supplement containing all material disclosures required by the terms of the 1933 Act. Applicant represents that it will not issue any Bonds unless they are rated in the highest bond rating category by an unaffiliated nationally recognized rating agency.

Applicant states that the Mortgage Certificates pledged to secure a Series may or may not represent the entire beneficial interest in the related mortgage pools and represents that the collateral securing each Series will serve as collateral only for that Series. Further, Applicant represents that the outstanding principal amount of the Mortgage Certificates securing a Series will be at least equal to the unpaid principal amount of such Series on their issue date.

Applicant also states that each Series will consist of one or more classes ("Classes"), one or more of which may be current-pay Bonds ("Non-Compound Interest Bonds") or compound interest Bonds ("Compound Interest Bonds"). Non-Compound Interest Bonds will bear interest on their outstanding principal balances at the rate established for such Class. A Compound Interest Bond is one on which interest accrues and is added to the principal of such Bond on each related payment date, and regarding which neither interest nor principal is due or payable until the first payment date specified for that Bond. Each Class, whether Non-Compound or Compound, will bear a separate interest rate and stated maturity date.

Applicant represents that the Mortgage Certificates for each Series will be pledged to and held by the Trustee or its nominee who will not be affiliated with Applicant. Until such Bonds are paid, Applicant will not be permitted to release any of the Mortgage Certificates from the lien of the Indenture except as provided below. Applicant also represents that at the time of issuance of a Series, the cash flow guaranteed by GNMA, FHLMC and/or FNMA on the Mortgage Certificates, plus the assumed reinvestment earnings calculated at the maximum permitted rate, together with the other collateral pledged (described below) to secure such Bonds, will be sufficient to pay the principal and interest on the Bonds when due.

Applicant also represents that at least annually an independent public accountant will audit the books and records of Applicant and will report on whether the anticipated payments of principal and interest on the Mortgage Certificates continue to be adequate to pay the principal and interest on the Bonds in accordance with their terms. Upon completion, copies of such report and statement with regard to the scheduled payments on the Mortgage Certificates will be provided to the Trustee.

Applicant states that in the event principal payments on the Bonds are made other than on a monthly basis, the Bonds may provide for mandatory redemptions to the extent that principal payments on the Mortgage Certificates cannot be invested at a rate which will provide sufficient income to pay interest on the Bonds. Applicant also states that the Bonds will not provide for redemption (as defined in the Act) at the option of Bondholders and that except in the event of a default, Bondholders will not be entitled to compel the liquidation of the related pledged Mortgage Certificates.

According to Applicant, the other collateral pledged to secure the Bonds will include a separate collection account ("Collateral Proceeds Account") for each Series and may include a debt service or other reserve fund ("Reserve Fund"), and a graduated principal payment fund ("GPM Fund"). Such GPM Fund would be sufficient to cover any potential cash flow shortfall relating to any Mortgage Certificates which were backed by graduated payment mortgage loans. Any Reserve Fund would consist of cash, a letter of credit or eligible investments. The Collateral Proceeds Account for each series will be established by the Trustee for receipt of all monthly principal and interest distributions on the Mortgage Certificates securing the Series, payments from any GMP Fund, reinvestment income thereon and any initial deposit required by the prospectus supplement. Applicant states that the Trustee is authorized to invest the funds of the Collateral Proceeds Account, the Reserve Fund and any GPM Fund in United States government obligations and certain other eligible investments. Applicant states such investments will mature on or prior to the next payment date for the Series.

Finally, Applicant represents that any substitution of Mortgage Collateral will be of equal or better quality, have similar payment terms and cash flow, and be insured or guaranteed to the same extent as the Mortgage Collateral being replaced. Further, Applicant represents that it will not substitute new collateral for more than 40% of the aggregate face value of the certificates initially pledged as Mortgage Collateral and that no substitution will be made for substituted Mortgage Collateral.

Applicant submits that its activities will promote the public interest by expanding the market for mortgage securities, there by increasing the pool of funds available for mortgage loans and increasing the capacity of mortgage

lenders to meet the housing finance needs of the nation.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than April 18, 1986, at 5:30 p.m., do so by submitting a written request setting forth the nature of his interest, the reasons for his request, and the specific issues, if any, of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personally or by mail upon Applicant(s) at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date, an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86-7120 Filed 3-31-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 15008; (File No. 813-73)]

PaineWebber Executive Investments Fund, L.P. and PaineWebber Incorporated; Employees; Securities Companies Application

March 24, 1986.

Notice is hereby given that PaineWebber Executive Investments Fund, L.P., a Delaware limited partnership (the "Initial Partnership") and PainWebber Incorporated, a Delaware corporation ("PWI") (the Partnership and PWI being sometimes collectively referred to herein as "Applicants"), 1285 Avenue of the Americas, New York, New York 10019, filed an application on December 24, 1985, and an amendment thereto on March 12, 1986, pursuant to sections 6(b) and 6(e) of the Investment Company Act of 1940 ("Act"), for an order exempting the Initial Partnership and all similar partnerships offered to the same class of investors as the limited partner investors in the Initial Partnership (collectively, "Partnerships"), from all provisions of the Act and the rules thereunder or, in the alternative, exempting the Partnerships from each and every provision of the Act and rules thereunder except sections 9, 17 (with certain exceptions), 30 (with certain exceptions), 36 and 37 and all administrative and jurisdictional sections of the Act and the rules thereunder necessary to enforce compliance with the terms of the order as granted. Applicants also request an order, pursuant to section 45(a) of the Act, granting confidential treatment for certain reports to be filed with the Commission. All interested persons are referred to the application on file with the Commission for a statement of the representations contained therein, which are summarized below, and to the Act for the text of the applicable statutory provisions thereof.

Applicants state that the Initial Partnership is the first of a proposed series of investment partnerships that will provide in-house capital growth investment programs enabling certain key employees of Paine Webber Group Inc. and its operating subsidiaries ("Painewebber") to pool their investment resources and to receive the benefit of certain investment opportunities which come to the attention of PaineWebber without the necessity of each investor identifying and analyzing such opportunities. Applicants submit that limitations on the class of persons who may subscribe for, acquire or hold interests in the Partnerships, in conjunction with other characteristics, will qualify each such Partnership as an employees' securities company under section 2(a)(13) of the Act.

According to the application, the limited partnership interests in the Partnerships will be offered only to employees of PaineWebber who are professionals experienced in the investment banking, securities or commodities business, or in administrative, financial, accounting, legal or operational activities related thereto, and who are equipped by experience and education to understand and evaluate the structure, management and plan of the Partnership as compared to other investment opportunities and to evaluate the risks of investing in the Partnerships (the "Eligible Employees"). Applicants expect that of approximately 450 Eligible Employees for the Initial Partnership, all but 20 will (a) have had an individual income in excess of $150,000 in each of the two most recent years and reasonably expect an income in excess of $150,000 in the current year, (b) have been limited partners in an earlier Partnership, or (c) be key employees who, although not meeting the standards set forth in clause (a), have been recently hired or promoted or awarded compensation increases by PaineWebber and, therefore, reasonably expect income in excess of $175,000 in the following year.

Applicants represent that each Partnership will be structurally and operationally similar. Applicants further represent that each Partnership will bear the costs and expenses incurred with the offer and sale of limited partnership interests and in connection with the organization of the Partnership and its general partner. All of the Partnerships will have minimum eligibility rquirements for participants, minimum and maximum contributions, and similar restrictions and allowances with respect to such characteristics as transferability. The management of each of the Partnerships will be vested exclusively in its general partner ("General Partner") which will be an indirect, wholly-owned subsidiary of Paine Webber Group Inc. Applicants state that the directors and officers of the General Partner shall be officers and employees of PWI who are also Eligible Employees. No compensation will be paid to the General Partner or to its directors or officers other than for out-of-pocket expenses as described in the application. Applicants represent that each General Partner shall observe the standards prescribed in sections 9, 36, 37 and 57(f)(3) of the Act.

Applicants state that most investment opportunities will come to the attention of the General Partners by PaineWebber and that the General Partners will rely upon the investigations of such investment opportunities that are conducted for clients of PaineWebber and/or the account of PWI. Applicants seek an exemption from section 17 in order to allow the Partnerships to invest in investment opportunities in tandem with (i) PaineWebber, (ii) investment vehicles organized by PWI ("PW investment vehicles") or (iii) affiliated persons of Paine Webber Group Inc. (as defined in the Act) (individually, a "Co-Investor").

According to the application, joint transactions in which a Partnership could participate might include the following: (1) An investment by one or more Partnerships in a company, partnership or investment vehicle not offered, sponsored or managed by PaineWebber or an affiliate of Paine Webber Group Inc. (a) in which PaineWebber, a PW investment vehicle or an affiliated person of Paine Webber Group Inc. is a participant or plans to become a participant or (b) with respect to which PaineWebber or an affiliate of Paine Webber Group Inc. is entitled to receive placement fees, brokerage commissions or other economic benefits; (2) an investment by one or more Partnerships in any PW investment vehicle; and (3) an investment by one or more Partnerships in which a PW

investment vehicle is a participant or plans to become a participant.

Applicants undertake with respect to the section 17(d) relief requested that (i) investments made concurrently with a Co-Investor will be made by the Partnerships on the same basis as the Co-Investor, (ii) the Board of Directors of the General Partner will determine that any such investment is fair and reasonable to the Partnership, (iii) the amount invested by Co-Investors in all joint investments with a Partnership will be greater than or equal to the amount invested by the Partnership in all such joint investments and (iv) the General Partner will obtain a commitment from each Co-Investor that the Co-Investor will not dispose of its investment in such joint investment without giving sufficient, but not less than one day's, notice to the General Partner so that the Partnership has the opportunity to dispose of its investment in the joint investment prior to or concurrently with and on the same terms as the Co-Investor. Applicants submit that the joint investments will not be made on a basis different from or less advantageous than that of other Co-Investors and are consistent with the provisions, policies and purposes of the Act. Applicants represent that they recognize that any types of transactions otherwise subject to section 17(d) of the Act for which exemptive relief has not been requested would require specific approval by the Commission. In addition, Applicants specifically represent and concede that the General Partner is subject to section 36 of the Act and will, at all times, comply with the requirements of such section and of sections 57(f)(3) and 57(h) of the Act.

Applicants also seek an exemption from section 17(a) of the Act to permit the Partnerships: (1) To purchase from PaineWebber or PW investment vehicles securities or interests in properties previously acquired for the account of PaineWebber or PW investment vehicles and of the type which are consistent with the investment objectives of the Partnerships and (2) to make investments in organizations (i) which PWI and/or the PW investment vehicles already own 5% or more of the voting partner or of employee an affiliated person of Paine Webber Group Inc., (ii) which has as an officer, director, partner or employee of an affiliated person of Paine Webber Group, Inc., (iii) which is directly or indirectly controlled by Paine Webber Group Inc. or (iv) which is otherwise affiliated with a Partnership. If such investment opportunities arise at a time when a Partnership does not have funds to invest or is not able for other reasons to commit funds, Applicants submit that PaineWebber or a PW investment vehicle might "bank" the investment by making such investment and thereafter making a portion of the investment available to a Partnership. The Board of Directors of the General Partner would determine that any such transaction is fair and reasonable to the limited partners involved and no fees in addition to the purchase price would be changed by PaineWebber or the PW investment vehicle.

Applicants wish to permit the Partnerships to invest in money market funds advised or administered by Paine Webber. Applicants also wish to permit the Partnerships to purchase securities underwritten on a principal basis by PWI (including as member of a selling group) on terms at least as favorable as those offered to investors other than affiliated persons of Paine Webber Group Inc., and to participate as a selling securityholder in a public offering that is underwritten on a principal basis by PWI (including as a member of a selling group).

Applicants represent that these section 17(a) transactions will only be effected upon a determination by the Board of Directors of the General Partner that the terms of the transaction are reasonable and fair to the limited partners of the Partnerships involved in the transaction and do not involve overreaching of the Partnerships or their limited partners on the part of any person concerned. Applicants specifically represent and concede that the General Partner will at all times comply with sections 57(f)(3) and 57(h) of the Act and submit that exemptions from section 17(a) as described above are consistent with the policies of the Partnerships and the protection of investors and necessary to promote the basic purpose of the Partnerships.

Applicants seek an exemption from section 17(f) to the extent necessary to permit PWI to act as custodian without a written contract and Rule 17g–1 since Applicants expect that all directors of each General Partner will be affiliated persons of the relevant Partnership. In addition, Applicants request an exemption from section 30 of the Act to the extent necessary to exempt the Partnerships from filing periodic reports with the Commission and to permit the Partnerships to report annually to the limited partners in the manner prescribed by the Partnership Agreement. Applicants further request that any such filings made by the Partnerships with the Commission be afforded confidential treatment under section 45(a) of the Act. Applicants state that each year the Partnerships will send the limited partners audited financial statements and a report setting forth information with respect to each limited partner's allocated share of income, gains, losses, credits and other items for Federal income tax purposes.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than April 17, 1986, at 5:30 p.m., do so by submitting a written request setting forth the nature of his interest, the reasons for his request, and the specific issues, if any, of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personnally or by mail upon Applicant(s) at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date, an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86–7119 Filed 3–31–86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. IC–15016; File No. 812–6303]

Filing of Application and Opportunity for Hearing; Swink & Company, Inc. and Jimmy Dale Swink

March 26, 1986.

Notice is hereby given that Swink & Company, Inc. ("Swink & Co.") and Jimmy Dale Swink ("Swink"), One Spring Plaza, 4th and Spring Streets, Little Rock, Arkansas 72201, filed an Application of February 11, 1986 pursuant to section 9(c) of the Investment Company Act of 1940 (the "Investment Company Act") for a permanent order exempting them from the provisions of sections 9(a)(2) and 9(a)(3) of the Investment Company Act.

Swink states that he is the President of Swink & Co. and is the holder of 100% of its common stock. Swink & Co. states that it is a broker-dealer registered pursuant to the Securities Exchange Act of 1934.

On February 21, 1984, Swink & Co. and Swink (collectively, the "Applicants"), in an action entitled *Securities and Exchange Commission v. Swink & Company, Inc. and Jimmy Dale*

Swink, the United States District Court for the Eastern District of Arkansas entered an Order of Permanent Injunction against the Applicants. The Order enjoined the Applicants from violating net capital, customer protection, recordkeeping and notification provisions of the Securities Exchange Act of 1934. The Applicants consented to the entry of the Order of Permanent Injunction without admitting or denying the allegations of the Commission's complaint.

The Applicants propose to sponsor registered unit investment trusts. But, section 9(a)(2) of the Investment Company Act prohibits persons who, by reason of any misconduct, have been enjoined from engaging in any conduct or practice in connection with activities as a broker-dealer, from serving or acting in the capacity of employee, officer, director, member of an advisory board, investment adviser, or depositor of any registered investment company, or principal underwriter for any registered open-end company, registered unit investment trust, or registered face-amount certificate company. Section 9(a)(3) extends these prohibitions to companies whose affiliated persons are subject to the prohibitions of section 9(a)(2).

Section 9(c) of the Investment Company Act provides that, upon application, the Commission may grant to a person, either unconditionally or on an appropriate temporary or conditional basis, an exemption from the provisions of section 9(a). The applicant must establish that the prohibitions of section 9(a), as applied to such person, are unduly or disproportionately severe or that the conduct of such person has been such as not to make it against the public interest or protection of investors to grant such application.

Applicants submit that the probibitions of section 9(a) of the Investment Company Act, to the extent applicable by virtue of the entry of the Order of Permanent Injunction, would be unduly and disproportionately severe as applied to them. Additionally, Applicants submit that their conduct has been such as not to make it against public interest or protection of investors to grant their Application.

The Applicants make the following representations in support of their submissions:

1. The Commission's injunctive action arose out of net capital and bookkeeping violations which ensued from Swink & Co.'s unsuccessful efforts (resulting from unreliable computer software) to automate its bookkeeping and recordkeeping functions;

2. No one was injured by the actions which gave rise to the Commission's injunctive action and no allegations of investor harm or violations of the antifraud provisions of the federal securities laws were made by the Commission;

3. Swink & Co. and Swink have complied with the Order of Permanent Injunction since its imposition, and have taken action to ensure that their accounting system is functioning properly and that any weaknesses are detected as soon as possible; and

4. Swink & Co. has employed an experienced certified public accountant as its chief financial officer. Entry into its proposed new line of business will not greatly increase bookkeeping and recordkeeping responsibilities.

Notice Is Further Given that any interested person may, not later than May 5, 1986, submit to the Commission a written request for a hearing on the application accompanied by a statement as to the nature of the person's interest, the reasons for such request and the issues, if any, of fact or law proposed to be controverted. Any such request should be addressed: Secretary, Securities and Exchange Commission, Washington, DC 20549. A copy of such request shall be served personally or by mail upon the Applicants at the address stated above. Proof of such service (by affidavit or, in the case of an attorney, by certificate) shall be filed contemporaneously with the request. As provided by Rule O–5 of the Rules and Regulations promulgated under the Investment Company Act, an order disposing of the application herein will be issued as course following said date unless the Commission thereafter orders a hearing upon request or upon the Commission's own motion. Person who request a hearing, or advice as to whether a hearing is ordered, will receive any notices and orders issued in this matter, including the date of the hearing (if ordered) and any postponement thereof.

By the Commission.

John Wheeler,

Secretary.

[FR Doc. 86–7185 Filed 3–31–86; 8:45 am]

BILLING CODE 8010–01–M

Filing of Application To Withdraw from Listing and Registration by Trans World Airlines; Senior Exchangeable Variable Rate Notes due 1994 (File No. 1–7815)

March 25, 1986.

The above named issuer has filed an application with the Securities and Exchange Commission pursuant to section 12(d) of the Securities Exchange Act of 1934 and Rule 12d2–2(d) promulgated thereunder, to withdraw the specified security from listing and registration on the New York Stock Exchange, Inc.

The reasons alleged in the application for withdrawing this security from listing and registration include the following:

Currently, there are only three holders of record of the Notes. Of such record holders, one holds for two persons and one holds for eleven persons. There has been no trading in the Notes for at least the last eight months. There is no requirement in the indenture pursuant to which the Notes were issued to list the Notes on a national securities exchange.

Trans World Airlines views the Notes as not being publicly traded, and, therefore, requests their removal from registration and listing.

Any interested person may, on or before April 15, 1986, submit by letter to the Secretary of the Securities and Exchange Commission, Washington, DC 20549, facts bearing upon whether the application has been made in accordance with the rules of the Exchange and what terms, if any, should be imposed by the Commission for the protection of investors. The Commission, based on the information submitted to it, will issue an order granting the application after the date mentioned above, unless the Commission determines to order a hearing on the matter.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 86–7187 Filed 3–31–86; 8:45 am]

BILLING CODE 8010–01–M

SMALL BUSINESS ADMINISTRATION

Advisory Committee on Veterans Affairs; Reestablishment

Pursuant to the Federal Advisory Committee Act, the U.S. Small Business Administration will reestablish the charter of the Advisory Committee on Veterans Business Affairs to implement Pub. L. 93–237 and Pub. L. 97–72 which mandate that the SBA give special consideration to veterans and establish a loan program for Vietnam-era and

disabled veterans. The Committee will terminate September 30, 1986.

Jean M. Nowak,

Director, Office of Advisory Councils.

March 26, 1986.

[FR Doc. 86-7100 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

Columbus District Advisory Council Meeting

The U.S. Small Business Administration, Region V, located in the geographical area of Columbus, Ohio, will hold a public meeting at 9:30 a.m. on Thursday, April 24, 1986, at the U.S. Federal Courthouse, 85 Marconi Boulevard, Conference Room 220 (Second Floor), Columbus, Ohio 43215 to discuss such matters as may be presented by members, staff of the Small Business Administration and others attending.

For further information, write or call Frank D. Ray, District Director, U.S. Small Business Administration, 85 Marconi Boulevard, Fifth Floor, Columbus, Ohio, 43215, (614) 469-7310.

Jean M. Nowak,

Director, Office of Advisory Councils.

March 21, 1986.

[FR Doc. 86-7087 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

[License No. 04/05-0022]

First North Florida Small Business Investment Co.; Filing of Application for Transfer of Ownership and Control

Notice is hereby given that an application has been filed with the Small Business Administration (SBA) pursuant to § 107.601 of the Regulations governing small business investment companies (13 CFR 107.601 (1985)) for Transfer of Ownership and Control of First North Florida Small Business Investment Company (Licensee), 1400 Gadsden Street, Quincy, Florida 32351, a Federal Licensee under the Small Business Investment Act of 1958 (The Act), as amended (15 U.S.C. 661 *et seq.*).

Pursuant to an agreement dated October 29, 1985, Wetterau Incorporated (Wetterau) acquired 100 percent of the issued and outstanding stock of the Licensee. Wetterau is a Missouri corporation located at 8920 Pershall Road, Hazelwood, Missouri 63042-2809.

The officers and directors of the Licensee will be as follows:

E. Canty Higdon,[1] President and Director

Eldon Greene, Secretary, Treasurer and Director

John B. Higdon, Jr., Director

The Licensee will retain its corporate name and location.

Matters involved in SBA's consideration of the application include the general business reputation and character of the proposed owners and management, and the probability of successful operations of the company under their management, including adequate profitability and financial soundness, in accordance with the Small Business Investment Act of 1958, as amended, and the SBA Rules and Regulations.

Notice is further given that any person may, not later than 30 days from the date of publication of this Notice, submit written comments on the proposed Applicant. Any such communication should be addressed to the Deputy Associate Administrator for Investment, Small Business Administration, 1441 "L" St., NW., Washington, DC. 20416.

A copy of the Notice shall be published in newspapers of general circulation in Quincy, Florida and St. Louis, Missouri.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Dated: March 26, 1986.

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

[FR Doc. 86-7086 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

[1] Previously officers and directors.

[Application No. 04/04-0238]

The Remington Fund, Inc.; Application for License To Operate as a Small Business Investment Company

An application for a license to operate a small business investment company under the provisions of the Small Business Investment Act of 1958, as amended (15 U.S.C. 661, *et seq.*) has been filed by The Remington Fund, Inc. (TRF), 1927 First Avenue North, Birmingham, Alabama 35202, with the Small Business Administration (SBA) pursuant to 13 CFR 107.102 (1986).

The Officers, directors and shareholders of the Applicant are as follows:

Lana E. Sellers, President and Director, 3613 Westbury Road, Birmingham, Alabama 35223

John J. McMahon, Jr., Vice President and Director, 3132 Overhill Road, Birmingham, Alabama 35223

William Ralph Cook, Vice President and Director, 2744 Abingdon Road, Birmingham, Alabama 35223

Morris C. Benners, Jr., Secretary and Director, 3757 North Woodridge Road, Birmingham, Alabama 35223

James R. McWane, Director, 3320 East Briarcliff, Birmingham, Alabama 35223

McWane, Inc.,[1] 80% Shareholder, 23 Inverness Center Parkway, Birmingham, Alabama 35243

National Bank of Commerce of Birmingham,[2] 20% Shareholder, 1927 First Avenue North, Birmingham, Alabama 35202

The Applicant, TRF, an Alabama corporation will begin operations with $1,500,000 paid in capital and surplus. TRF will conduct its activities primarily in the State of Alabama but will consider investments in business in other areas in the United States.

Matters involved in SBA's consideration of the application include the general business reputation and character of the proposed owners and management, and the probability of successful operations of the Applicant under their management, including profitability and financial soundness in accordance with the Small Business Investment Act of 1958, as amended, and the SBA Rules and Regulations.

Notice is further given that any person may, not later than 30 days from the date of publication of this Notice, submit written comments on the proposed applicant.

Any such communication should be addressed to the Deputy Associate Administrator for Investment, Small Business Administration, 1441 "L" Street, NW., Washington, DC 20416.

A copy of the Notice will be published in a newspaper of general circulation in Birmingham, Alabama.

(Catalog of Federal Domestic Assistance Program No. 59.011 Small Business Investment Companies)

Dated: March 26, 1986.

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

[FR Doc. 86-7089 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

[1] Approximately 70% owned by James R. McWane and immediate family.

[2] 100% owned by National Commerce Corporation which is 100% owned by James R. McWane.

[License Application No. 02/02-5496]

Trico Venture, Inc.; Application for a License To Operate as a Small Business Investment Company

An application for a license to operate as a small business investment company (SBIC) under the provisions of section 301(d) of the Small Business Investment Act of 1958, as amended, (the Act), (15

U.S.C. 661 et seq.), has been filed by Trico Venture, Inc., 805 Avenue L, Brooklyn, New York 11230, with the Small Business Administiation (SBA), pursuant to 13 CFR 107.102 (1986).

The officers, directors and shareholders of the Applicant are as follows:

Name and address	Title or relationship	Percent ot owner-ship
Avruhum Donner, 1282 East 10th Street, Brooklyn, New York 11230.	President, Treasurer, Director.	9.00
Saul Wolf, 1520 50th Street, Brooklyn, New York 11215.	Vice President, Director.	45.50
Fay Pinter, 1199 East 8th Street, Brooklyn, New York 11230.	Secretary Director.	45.50

Mr. Donner is also the President, 50 percent shareholder, and a director of another section 301(d) SBIC, Avdon Capital Corporation (License No. 02/02-5456). Section 107.602 of SBA's Regulations governing SBIC's requires SBA's prior written approval when two or more Licensees will have common officers, directors, managers, or a Control Person or a stockholder or partner owning or controlling directly or indirectly ten or more percent of the stock or ownership interest of the Licensees. SBA intends to grant that approval in this instance.

The Applicant, a New York corporation, will begin operations with an initial private capital of $1,000,000, and will operate in the State of New York, primarily Brooklyn.

As an SBIC licensed to operate under section 301(d) of the Act, the Applicant will provide financial and managerial assistance solely to small business concerns which will contribute to a well-balanced national economy by facilitating ownership in such concerns by persons whose participation in the free enterprise system is hampered because of social or economic disadvantages.

Matters involved in SBA's consideration of the Application include the general business reputation and character of the proposed owners and management, and the probability of successful operation of the Applicant under their management, including adequate profitability and financial soundness, in accordance with the Act and the SBA Rules and Regulations.

Notice is hereby given that any person may, not later than 30 days from the date of publication of this notice, submit written comments on the proposed SBIC to the Deputy Associate Administrator for Investment, Small Business Administration, 1441 L Street, NW., Washington, D.C. 20416.

A copy of this notice shall be published in a newspaper of general circulation in Brooklyn, New York.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Dated: March 24, 1986.

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

[FR Doc. 86-7088 Filed 3-31-86; 8:45am]

BILLING CODE 8025-01-M

[License No. 09/09-0365]

VK Capital Co.; Issuance of a Small Business Investment Company License

On December 6, 1985, a notice was published in the **Federal Register** (50 FR 50029) stating that an application has been filed by VK Capital Company, with the Small Business Administration (SBA) pursuant to § 107.102 of the Regulations governing small business investment companies (13 CFR 107.102 (1985)) for a license as a small investment company.

Interested parties were given until close of business January 5, 1986, to submit their comments to SBA. No comments were received.

Notice is hereby given that, pursuant to section 301(c) of the Small Business Investment Act of 1958, as amended, after having considered the application and all other pertinent information, SBA issued License No. 09/09-0365 on February 7, 1986, to VK Capital Company to operate as a small business investment company.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Dated: March 24, 1986.

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

[FR Doc. 86-7084 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

[License No. 09/09-0365]

VK Capital Co.; Filing of an Application for an Exemption Under the Conflict of Interest Regulation

Notice is hereby given that VK Capital Company, 50 California Street, San Francisco, California 94111, a Federal Licensee under the Small Business Investment Act of 1958, as amended, has filed an application with the Small Business Administration (SBA) pursuant to § 107.903 of the Regulations governing small business investment companies (13 CFR 107.903 (1985)) for approval of conflict of interest transactions.

Subject to SBA approval VK Capital Company proposes to invest in Berkeley Quartzlab, Inc., d/b/a Berkeley Glasslab, 1279 Quarry Lane, Pleasanton, California 94566.

The proposed financing is brought within the purview of § 107.903(b) of Regulations because Mr. Bernard M. Goldsmith, a General Partner of VK Capital Company, is a member of the Board of Directors of Berkeley Glasslab, and therefore is considered an Associate of VK Capital Company as defined by § 107.3 of the Regulations.

Notice is hereby given that any interested person may, not later than (15) days from the date of publication of this Notice, submit written comments on the proposed transaction to the Deputy Associate Administrator for Investment, Small Business Administration, 1441 L Street, NW., Washington DC 20416.

A copy of this Notice will be published in a newspaper of general circulation in the Pleasanton, California area.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies).

Dated: March 24, 1986.

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

[FR Doc. 86-7085 Filed 3-31-86; 8:45 am]

BILLING CODE 8025-01-M

DEPARTMENT OF STATE

[Public Notice 959]

Privacy Act of 1974; Systems of Records: Annual Publication

The Privacy Act of 1974 [5 U.S.C. 552a(e)(4)] requires agencies to publish annually in the **Federal Register** a notice of the existence and character of their systems of records. The Department of State last published the full text of its systems of records at 42 FR 49699, September 17, 1977.

A document published at 47 FR 8719, March 1, 1982, further updated the systems of records. Since that time the following new system of records was proposed and adopted: STATE-55, March 29, 1985 (50 FR 12681). For the convenience of the public, this system description is published below.

The full text of the Department of State systems of records also appears in Privacy Act Issuances, 1984 Compilation, Volume II, page 504.

Dated: March 11, 1986.

Donald J. Bouchard,

Assistant Secretary for Administration.

STATE-55

SYSTEM NAME:

Security Access Control Records.

SECURITY CLASSIFICATION:

Unclassified.

SYSTEM LOCATION:

Department of State, 22201 C Street NW., Washington, DC 20520; Department of State domestic annexes, field offices, and missions; United States embassies, consulates, and missions overseas.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Full-time permanent employees of the Department of State; visitors to the Department of State Main Building, to its domestic annexes, field offices, missions, and to United States embassies, consulates, and missions overseas; and all other individuals requiring access to official Department of state premises who have undergone or are undergoing security clearance.

CATEGORIES OF RECORDS IN THE SYSTEM:

For visitors: Name, temporary badge number, host's name, office symbol, room number, and telephone number; for all others: Name, date and place of birth, home address, employer, employer's addrsess, home and office telephone numbers, Social Security Account Number, specific areas and times of authorized accessibility, escort authority, status and level of security clearance, issuing agency and issue date; and for all individuals; date and times of building entrance and exit.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

22 U.S.C. Section 2658; Executive Order 10450; Executive Order 12356; and Section 506(a) of the Federal Records Act of 1950, as amended [44 U.S.C. 3101].

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSE OF SUCH USES:

For routine administrative, managerial, and security purposes by officials on a need-to-know basis in order to: Better track, manage, and control access to buildings and restricted areas under the jurisdiction of the Department of state; to determine the status of individuals entering Department of State premises; and to provide data requisite to investigations and security reports. The principal users of this information outside the Department of State are: Department of Treasury; U.S. Office of Personnel Management; Agency for International Development; U.S. Information Agency; Arms Control and Disarmament Agency; U.S. Secret Service; Immigration and Naturalization Service; Department of Defense; Central Intelligence Agency; Department of Justice; National Security Agency; Drug Enforcement Adminisration; any other Federal, state, or municipal law enforcement agency for law enforcement purposes; any other agency or Department of the Federal Government pursuant to statutory intelligence responsibilities or other lawful purposes; and any other agency or Department of the Executive Branch having oversight or review authority with regard to investigative responsibilities. Also see the "Routine Uses" paragraph of the Prefatory Statment published in the **Federal Register** (42 FR 49699, September 27, 1977).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Hard copy, computer media.

RETRIEVABILITY:

By individual name, badge number, and Social Security Accot Number (for others than visitors), as well as by each "category of record in the system."

SAFEGUARD:

All employees of the Department of State have undergone a background security investigation. All records containing personal information are maintained in secured file cabinets or in restricted areas, access to which is limited to authorized personnel. All records containing personal information on a computerized data base are accessible only through computer media under Department of State jurisdition and placed in restricted area access to which is limited to authorized personnel. Access to computerized files is password-protected and under the direct responsibility of the system manager. The system manager has the capability of printing audit trails of access from the computer media, thereby permitting regular *ad hoc monitoring of computer usage.*

RETENTION AND DISPOSAL:

Computerized information on individuals is maintained for a maximum of three years after date of access. Hard copy computer listings and reports are maintained for a maximum of six months after date of creation.

SYSTEM MANAGER(S) AND ADDRESS:

Chief, Domestic Operations, Office of Security, Department of State, 2201 C Street NW., Washington, D.C. 20520 for Main State Building, domestic annexes, field offices and missions; Security Officers at respective U.S. embassies, consulates, and missions overseas.

NOTIFICATION PROCEDURE:

Individuals who have reason to believe the Security Access Control System might contain records pertaining to them should write to the Information and Privacy Coordinator, Foreign Affairs Information Management Center, Room 1239, Department of State, 2201 C Street NW., Washington, D.C. 20520. The individual must specify that he/she wishes the records of the Security Access Control System to be checked. At a minimum, the individual must include: Date and place of birth; current mailing address and zip code; signature; and date(s) of access to Department of State installations, if possible.

RECORD ACCESS PROCEDURES:

Individuals who wish to gain access to or amend records pertaining to themselves should write to the Information and Privacy Coordinator, Foreign Affairs Information Management Center (address above).

CONTESTING RECORD PROCEDURES:

(See above).

RECORD SOURCE CATEGORIES:

The individual, Department of State Security Records.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. 86-6950 Filed 3-31-86; 8:45 am]

BILLING CODE 4710-24-M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Environmental Impact Statement: Erie County, NY

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an environmental impact statement will be prepared for a proposed highway project in Erie County, New York.

FOR FURTHER INFORMATION CONTACT:

Roger H. Edwards, Director, Facilities Design Division, New York State Department of Transportation, State

Campus, 1220 Washington Avenue, Albany, New York 12232, Telephone: (518) 457–6452.

or

Victor E. Taylor, Division Administrator, Federal Highway Administration, New York Division, Leo W. O'Brien Federal Building, 9th Floor, Clinton Avenue and North Pearl Street, Albany, New York 12207, Telephone: (518) 472–3616.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the New York State Department of Transportation (NYSDOT) will prepare an environmental impact statement (EIS) on a proposal to modify the terminus of the Lockport Expressway (I–990) in Erie County, New York. The widening of Millersport Highway (NY 263) to four lanes between the terminus of the Lockport Expressway and Transit Road (NY 78) will also be considered. The proposed work is considered necessary to improve the terminus of the Lockport Expressway (I–990) with North French Road.

Alternatives under consideration include: (1) Continued maintenance of the existing highway system in the area of the Lockport Expressway (I–990) terminus; (2) low cost operational improvements to the existing highway system; (3) improvements to the existing highway system to include grade separation of North French Road and Millersport Highway (NY 263), and widening of Millersport Highway (NY 263) between North French Road and Transit Road (NY 78); and (4) extension of the Lockport Expressway beyond North French Road to Millersport Highway (NY 263) via either Hopkins Road, Smith Road, or New Road alternatives. Incorporated into and studied with the various build alternative will be design variations of grade and alignment.

Letters describing the proposed action and soliciting comments will be sent to appropriate Federal, State, and local agencies, and to private organizations and citizens who have previously expressed interest in this proposal. Also planned are early coordination and exchanges of information with the public and agencies through public information meetings, direct requests to other agencies to become cooperating agencies, and early notification and solicitation with entities affected by the proposed action through the clearinghouse process. In addition, a public hearing will be held. Public notice will be given of the time and place of the meetings and hearings.

The draft EIS will be available for public and agency review and comment. No formal scoping meeting is planned at this time. To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments and suggestions are invited from all interested parties. Comments or questions concerning this proposed action and the EIS should be directed to the NYSDOT or FHWA at the addresses provided above.

Issued on: March 21, 1986.

Victor E. Taylor,

Division Administrator, Federal Highway Administration, Albany, New York.

[FR Doc. 86–7106 Filed 3–31–86; 8:45 am]

BILLING CODE 4910–22–M

National Highway Traffic Safety Administration

Rulemaking, Research and Enforcement Programs; Public Meeting and Announcement of Technical Meeting on Current, Planned and Prospective Research on Crash Avoidance

AGENCY: National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation.

ACTION: Supplemental notice.

SUMMARY: This supplemental notice announces a public meeting at which NHTSA will answer questions from the public and the industry regarding the agency's rulemaking, research and enforcement programs and at which NHTSA's current, planned and prospective research on crash avoidance will be discussed. The agency also seeks papers and oral presentations from industry and the private sector on crash avoidance research and development. This notice provides additional information about the technical meeting on crash avoidance research.

DATES: The agency's regular, quarterly public meeting relating to the agency's rulemaking, research and enforcement programs will be held on April 15, 1986 beginning at 10:30 a.m.

Requests to make a formal presentation on crash avoidance research must be submitted not later than April 7, 1986, to Robert Nicholson, NRD–50, Office of Crash Avoidance Research, National Highway Traffic Safety Administration, 400 Seventh Street, S.W., Washington, D.C. 20590 (202–755–8753).

The public meeting will be held in Room 2230, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590.

SUPPLEMENTARY INFORMATION: Following the regular, quarterly public meeting on April 15, NHTSA will present a technical meeting to brief interested persons on the status of its crash avoidance research program. The presentations will begin at 1:30 p.m. on the afternoon of the 15th with an introduction to the NHTSA crash avoidance program area and a discussion of the accident data base being developed to help identify crash avoidance problems. An overview of crash avoidance research activities and needs will be presented by an industry representative. The meeting will resume at 9:30 a.m. on Wednesday morning, April 16. NHTSA will make a presentation on the status of its heavy duty vehicle research program, light vehicle dynamics and simulation program, and driver-vehicle interaction program. In the heavy duty vehicle area, the programs to be discussed will be research on vehicle performance during crash avoidance maneuvers and work being conducted in response to Congressionally mandated studies of heavy truck safety. In the light vehicle dynamics area, the programs to be discussed are radar warning device research, and vehicle stability and control. Finally, the NHTSA research in lighting, visibility and vehicle conspicuity will be discussed. At 1:00 p.m. presentations will be made by industry on the status of their crash avoidance programs. Persons interested in making such a presentation should contact Mr. Robert Nicholson (202) 755–8753.

Issued on: March 27, 1986.

Michael M. Finkelstein,

Associate Administrator for Research and Development.

[FR Doc. 86–7127 Filed 3–31–86; 8:45 am]

BILLING CODE 4910–59–M

Research and Special Programs Administration

International Standards on the Transport of Dangerous Goods; Meeting

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Notice of public meeting.

SUMMARY: This notice sets forth the venue and proposed agenda for a public meeting which will review the recent activities of the RSPA relating to the development of international standards for the transport of dangerous goods.

DATE: May 21, 1986, 9:30 a.m. to 1:00 p.m.

ADDRESS: Room 4234, Nassif Building, 400 7th Street, SW., Washington, DC 20509.

FOR FURTHER INFORMATION CONTACT: Edward A. Altemos, International Standards Coordinator, Office of Hazardous Materials Transportation, Department of Transportation, Washington, DC 20509. (202) 426–0656.

SUPPLEMENTARY INFORMATION: Particular topics to be reviewed at this meeting will include:

1. Results of the most recent meetings of the Group of Rapporteurs and the Group of Experts on Explosives of the United Nations Committee of Experts of the Transport of Dangerous Goods.

2. Status of the development of the International Civil Aviation Organization's (ICAO) dangerous goods regulations and results of the tenth meeting of the ICAO Dangerous Goods Panel.

3. Recent decisions of the RID/ADR Joint Meeting with respect to the transport of dangerous goods by rail and road in Europe.

Interested persons are invited to attend and participate in this meeting. Persons planning to attend the meeting are cautioned that this meeting is intended to review the most recent activities and decisions of international organizations governing the transport of dangerous goods. Therefore, it is recommended attendees be familiar with these organizations, their functions and the standards issued by them.

Issued in Washington, DC, on March 25, 1986.

Joseph T. Horning,

Acting Director, Office of Hazardous Materials Transportation.

[FR Doc. 86–7128 Filed 3–31–86; 8:45 am]

BILLING CODE 4910–60–M

DEPARTMENT OF THE TREASURY

Fiscal Service

[Dept. Circ. 570, 1985 Rev., Supp. No. 17]

Surety Companies Acceptable on Federal Bonds; Change of Name to Selective Insurance Company of America

Selected Risks Insurance Company, a New Jersey corporation, has formally changed its name to Selective Insurance Company of America, effective January 1, 1986. The Company was last listed as an acceptable surety on Federal bonds at 50 FR 27130, July 1, 1985.

A Certificate of Authority as an acceptable surety on Federal bonds, dated January 1, 1986, is hereby issued under Sections 9304 to 9308 of Title 31 of the United States Code, to Selective Insurance Company of America, Branchville, New Jersey. This new Certificate replaces the Certificate of Authority issued to the Company under its former name. The underwriting limitation of $11,881,000 established for the Company as of July 1, 1985 remains unchanged until the July 1, 1986 revision is published.

Certificates of Authority expire on June 30, each year, unless revoked sonner. The Certificates are subject to subsequent annual renewal so long as the companies remain qualified (31 CFR Part 223). A list of qualified companies is published annually as of July 1 in the Treasury Department Circular 570, with details as to underwriting limitations, areas in which licensed to transact surety business and other information. Federal bond-approving officers should annotate their reference copies of the Treasury Department Circular 570, 1985 Revision, at page 27130 to reflect this change. Copies of the Circular may be obtained from the Surety Bond Branch, Finance Division, Financial Management Service, Department of the Treasury, Washington, DC 20226, or by calling (202) 634–2351.

Dated: March 26, 1986.

W.E. Douglas,

Commissioner, Financial Management Service.

[FR Doc. 86–7079 Filed 3–31–86; 8:45 am]

BILLING CODE 4810–35–M

Sunshine Act Meetings

Federal Register
Vol. 51, No. 62
Tuesday, April 1, 1986

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

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1

PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

STATUS: Open. The Council also will hold an executive session to discuss pending litigation.

TIME AND DATE: April 9, 1986, 1:00 p.m.; April 10, 1986, 9:00 a.m.

PLACE: Village Red Lion, Missoula, Montana.

MATTERS TO BE CONSIDERED:

- Preliminary Council Action on Wildlife Mitigation for Hungry Horse Dam.
- Staff Presentation of Issue Paper on Hydropower Responsibility for Salmon and Steelhead Losses.
- Staff Briefing on Columbia River Fish and Wildlife Program Data Base.
- Staff Briefing on Columbia River Fish and Wildlife Program Amendment Applications and Process.
- Staff Report on Columbia River Basin Fish and Wildlife Program Measures in Montana.
- Staff Presentation of Issue Paper on Bonneville Power Administration's Conservation/Modernization Program.
- Council Business.

Public comment will follow each item.

FOR FURTHER INFORMATION CONTACT: Ms. Bess Atkins, (503) 222-5161, or toll-free 1-800-222-3355 (Montana, Idaho or Washington) or 1-800-452-2324.

Edward Sheets,

Executive Director.

[FR Doc. 86-7211 Filed 3-28-86; 9:22 am]

BILLING CODE 000-00-M

2

POSTAL SERVICE

(Board of Governors)

The Board of Governors of the United States Postal Service, pursuant to its Bylaws (39 CFR 7.5) and the Government in the Sunshine Act (5 U.S.C. 552b), hereby gives notice that it intends to hold meetings at 1:00 p.m. on Monday, April 7, 1986, in Atlanta, Georgia, and at 8:00 a.m. on Tuesday, April 8, 1986, in the Atlanta Post Office, 3900 Crown Road, Atlanta, Georgia. As indicated in the following paragraph, the April 7 meeting is closed to public observation. The April 8 meeting is open to the public. The Board expects to discuss the matters stated in the agenda which is set forth below. Requests for information about the meeting should be addressed to the Secretary of the Board, David F. Harris, at (202) 268-4800.

By telephone vote on March 7, 14 and 17, 1986, a majority of the Members contacted and voting, the Board voted to close to public observation its meeting scheduled for April 7. (See 51 FR 8742, March 13, 1986 and 51 FR 9750, March 20, 1986.) The meeting will concern consideration of a proposed capital investment for long-life vehicles and proposed temporary third-class domestic mail classification schedule changes—sacking requirement.

Agenda

Monday Session

April 7, 1986—1:00 p.m. (Closed)

1. Consideration of the proposed capital investment for long-life vehicles.
2. Consideration of proposed temporary third-class domestic mail classification schedule changes—sacking requirements.

Tuesday Session

April 8, 1986—8:00 a.m. (Open)

1. Minutes of the Previous Meeting, March 3-4, 1986.
2. Remarks of the Postmaster General.
3. Amendment to the Bylaws of the Board of Governors.
4. Compensation of Officers.
5. Quarterly Report on Financial Performance.
6. Report on Finance Group Programs.
7. Capital Investment: Grand Central Station, New York.
8. Tentative Agenda for May 5-6, 1986, meeting in Washington, DC.

David F. Harris,

Secretary.

Paul J. Kemp,

Alternate Liaison Officer for the U.S. Postal Service.

[FR Doc. 86-7260 Filed 3-28-86; 2:35 pm]

BILLING CODE 7710-12-M

federal register

Tuesday
April 1, 1986

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 405

Medicare and Medicaid; Payment for the Costs of Malpractice Insurance; Interim Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BERC-340-IFC]

Medicare and Medicaid; Payment for the Cost of Malpractice Insurance

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: In this final rule we are adopting an apportionment methodology for determining reasonable cost reimbursement for hospital malpractice insurance costs. The new apportionment policy for hospitals will divide total malpractice insurance premium cost into two components. The "administrative component," which accounts for 8.5 percent of total premium cost, will be included in the General and Administrative cost center and will be apportioned on the basis of the individual hospital's Medicare utilization rate. The "risk component," which comprises 91.5 percent of total cost, will be apportioned on the basis of a formula that takes into account the individual hospital's utilization as well as the national Medicare patient utilization rate and the national Medicare malpractice loss ratio (as adjusted to account for associated claims handling costs). Effectively, the "scaling factor formula" will relate the national utilization rate to the adjusted national loss ratio. As a hospital's own utilization rate exceeds or falls below the national utilization rate, the risk component will be reimbursed on the basis of a "scaling factor" that is more or less than the national Medicare malpractice loss ratio. Different apportionment policies are being adopted for Medicare skilled nursing facilities and for providers of services under the Medicaid and Maternal and Child Health programs. This final rule replaces our current apportionment policy for reimbursement of malpractice insurance costs and is applicable, subject to the rules of reopening and administrative finality, to cost reporting periods beginning on or after July 1, 1979.

DATES: Effective date: These regulations are effective May 1, 1986.

Comment period: Although these regulations are final, comments may be submitted as described in section IV of this preamble. To assure consideration, comments must be received by 5:00 p.m. on May 1, 1986.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-340-IFC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC.; or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BERC-340-IFC. Comments will be available for public inspection as they are received, beginning approximately one week after publication of this document, in Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890); and in Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland on Monday through Friday of each week from 8:00 a.m. to 4:30 p.m. (phone: 301-594-9630).

FOR FURTHER INFORMATION CONTACT:

Paul Trimble, (301) 594-8640, Office of Reimbursement Policy;

or

John Eppinger, (301) 594-5354.

Timothy Greene, (301) 597-5710, Office of Research and Demonstrations;

Charles Waldron, (301) 597-5774, Bureau of Data Management and Strategy.

SUPPLEMENTARY INFORMATION: To assist the reader in reviewing this document, we are providing the Table of Contents below.

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I. Background

For cost reporting periods beginning prior to July 1, 1979, malpractice insurance costs (that is, the amount of money a provider pays to purchase malpractice insurance from an insurance company or contributes to a self-insurance fund) were apportioned to Medicare (title XVIII of the Social Security Act (the Act)) in accordance

with a utilization formula applicable to all costs incurred by providers of health care services. Medicare utilization is measured by patient days for routine areas and by departmental charges for ancillary service departments. The utilization formula, adopted by the Secretary at the outset of the Medicare program (31 FR 14808, November 23, 1966), treated provider overhead expenses as indirect costs, many of which were combined in the administrative and general pool of provider costs. (In the discussion below, we refer to general and administrative (G & A) costs to conform to the terminology commonly used in court opinions.) Malpractice insurance costs were included in the G & A cost center, which in turn was allocated among various revenue-producing cost centers. The revenue-producing cost centers were then apportioned between Medicare and non-Medicare patients on a utilization basis in order to determine Medicare's share of the costs incurred. Thus, for example, if Medicare patients constituted 30 percent of the routine patient-days at a hospital for a given year, Medicare would reimburse the hospital for 30 percent of the portion of G & A costs, including malpractice insurance costs, that were allocated to the inpatient routine area.

The use of utilization as a method of apportionment was predicated on the supposition that, in general, all provider costs in a department apply to all patients in the same relative proportion as the patient's utilization of the services of that department. Thus, while there might be some minor variations, we assumed that "where a particular cost might be allocated disproportionately to or from the [Medicare] program, there will be other costs disproportionately allocated in the other direction which will compensate for the first cost. In this manner, the program is presumed to bear its fair share of the total allowable cost." HEW (Health, Education and Welfare) Intermediary Letter No. 234 (June 2, 1967).

On March 15, 1979, we proposed (44 FR 15744) to discontinue the utilization method of apportioning malpractice insurance costs because we believed that Medicare was paying a disproportionate amount of providers' malpractice insurance costs. This proposal was based partially on a study by a Departmental consultant, Westat, Inc., (Westat Study), which found that malpractice losses paid to, or on behalf of, Medicare patients were significantly less frequent and signicantly less frequent and significantly lower in amount than losses paid for other patient populations. In response to the extraordinary increase in malpractice insurance costs and the disproportionately small amount of paid malpractice claims attributable to Medicare patients, we proposed to remove malpractice insurance costs from the G & A pool and to apportion those costs directly based on a provider's five-year malpractice claims-paid history. (This policy applied only to hospitals and skilled nursing facilities (SNFs). In this discussion, for ease of reference, we use the term "providers" when we need to refer to both types of facilities. Rules for reimbursement of the costs of malpractice insurance for other providers under Medicare are described in applicable cost report instructions contained in the Provider Reimbursement Manual (HCFA Pub. 15–2.).) In the March 15, 1979 document, we proposed that if a provider paid a malpractice claim during its current cost reporting period or during its preceding four cost reporting periods, Medicare would reimburse an amount equal to the ratio of the provider's malpractice insurance losses paid to Medicare patients compared to its total malpractice losses paid to all patients during that five-year period, times total premium cost. We also proposed that providers with no loss experience during the five-year period would be reimbursed in accordance with an actuarial estimate.

After consideration of public comments on the proposed rule, we published a final rule on June 1, 1979 (44 FR 31641). The final rule amended 42 CFR 405.452(b)(1) and was applicable to cost reporting periods beginning on or after July 1, 1979. Those regulations, recodified as 42 CFR 405.452(a)(1)(ii) (48 FR 39811, September 1, 1983) ("the 1979 malpractice rule"), retained the claims-paid formula for providers with malpractice losses but established use of a national ratio for providers with no malpractice losses. If a provider had no malpractice loss experience during the five-year period, Medicare's share of the provider's malpractice insurance costs for the current reporting period was determined on the basis of the national ratio of malpractice losses paid to Medicare patients compared to malpractice losses paid to all patients. The final rule established the national ratio at 5.1 percent.

The 1979 malpractice rule was controversial. It was the subject of numerous lawsuits and was criticized by a number of courts. As a result, we were led to analyze malpractice loss data that were submitted by Medicare hospitals, and we concluded that these data support the underlying premise of the 1979 malpractice rule: that malpractice losses paid to Medicare patients account for a disproportionately small share of total malpractice losses, and therefore a reimbursement formula that more accurately apportions these costs was necessary. However, these data also indicated that the national ratio is higher that the level established in 1979.

For these reasons, we issued a notice of proposed rulemaking ("the NPRM" or "the proposed rule") on June 17, 1985 (50 FR 25178) in which we proposed to amend the 1979 malpractice rule, subject to our rules of administrative finality and reopening (§§ 405.1801, 405.1885, and 405.1877), effective for cost reporting periods beginning on or after July 1, 1979. We proposed to retain the claims-paid formula; however, we invited suggestions for alternative methods. Additionally, we proposed to establish the national Medicare malpractice loss ratio at 11.6 percent for hospitals (based on data accumulated at that time in the Hospital Cost Report Information System (HCRIS) file).

Because we had no data to support an increase in the Medicare national ratio for SNFs, we proposed to retain the 5.1 percent figure for these providers. With respect to malpractice losses attributable to services furnished under the Medicaid (title XIX of the Act) or the Maternal and Child Health programs (title V of the Act), we indicated that we had preliminary data only and were unable to determine whether to propose a change in the national ratio of 7.5 percent applicable to those programs. Therefore, we did not propose a change in the 7.5 percent figure, but we stated that we were continuing to study the issue and invited specific comments and data concerning it.

Finally, we proposed to establish a procedural mechanism for periodically updating the national ratio on the basis of actual cost report data. We proposed to provide for public notice and comments of any proposed changes in the national ratio, in addition to publishing a subsequent notice to issue any new ratio and respond to comments received.

II. Provisions of This Final Rule

During the public comment period, we received 50 comments concerning the proposed rule. In addition, one commenter submitted the 11-volume rulemaking record for the 1979 malpractice rule, which included more than 600 comments. One commenter largely agreed with the proposed rule, but suggested certain clarifications and

changes. The remaining comments on the NPRM were critical of various aspects of the rulemaking. The commenters included hospitals, associations of hospitals, law firms, actuaries, insurance companies, and consultants. In addition, during the comment period we received several requests for data and information under the Freedom of Information Act (5 U.S.C. 552) (FOIA). The (FOIA) requesters used the information and data released to analyze the proposed rule further and to submit four additional extensive and detailed comments. In total, we received 54 pieces of correspondence from the commenters.

We have considered all of the comments and have analyzed the data and arguments submitted by the commenters. We have obtained information from several sources (for example, the National Association of Insurance Commissioners, the Insurance Services Office, and the St. Paul Fire and Marine Insurance Company) and contracted for the service of an actuarial consultant to help in our analysis. As a result of these efforts, we have decided to change our policy for apportioning Medicare's share of hospital malpractice insurance costs. The new Medicare hospital malpractice insurance apportionment requirements are contained in a new § 405.457 of the regulations; the new policy was briefly described above in the Summary section of this preamble, and is explained in detail below.

At this time, we lack sufficient data concerning SNFs to permanently change our Medicare SNF malpractice insurance apportionment policy. Therefore, we are continuing to study this matter. In the interim, we are changing our SNF policy to provide that SNFs include their total malpractice insurance costs in the G&A cost center for apportionment on a utilization basis. The new requirements for reimbursement of SNF malpractice insurance costs are included in new § 405.457.

In addition, we do not have adequate data on which to construct a reimbursement methodology for providers under the Medicaid or Maternal and Child Health programs. We have concluded that this matter should be left to the discretion of the States under current law.

A. Hospitals

1. Overview of the Development of This Final Rule As It Applies To Hospitals

In response to the comments on the proposed rule, we considered further the alternatives discussed in the NPRM and various other alternatives. (See, sections III.F., IV.E., and IV.F., below.) Our analysis of the HCRIS data and of the data underlying a closed-claim study by the National Association of Insurance Commissioners (NAIC), among other data sources, confirmed our determination that hospital malpractice insurance costs must be apportioned on a special basis. Specifically, the HCRIS data showed that there is a greater than three-to-one ratio between the national Medicare patient utilization rate and the national ratio of Medicare paid claims as compared to total paid claims. The NAIC data showed that the average indemnity for patients 65 and older was approximately one-half the average indemnity for patients under 65. (In 1982, approximately 97 percent of the 65 and older population were Medicare Part A beneficiaries while only about 1.5 percent of the under-65 population were Part A beneficiaries. Since these percentage relationships change little over time, use of data based on these two age groups enables us to readily distinguish between Medicare and non-Medicare patients.) The NAIC data showed further that the average defense costs for patients 65 and older were much lower, and that, relative to patient utilization, patients 65 and older submit fewer claims than do younger patients.

Primarily because the relatively aged Medicare patient population are paid fewer and smaller malpractice claims than non-Medicare patients, we concluded that it would be improper to simply include the totality of these costs in the G&A pool for apportionment on a utilization basis. (See, section III.C., below.) However, the criticisms of the 1979 malpractice rule and the proposed rule convinced us of the necessity of revising the claims-paid methodology. Several factors raised by the commenters on the NPRM and in the litigation of the 1979 rule led us to consider a new approach to apportioning hospital malpractice insurance costs. (See, section II.E., below.) Under this approach, which we are adopting in this final rule, total malpractice premium cost is divided into two components, which are apportioned on different bases that reflect Medicare's utilization of the services underlying the subcosts in each of the two components. The "administrative component" accounts for subcosts for services that are used proportionately by Medicare and non-Medicare patients, and thus are properly includable in the G&A pool for apportionment on a utilization basis. The "risk component" reflects subcosts for services that are used at disproportionately low levels by Medicare patients, and thus are properly apportioned on a special basis.

Due to the complexity of the issues raised by the commenters on actuarial and related matters, we retained an actuarial consultant to assist us in the development of an appropriate alternative. The consultant agreed with our determination that a fair and reasonable approach to apportioning malpractice costs was to divide total premium cost into two components that, as described above, reflect Medicare utilization of the underlying services. The consultant also concurred in our determination to apportion the risk components on a special basis and to return the administrative portion to the G&A pool for apportionment on a utilization basis.

The specific technical assistance provided by the consultant fell into three main categories. First, the consultant explained how hospital malpractice insurance policies are established. The consultant also advised how insurance industry premium-setting practices might be related to the apportionment issue addressed in this rulemaking.

Second, the consultant described the specific subcosts that constitute total premium cost. The consultant also advised how total premium cost could be divided, for apportionment policy purposes, into components that reflect Medicare utilization of the services underlying the various subcosts in each component.

Third, the consultant advised how the risk component of total premium cost—the part that reflects subcosts for services that are utilized at disproportionately low levels by Medicare patients—could be apportioned in a fair and reasonable manner. The consultant's specific advice pertained primarily to the adjustment of the national ratio of Medicare malpractice losses to total losses, and to the scaling factor formula that, under this final rule, will be used to scale each hospital's utilization rate in order to account for Medicare's under-utilization of the services that make up the risk component.

2. Division of Premium Into Two Components

Under the methodology that we have adopted for reimbursing Medicare's share of a hospital's malpractice insurance costs, the premium is divided into two components. The "administrative component," which is 8.5 percent of total premium cost, is included in the G&A cost center and is apportioned on the basis of the

hospital's own Medicare utilization rate. The administrative component includes the fixed general overhead expenses of an insurance company (e.g., company overhead costs, underwriting costs, risk management costs, etc.) plus an appropriate share of commissions paid to insurance agents and of premium and payroll taxes. Because these subcosts are, at most, only slightly affected by the frequency and amount of malpractice claims, we believe that Medicare patients and non-Medicare patients use the underlying services at proportionate levels. Thus, these subcosts are properly includable in the administrative component of total premium cost and subject to apportionment on a utilization basis.

The percentage of the premium that makes up the administrative component was determined in the following manner. We determined that the fixed general overhead expenses of the insurer are 7.5 percent of total premium cost. We determined further that commissions are 9.0 percent of the premium and that taxes are 3.0 percent of total cost. However, commissions and taxes—a combined 12 percent of total premium cost—constitute insurer expenses that are properly related to both the administrative component and the risk component of total cost. Thus, in order to calculate the total administrative component, i.e., fixed general overhead expenses plus a share of commissions and taxes that is proportionate to the administrative component, we divided the fixed overhead expense percentage figure by total premium cost minus the percentage figure for commissions and taxes, as follows:

.075 divided by .88 (100%−12%)=.085.

The "risk component" of the premium, which is the remaining 91.5 percent of total premium cost (100% minus the administrative component (8.5%)=91.5%), accounts for insurer expenses that are directly related to insurance risk. The risk component is composed of the subcosts of the premium that are not included in the administrative component. Thus, the risk component includes the remaining share of commissions and taxes that, as explained above, is directly proportionate to the risk component of total premium cost. The risk component also includes an amount set aside for the insurer's anticipated loss experience. Additionally, the risk component includes expenses associated with losses. Expenses associated with losses include two kinds of claims handling costs. Allocated loss adjustment expenses (ALAE) are defense costs related to specific claims. Unallocated loss adjustment expenses (ULAE) are claims department overhead expenses that, while not identifiable to specific claims, are nonetheless related to the risk assumed by the insurer in issuing the policy. (Neither the administrative component nor the risk component includes an amount for profit. We have determined that because, in general, the return on the insurer's financial investment of the premium is sufficient to generate adequate insurer profit, it is not appropriate to include an amount for profit in either component of the premium.)

The subcosts that constitute the risk component of total premium cost are significantly affected by the frequency and amount of malpractice claims. Primarily because Medicare patients have fewer and smaller claims than non-Medicare patients, we have determined that it is necessary to apportion the risk component of total premium cost on the special basis established by this final rule. (See, section III.C., below.) This final rule will apportion the risk component on the basis of a formula that "scales" the individual hospital's own Medicare patient utilization rate in accordance with the national Medicare patient utilization rate and the national Medicare malpractice loss ratio (as adjusted to account for associated claims handling costs). Application of this "scaling factor formula" will result in a "scaling factor" which, when multiplied by 91.5 percent, will determine the hospital's reimbursement for the risk component.

To simplify, the scaling factor results from two main features of the formula. First, the scaling factor formula effectively equates the national Medicare patient utilization rate with the adjusted national Medicare malpractice loss ratio. Second, as the individual hospitals own Medicare patient utilization rate exceeds or falls below the national utilization rate, the scaling factor will be more or less than the adjusted national loss ratio. For example, if a hospital's utilization rate equalled the national utilization rate, then the provider's scaling factor would slightly exceed the adjusted national ratio. In this case, the hospital would be reimbursed for the risk component of its malpractice insurance cost by multiplying 91.5 percent of total premium cost times a scaling factor slightly greater than the adjusted national ratio. (As explained below, the different time lag ("claims tail") between the occurrence of an incident and the closure of a claim for Medicare and non-Medicare patients necessitates use of two different national utilization rates in the scaling factor formula—one that incorporates the claims tail for Medicare patients and one that includes the claims tail for non-Medicare patients. This fact explains why the scaling factor for a hospital with the national Medicare utilization rate slightly exceeds the adjusted national Medicare loss ratio.) A hospital with an above-average utilization rate would have the risk component reimbursed on the basis of a scaling factor greater than the adjusted national ratio. Similarly, for a provider with a below-average utilization rate, a scaling factor lower than the adjusted national ratio would be multiplied by 91.5 percent of total premium cost.

Scaling Factor Values and Medicare's Share of the Risk Component

In the following table, a hospital may find, according to its own Medicare utilization rate, the appropriate scaling factor. (The table is furnished primarily for informational purposes. In determining the scaling factor for a specific hosptial in a given fiscal year, the scaling factor formula will include the hospital's precise Medicare utilization rate for that year.) This factor, derived from the scaling factor formula, is the percentage that is multiplied by 91.5 percent to determine the percentage of total premium cost that Medicare will reimburse for the risk component of total costs. The table also describes Medicare's share of the risk component for a given utilization rate and the corresponding scaling factor.

Hospital medicare utilization rate (percent)	Scaling factor	Medicare share of risk component (percent)
0.00	0.000	0.00
1.00	0.002	0.22
2.00	0.005	0.45
3.00	0.007	0.68
4.00	0.010	0.92
5.00	0.013	1.15
6.00	0.015	1.40
7.00	0.018	1.64
8.00	0.021	1.89
9.00	0.023	2.14
10.00	0.026	2.40
11.00	0.029	2.66
12.00	0.032	2.93
13.00	0.035	3.20
14.00	0.038	3.48
15.00	0.041	3.76
16.00	0.044	4.04
17.00	0.047	4.33
18.00	0.051	4.63
19.00	0.054	4.93
20.00	0.057	5.23
21.00	0.061	5.54
22.00	0.064	5.86
23.00	0.068	6.18
24.00	0.071	6.51
25.00	0.075	6.85
26.00	0.079	7.19
27.00	0.082	7.53
28.00	0.086	7.89
29.00	0.090	8.25
30.00	0.094	8.62

Hospital medicare utilization rate (percent)	Scaling factor	Medicare share of risk component (percent)
31.00	0.098	8.99
32.00	0.102	9.38
33.00	0.107	9.77
34.00	0.111	10.16
35.00	0.116	10.57
36.00	0.120	10.99
37.00	0.125	11.41
38.00	0.129	11.84
39.00	0.134	12.29
40.00	0.139	12.74
41.00	0.144	13.20
42.00	0.149	13.67
43.00	0.155	14.16
44.00	0.160	14.65
45.00	0.166	15.15
46.00	0.171	15.67
47.00	0.177	16.20
48.00	0.183	16.74
49.00	0.189	17.30
50.00	0.195	17.86
51.00	0.202	18.45
52.00	0.208	19.04
53.00	0.215	19.65
54.00	0.222	20.28
55.00	0.229	20.93
56.00	0.236	21.59
57.00	0.243	22.26
58.00	0.251	22.96
59.00	0.259	23.68
60.00	0.267	24.41
61.00	0.275	25.17
62.00	0.284	25.95
63.00	0.292	26.75
64.00	0.301	27.57
65.00	0.311	28.42
66.00	0.320	29.29
67.00	0.330	30.20
68.00	0.340	31.12
69.00	0.351	32.08
70.00	0.361	33.07
71.00	0.373	34.10
72.00	0.384	35.15
73.00	0.396	36.24
74.00	0.408	37.37
75.00	0.421	38.54
76.00	0.434	39.75
77.00	0.448	41.01
78.00	0.462	42.31
79.00	0.477	43.66
80.00	0.492	45.06
81.00	0.508	46.52
82.00	0.525	48.04
83.00	0.542	49.61
84.00	0.560	51.26
85.00	0.579	52.97
86.00	0.598	54.76
87.00	0.619	56.62
88.00	0.640	58.58
89.00	0.662	60.62
90.00	0.686	62.76
91.00	0.710	65.00
92.00	0.736	67.36
93.00	0.763	69.83
94.00	0.792	72.44
95.00	0.822	75.19
96.00	0.853	78.09
97.00	0.887	81.15
98.00	0.922	84.40
99.00	0.960	87.84
100.00	1.000	91.50

a. *The Main Terms of the Scaling Factor Formula.* Before describing the scaling factor formula and illustrating its operation, we will explain each of the main terms of the formula and how they were established.

The "u" term: the individual hospital's own Medicare patient utilization rate.—The "u" term in the scaling factor formula is a function that represents the individual hospital's own Medicare patient utilization rate for the cost reporting period in question. The value of u is based on the ratio of the hospital's total Medicare-covered inpatient days of care to its total inpatient days of care.

The "R" term: the adjusted national Medicare malpractice loss ratio.—The "R" term in the scaling factor formula is a constant that represents the national Medicare malpractice loss ratio, as adjusted to account for associated claims handling costs. As explained above, under the 1979 malpractice rule, providers with no loss experience during the applicable five-year period were reimbursed on the basis of the national ratio of claims paid to Medicare patients as compared to all patients. In the NPRM, we proposed to update and revise the national ratio by increasing it from 5.1 percent to 11.6 percent. This proposal was based on hospital-reported data in the HCRIS file. The HCRIS malpractice claims-paid data is from cost reporting periods ending in 1979 through 1983, along with loss data from cost reporting periods ending in 1978 through 1982. HCRIS currently shows that the national ratio of malpractice losses paid to Medicare patients as compared to all patients is 11.8 percent.

For purposes of inclusion in the scaling factor formula, we have adjusted the national Medicare malpractice loss ratio from 11.8 percent to 13.2 percent in order to account for the claims handling costs—including allocated loss adjustment expenses (ALAE) and unallocated loss adjustment expenses (ULAE)—associated with Medicare claims. Our upward adjustment of the national ratio to account for ALAE is based on hospital-only data derived from the NAIC study. The NAIC data pertaining to average indemnities, average ALAE, and the ratio of average ALAE to average indemnity is as follows:

Patient age	Average indemnity	Average ALAE	Ratio of average ALAE to average indemnity
Under 65	$7,211	$1,649	.229
65 and older	$3,025	$961	.318
Relativity between patient groups	.419	.583	1.389

The NAIC data shows that while the average indemnity for patients 65 and older is 41.9 percent of the average indemnity for patients under 65, the average ALAE for patients 65 and older is 58.3 percent of the average ALAE for patients under 65. Thus, the NAIC data establishes the existence of a relativity of 1.389 between the two groups of patients with respect to the comparative ratio of their average ALAE to their average indemnity. This means that average ALAE does not correlate exactly with the average indemnity. In order to account for the different proportion of the ratio of ALAE to losses for Medicare patients as compared to non-Medicare patients, we have, as explained below, upwardly adjusted the national Medicare malpractice loss ratio to account for this particular relativity.

The NAIC data includes no specific information on ULAE, and none is available from any other source. Insurers typically treat ULAE as a flat percentage (generally about 5 percent) of losses and ALAE. We have determined, however, that ULAE is more highly correlated with the number of claims and other defense costs than with the amount of loss. In order to reflect Medicare's relatively higher non-ALAE claims handling costs per claim, we have also upwardly adjusted the national Medicare malpractice loss ratio to account for ULAE.

As explained above, the NAIC data shows that the ratio of ALAE to losses for Medicare patients is 1.389 times the corresponding ratio for non-Medicare patients. In adjusting the national ratio to account for this relativity, we rounded the comparative ratio of ALAE to losses to 1.4. Furthermore, in the absence of specific data on ULAE, we assumed that the ratio of ULAE to losses plus ALAE for Medicare patients was 1.4 times the corresponding ratio for non-Medicare patients. Thus, we assumed that ULAE was disproportionately incurred by Medicare patients, just as the NAIC data shows that Medicare patients disproportionately incurred ALAE.

Other subcosts of the malpractice insurance premium are normally assumed to be ratios of the final premium, and, as such, tend to vary in proportion to losses. Therefore, we determined that there is no need to adjust the national Medicare malpractice loss ratio to account for subcosts other than ALAE and ULAE.

In order to adjust the national ratio to account for ALAE and ULAE, two computations were made in sequence involving, first, ALAE, and then ULAE.

ALAE

We determined, based on 11 years of data from the St. Paul Insurance Company, that the percentage of ALAE to losses is 42.2 percent. Therefore, losses plus ALAE equal 142.2 percent. However, Medicare patients account for, relative to non-Medicare patients, a different share of losses (11.8 percent versus 88.2 percent for non-Medicare patients) and a different proportion of

ALAE to losses (1.4 times greater than non-Medicare patients).

Therefore:

If:

A = The ratio of ALAE to losses for non-Medicare claims

.118 = The national Medicare malpractice loss ratio

.882 = The national non-Medicare malpractice loss ratio

.422 = The ratio of total ALAE to total losses

1.4 = The relativity of the ratio of Medicare ALAE to Medicare losses as compared to the ratio of non-Medicare ALAE to non-Medicare losses

Then:

$[.118x(1+1.4A)]+[.882x(1+A)]=1.422$

$.118+.1652A+.882+.882A=1.422$

$1.0472A=.422$

$A=.403$

And:

	Non-normal	Normalized (based on a percentage of 1.422)
$.118x[1+(1.4x.403)]$ =	.185	.130
$.882x(1+.403)$ =	1.237	.870
Total	1.422	1.000

Thus, to take into account ALAE, the national ratio of .118 is increased to .130.

ULAE

Because ULAE is generally assumed to be 5 percent of losses plus ALAE, losses plus ALAE plus ULAE equal 105 percent. As with ALAE, however, Medicare has both a different share of losses and a different proportion of ULAE to losses plus ALAE.

Therefore:

If:

Y = The ratio of ULAE to losses plus ALAE for non-Medicare claims

.130 = The ratio of Medicare losses plus ALAE to total losses and ALAE (from above)

.870 = The ratio of non-Medicare losses plus ALAE to total losses plus ALAE (from above)

.050 = The ratio of ULAE to total losses plus ALAE.

1.4 = The relativity of the ratio of Medicare ULAE to Medicare losses plus ALAE as compared to the ratio of non-Medicare ULAE to non-Medicare losses plus ALAE.

Then:

$[.130\times(1+1.4Y)]+(.870\times(1+Y)]=1.050$

$.130+.182Y+.870+.870Y=1.050$

$1.052Y=.050$

$Y=.048$

And:

	Non-Normal	Normalized (based on a percentage of 1.05)
$.130\times[1+(1.4\times.048)]$ =	.139	.132
$.870\times(1+.048)$ =	.912	.868
Total	1.051	1.000

Thus, to take into account ULAE, the national ratio of .130 (as factored for ALAE) is increased to .132.

The "U_1" and "U_2" terms: the national Medicare hospital utilization rate, as adjusted for the different "claims tail" for Medicare patients and non-Medicare patients, respectively.— The "U_1" term in the scaling factor formula is a constant that represents the national Medicare hospital utilization rate for the cost reporting periods that are properly related to the periods on which the adjusted national Medicare malpractice loss ratio is based. In deriving the value of the U_1 term, we recognized that there is a time lag ("claims tail") between the occurrence of an incident and the closure of the claim arising from the incident. The HCRIS–derived national Medicare malpractice loss ratio is based on malpractice loss data for cost reporting periods ending in 1979 to 1983, in addition to loss data for cost reporting periods ending in 1978 to 1982. It was necessary to relate the national loss ratio to incidents and Medicare utilization rates for the five-year period that reflects the claims tail for Medicare patients for the losses contained in HCRIS.

Our analysis of the data underlying the NAIC study indicates that, for claimants 65 and over, the average time lag between incident and claim closure is 17 months—approximately a year and a half. For two reasons, we have based the U_1 term on the weighted average utilization figures for the five-year period from January 1, 1977 through December 31, 1981 and for the five-year period from January 1, 1978 through December 31, 1982. First, because the HCRIS malpractice loss data is for cost reporting periods ending from 1979 to 1983, along with HCRIS loss data for periods ending from 1978 to 1982, it is necessary to consider utilization data for the five-year period ending December 31, 1981, in addition to the December 31, 1982 five-year period. In this way, the U_1 term will take into account the claims tail that corresponds to the two five-year periods of HCRIS loss data.

Second, because Medicare utilization data is available on only a calendar year basis, it was not possible to base the U_1 term on five-year periods extending from mid 1977 through mid-1982 and from mid-1976 through mid-1981.

By year, Medicare utilization data (from the February 15, 1985 "Budget Briefing Book" for fiscal year 1986 prepared by HCFA's Bureau of Data Management and Strategy) and non-Medicare utilization data (from the American Hospital Association's annual report, *Hospital Statistics*, (1974 to 1984 editions), are as follows (all amounts are in millions):

Period	Days of Total Hospitalization Utilization	Days of Medicare Hospital Utilization	Medicare Utilization Ratio
1976	261	94.2	.361
1977	261	96.4	.369
1978	262	99.1	.378
1979	265	102.0	.385
1980	273	107.8	.395
1981	278	109.7	.395
1982	278	111.7	.402
1983	273	109.3	.400
1978–82	1,356	530.3	.3911
1977–81	1,339	515.0	.3846
1976–80	1,322	499.5	.3778

The average Medicare utilization rate for the five-year period ending December 31, 1982 is .3911. The average utilization rate for the five year period ending December 31, 1981 is .3846. The combined arithmetic average of the rates for these two five-year periods is .388. Thus, we have determined that, for purposes of the scaling factor formula, the value of the U_1 term is 38.8 percent.

Like the "U_1" term, the "U_2" term in the scaling factor formula is a constant that represents the national Medicare hospital utilization rate for the cost reporting periods that are properly related to the periods on which the adjusted national Medicare malpractice loss ratio is based. The difference between the U_1 and U_2, terms is that the latter is based on utilization data that takes account of the claims tail for non-Medicare patients, which is approximately one year longer than for Medicare patients.

Our only measure of non-Medicare patient utilization is derivative of our Medicare patient utilization data. As explained below, this fact is reflected in the scaling factor formula where the non-Medicare utilization rate is derived by subtracting the Medicare utilization rate from 1. However, the NAIC data shows that the claims tail for non-Medicare patients is longer than the lag period for Medicare patients—31 months as compared to 17 months. Thus, it was

necessary to introduce the U_2 term into the scaling factor formula in order to relate the national loss ratio to incidents and Medicare utilization rates for the five-year period that reflect the longer claims tail for non-Medicare patients. Once established, the U_2 term enables us to derive, part of the scaling factor formula, the non-Medicare hospital utilization rate.

We established the value of the U_2 term in the same way that we determined the value of the U_1 term. Because the claims tail for non-Medicare patients is approximately one year longer than the lag period for Medicare patients, the U_2 term is based on the weighted average utilization figures for the five-year period from January 1, 1976 through December 31, 1980 and for the five-year period from January 1, 1977 through December 31, 1981. As explained above, the average Medicare utilization rate for the five-year period ending December 31, 1981 is .3846. The average Medicare utilization rate for the five-year period ending December 31, 1980 is .3778. The combined arithmetic average of the rates for these two five-year periods is .381. Thus, for purposes of the scaling factor formula, we have set the value of the U_2 term at 38.1 percent.

b. *The Scaling Factor Formula.* As described above, this final rule apportions the risk component of total premium cost through the use of the scaling factor formula. Application of the formula results in a scaling factor that is multiplied by 91.5 percent of total premium cost in order to determine Medicare reimbursement of the risk component. Effectively, the scaling factor formula equates the adjusted national Medicare malpractice loss ratio (i.e., R=13.2 percent) to the national Medicare patient utilization rate. As the individual hospital's own current Medicare patient utilization rate (i.e., the u term in the formula) exceeds or falls below the adjusted national ratio, the scaling factor will be more or less than 13.2 percent and Medicare's share of the risk component will change accordingly.

The formula determines the scaling factor by comparing the average Medicare risk level with the average risk level of all patients. Specifically, an individual hospital's own scaling factor is obtained by dividing its own average Medicare risk level by the sum of its own average Medicare risk level and its own average non-Medicare risk level. The scaling factor formula that is used in determining Medicare's share of the risk component reads as follows:

$$\frac{u \times (R/U_1)}{[u \times (R/U_1)] + [(1 - u) \times (1 - R)/(1 - U_2)]}$$

U_1 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for Medicare patients.

U_2 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for non-Medicare patients.

R = The national Medicare malpractice loss ratio, as adjusted for associated claims handling expense.

u = The hospital's own Medicare utilization rate for the cost reporting period based on a ratio of the hospital's total Medicare-covered inpatient days of care to its total inpatient days of care.

R/U_1 = The national Medicare malpractice loss ratio compared to the national Medicare utilization rate.

$(1-R)/(1/U_2)$ = The national non-Medicare malpractice loss ratio compared to the national non-Medicare utilization rate.

The scaling factor formula consists of two main parts, as follows:

Part one—The hospital's own Medicare utilization rate (u) is multiplied by the quotient of the adjusted national Medicare malpractice loss ratio (R) divided by the national Medicare utilization rate (U_1).

Part two— The product that was derived in part one is divided by the sum of:

(a) The hospital's own Medicare utilization rate (u) multiplied by the quotient of the adjusted national Medicare malpractice loss ratio (R) divided by the national Medicare utilization rate (U_1); and

(b) The product of the hospital's own non-Medicare utilization rate (1–u) multiplied by the quotient of the national non-Medicare malpractice loss ratio (1–R) divided by the national non-Medicare utilization rate (1 U_2).

Example: Apportionment of the malpractice insurance costs of a hospital that averages 75 percent Medicare utilization during the applicable cost reporting period is calculated as follows:

Step one.— The administrative component of the premium (8.5 percent) is included in the G&A cost center and is apportioned on a utilization basis. Thus, the hospital would be reimbursed approximately .085 times .75, or 6.38 percent of its premium, for the administrative component. (This figure would vary slightly depending on the hospital's own Medicare utilization in each of its patient care departments.)

Step two—The risk component of the premium (91.5 percent) is apportioned in accordance with the scaling factor formula, as follows:

$$\frac{.75 \times (.132 / .388)}{[.75 \times (.132/.388)] + [(1 - .75) \times (1 - .132)/(1 - .381)]} = .421$$

Thus, the hospital would be reimbursed .915 times .421, or 38.54 percent of its premium for the risk component. Thus, in this example, Medicare reimbursement would account for 6.38 percent plus 38.54 percent, or 44.92 percent of this hospital's total malpractice insurance premium. In the impact analysis section of the preamble, there is a table that describes the percentage reimbursement of malpractice insurance costs in increments of Medicare utilization from 0 percent through 100 percent.

3. Updating of Factors Affecting Malpractice Insurance Cost Reimbursement

This final rule provides that, based on actual cost report data, HCFA will periodically calculate the adjusted national ratio of malpractice losses paid to Medicare beneficiaries to malpractice losses paid to all patients and the national average Medicare patient utilization rate. From time to time, as changes in these factors might be warranted, HCFA will publish a notice in the **Federal Register** describing proposed changes for public comment. In a subsequent **Federal Register** notice, HCFA will issue any changes necessary and respond to comments received.

4. Allowable Uninsured Malpractice Losses and Related Direct Costs Incurred by Hospitals.

In this final rule, we are retaining for hospitals in new § 405.457(b)(6) the provision from the current regulations pertaining to allowable uninsured malpractice losses. If a hospital pays allowable uninsured malpractice losses to or on behalf of Medicare beneficiaries in order to comply with deductible or coinsurance provisions of its malpractice insurance policy, as a result of an award in excess of reasonable coverage limits, or as a governmental provider, those losses and related direct costs may be directly assigned to Medicare for reimbursement.

B. SNFs

We have so far been unable to develop data that are sufficient for determining the most appropriate apportionment method for allowable malpractice insurance costs for SNFs under Medicare. Therefore, we have decided to allow SNFs to include their

total allowable malpractice insurance costs in the G & A cost center, so that these costs will be apportioned on the basis of the SNFs' Medicare utilization. Meanwhile, we will continue to study this issue and to seek additional sources of data. In the future, we will take action as appropriate based on the information we gather.

C. Medicaid

In the preamble of the proposed rule, we indicated that we would continue to seek data that would be appropriate for Medicaid. Hospitals have not always separately shown Medicaid malpractice insurance costs and patient statistics in the Medicare cost report. Subsequent to publication of the proposed rule, we surveyed hospitals to obtain additional data. However, we still do not have adequate data that would support a methodology for Medicaid that is comparable to that which we are adopting for Medicare under this final rule. While we were able to determine the ratio of Medicaid losses to total losses, our data are not sufficient with respect to Medicaid utilization based on patient days. We have only 1,626 hospital cost reports (out of more than 5,000 hospital cost reports contained in the HCRIS data base) showing Medicaid patient-day statistics. Also, our limited patient-day statistics do not correlate to the proper time periods for the ratio of Medicaid losses to total losses.

Accordingly, we are not attempting to provide a Medicaid apportionment methodology for malpractice insurance costs. In light of the absence of data sufficient to establish a Medicaid apportionment methodology similar to the Medicare hospital policy we are adopting, we believe that states should, within the flexibility allowed under section 1902(a)(30) of the Act, use whatever methodology they find to be most appropriate.

D. The Maternal and Child Health Program

The Maternal and Child Health program generally uses the same method of apportionment as Medicaid. Because of the problems with the Medicaid data mentioned above, we are unable to determine the most appropriate apportionment method for the cost of malpractice insurance under this program. Therefore, we will not attempt to establish a malpractice apportionment methodology for the program but defer instead to the states for appropriate action.

E. This Final Rule Addresses the Major Criticisms of the 1979 Malpractice Rule and the June 1985 Proposed Rule

In the response to comments and the impact analysis sections of this preamble (sections III and IV below, respectively), we specifically address the major criticisms of the 1979 malpractice rule raised in connection with the litigation, along with the criticisms made by the public of the June 1985 proposed rule. The major criticisms, along with the pertinent part of the preamble in which they are discussed, are summarized as follows:

- There is allegedly no rational basis for removing malpractice insurance costs from the G & A pool and for discontinuing the utilization method of apportioning those costs. See, section III.C.
- Neither the 1979 malpractice rule nor the June 1985 proposed rule accounts for malpractice insurance expenses other than claims loss. Thus, some hospitals have stated that they are denied reimbursement for indirect costs of caring for Medicare beneficiaries. See, section III.D.
- Malpractice insurance is a necessary cost of doing business. Therefore, Medicare reimbursement should not be based on a provider's loss experience and claimant identity. See, section III.D.
- Medicare reimbursement for malpractice costs based on loss experience over five-year periods yields allegedly bizarre reimbursement results that are not equitable, especially since the prospective payment system has replaced the cost-based reimbursement system. See, sections III.D. and III.G.
- To the extent that the national Medicare malpractice loss ratio is based on the Westat Study, the ratio has no rational basis. See, sections III.B. and III.E.

As discussed in detail in the referenced portions of this preamble, this final rule accommodates the commenters' concerns and eliminates the bases for these criticisms.

F. Application and Implementation of This Final Rule

This final rule applies to cost reporting periods of Medicare hospitals and SNFs beginning on or after July 1, 1979, subject to the rules of administrative finality and reopening. It is effective beginning on or after May 1, 1986. The intermediary will automatically calculate reimbursement amounts for all open cost reports, including the cost reports for which the provider has timely appealed its reimbursement for malpractice insurance costs to the intermediary or the Provider Reimbursement Review Board (PRRB) in accordance with 42 CFR Part 405, Subpart R, of the Medicare regulations and that appeal is still pending. Within the reopening period specified in the regulations (that is, three years from the date of the NPR or last review decision), a provider may also request that a cost report determination be reopened for recalculation under this final rule. The Medicare statute and regulations require providers to furnish the intermediary with all reports and data it may require to recompute the affected cost reports.

In order to ensure that no provider will be disadvantaged by the retroactive application of this final rule, the intermediaries will not make adjustments under this rule to cost reports for cost reporting periods beginning prior to May 1, 1986, if such adjustments would result in less reimbursement to the provider for malpractice insurance costs than the amount payable under the 1979 malpractice rule.

With respect to the hospital-specific portion of the payment rates under the prospective payment system (PPS), adjustments to base year costs to take into account any additional reimbursement a hospital may receive under this final rule will be made for PPS reporting periods beginning on or after May 1, 1986. See, 42 CFR 412.72. (50 FR 12740, March 29, 1985); 49 FR 251 (Jan. 3, 1984). The "federal" portion of the PPS payment rate for a hospital will not be altered as part of this final rule. However, as part of our upcoming overall review of the PPS rate levels, we will consider the extent to which adjustments may be appropriate as a result of this revised policy.

III. Response to Public Comment

A. The Necessity of Reconsideration and Revision of the Current Policy

Comment: The notice of proposed rulemaking (NPRM) was published solely because the Department was concerned that adverse court decisions left at risk the current malpractice insurance apportionment policy.

Response: We reconsidered our current policy in response to the litigation challenging that policy, and in order to reassess the validity of the policy. As explained in the NPRM and in our response to comments (see, section III.C., below), our reconsideration of current policy has confirmed our determination, made originally in 1979, that malpractice insurance costs should not be apportioned strictly on a

utilization basis because Medicare patients file and are paid a disproportionately small share of malpractice claims. While we remain convinced that malpractice loss experience is a sound basis for apportioning most of total premium cost, our reexamination of current policy—including our consideration of comments received on the NPRM—has led to a change in that policy. Under this final rule, the administrative component of total premium cost will be returned to the G&A pool and apportioned on a utilization basis. The predominant risk element will be apportioned on the basis of the individual provider's Medicare patient utilization rate, as scaled in accordance with the adjusted national ratio. (*See*, section II.A., above.) The result is an improved malpractice insurance apportionment policy that satisfies the requirements of section 1861(v)(1)(A) of the Act and that responds to the major concerns raised about our current policy. (See, section III.G., below, and section II.E., above.) Under this rule many hospitals will receive significantly greater reimbursement for malpractice insurance costs than they would have received under the 1979 malpractice rule. Since this final rule will change, improve, and supplant current policy, our reasons for undertaking this rulemaking clearly extend beyond improving our litigative position with respect to the 1979 malpractice rule.

Comment: A new rulemaking is premature; reconsideration of current policy should await final resolution in the courts of the validity of the 1979 malpractice rule.

Response: There is ample precedent for revising an administrative policy in the midst of litigation concerning that policy. While it is indisputably the function of the courts to adjudicate the validity of the 1979 malpractice rule, the Secretary has a continuing responsibility to administer the Medicare program in an efficient manner that comports with applicable statutory requirements and to change policies as the need arises. Revision of our current apportionment policy was necessitated by numerous court decisions that invalidated the 1979 malpractice rule. Although the courts imposed relief in the particular cases for which decisions were rendered, it is the Secretary's duty to adopt programmatic policy changes that are responsive to these court decisions. As explained above (see, section II.E.), this final rule responds to the major criticisms of our current policy that were made by the courts and by the commenters on the NPRM.

If we were to forego reconsideration of current policy until the validity of the 1979 malpractice rule were finally decided by the courts, then there likely would be inconsistent and unfair reimbursement results among different providers. For example, a provider might receive, for a given cost reporting period, a judgment invalidating the 1979 malpractice rule and mandating reimbursement on a utilization basis. Yet the Secretary has determined that Medicare beneficiaries use a disproportionately small share of premium cost and that application of the utilization method to these costs is contrary to section 1861(v)(1)(A) of the Act. Thus, providers paid on this basis would receive a windfall. By contrast, once this final rule becomes effective, most providers will be subject to the new apportionment policy, which, we are confident, satisfies all statutory requirements. The Secretary is obliged to ensure that all providers are reimbursed in accordance with a formula meeting all statutory requirements, and to see that providers do not receive excess reimbursement. These results can be achieved by completing this rulemaking as expeditiously as possible.

Comment: The rulemaking is a "sham" because the proposed rule diverges little from the 1979 malpractice rule. Also, restricting retroactive application of the new rule to providers whose premium costs are on appeal or subject to reopening, combined with the limited adjustments to be allowed to the prospective payment system (PPS) rates, means that providers will receive little more reimbursement under the new rule than under the 1979 malpractice rule.

Response: We believe that there is no sound basis for characterizing this rulemaking as a sham. First, the proposed rule differed importantly from the 1979 rule. The proposed rule would have updated the national ratio, applicable to providers with no loss experience during the five year period, and established a procedural mechanism for periodically revising the national ratio. The proposed rule was based primarily on the new reliable HCRIS data. The preamble to the NPRM also specified how the proposed rule would be implemented retroactively and how it might affect a hospital's PPS rates.

Second, in this final rule, we have fully responded to the major concerns raised in comments on the NPRM. Instead of apportioning premium cost solely on a claims-paid basis, the final rule introduces each hospital's own utilization rate into the apportionment methodology. The administrative component of malpractice premium cost will be returned to the G&A pool and apportioned entirely on a utilization basis. The predominant risk component will be apportioned on the basis of the individual provider's patient utilization rate, as scaled in accordance with the adjusted national ratio.

Third, while the results of a rulemaking are obviously important so is the process by which an agency develops a proposal, considers and responds to public comments, and adopts a final rule. In this case, the new rule is based on empirical data different from that upon which the 1979 malpractice rule was based. (*See*, section III.B., below.) Also, the new rule is the result of agency consideration of comments received on the 1985 NPRM, in addition to those submitted in 1979. As explained above (*see*, section II.E.), this final rule responds directly to the main criticisms of the proposed rule.

Finally, while we do not agree that the genuineness or validity of a rulemaking should be judged on the basis of its fiscal impact, this final rule is, in fact, more costly than any alternative considered other than returning to the utilization method. (*See*, section IV.F., below.) Discussions of the fiscal impact of the proposed and final rules and the other alternatives considered were included in the impact analysis section of the NPRM and this final rule. Many providers will receive considerably more reimbursement under the new rule than under the 1979 malpractice rule. (*See*, section IV.B., below.) Hospitals will receive utilization based reimbursement for the administrative part of total premium cost. Since the predominant risk element will be partially reimbursed on the basis of each hospital's utilization rate, hospitals will also receive reimbursement for the risk part of total malpractice insurance cost.

Comment: The rulemaking is an unconstitutional attempt by the executive branch to usurp the powers of the judiciary. Several courts, upon finding invalid the current malpractice rule, have mandated as relief reimbursement on a utilization basis in lieu of allowing the Secretary to undertake suitable corrective action (including the possibility of new rulemaking).

Response: Once this final rule becomes effective, "reasonable cost" reimbursement determinations for malpractice insurance costs incurred in periods beginning on or after July 1,

1979, will be, for the most part, based on the provisions of this regulation. This rulemaking does not detract from the powers of the judiciary to consider hospitals' claims for reimbursement in excess of the amounts allowed by this regulation. Instead, this new rule attempts to eliminate the shortcomings of the 1979 malpractice rule that were found by the courts, and to adopt an apportionment policy that satisfies the concerns of those courts. Rather than "usurping the powers of the judiciary," this final rule acknowledges the views expressed by the courts and others, and establishes a policy that will withstand judicial scrutiny.

Comment: The public was not given a meaningful opportunity to comment on the proposed rule because timely access to the documents relied on in the development of the proposal was denied.

Response: Several commenters made requests under the Freedom of Information Act (FOIA) for materials relied on in the development of the proposed rule. The main new information relied on by the agency was data from Medicare's Hospital Cost Report Information System (HCRIS). On July 22, 1985, computer tapes, record layouts, and sample printouts from the parts of the HCRIS data base relied on in the development of the proposed rule were released to the FOIA requesters that sought this information. On July 26, 1985, all the records releasable under the FOIA were sent to all of the FOIA requesters. The requesters were advised that comments on the NPRM concerning matter raised in the material released under the FOIA would be considered through August 16, 1985. Since nearly one month elapsed between the release of the central HCRIS information and the extension given to FOIA requesters, these commenters clearly had ample opportunity to consider and comment meaningfully on the proposed rule. The detailed and sophisticated comments submitted on the proposal by these commenters, e.g., the multifaceted analyses performed on the HCRIS data tapes, show that they had a more than adequate opportunity to comment. Since the remaining commenters did not request the materials relied on in the development of the proposed rule, we can only assume that the 45-day comment period was adequate for their purposes. In light of the fact that we were reconsidering a longstanding and oft-litigated policy, these commenters apparently concluded that they had information sufficient to comment meaningfully on the proposal.

Comment: The public was denied a meaningful opportunity to comment on the Department's use of the HCRIS data because information describing, for example, the agency's study methodology, underlying assumptions, and justifications for such assumptions was not made available.

Response: The manner in which the HCRIS data were used in the development of the proposed rule was described in the NPRM and is elucidated further in our response to comments. (*See*, section III.B., below.) As explained above, the pertinent data tapes and all documents concerning our use of the HCRIS data were made available in time to provide ample opportunity for public comment. Upon request, HCFA even made available the services of its analysts to answer questions pertaining to the use of the HCRIS computer tapes. Apparently, some commenters wanted us to create documents explaining our use of HCRIS, in addition to the HCRIS records that were actually relied on by the agency. Neither the APA nor the FOIA require us to create records beyond those that were actually relied on in this rulemaking.

Comment: Providers should be reimbursed their malpractice insurance costs on a utilization basis in order to avoid a repetition of the widespread litigation surrounding the 1979 malpractice rule. Also, it is pointless to prolong this dispute because it only pertains to the cost-based reimbursement system, whereas hospitals are now reimbursed under the prospective payment system (PPS).

Response: As explained below, our reconsideration of current malpractice insurance apportionment policy has confirmed our 1979 determination that the utilization method over-reimbursed malpractice insurance costs. (*See*, section III.C., below.) However, we have adopted the commenter's suggestion in part by introducing each hospital's utilization rate into the apportionment formula. In any event, the prospect of further litigation on this issue is not a sufficient reason for adopting a method of apportioning malpractice costs that would violate section 1861(v)(1)(A) of the Act and give hospitals a windfall at the expense of the Medicare Trust Funds. Furthermore, while most hospitals are now subject to the prospective payment system, this final rule would nonetheless apply in the future to inpatient services furnished by all or part of more than 36 percent of the total number of hospitals, as well as to outpatient services furnished by all hospitals. (*See*, section IV., below.) In order to fill a void in an unsettled area of the law, this rule also will be applied retroactively to pre-prospective payment cost reporting periods. (*See*, section III.I , below.)

Comment: The proposed rule constitutes an attempt to circumvent the court decisions invalidating the 1979 malpractice rule through impermissible *post hoc* rationalization. Also, an agency may not remedy defects in a regulation by adopting a new rule that is equally defective for the same or other reasons.

Response: This final rule differs in several important respects from the 1979 malpractice rule. The substantive terms of the two rules are different from one another. (*See*, sections II.A. and II.E., above.) The two rules also are based on different empirical data. (*See*, section III.B., below.) This rule is the result of our consideration of comments received on the NPRM, in addition to those submitted in 1979. Thus, these differences between the final rule and the 1979 malpractice rule show that this rulemaking does not constitute a *post hoc* rationalization of the 1979 rule. Finally, even if it were assumed that the new rule and the 1979 rule were very similar, the courts have held that a new rule similar to one held invalid can be adopted as long as all requirements of the Administrative Procedure Act are satisfied. According to the courts, mere similarity between a new rule and an invalidated predecessor rule does not mean that the new rulemaking is an exercise in *post hoc* rationalization of the prior rule.

B. The Impact of the New HCRIS Data on the Apportionment of Malpractice Insurance Costs

Comment: The Department's continued reliance on the study published in 1979 by Westat, Inc. (Westat Study) to support its decision to remove malpractice insurance costs from the G&A pool and for other purposes fatally undermines the proposed rule.

Response: Our adoption of this final rule is not based in any way on the Westat Study. Our final decision to remove malpractice insurance costs from the G & A pool is based primarily on the HCRIS data. (See, section III.C., below.)

1. The Reliability of the HCRIS Data

Comment: The HCRIS data have not been validated and were used selectively to suit the department's purposes.

Response: As explained in detail below, we thoroughly validated the HCRIS data and used the data in a

rigorous, consistent manner for various purposes.

Comment: The HCRIS data base cannot be of "very high quality" since it was not even considered for use in setting the FY 1986 PPS rate or for recalibration purposes.

Response: HCRIS was not used for PPS recalibration because not enough data from settled cost reports were available when needed. We do not expect to have enough hospital cost reports in HCRIS from the first year of PPS (i.e., fiscal year 1984) until spring 1986. For recalibration, we used the most recent available data: charge data from fiscal year 1984 claims extracted from the PATBILL file. (*See,* 50 FR 35652–35659 (Sept. 3, 1985).)

Comment: Some commenters questioned why the proposed rule was based on HCRIS data for only the 21-month period from January 1, 1982 through September 29, 1983.

Response: The 21-month period was used for both the proposed rule and this final rule because it mirrors the cost reporting periods available from the HCRIS data base. More recent cost reports are not available in sufficient numbers to ensure statistical reliability. However, because the 1979 malpractice rule is based on providers' loss experience for the current and four preceding cost reporting periods, HCRIS contains malpractice loss data for cost reporting periods ending on or after January 1, 1978 through periods ending on September 29, 1983—a period of nearly six years.

Comment: Various commenters asked for a detailed justification of our statement that the HCRIS data are of "very high quality."

Response: The HCRIS data were subjected to extensive edits and checks in the construction of both the data base and the analytic files used in the research underlying both the proposed rule and this final rule. To insure that accurate data were used, only cost reports which were either audited or settled (pursuant to HCFA audit guidelines established for use by Part A Medicare fiscal intermediaries) were selected from HCRIS for this use.

HCRIS data are obtained from the intermediary through an automated desk review (ADR) system approved for both preparation of the Medicare hospital cost report (substitute Form HCFA–2552) and intermediary desk review. In addition, HCFA tests each ADR system for compliance with HCRIS transmission requirements prior to receipt of any data from the ADR system. These ADR systems include many consistency edits which must be satisfied in order for the data to be transmitted to HCFA. Also, HCFA imposes some additional data edits prior to the acceptance of each cost report. HCFA has conducted lengthy reviews of the HCRIS data by obtaining copies of cost reports from the intermediaries and comparing selected data elements to data extracted from HCRIS. The results of the various reviews are voluminous since they require the cost report, a printout of the HCRIS data set as it came to HCFA for processing, a printout of the HCRIS master file for that report and a copy of the extract report used for comparison. These sophisticated processes ensure that the hospital's cost and the malpractice worksheet (Worksheet D–8) are complete and accurate upon entry into HCRIS.

Comment: Random checks of HCRIS data elements against records maintained by specific hospitals indicate substantial errors in the HCRIS data file. For example, while numerous hospitals reported $1 in paid claims, these items were arbitrarily assigned a value of $0 in the analysis performed for the NPRM.

Response: The presence of $1 in paid losses may be due to either of two factors. First, it may indicate an intermediary determination that a loss was incurred that a hospital was either unwilling or unable to document adequately. Alternatively, it may be indicative of data required to satisfy one or more of an ADR vendor's edits. This change of total paid loss from $1 to $0 was made to remove distortion from the paid loss figures. The difference in total paid losses ($59) was less than 0.00001% of the total. With such a statistically miniscule difference, the same result would have been reached regardless of whether these values were changed.

Comment: Some commenters conceded that the HCRIS data used in the proposed rule were from a substantial majority of participating hospitals, but inquired why some hospitals were excluded from the data base.

Response: The difference between the 6,657 hospitals in the HCFA Provider of Services (POS) file and the HCRIS file used in the NPRM was caused by: (1) the unavailability of an audited or settled cost report; or (2) the inability to automate the cost report. The latter of the two groups of reports excluded from HCRIS fall into one of two main categories: (1) cost reports that cannot be processed by an ADR system because the number of cost centers used exceed system limitations; and (2) cost reports which cannot be processed by HCRIS for technical reasons such as the hospital's use of swing beds, or its use of double, multiple, or matrix methods of cost apportionment. Thus, only cost reports that did not satisfy our stringent auditing standards for HCRIS and reports that could not be processed for technical reasons were excluded from the HCRIS data base.

The NPRM was based on the HCRIS data file as of April 1985. At that time, HCRIS contained 77.6 percent of the cost reports for reporting periods ending on January 1, 1982 through September 29, 1983. HCRIS is updated continuously as part of our effort to maximize the currency and accuracy of the data base. For example, a specific cost report for a period ending in 1982 might be replaced by an audited or settled cost report for the same provider for the subsequent period. Thus, this final rule is based on the HCRIS data file as of August 1985, at which time HCRIS included 77.1 percent of the cost reports for periods ending January 1, 1982 through September 29, 1983.

Comment: Since the 1979 malpractice rule became effective, some hospitals have not reported their malpractice paid claims on Worksheet D–8 because the data were not available or for various other reasons. This means that the HCRIS data are necessarily incomplete and inaccurate.

Response: All providers choosing to furnish services to Medicare beneficiaries agree to maintain their books and records in a manner so that they may be examined to determine proper reimbursement. (See, 42 CFR 405.406 (c) and (d), 405.453 (a) and (c).) When the 1979 malpractice rule first became effective, paid loss data had not previously been required to be kept for determining Medicare reimbursement. Upon implementation of the rule in 1980, however, most, if not all, hospitals obtained this data from their insurers pertaining to all prior periods (1975–1979). By 1982 or 1983, each participating hospital therefore should have known of losses it paid, or losses paid on its behalf, for each year beginning in either 1978 or 1979. As a result of validating the loss data, HCFA learned that some of the providers with actual loss experience (59 of 2,320) were either unwilling or unable to report paid losses for some reason. Noncompliance with recordkeeping requirements aside, there is no basis for the assertion that the absence of data from such an extremely small number of hospitals invalidates the HCRIS data base.

Comment: The preamble to the NPRM does not explain what was done to ensure that the information reported on the HCRIS hospitals' malpractice worksheet (Worksheet D–8) was complete and accurate. Similarly, no

explanation was given of how HCFA confirmed the accuracy of the 3,600 HCRIS cost reports that reported no malpractice paid claims.

Response: Fiscal year 1982 and 1983 cost reports were heavily audited because they served as the base year for both rate-of-increase limits, as required by the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), and the hospital-specific portion of the prospective payment rates. This extensive auditing of the 1982 and 1983 cost reports supports reliance on HCRIS as an accurate source of malpractice loss data.

Comment: The preamble to the proposed rule states that malpractice loss data for Medicaid and the Maternal and Child Health program patients are excluded from HCRIS because hospitals do not always report these costs and because HCFA does not routinely review them for completeness and accuracy. The shortcomings of the Medicaid and Maternal and Child Health Care program data undermine the completeness and accuracy of HCRIS for Medicare purposes too.

Response: Our reasons for postponing any change in the NPRM to the national loss ratios applicable to Medicaid and the Maternal and Child Health program do not in any way detract from the adequacy of HCRIS for Medicare purposes. HCRIS contains audited data obtained from Medicare fiscal intermediaries. When both Medicare and non-Medicare paid losses in the current and four preceding periods are reported accurately, malpractice premium costs can be apportioned properly. HCRIS data are taken from cost reports of hospitals participating in the Medicare program that are processed by intermediaries. Since it is immaterial to the proper determination of Medicare reimbursement whether a Medicaid paid loss is identified separately (i.e., in addition to being included in total paid losses), no audit emphasis was placed on separately classifying and reporting the different kinds of non-Medicare paid losses.

HCFA recognized from early review of HCRIS data that Medicaid and Maternal and Child Health data were not being consistently reported for purposes of Medicare reimbursement. Consequently, HCFA undertook a survey of 2,302 providers that reported some loss experience and either no Medicaid losses, no Medicaid inpatient days or no Medicaid discharges. As explained above (see, section II.C.), we were able to determine the ratio of Medicaid losses to total losses. However, because we lack adequate Medicaid patient-day statistics to construct a Medicaid apportionment methodology similar to the Medicare methodology we are adopting for hospitals, we have decided to allow the states to establish appropriate policies.

Comment: In response to FOIA requests, several commenters were furnished copies of a computer printout titled "Data Elements Used for Malpractice Impact Estimates". The printout summarized an analysis of various providers' reported malpractice premium costs and the amount of premium costs reimbursed by the Medicare program. Various commenters suggested that the following specific criticisms of the printout show that the HCRIS data are unreliable: (1) The printout omitted reported premium costs and the amounts reimbursed by Medicare for a specific hospital (Provider No. 05–0307) that reported its malpractice costs and received reimbursement. (2) The printout revealed that HCFA understated the amount of Medicare reimbursement for two hospitals (Provider Nos. 05–0583 and 05–0584) by subtracting the deductible and coinsurance amounts attributable to Medicare from the reimbursable amount of premium cost. (3) The printout sometimes listed a negative number as the amount of Medicare reimbursement. (4) The printout includes no data on total malpractice costs (MPREM), the premium amounts reimbursed by Medicare (MPXVIII), total costs (TOTCOSTS) and inpatient costs (IPCOSTS) for the states of Maine, Maryland, Missouri, and New Mexico (a total of 275 hospitals). (5) The printout shows that none of the 68 South Carolina hospitals were paid any malpractice costs by Medicare. (6) The printout lists only 1 of the 267 New York hospitals as reporting an amount for both malpractice premium costs and Medicare reimbursement. (7) The printout shows that 95 percent of Florida's 201 hospitals did not report premium costs and Medicare reimbursement. (8) High percentages of premium and reimbursement data were excluded for hospitals in Massachusetts (87 percent not reported), Tennessee (83 percent excluded), and Oklahoma (75 percent not listed). (9) One hospital (Provider No. 05–0329) showed premium costs of nearly $30,000 and a negative reimbursement amount of over $54,000, while another hospital (Provider No. 05–0241) showed reimbursement nearly double its premium cost. (10) While the NPRM states that the sample was based on 5,281 Medicare cost reports from HCRIS, the printout lists 5,512 providers. Thus, 231 hospitals were inexplicably excluded from HCFA's analysis. (11) The printout showed no data for 37.8 percent of the 5,512 providers; listed 20.4 percent of the hospitals as receiving reimbursement for $0 in premium costs; showed 72 providers with negative reimbursement; and listed 122 hospitals with premium costs of only $1.

Response: These commenters have misused the data furnished by HCFA in response to their FOIA requests. The printout entitled "Data Elements Used for Malpractice Impact Estimates" contained HCRIS data supplied to the Office of the Actuary in 1984. The HCRIS data supplied to the Office of the Actuary was from the fall of 1984, and it included all cost reports available. The Office of the Actuary merged the fall 1984 HCRIS data with another data file, and used the combined data solely for purposes of estimating fiscal impacts for the NPRM. By contrast, the HCRIS data used in the NPRM to revise the national ratio, determine the Medicare patient utilization rate, and calculate the ratio of malpractice insurance costs to the total G & A pool were furnished to the Office of Research in June 1985. The data supplied to the Office of Research was from April 1985, and it was limited to all available settled or audited cost reports.

For the following reasons, none of the specific criticisms of the printout undermines the reliability of the HCRIS data:

(1) The audited or settled cost report of the specific hospital referred to (Provider No. 05–0307) was not yet included in the HCRIS data base in 1984. In the June 1985 data its malpractice premiums and Medicare reimbursement were listed as $156,323 and $147,248, respectively. Because only the June 1985 data were used for the proposed rule, this omission in the 1984 data is irrelevant.

(2) As to the comment pertaining to Provider Nos. 05–0583 and 05–0584, the data shown in the printout listing were used for impact analysis purposes only, and should not be construed as having come directly from the HCRIS data base. As explained in detail below (see, section III.C.3.), deductibles, coinsurance amounts, and other allowable uninsured loss payments and associated direct costs were included in malpractice insurance expense in the HCRIS data used in the NPRM and the final rule.

(3) It must be emphasized that the printout itself was not used in the development of the NPRM or the final rule. While the printout sometimes listed negative numbers for malpractice costs, no negative numbers appear on the HCRIS tapes used in this rulemaking.

Moreover, the negative amount of malpractice premiums on the printout reflect only the manner in which these data elements from Worksheet A–8, Lines 35 to 43 are transmitted to HCRIS via one of four automated desk review (ADR) vendors' systems. The Actuary also noted this feature of the data when it was furnished in 1984. However, the accuracy of the actual numbers is not affected by this factor, and the use of the absolute value in these instances will yield the accurate amount of malpractice premiums. Moreover, the values were properly treated for the purposes of the NPRM and the final rule.

(4)–(8) Audited cost report data from Maine, Maryland, Missouri and New Mexico were not available until after the printout was produced. Similarly, the printout information on South Carolina, New York, Florida, Massachusetts, Tennessee, and Oklahoma hospitals was superseded by the audited June 1985 data. Updated data from these states were included in the computation of the revised national ratio as proposed. The following table illustrates the completeness of the HCRIS data used to determine the revised ratio:

	Malpractice costs		Hospitals with losses	Hospitals without losses
	Medicare	Total		
Maine	$4,250	$16,058	2	9
Maryland	396,776	8,538,725	29	26
Missouri	1,478,067	14,281,245	81	62
New Mexico	388,677	1,500,296	16	10
South Carolina	204,146	1,596,297	13	67
New York	2,939,473	22,274,781	44	49
Florida	3,451,156	22,526,028	64	64
Massachusetts	827,220	5,438,171	60	56
Tennessee	877,047	3,715,308	48	65
Oklahoma	779,093	3,505,911	37	89

(9) The figures cited by the commenters were not in the June 1985 HCRIS data used in the NPRM. The June 1985 data show that Provider No. 05–0329, for its cost reporting period ending November 1982, had $54,120 in malpractice premium costs and zero reimbursement. For Provider No. 05–0241, FYE November 1982, the malpractice premiums and Medicare reimbursement for malpractice premium costs were $88,343 and $4,505 (5.1 percent national ratio used), respectively.

(10) The 5,512 count refers to the number of cost report files furnished to the Actuary in 1984—a total which included some "as submitted" cost report data. The printout referred to by the commenter was produced more than six months earlier than the data set used to prepare the proposed rule. Only the most recent and most accurate data available were used in preparation of the NPRM. The data furnished in June 1985 to the Office of Research for use in the preparation of the revised national ratio consisted of 5,465 cost reports containing only audited or settled data. The 5,281 hospital set was used to analyze malpractice costs as a percentage of total G and A costs including malpractice costs. (The NPRM erroneously stated that the 5,281 hospital set, rather than the 5,465 hospital set, was used in the preparation of the revised national ratio.) Finally, a set of 5,472 HCRIS hospitals was used in the NPRM to derive the estimated national Medicare patient days utilization figure of 40.5 percent. As explained below, subsequent analysis of HCRIS shows that the Medicare proportion of patient days to total patient days is 42.90 percent.

(11) These statistics pertain to the listing produced by the Actuary from the fall 1984 HCRIS data. The printout reflects only raw data furnished to the Actuary. The absence of a reimbursement figure for 20.4 percent of the hospitals represents the manner in which one of the ADR vendors chose to meet HCRIS requirements, i.e. by furnishing only the data necessary to compute the Medicare reimbursement for malpractice. The data used in the NPRM was computed from the reported HCRIS data when the malpractice loss totals (Worksheet D–8, Line 6, Columns 1–4) were not supplied by the ADR vendor system. Because the 1984 data that were furnished to the Actuary were only used in this rulemaking for impact analysis purposes, the printout statistics referred to by the commenter are irrelevant.

Comment: In response to FOIA requests, several commenters were furnished the HCRIS computer tape used in the development of the proposed rule. Based on their independent assessments of the tape, these commenters criticized the HCRIS data as follows: (1) The preamble to the proposed rule states that 1,646 hospitals reported $66.7 million in Medicare malpractice losses, and that total premium costs were $708 million annually. However, the HCRIS tape indicates that only 1587 hospitals actually had a Medicare paid-claims history while 2,320 hospitals reported some claims paid experience. (2) The presence of 59 cost reports with $1 for total claims paid shows the unreliability of HCRIS. (3) The preamble states that total malpractice insurance costs are about $708 million annually whereas the HCRIS tape indicates a total premium figure of only $500,672,422. (4) More than half of the hospitals included in HCRIS, 2,641 hospitals, did not report any malpractice losses during the relevant five-year period. While some of these hospitals actually incurred no losses, others were unable to determine their five-year loss history and so they claimed the national ratio. If the portion that did not identify its own history had reported accurately, the proposed national ratio of 11.6 percent might have changed significantly.

(5) The proposal to retain the Medicaid national ratio of 7.5 percent is contradicted by the HCRIS tapes, which indicate that the five-year ratio of Medicaid losses to total losses is 14.5 percent.

Response: We do not believe that any of the foregoing criticisms based on independent analyses of the HCRIS computer tape detracts from the reliability of the HCRIS data. Our specific responses are as follows:

(1) The preamble to the proposed rule states that 1,646 hospitals reported $66.7 million in Medicare malpractice losses out of $562.5 million total malpractice losses. These figures pertain to hospitals in the HCRIS data base. The $708 million figure for total malpractice insurance costs is an estimate of malpractice insurance costs for the universe of 6,657 U.S. short-stay and long-term hospitals on the HCFA Provider of Service (POS) file and is based on the malpractice insurance expense of 5,281 HCRIS file hospitals.

The apparent discrepancy between the NPRM (1,646) and the data tape (1,587) with respect to the number of hospitals with some loss experience is attributable to the manner in which cost reports are settled and processed. After auditing 59 of the 1,646 cost reports, the fiscal intermediary was unable to obtain satisfactory documentation from the provider pertaining to its loss history, and the intermediary was precluded from making payment for any malpractice costs. To effect settlement properly using an automated desk review system, the intermediary listed a nominal amount ($1) for both Other and Total losses. HCFA verified this practice prior to using these data. (See discussion below under paragraph (2) in our response to immediately succeeding part of this comment.) The 1,646 figure includes these 59 cost reports because the providers did sustain some losses.

It is true that 2,320 HCRIS hospitals reported some loss experience. However, the proposed national ratio was determined by dividing the nationally estimated sum of all Medicare paid losses (based on the 1,646 HCRIS hospitals with Medicare losses) by the nationally estimated sum of all paid losses (based on the 2,320 HCRIS hospitals with losses of any kind).

(2) To effect settlement properly using an automated desk review system as implemented by one vendor, a nominal amount ($1) was input for Other Losses, Total Losses and Total Premiums for 59 cost reports. As explained above, the intermediaries verified this practice prior to the use of this data. Bearing in mind that the June 1985 HCRIS data used in the NPRM was either audited or settled, the effect of the use of $1 rather than $0 entries for 59 cost reports is statistically insignificant.

(3) The $500,672,422 figure is the correct total for malpractice premium expenses for the 5,281 HCRIS hospitals studied to develop an estimate of malpractice expense as a share of malpractice expense plus G & A expense. The $708 million figure is a correct estimate of total malpractice premium costs for the universe of 6,657 U.S. short-stay and long-term hospitals on the HCFA Provider of Service (POS) file. The $708 million figure was based on the $500.6 million figure for the HCRIS hospitals, as extrapolated to the universe with HCRIS geographic estimates weighted by number of beds.

(4) Absent evidence to the contrary (and none was submitted by the commenters) we have no reason to believe that a report of no malpractice losses during the pertinent five year period was unrepresentative of the hospital's actual loss experience during that period. Thus, it is mere conjecture as to whether the national ratio would have changed "significantly" if some of these providers had reported their experience "accurately."

(5) As explained above, our analysis of the validation results and familiarity with reporting practices regarding Medicaid data led us to postpone any change in the NPRM to the Medicaid national ratio until better data became available. A survey of hospitals with loss experience but no reported Medicaid losses, Medicaid days or Medicaid discharges has been completed. The addition of this hospital survey data to the HCRIS data is preferable to using the HCRIS data alone, as the commenter has done, for purposes of estimating the national ratio for Medicaid. (While the Medicaid survey data was added to HCRIS for Medicaid purposes, the HCRIS data used in this final rule to determine the Medicare hospital national ratio and the proportion of malpractice expense in the G & A pool did not include the survey data.) The HCRIS data base simply did not contain Medicaid loss or utilization data in most cases. This created doubt about whether Medicaid losses were included in "Other Losses." However, as explained in section II.C., our data on Medicaid utilization are an insufficient basis for developing a methodology for Medicaid similar to that developed for Medicare hospitals under this final rule. Therefore, we are deferring to the states to establish their own appropriate methodology for Medicaid.

2. The Methodological Assumptions Underlying the Analysis of the HCRIS Data

Comment: The Department never prepared a formal methodology for analyzing the HCRIS data.

Response: The methodology used to analyze the HCRIS data was described in the preamble to the NPRM and is elucidated further in our response to comments in this final rule.

Comment: The Department used three separate files from the HCRIS computer tape, each containing records for different, partially overlapping sets of hospitals and containing different information about those hospitals. The failure to create a uniform, merged data set raises serious issues of data comparability. In particular, the use of unmerged and inconsistent data has biased HCFA's attempt to weight the data.

Response: In using the HCRIS data base for several specific purposes during this rulemaking, we were confronted with a choice between two options. First, we could base a specific calculation (e.g., the national ratio, the patient utilization rate, or the ratio of malpractice expense to the totality of G & A costs plus malpractice expense) on the largest set of hospitals for which there was complete data in HCRIS on the specific parameter in question. Alternatively, we could base all of the necessary calculations on one set of hospitals for which there was complete data in HCRIS on all of the parameters under study.

We decided to base each calculation made for the NPRM on the largest data base available for the parameter at issue. For example, if HCRIS included the necessary data for a specific hospital on paid losses but lacked data on patient days, then that hospital was included in the set of hospitals used to calculate the national ratio but was excluded from the set underlying our determination of the utilization rate.

For purposes of this final rule, we recalculated these three parameters based on more recent HCRIS data from August 1985. Initially, we determined the national ratio, the national utilization rate, and the ratio of malpractice insurance expense to total G & A costs (plus malpractice expense) on the basis of a single merged data set of 5180 HCRIS hospitals. The results, weighted by hospital-bed, were as follows: estimated national ratio=11.07 percent; national patient utilization rate=42.9 percent; and malpractice expense=6.1 percent of total G & A costs (plus malpractice expense).

Use of a unitary data set necessitated the elimination from the data set of 702 hospitals with data on malpractice losses but no data on malpractice insurance expense. To ensure that the national ratio was based on the maximum number of hospitals reporting adequate loss data, we recomputed the national ratio on the basis of a 5882 HCRIS hospital set. The result, weighted by hospital-bed, was an estimated national ratio of 11.8 percent. Because the 5882 HCRIS hospital set is significantly larger than the 5180 hospital set, it is more representative of the universe. Thus, we have determined that, for purposes of this final rule, the national ratio is 11.8 percent.

Our use of the largest possible set for a given calculation ensured that each resultant figure was as accurate as possible. While the alternative calculation method also is acceptable, it may not be as precise as the method used primarily in this rulemaking. Each of the figures derived from HCRIS was separately weighted to ensure against bias. Also, since there were good data in HCRIS on each of the parameters involved for the vast majority of hospitals, any differences in the resultant figures under the two methods would be negligible.

Comment: An internal memorandum dated April 22, 1985 from Dr. J. Michael Fitzmaurice to Mr. Gene Stickler identified 5 variables and 4 regression analyses as priorities for the analysis of the HCRIS data. Yet only 4 of the 5 variables and none of the regression analyses were performed by HCFA. While other, less important calculations were completed, HCFA's failure to perform these top priority ones undermines the reliability of the analysis performed.

Response: In addition to mischaracterizing the April 22, 1985 memorandum, the commenter has misperceived the memorandum's role in this rulemaking Apparently, the commenter meant to refer to 5 tables, rather than 5 variables. The memorandum listed various tables, data sets, variables, and regression equations as possible sources of general study. It also rank-ordered research priorities in terms of tables, variables within tables, data sets, and finally, the regression equations. Priorities also were set within each of these four research areas.

When the memorandum was prepared, the character of any proposed rule was still undetermined. To facilitate the choice of an alternative, the most expansive research program available was devised and reflected in the April 22, 1985 memorandum. Once the character of the proposed rule was settled on, however, it was determined that a more focused inquiry would be appropriate.

Comment: The preamble comparison of HCRIS malpractice loss data and patient utilization data is irrelevant because it is based on mismatched statistics. The HCRIS loss data relate to claims paid from 1978 through 1983 while the utilization data apply only to 1982 and 1983. In general, the HCRIS loss data should be related to services provided in 1975 through 1980 or earlier—a period when patient utilization was much lower. At the minimum, loss data for each year reported in HCRIS should be related to the overall utilization rate for the corresponding year. Because of the three year average lag (i.e., "claims tail") between the typical hospital malpractice incident and the corresponding malpractice payment, the fairest comparison would be between the loss data for a given year and the utilization rate for a period beginning three years earlier.

Response: Included in our response to comments pertaining to the removal of premium costs from the G & A pool is a chart describing HCRIS loss data from 1978–1983 and Medicare utilization data from 1975–1983. As discussed below, Medicare's general patient utilization rate is, in general, more than three times greater than the claims-paid ratio, regardless of whether the claims-paid ratio is compared to the utilization rate for the same year or for a period that is earlier. (*See*, section III.C., below.) Based on NAIC closed claim data, we have concluded that there is a substantial "claims tail," as the commenter suggests, but that it differs between Medicare and non-Medicare losses. The NAIC data indicate that the average period between a malpractice occurrence and the payment of a claim to a Medicare beneficiary is approximately 1.5 years, while the malpractice claims to non-Medicare patients are paid an average of 2.5 years following the occurrence. Therefore, we have incorporated these lag periods into our formula for reimbursing the risk portion of total malpractice premium costs by relating the adjusted national ratio to the national patient utilization rate for the appropriate prior cost reporting periods. (*See*, section II.A.2., above.)

Comment: The preamble to the proposed rule fails to justify the statement that since a hospital's exposure to malpractice risk is related to the volume of services it provides, it would be better to weight each group in the sample by number of beds rather than by the number of hospitals.

Response: We believe that the number of beds is fairly representative of capacity and volume of services rendered. A greater number of beds generally reflects a greater patient population that, at least in the aggregate, receive a greater number of services. (It is also important to note the fact that some of the larger acute care hospitals render more intensive services generally.) This greater volume of services increases exposure to malpractice risk.

Comment: Bed-days would have been a more appropriate basis for weighting the sample than bed-size.

Response: We assume that the commenter meant that the number of patient days ("bed-days") is better than the number of beds for weighting purposes. (If by bed-days the commenter meant available bed-days, use of that factor could not be preferable to using the number of beds, because available bed-days equal 365 times the number of beds, and thus the two numbers are directly proportional.) Hospital patient days might have led to a more precise estimate, but the data was not available on the Provider of Service (universe) file.

3. The Quantitative Results of the Analysis of the HCRIS Data

Comment: The absolute values published by HCFA in the NPRM produce a national ratio of 11.9 percent, not 11.6 percent.

Response: We agree that the absolute values published in the NPRM would produce a "national ratio" of 11.9 percent. However, the statistics cited are from an unweighted analysis of data on hospitals in the HCRIS file. As explained in the NPRM, we weighted the hospitals in the HCRIS file to insure that the updated national ratio correctly reflected the proportion of hospitals in the universe. After making the adjustments described in the NPRM, the result was our proposed national ratio of 11.6 percent. However, based on even more current weighted HCRIS data, the national ratio will be set at 11.8 percent.

Comment: The HCRIS data show that the average of Medicare claims ratios for hospitals with current period paid-claims experience was .269 and, for hospitals with Medicare paid-claims experience, .393. These figures—unlike the proposed "national ratio" of .116—represent the Medicare malpractice loss that, on the average, an individual hospital would experience. Thus, they cast great doubt on the validity of the proposed national ratio.

Response: Since the proposed rule would have used the national ratio to calculate Medicare reimbursement of premiums for hospitals with no malpractice losses, it was inappropriate to apply a ratio based solely on hospitals that incurred period malpractice losses or Medicare malpractice losses. The commenter has used a different methodology and a different, smaller sample of hospitals, and has therefore obtained different loss ratios. By averaging individual hospital ratios for providers with some current period or Medicare experience, the commenter's methodology gives excessive weight to the many smaller hospitals which account for relatively less malpractice expense. (For the HCRIS data released under the FOIA, for example, hospitals with under 100 beds accounted for 51 percent of hospitals, but only 6 percent of total paid claims and 7 percent of Medicare paid claims). Additionally, the ratio based on hospitals with Medicare losses is clearly biased, since it includes those with only Medicare losses and excludes those with only non-Medicare losses. A methodology that includes a comparison of all losses is necessary, since any other approach would produce biased results. Further, use of a five-year average, rather than data based solely on the current period, offers a broader, more credible basis of comparison, since year-to-year variations may be expected. Our methodology thus gives a more accurate measurement of the share of the nation's total hospital malpractice expense attributable to Medicare patients.

Under this final rule, the adjusted national ratio will be used, along with utilization factors, to apportion the predominant risk portion of premium cost. Since the national ratio will partially determine each hospital's reimbursement for part of premium cost, it should be based on the experience of the broadest group of hospitals possible. As explained below (see, section III.D.), this is consistent with how the insurance industry uses experience data in establishing premiums.

Comment: The HCRIS data show that hospitals similarly situated do not have (as one would expect from HCFA's premise) lower premiums when Medicare utilization is higher. The correlation coefficient of premiums and

Medicare utilization (from the HCRIS data) is positive, not negative.

Response: The comment is based on an inappropriate and misleading comparison. First, it is necessary to adjust premiums for volume of service. A positive correlation, such as the commenter reports, is possible if Medicare patients tend to use high volume (e.g., larger) hospitals which have higher premiums per hospital. Second, correlation analysis is a weak tool for testing whether "similarly situated" hospitals pay lower premiums if they have lower Medicare utilization. The analysis should use appropriate multivariate techniques (e.g., multiple regression) to control for the many variables which affect premium levels.

Comment: A simple regression analysis of the HCRIS data shows that variables related to the size of the facility or the total number of patient days in the facility are the only variables that demonstrate a strong correlation with the amount of malpractice insurance premium costs. In particular, a regression analysis using malpractice insurance premiums as the dependent variable, and patient days, control variables, and losses per patient day as the independent variables, showed that losses account for only 12 percent of the explained variance while patient days account for 77 percent of the explained variance—results which clearly support the pre-1979 utilization method of apportionment.

Response: Under this final rule, a hospital's particular loss experience does not determine its reimbursement for malpractice insurance costs. Rather, a hospital's own utilization rate and the adjusted national loss ratio are the primary determinants of malpractice insurance reimbursement.

The regression analyses relied on by the commenters were performed as part of a study which sought to explain malpractice insurance premiums (total per hospital) for 5,275 hospitals with two sets of independent variables:

Patient days or number of beds;

Losses paid per patient day or per bed for the current and four preceding years for each hospital.

Also, the following control variables were used:

Census division;

Ownership type (non-profit, proprietary, government);

Urban or rural;

Teaching status (ratio of interns and residents to beds).

The regression analyses presented (one using patient days and one using beds among the independent variables) have several problems which make their interpretation and evaluation difficult and raise these fundamental questions about their relevance or validity:

(1) The commenters' conclusion that the regression analysis shows that measures of hospital size (patient days and number of beds per hospital) and other hospital attributes explain most of variation in total premium cost is based on an inappropriate statistical test and a faulty choice of dependent variable. The dependent variable used was *total premium cost*, which was statistically related to *paid claims per patient day or per bed*. Because the insurance industry's basic rating structure does not relate one-to-one to Medicare and non-Medicare usage and because total premium cost as a measure of malpractice risk is biased by different State liability levels, it is an inappropriate dependent variable. The appropriate statistical test would examine the relationship between premiums *per patient day* (or *per bed*) and paid losses *per patient day* (or *per bed*). The finding that patient days (or number of beds) explain most variation in total premiums is little more than a finding that large hospitals pay more in total premiums. We assumed in developing the proposed rule that exposure to malpractice risk increases with service volume. Thus, this finding confirms our assumption.

(2) Our reanalysis of the study relied on by the commenters indicates that, in both regressions presented, the paid losses variables are statistically significant in explaining total premium cost. They are significant at a 99 percent confidence level. This contradicts the claim that they do not show a strong correlation with premium cost. The regression analyses demonstrate that paid losses *are* strongly correlated with premiums. The incompletely reported results prevent direct examination of the statistical significance of the paid losses variables. However, we used the information presented to calculate the statistical significance of these variables in both regressions. We used an F test to determine the contribution of the paid losses variable to the explanation of variance in each equation. In both cases, the paid losses variable contributed to the explanatory power of the equation with statistical significance exceeding 99 percent. (Calculated F statistics for the paid losses variable equaled 375.9 and 689.2 for the patient days and beds equations, respectively, far exceeding the highest relevant tabulated cutoff point of $F(.01, 1, 1000) = 6.66$).

(3) The regression analyses *do not test* the validity of the relationship between total premium costs and total paid losses per hospital (as distinct from paid losses per patient day or per bed). The statistical findings that the paid losses variables explain little of the variation in total premium costs does not demonstrate that the relationship between premium costs and losses per hospital is weak.

(4) Despite the weaknesses of the study, which should bias the analysis against finding an impact of paid losses on premiums, the results indicate that losses account for a significant portion of the variation in premiums. Specifically, the paid-losses variable accounts for almost one-eighth of the explanatory power of the patient day equation and one-fifth of the explanatory power of the bed equation (explaining 4.4 percent and 7.8 percent of total variance, respectively).

Comment: The HCRIS data indicate that reported malpractice insurance losses amount to only 35.5 percent of total premium costs for the comparable period. Thus, nearly two-thirds of malpractice premium costs incurred by hospitals in the HCRIS file were for costs other than the payment of claims. Other commenters stated variously that the HCRIS data tapes indicated that, for hospitals with paid claims, the ratio of paid losses to premium costs is: 33.5 percent; 25.14 percent; and 16 percent.

Response: As discussed in detail below (see, section III.D.), we have determined that the anticipated loss subcost of total premium cost is about 55 percent of total cost. Any divergence between our determination about anticipated losses and what HCRIS might show about the ratio of paid losses to malpractice premium exprense is presumably attributable to two facts. First, HCRIS includes only closed claims while our determination about the anticipated loss subcost is based on open and closed claims. Second, as explained below (see, section III.C.3.), the HCRIS measure of malpractice insurance expense includes costs (e.g., deductibles, copayments, etc.) beyond those that the insurance industry considers to be premium cost. In addition, we recognize that malpractice premiums are used to pay general costs and costs associated with losses as well as to pay the malpractice losses themselves. This final rule accordingly provides that the administrative component of premium cost will be returned to the G & A cost center and apportioned on a utilization basis, while the risk portion, including amounts attributable to the payment of losses and expenses relating to losses (i.e., ALAE and ULAE), will be reimbursed based on the provider's utilization rate

scaled to the national ratio of Medicare malpractice losses to total losses.

Comment: One commenter was unable to replicate seven of our calculations and concluded that the following figures relied on in the NPRM were inaccurate: (1) weighted malpractice expenses; (2) weighted malpractice expenses plus G&A expense; (3) weighted Medicare patient days; (4) weighted total patient days; (5) total malpractice premiums; (6) total G&A costs; (7) ratio of total permiums to G&A plus premium costs.

Response: The commenter's assertion that we miscalculated seven figures is based on several erroneous assumptions and miscalculations of its own. Regarding the first four figures, the commenter contrasts its calculation of weighted malpractice expenses, weighted malpractice and G & A expense, weighted Medicare patient days, and weighted total patient days with our calculation of those figures. The HCFA data are from, and the commenter's calculations are based on, tables included in memoranda released under the FOIA (i.e., sections "Q" and "R" of the FOIA response). The first two figures are based on tables prepared on May 7, 1985. (See, section Q of the FOIA response.) The second two figures are based on tables from June 11, 1985. (*See*, section R of the FOIA response.)

The commenter correctly presented HCFA's Table 8 results for New England for 3 variables. In the case of weighted malpractice and G & A expense, the commenter seemingly made a typographical error, presenting the last six digits of its own estimate as the last six digits of the HCFA calculations. The commenter calculated its estimate of the New England "All Hospitals" value for each variable by multiplying the New England "All Hospitals" sampling weight from Table 3 and the relevant variable in Table 4. For example, for New England malpractice premium expense ("MPX"):

33,103,938 (commenter estimate) = 1.4123664 (Table 3) * 23,438,633 (Table 4).

HCFA used a more detailed and, we believe, more accurate method to develop regional estimates. We calculated weighted values *for each variable for each region-hospital size cell separately* and then summed the cell values to get the regional total. To be specific, the weighted total for each region-size cell (Table 8) equals the sampling weight for beds (Table 3) times the HCRIS variable value (Table 4). The value for "All Hospitals" in Table 8 for each region equals the sum of the values for the four size cells. For example, for MPX for New England, 0–99 beds:

3,262,258.2 (Table 8) = 1.2411990 (Table 3) * 2,628,312 (Table 4) and MPX. New England, All Hospitals is:

33,531,323 = 3,262,258.2 (Table 8) + 10,570,681 (Table 8) + etc. = 1.2411990 (Table 3) * 2,628,312 (Table 4) + 1.2569385 (Table 3) * 8,409,863 (Table 4) + etc.

With respect to the final three figures, the commenter asserts that HCFA miscalculated total premiums and total G&A costs, leading to a slight underestimate of the ratio of malpractice expense to G&A cost. The commenter cites a $708 million HCFA calculation of total premiums and an $11.5 billion calculation of G & A costs. It presents alternative estimates for the two variables from the HCRIS data of $500,672,422 and $7,788,486,416, respectively. In fact, the HCFA figures are correct calculations for the universe of U.S. hospitals, while the commenter's estimates relate solely to the smaller sample of HCRIS hospitals.

- The $708 million figure cited in the NPRM is HCFA's weighted estimate of malpractice expense for all hospitals, as derived from Table 8.
- The $11.5 billion figure is actually HCFA's weighted estimate of malpractice *plus* G&A expense, not just G & A expense. It also is derived from Table 8.
- The $500,672,422 figure is malpractice expense for *only* HCRIS hospitals, as derived from Table 4.
- The $7,788,486,416 figure is G&A expense for only HCRIS hospitals. It equals the value of G&A expense calculated using the microcomputer program and HCRIS data which we used to create Table 4. It differs from the value presented in the table due to rounding in the construction of the table and inclusion of malpractice costs in the table total. This value must have been calculated by the commenter from the HCRIS tape. It differs from the higher $11.5 billion figure since (1) the higher number also includes malpractice expense and (2) the higher number pertains to all U.S. hospitals while the lower number applies only to the HCRIS sample.

Comment: HCRIS data indicate that of the 5,281 hospitals used to update the national ratio, 2,961 (i.e., 56.1 percent) had no paid claims for the entire 5 year period reviewed. Thus, the risk of a malpractice award over a five-year period is less than 50 percent for the average hospital. Because of the advent of PPS, the majority of hospitals would be subject to the proposed rule for only a four- or five-year period. This means that, in all likelihood, a given hospital would receive inadequate reimbursement under the proposed rule. Also, these unfair results would not, as HCFA claimed in the 1979 rulemaking, average out over the long run because most hospitals would not be subject to the rule for more than four or five years.

Response: Of the 5,4 5 HCRIS hospitals used in the proposed rule to revise the national ratio, 3,145 (or 58 percent) reported no paid claims during the applicable five-year period. Under this final rule, a provider's reimbursement for premium cost will not depend on its own loss experience history. Rather, reimbursement will depend on its utilization rate and the adjusted national ratio of Medicare losses to total losses. The "unfair results" that commenters complained would result from application of Medicare's 1979 malpractice rule are therefore eliminated under this new regulation, regardless of how long a hospital is subject to the new rule, reimbursement results in any given year will satisfy all statutory requirements. (*See*, section III.G., below.)

C. Removing Malpractice Costs From the G & A Pool Is Supported by the Evidence and Does Not Result in a Distortion of Apportionment of the Costs That Remain in the G & A Pool

Comment: The cost of malpractice insurance should not be directly apportioned. First, the marketing and administrative parts of total premium cost, and perhaps a significant part of legal expenses associated with claims, are not directly attributable to individual patients and thus should be prorated between Medicare and non-Medicare patients. Second, the parts of insurance expense associated with the cost of malpractice awards are a cost of doing business that, like liability or fire insurance, should be apportioned on a utilization basis.

Response: This final rule largely accommodates the concerns of the commenter. Hospital malpractice insurance costs will be removed from the G & A cost center and apportioned on a special basis, different from other G & A costs. Our new apportionment methodology will return the administrative component of total premium cost to the G & A pool for reimbursement on a utilization basis. The subcosts that constitute the administrative portion are not identifiable to specific claimants or risk-related activities. Because there is no evidence that Medicare patients disproportionately use the underlying services, it is fair to apportion these expenses on a utilization basis. Furthermore, the predominant risk component of premium cost will be

apportioned in accordance with each hospital's own utilization rate and the adjusted national ratio of Medicare paid losses to total losses. In contrast to the administrative part of total premium cost, the risk component is identifiable to specific claimants and risk-related activities. While the risk component (like the administrative portion) is obviously a cost of doing business, this does not mean that it must be apportioned on a utilization basis. For the reasons set forth in the NPRM and elucidated further below, the utilization method of apportioning premium costs distorted the presumed balance of the G & A pool. In order to restore the balance of the G & A cost center, it is necessary to apportion the risk component of premium cost on the special basis established by this final rule.

Comment: The supposition that the overhead costs that constitute the G & A pool were in "balance" when the utilization method of apportioning G & A costs was adopted is not supported by any data. Also, a study by the Department in July 1978 of whether the utilization method prevented cost-shifting between Medicare beneficiaries and non-Medicare patients showed that Medicare paid a disproportionately small share of total G & A costs, which at that time included malpractice premium costs. The 1978 study concluded that removal of malpractice insurance premium costs from the G & A pool would result in Medicare payment of an even smaller proportion of the program's "fair share" of G & A costs. These findings were confirmed by a 1981 study which found, based largely on HCFA data, that in 1979 non-Medicare patients were subsidizing Medicare patients at the rate of $41 per patient day. (See, Health Insurance Association of America, *Joint Study Group on Cost Shifting* (1981).)

Response: As explained in the preamble to the proposed rule, we assumed in applying the utilization method to the whole G & A pool (after first subjecting the G & A pool to the general cost finding rule) that any disproportionality in favor of the program caused by a particular G & A cost would be balanced or offset by other costs that might be apportioned in favor of non-Medicare patients. (See, HEW Intermediary Letter No. 234 (June 2, 1967).) We thus concluded that the utilization method would ensure that Medicare paid its fair share of total G & A costs and would guard against cost shifting between the program and non-Medicare patients.

The presumption that the utilization method would maintain, in general, an approximate balance of program and non-Medicare costs was justified. First, it is the best method of apportioning most overhead costs because, in general, it is impossible to apportion these costs more precisely without creating a grossly inefficient and overly burdensome apportionment system. For example, to directly apportion administrative salaries, it might be necessary to fully measure the time spent by each employee.

Second, the flexibility provided under Medicare reimbursement practices with respect to reporting G & A costs makes a more precise differentiation between Medicare and non-Medicare costs virtually impossible. For example, Medicare permits providers to report G & A costs as an undifferentiated whole or to classify them into the following component cost centers: (1) nonpatient telephones; (2) data processing; (3) purchasing, receiving, and stores; (4) admitting; (5) cashiering and accounts; and (6) other administrative and general costs. (*See*, Provider Reimbursement Manual, HIM 15–1, section 2313.1.) While the costs includable in a specific component cost center are generally well-defined, there is some variability among providers regarding the exact costs included in each component center. Similarly, there is some variability regarding exactly which costs are included in the overall G & A pool.

Third, the great flexibility associated with reporting of G & A costs makes it virtually impossible to determine scientifically whether the G & A pool is balanced between costs incurred by Medicare beneficiaries and those incurred by non-Medicare patients. The problem is compounded by the fact that there are an extraordinary number of constituent costs in the G & A pool, along with considerable variation among providers as to exactly how these particular costs are defined.

In the late 1970's, we attempted to increase the uniformity of the cost reporting system. A uniform reporting system was authorized by section 19 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Pub. L. 95–142), which provided for a common standard of cost measurement and communication through the use of uniform reporting principles, a uniform cost classification system, and uniform statistical and data source definitions. However, our efforts were strongly opposed by the hospital industry. The result is a reporting system so flexible and variable as to preclude a scientific study of historical changes of discrete costs within the G & A pool.

The July 1978 study performed by a departmental employee (referred to by some commenters as the "Maher Study") was based solely on data pertaining to one unnamed 400+ bed, nonprofit hospital. Thus, any conclusions drawn by the study's author were derived from a statistically unreliable sample of the universe of Medicare providers. Furthermore, the cost data underlying the study's calculations of potential Medicare reimbursement were based exclusively on the hospital's own cost estimates and were never subjected to any form of audit verification. Because the study was based on an invalid sample and unverified data, it is not an appropriate basis on which to predicate Medicare apportionment policy for malpractice insurance premium costs.

The 1981 study conducted by the Health Insurance Association of America ("HIAA Study") is a brief discussion of the alleged shifting of costs of treatment of publicly insured patients (that is, Medicare and Medicaid) to privately insured patients. The study assumed that the public programs pay less than their fair share of hospital costs and developed estimates of the amount by which public payments allegedly fell short of their fair share of total costs. The study did not conduct any research to determine whether such a shortfall exists but instead simply set out to calculate its magnitude.

Besides having a different objective, the HIAA Study is irrelevant to the question of the proper apportionment policy for malpractice insurance premium costs. The study purportedly calculates the shifting of costs, in general, from the universe of Medicare and Medicaid patients to the class of privately insured patients. While the Medicare G & A cost center is listed, along with other cost centers, as a source of alleged cost shifting, that particular cost center was not studied in isolation. Thus, the study did not even discuss alleged cost-shifting within the G & A cost center per se. Instead, the specific rate of cost-shifting cited by the commenter from the study actually purported to describe the extent to which private patients were subsidizing *Medicare and Medicaid patients on a programmatic basis.* Since this figure, like the HIAA Study generally, reveals nothing about subsidization of *Medicare G & A costs,* it provides no basis for assessing the balance of the G & A pool or of the effect of malpractice insurance costs on the presumed balance of the G & A cost center.

1. The Increase in Malpractice Insurance Premium Costs.

a. *The Relevance and Magnitude of the Cost Increase.*

Comment: The rate of increase of malpractice insurance costs is irrelevant to the propriety of removing those costs from the G&A pool.

Response: If malpractice insurance costs were underutilized by Medicare beneficiaries and constituted a significant portion of the G&A pool, then an extraordinary increase in those costs would distort the presumed balance of the G&A pool unless there were an equally extraordinary increase in some other significant G&A cost that was over-utilized by the program. As explained above, when the utilization method of apportioning G&A costs was adopted in 1966, it was presumed that any tendency to distort the overall balance of the pool caused by a particular cost would be offset by some countervailing G&A cost. The implicit assumption was that particular costs in the G&A pool would increase at relatively the same rate over a long period of time. However, malpractice premium costs—a significant cost in the G&A pool that was under-utilized by Medicare beneficiaries—increased at an extraordinary rate relative to other costs and thus distorted the presumed balance of the G&A pool. It is therefore necessary to directly apportion malpractice insurance costs in order to restore the presumed balance of the G&A cost center.

Comment: HCFA's statement that an increase of 263 percent in malpractice insurance premium costs between 1960 and 1970 supports removal of premium costs from the G&A pool is mistaken. First, the report from which the 263 percent figure was gleaned apparently applies to physicians, not hospitals. Second, the Medicare program did not begin operation until 1966 and the utilization method of apportioning G&A costs was not adopted until 1966. The growth in premium costs from 1960 until 1966 could not have distorted the balance of the G&A pool after 1966.

Response: While the report relied on in the NPRM pertained to physicians and hospitals, it clearly shows a 262.2 percent cumulative increase in premium costs for *only hospitals* between 1960 and 1970. (See, *Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice* 13 (1973)). The report also shows that while premium costs increased only 15.6 percent in the period between 1960 and 1966, these costs increased 213.3 percent from 1966 through 1970. The report showed an additional 47 percent increase from 1970 through 1972. Thus, when the Medicare program began operation and the utilization method of apportioning G&A costs was adopted, malpractice premium costs had risen an average of only 2.4 percent per year for the preceding six year period of 1960–1966. For the subsequent six year period of 1966–1972, premium costs increased an average of 29 percent per year, yielding a 361.3 percent cumulative growth for that period.

Comment: The Westat Study is an unreliable basis for establishing any increase in malpractice insurance costs or awards from 1970 through 1976.

Response: As explained above (see section III.B.), this final rule is not based in any way on the Westat Study. Statistics derived from American Hospital Association (AHA) data, used for purposes of establishing a market basket of cost inputs for calculating increases in hospital expenditures, show that malpractice insurance premiums increased a cumulative 793 percent from 1970 through 1976. (*See,* Mark S. Freeland, *et al.,* "National Hospital Input Price Index," *Health Care Financing Review,* Vol. 1, No. 1 (Summer, 1979): 37–61, especially p. 45, Table 3). Premium costs increased a cumulative 1131.9 percent from 1970 through 1978. (Id.) Although the quality of these data does not equal that of other more conventional economic time series used in the hospital input price index, it is the only available national data source we know of on premium costs for that time period. (*See, id.* at 56–57.) Notably, malpractice insurance premiums were the most rapidly increasing category in the market basket—averaging a 36.9 percent annual increase from 1970 through 1978 including a 100 percent increase in 1975 alone. (See *id.* at 45, 56–57.)

Comment: Since the proposed rule would apply to cost reporting periods beginning on or after July 1, 1979, HCFA should ascertain whether premium costs increased subsequent to 1976.

Response: The AHA-derived data, used for market basket purposes as explained above, shows that hospital malpractice insurance premiums increased a cumulative 38 percent in the period of 1977 and 1978. (*See,* Freeland, *et al., id.,* 1979.) The AHA-derived data show an additional cumulative increase in premium costs of 26.5 percent for the 1979–1980 period. (HCFA, unpublished data.) Thus, over the 1977–80 period, malpractice premium costs underwent a cumulative increase of 74.6 percent.

Beginning in 1981, the market basket price for hospital malpractice insurance premiums was based on actuarial information supplied by the Insurance Services Office (ISO). These data are based on total premium growth, not premiums per unit of coverage, and their growth reflect increases in volume of business as well as premium increases. Nonetheless, the ISO data represent the best available national data we know of on premium growth for the period from 1981 through 1985. The ISO data show that hospital premiums increased a cumulative 69.4 percent from 1981 through 1985. (HCFA, unpublished data.)

St. Paul Fire and Marine Insurance Company, the largest underwriter of hospital malpractice insurance policies, reported only a 31 percent cumulative increase in premium rates from 1977 to 1984. St. Paul reported an additional 38 percent increase in premium rates for 1985, which brings the cumulative increase for the 1977–1985 period to 80.8 percent. However, in 1975 St. Paul converted to the "claims-made" policy form from the "occurrence" form. Under the claims-made form used by St. Paul, the policy is not mature until the fifth year it is effective. This means that hospitals pay lower rates during the first four years of the policy. Thus, according to St. Paul, actual premiums paid by hospitals during the 1977–1984 period rose more than is indicated by their cumulative rate of change figure of 31 percent. In addition, increases by St. Paul in the basic limits of coverage from the $100,000/$300,000 range toward the $1 million/$3 million range for the typical policy are not reflected in the company's cumulative rate of change figure. Additionally, the St. Paul data exemplify a general relative slowdown in the rate of increase of premium costs in the late-1970s and early 1980s that stemmed from insurer decisions to remove physician coverage from hospital malpractice insurance policies. Once the effect of this action was fully realized, rates began rising precipitously again and they likely will continue to do so. For these reasons, and because St. Paul is only one underwriter of hospital malpractice insurance, the St. Paul data do not detract from the extraordinary increase in premium rates between 1977 and 1985, as shown by the national AHA-derived data and the ISO data.

Comment: Even if it were assumed that the NPRM claims about the rate of increase of premium costs between 1960 and 1976 were true, there is no basis for taking this experience to predict subsequent inflationary trends for these costs. Since no empirical data on hospital malpractice insurance premium costs exist for the period after 1976, HCFA's implicit assumption of continued inflationary increases is unsupportable. Despite the lack of post-

1976 data. HCFA apparently has undertaken no study of the malpractice worksheet (Worksheet D–8) to determine hospitals' actual premium costs since 1979.

Response: As explained above, the AHA-derived data used for market basket purposes indicate that hospital malpractice premium costs increased a cumulative 74.6 percent from 1977 through 1980. The ISO data used for the same purposes shows that these costs increased 69.4 percent in the period from 1981 through 1985. The availability of the national premium growth data that was used for market basket purposes obviates the necessity of studying Worksheet D–8.

b. *The Extraordinary Increase in Premium Costs Relative to Other Cost Measures.*

Comment: Divorced from information on general inflationary trends and on inflation in medical or hospital costs, specifically, increases in malpractice premium costs cannot be characterized plausibly as "extraordinary".

For example, even if it were assumed that, as the NPRM states, premium costs increased 94 percent between 1970 and 1976, such an increase would not be aberrant. The Consumer Price Index (CPI) increased 55 percent between 1970 and 1976; the health care component of the CPI increased 63 percent during that time; and Medicare Part A outlays increased 254 percent for the same period. (*See*, 1985 Medicare Trustees Report.) Similarly, Medicare Part A expenditures increased 484 percent between 1966 and 1976 (see, *id.*)—a rate of increase far greater than that alleged in the NPRM with respect to malpractice insurance costs.

Response: The commenter's figures are inaccurate and its hypothesis is not supported by the record, which shows that, relative to comparable price measures, malpractice insurance costs increased at a much faster rate. According to the 1985 *Economic Report of the President* (Table B–52), the Consumer Price Index increased 46.6 percent and the medical care component of the CPI increased 53.2 percent from 1970 to 1976, not 55 percent and 63 percent, respectively, as the commenter claims. (The commenter appears to have calculated 1969–1976 increases and presented them as 1970–1976 increases).

Medicare Hospital Insurance benefit payments increased from $4,604 million in fiscal year 1970 to $12,267 million in fiscal year 1976, and total Hospital Insurance Trust Fund disbursements increased from $4,953 million to $12,579 million over the same period. (See, 1985 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, p. 30, Table 5). These are increases of 155 percent and 154 percent, respectively, not 254 percent, as the commenter claims. (The commenter apparently divided 1976 disbursements rather than the 1970–76 increase, by 1970 disbursements and presented the result as the 1970–76 percentage increase.)

The commenter also cites a growth rate of 484 percent for Part A expenditures from 1966 through 1976. The growth of trust fund disbursements from fiscal year 1967, the first full year of the program, through fiscal year 1976 was 384 percent. (The commenter appears to have taken fiscal year 1967 data as 1966 data and made the same type of calculation error described in the previous paragraph). In any case, the 1967–76 growth rate in large part reflects large first year increases from a small base. In terms of annual growth rates, disbursements increased 47 percent per year between fiscal years 1967 and 1968, and then grew 16 percent per year until 1976.

Medicare Hospital Insurance benefit payments per Hospital Insurance beneficiary increased from $235.94 in 1970 to $484.62 in 1976. (1985 Annual Report of the Trustees, *id.*, p. 30, Table 5, and unpublished HCFA data.) This represents a 105 percent increase and, because it takes account of the increase in the number of beneficiaries, better measures Medicare's unit cost increase than does the commenter's estimate of 254 percent. The commenter's estimate is therefore incorrectly calculated and reflects increased utilization as well as increased payments per beneficiary. The 105 percent increase estimate, not the commenter's 254 percent, should be compared to the CPI increase of 53.2 percent for the same period. By contrast, hospital malpractice insurance premium cost increased 793 percent from 1970 through 1976 (Freeland *et al.*, id., 1979).

Comparison of hospital malpractice premium increases with similar CPI and Medicare information shows that premiums increased, in general, much more rapidly. For example, from 1966 through 1970 premiums increased 213.3 percent as compared to increases of 19.7 percent and 29.1 percent for the CPI and the CPI-Medical Care, respectively. Similarly, premiums increased 1458.4 percent from 1970 through 1980 as compared to increases of 112.2 percent (CPI), 120.5 percent (CPI-Medical Care), 389.1 percent (Medicare Part A Benefit Payments), and 384.3 percent (Medicare Part A Total Disbursements). From 1980 through 1985, premiums increased 69.4 percent while the CPI increased only 18.3 percent and the CPI-Medical Care increased only 36.4 percent.

Additional comparative evidence of the extraordinary increase in malpractice insurance premiums is available from three studies of the rate of increase of the totality of other G & A costs. A June, 1981 study by Applied Management Sciences, Inc., conducted for HCFA, consisted of analysis of a file of data from Medicare cost reports from 1,174 hospitals for 1971, 1973, 1975, and 1977. (Applied Management Sciences, Inc., "An Analysis of Hospital Administrative and General Costs," Silver Spring, Md.: AMS, June 3, 1981). The researchers studied samples of between 851 and 1,092 hospitals to determine the impact of various hospital characteristics, including dependence on Medicare patient revenue, on G & A costs per adjusted admission, G & A costs per adjusted patient day, and G & A costs as a percentage of total direct costs. A second study extended the 1981 study from 1977 through 1978 and examined cost centers other than G & A. (John L. Ashby, Jr., "An Analysis of Hospital Costs by Cost Center, 1971 Through 1978," *Health Care Financing Review*, Vol. 4, No. 1 (September, 1982): 37–53). As explained above, a third study by HCFA constructed a comprehensive hospital input price index, using AHA-derived data to develop a measure of malpractice insurance premium expenses. (Mark S. Freeland *et al.*, "National Input Price Index," *Health Care Financing Review*, Vol. 1, No. 1 (Summer, 1979): 37–62). The researchers presented data describing the percentage increase in hospital malpractice insurance expense by year for 1970 through 1978, with estimates for 1979 through 1981.

The 1981 AMS study showed that G & A costs per adjusted patient day increased at a rate of 13.1 percent per year and G & A costs per adjusted admission increased at a rate of 11.9 percent per year during the 1971–1977 period. (AMS, *id.*, p. 9.) The 1982 Ashby study used the expanded AMS data base and found that G & A costs increased 13.6 percent per year in the aggregate, 12.3 percent per year on an adjusted patient day basis, and 11.5 percent per year on an adjusted admission basis over the 1971–78 period. (Ashby, *id.*, p. 42, Table 4.) By contrast, hospital malpractice insurance expense increased at a compounded percentage rate of 38.2 percent per year from 1971 through 1978 (or a 863.9 percent cumulative increase) according to the HCFA price index constructed from AHA-derived data. (Freeland, *et al.*, *id.*, p. 45, Table 3.

Additional evidence stems from data showing that total hospital costs

increased between 1966 and 1978 at a far slower rate than malpractice insurance costs. (*See* Robert M. Gibson, *et al.*, "National Health Expenditures, 1983, *"Health Care Financing Review*, Vol. 6, No. 2 (Winter, 1984): 1–29, in particular p. 7, Table 2.) For example, national expenditures for hospital care increased 77.2 percent from 1966 through 1970 and 261.8 percent from 1970 through 1980. (*Id.*) By contrast, malpractice insurance premium costs increased 213.3 percent (1966–1970) and 1458.4 percent (1970–1980) during the same periods.

Thus, as the following table, "Comparative Growth Rates of Hospital Malpractice Insurance Costs and Other Representative Costs," shows in summary form, malpractice insurance premium costs have increased extraordinarily in that, in general, their rate of increase far outstrips comparable CPI, Medicare, and hospital care cost measures. The data sources for hospital malpractice premium cost, national hospital care expenditures, and Medicare G & A cost were described previously. Regarding the remainder of the information used to construct the following table, we present CPI-Medical Care data rather than the hospital CPI information, since the only relevant hospital CPI is the overly narrow hospital room index and because of definitional changes in the hospital index over time. Notably, the choice of a base year makes a substantial difference when calculating growth from the early years of the Medicare program. Calendar year 1966 reflects only 6 months of Medicare hospital benefit payments. Fiscal year 1967 (and calendar year 1967) represents the first full year of Medicare benefit payments. Thus, data on growth from 1966, as presented by the commenter and in this table, is a somewhat misleading measure of program growth.

The table is based on full year source data through 1984. Since full year 1985 CPI values are not available, we used the June, 1985 CPI (that is, mid-year) values as estimates. The Bureau of Labor Statistics reports that the CPI-All Items was 322.3 and that the CPI-Medical Care was 401.7 in June, 1985. Since full year 1985 Medicare outlay figures are not available, we used the estimates of benefit payments and total disbursements for 1985 from the Board of Trustees 1985 Annual Report (1985 Annual Report of the Trustees, *id.*, p. 30, Table 5). The Board examined two alternative projections, both of which yield the growth rates presented in the table. (The periods chosen for inclusion in the table enable ready comparison of the pertinent data sources and major time periods.)

COMPARATIVE GROWTH RATES OF HOSPITAL MALPRACTICE INSURANCE COSTS AND OTHER REPRESENTATIVE COSTS

Period	CPI all items (percent)		CPI medical care (percent)		Medicare part A benefit payments (percent)		Medicare part A total disbursements (percent)		National health expenditures: Hospital care (percent)		Medicare G & A costs (percent)		Hospital malpractice premiums (percent)	
	Total	Per year	Total	Per year	Total	Per year	Total	Per year	Total	Per year	Total	Per year	Total	Per year
1960 to 66	9.6	1.5	18.1	2.8	NA	NA	NA	NA	73.6	9.6	NA	NA	15.6	2.4
1966 to 70	19.7	4.6	29.1	6.6	475.1	54.9	426.6	51.6	77.2	15.4	NA	NA	213.3	33.0
1960 to 70	31.1	2.7	52.5	4.3	NA	NA	NA	NA	207.7	11.9	NA	NA	262.2	13.7
1970 to 78	68.0	6.7	81.9	7.8	245.1	16.7	244.2	16.7	172.1	13.3	NA	NA	1,131.9	36.9
1971 to 78	61.1	7.0	70.9	8.0	207.5	17.4	208.1	17.4	145.8	13.7		13.6	863.9	38.2
1971 to 80	103.5	8.2	107.1	8.4	335.8	17.8	333.5	17.7	226.8	14.1	NA	NA	1,119.4	32.0
1970 to 80	112.2	7.8	120.5	8.2	389.1	17.2	384.3	17.1	261.8	13.7	NA	NA	1,458.4	31.6
1980 to 84	26.1	6.0	42.7	9.3	72.6	14.6	71.6	14.5	NA	NA	NA	NA	66.7	13.6
1981 to 84	14.2	4.5	28.9	8.8	42.6	12.5	42.8	12.6	NA	NA	NA	NA	51.5	14.9
1981 to 85	18.3	4.3	36.4	8.1	57.9	12.1	58.7	12.2	NA	NA	NA	NA	69.4	14.1
1980 to 85	30.6	5.5	51.1	8.6	91.2	13.8	90.7	13.8	NA	NA	NA	NA	86.3	13.3

Comment: A corporation that owns and manages a chain of providers commented that its malpractice premium expenses increased 19.2 percent from 1979 to 1983 while the Hospital CPI increased 38 percent during that time.

Response: There is no reason to believe that the experience of a single hospital firm with a limited number of facilities is representative of the hospital malpractice insurance market as a whole. The HCFA national hospital input price index, using AHA-derived and ISO data, indicates that malpractice insurance premiums increased a cumulative 58.0 percent from 1979 through 1983. (HCFA, unpublished data.)

2. The Small Size and Number of Malpractice Claims Submitted by and Paid to Medicare Beneficiaries

Comment: Even if it were assumed that Medicare patients submit and are paid fewer and smaller malpractice claims than other patients, this would not justify removal of these costs from the G&A pool. As the NPRM states, the concept underlying the utilization method is that while Medicare may pay a disproportionately large share of some G&A costs such payments will be balanced by the program paying a disproportionately small share of other costs.

Response: While the utilization method ensures that, in general, Medicare will pay its fair share of G&A costs, we have always recognized that exceptions to this methodology may be necessary. As described in the NPRM, we initially paid providers 100 percent of their Medicare billing costs, a practice discontinued once billing became routine for providers. (*See*, Bureau of Health Insurance Intermediary Letter No. 218, April 19, 1967.) Our evidence is that the great under-utilization of malpractice insurance costs, together with the extraordinary increase in these costs and their significant size relative to the G&A pool, means that this particular disproportionality is not offset by other costs in the pool that may be over-utilized by the program. Thus, it is necessary to remove premium costs from the G&A pool and directly apportion them in order to restore the presumed balance of the G&A cost center.

a. *The Frequency of Medicare Claims.*

Comment: The HCRIS data has no bearing on the frequency or number of malpractice claims filed. Since the Westat Study is fatally defective, there is no support for the claim that Medicare patients submit fewer claims than other patients. Thus, HCFA has no basis for claiming that Medicare beneficiaries under-utilize the "claims handling expense" component of total premium cost—a component which the agency concedes is the second largest part of the total cost.

Response: It is indisputable that hospitals are subject to greatly increasing malpractice claims and lawsuits. For example, St. Paul reports that the frequency of hospital claims

reported on a calendar year basis increased more than 76 percent from 1979 to 1983. (*See*, Report I of the American Medical Association Special Task Force on Professional Liability and Insurance, "Professional Liability in the 1980s", p. 11 (October 1984).) St. Paul reports a 60 percent increase in frequency of claims between 1980 and 1984—from 2.1 claims per 100 occupied beds in 1980 to 3.4 in 1984. Claim severity increased 54 percent during the same five year period. According to St. Paul, these two factors are the primary determinants of the increase in premium rates. (*See*, The St. Paul's Hospital Update—Special Report (1985).)

Other companies also report great increases in frequency of claims. The Doctors Company, based in California, reported a 105 percent increase between 1979 and 1983. Claims per insured nearly doubled from 8.9 per 100 in 1979 to 16.7 in 1983. (*See*, Report I of the American Medical Association Special Task Force on Professional Liability and Insurance, "Professional Liability in the 1980s", p. 11 (October 1984).)

Contrary to the commenter's assertion, the NPRM nowhere stated that HCRIS pertained to the frequency of malpractice insurance claims. However, our analysis of the data underlying the NAIC closed-claimed study shows that, relative to hospital utilization, Medicare patients submit far fewer claims than non-Medicare patients. The NAIC study indicates that, for the period July, 1975 through December, 1978, 4,659 claims against hospitals by 65 and over individuals were closed, as compared to 17,689 claims against hospitals by under-65 individuals and 1,038 claims for persons of unknown age. Claims were more frequent for aged 65 and older individuals per million per year than claims for under-65 persons per million per year (i.e., 56.1 for 65 and older persons versus 25.8 for under-65 individuals). However, relative to the general population, hospital inpatients proportionately tend to be elderly. Thus, the key measure of claims frequency is numbers of claims per hospital utilization. The NAIC data show that claims for 65 and older individuals are less frequent when measured against hospital utilization. On an annual basis, 65 and over individuals account for 15 claims per million patient days (versus 34 claims per million patient days for the under-65 population). Furthermore, 65 and older individuals account for 163 claims per million admissions (versus 206 claims per million admissions for the under-65 population).

As explained above (see, section II.A.), the NAIC data indicate that the claims tail for 65 and over individuals is about 17 months, as compared to a claims tail of about 31 months for under-65 persons. The disparity between the two patient groups with respect to frequency of claims, as measured against hospital utilization, still applies when the different claims tails are taken into account. That is, when claims settled (e.g., in 1978) are compared with utilization in the estimated year of injury (e.g., 1976 for 65 and older persons versus 1975 for under-65 individuals), the 65 and older population still has less frequent claims. Taking into account the claims tails for the years included in the NAIC data, there were 13 claims per million patient days for 65 and older persons (versus 32 claims per million patient days for the under-65 population) and 145 claims per million admissions for 65 and older individuals (versus 200 claims per million admissions for the under-65 population).

As discussed below (see, section III.D.), claims handling expense (i.e., ALAE and ULAE) is affected by the frequency and amount of claims, both of which are lower for Medicare patients than non-Medicare patients. The NAIC data show that, for closed claims greater than zero, ALAE averaged $2,978 for 65 and older persons. This was 68.9 percent of the $4,325 average ALAE for under-65 persons, and 73.6 percent of the $4,044 average ALAE for persons of all ages. The NAIC results were essentially unchanged when closed claims equal to zero were included. For all closed claims, ALAE for 65 and older persons ($961) is 58.3 percent of under-65 ALAE ($1,649). Thus, just as Medicare patients have fewer malpractice claims relative to hospital utilization, so the average ALAE for Medicare patients is much lower than for non-Medicare patients.

Comment: Contrary to what is stated in the NPRM, there are reasons why Medicare patients may submit more claims than non-Medicare patients because of their lower average cost per claim. If this assumption were correct, then higher frequencies would offset lower average awards. Thus, there would be no basis for directly apportioning malpractice insurance costs.

Response: As explained above, the NAIC data indicate that, relative to hospital utilization, Medicare patients submit fewer malpractice claims than non-Medicare patients. Even if it were assumed that Medicare patients have higher claims frequencies, the great disparity between the national Medicare utilization rate and the national ratio of Medicare losses to total losses, among other reasons, would still require removal of malpractice insurance costs from the G&A pool. The HCRIS data implicitly recognizes all factors affecting claim costs. If the claims frequencies of Medicare patients were high enough to offset lower average awards, then the national ratio should approximate the Medicare patient utilization rate. But the utilization rate is more than three times the national ratio. Thus, even if, contrary to what is indicated by the NAIC data, Medicare patients file more claims than non-Medicare patients, it is proper to remove premium costs from the G&A pool because of the great disparity between Medicare utilization and paid losses, in addition to the other reasons discussed in the NPRM and elucidated further in our response to comments.

Comment: Even if it were assumed that, as the preamble states, Medicare patients *submit* fewer and smaller claims than non-Medicare patients, this would not establish that the program was bearing a disproportionate amount of malpractice insurance costs. On HCFA's own view, it is the loss element of premium cost that is the predominant component of total premium cost. The number of claims filed bears only on the claims handling component of total cost.

Response: The second reason adduced in the preamble to the proposed rule for removing malpractice insurance costs from the G&A pool inadvertently omitted any reference to the disproportionately small claims *paid* to Medicare beneficiaries. (See, 50 FR 25182, column 1.) As indicated elsewhere in the NPRM and in our response to comments, it is the disproportionately small share of claims submitted by and paid to Medicare patients that primarily justifies removing malpractice insurance costs from the G&A cost center.

Claims handling expense is affected by both the frequency and amount of claims, both of which are disproportionately smaller for Medicare patients than non-Medicare patients. As explained above, the NAIC data indicate that Medicare patients submit, relative to hospital utilization, fewer claims than non-Medicare patients. Also, the NAIC data show that Medicare patients have a lower average ALAE than non-Medicare patients. As explained below, the NAIC data also show that the average Medicare indemnity is much lower than the average non-Medicare indemnity. Thus, the NAIC data support our determination that Medicare patients

under-utilize the claims handling part of total premium cost.

The NAIC data also buttress the support furnished by HCRIS for our determination that Medicare patients under-utilize the parts of premium cost that pertain to losses. As described above, HCRIS shows that the national Medicare patient utilization rate is more than three times greater than the national ratio of losses paid to Medicare patients as compared to total losses. The NAIC data indicate that Medicare patients prevail less frequently than non-Medicare patients. In claims against hospitals, 32.3 percent of claims for 65 and older persons were settled for more than zero dollars (versus 38.1 percent for under-65 persons and 36.6 percent for all persons). Moreover, the NAIC data indicate that the average indemnity paid to 65 and older persons is much lower than for under-65 persons. For closed claims greater than zero, indemnities averaged $9,377 for 65 and older individuals, which was 49.9 percent of the $18,869 average for under 65 persons and 55.6 percent of the $16,869 average for all persons. The NAIC results are essentially unchanged when all closed claims (i.e., including those for a zero amount) are considered. For all closed claims for individuals 65 and older, the average indemnity ($3,025) was 41.9 percent of the under-65 average indemnity ($7,211).

b. *The Size of Medicare Paid Losses.*

Comment: HCFA cannot justify direct apportionment of malpractice premium costs on the basis of a disproportionately small share of claims paid because there is no significant relationship between premium cost and claims paid experience. Even if Medicare patients are paid a share of malpractice claims that is so disproportionately small as to distort the presumed balance of the G&A pool, only that part of total premium cost should be removed from the G&A cost center.

Response: As explained in detail below (see, section III.D.), malpractice loss experience is a major determinant of premium cost and constitutes a reasonable basis for partially determining Medicare's share of the predominant risk component of total premium cost. Since Medicare patients under-utilize the loss-related part of total premium cost, this element of total cost must be apportioned on the special basis established by this final rule. However, the administrative part of total cost is for services that are not attributable to specific patients or risk-related activities. Because there is no evidence that Medicare patients disproportionately utilize these services, we have decided to return the administrative component to the G&A cost center and apportion it on a utilization basis.

Comment: HCFA has not established that Medicare beneficiaries are paid a share of malpractice awards that is disproportionately small enough to warrant direct apportionment of premium costs. Moreover, the HCRIS data show that paid claims account for only 33.5 percent of malpractice insurance premium costs—not 70 percent or more of premium costs, as is claimed in the NPRM. Because HCFA has no evidence that Medicare beneficiaries under-utilize the other two thirds of total premium cost, there is no sound basis for removing malpractice costs from the G&A pool.

Response: As the following table makes clear, Medicare beneficiaries are paid a disproportionately small share of total malpractice awards as compared to the overall Medicare patient utilization rate.

	Paid loss data [1]			Medicare utilization (percent)[2]
	Medicare	Total	Ratio (percent)	
1975	N/A	N/A	N/A	1975 34.9
1976	N/A	N/A	N/A	1976 36.1
1977	N/A	N/A	N/A	1977 36.9
1978	$3,316,245	$27,124,451	12.23	1978 37.8
1979	$7,395,132	$69,292,909	10.67	1979 38.5
1980	$10,662,456	$93,583,644	11.39	1980 39.5
1981	$12,978,700	$122,367,612	10.61	1981 39.5
1982	$22,088,650	$159,597,886	13.84	1982 40.2
1983	$10,230,780	$90,460,923	11.31	1983 40.0

[1] SOURCE: Unweighted, raw data from the HCRIS data base.

[2] SOURCE: Unweighted, raw data derived from the February 15, 1985 "Budget Briefing Book" for fiscal year 1986 prepared by HCFA's Bureau of Data Management and Strategy.

Regardless of whether the claims paid ratio is compared to the utilization rate for the same year or, in order to account for the claims tail, for earlier periods, Medicare's general patient utilization is, on average, more than three times greater than the program's share of paid losses.

As explained in the NPRM, we attribute this disproportionality between Medicare claims paid experience and Medicare utilization to the fact that the relatively aged Medicare patient population have fewer and smaller malpractice awards than non-Medicare patients. As explained above, the NAIC data show that Medicare patient claims are fewer in number and smaller in average size than non-Medicare patient claims. For the reasons indicated in the NPRM and in our response to comments, this disproportionality is significant enough to warrant removing malpractice premium costs from the G&A pool. This action is necessary to restore the presumed balance of the G&A cost center.

As explained in detail below (see, section III.D.), we have determined that the anticipated loss subcost of the risk component of total premium cost is about 55 percent of total premium cost. Any divergence between our determination about the anticipated loss subcost and the HCRIS data regarding the ratio of paid losses and malpractice "premium expense presumably stems from two facts. First, we considered open and closed claims in determining the anticipated loss subcost while HCRIS includes only closed claims. Second, as explained below (see, section III.C.3.), the measure of malpractice insurance expense contained in HCRIS includes costs (e.g., deductibles copayments, etc.) besides those that the insurance industry considers to be premium cost.

In addition, this final rule reflects our determination that the risk component of premium cost is based on more than anticipated loss experience. In determining that the risk component is 91.5 percent of total premium cost, we have taken into account various expenses (for example, ALAE and ULAE) besides anticipated loss experience. Since Medicare patients under-utilize the risk component of total premium cost, we have decided to apportion that element on the special basis established by this final rule. But because there is no evidence that Medicare patients disproportionately use the services underlying the administrative component of total premium cost, that portion will be returned to the G&A pool and apportioned under the utilization method.

Comment: The HCRIS data on malpractice losses from 1978 to 1983 cannot support any conclusions about the relative loss experience of Medicare and non-Medicare patients during that period. The premiums charged by insurers during the past five years constituted a best estimate of the risk-of-loss under the policy in the then-future period. Neither the insurer nor the hospital had the benefit of hindsight that the Secretary has gained from the HCRIS data.

Response: As explained above, comparison of the national ratio and the Medicare utilization rate shows that the former is less than one-third of the latter, regardless of whether the national ratio is compared with the utilization rate for the same period or for earlier periods that would reflect the claims tail. There is no reason to believe that this under-utilization of the major part of premium cost by program beneficiaries will change in future years. However,

under this final rule, we will continue to monitor the national ratio of Medicare losses to total losses. New § 405.457(b)(5) establishes a procedural mechanism for revising that figure, should the need arise.

Comment: One commenter submitted evidence allegedly showing that ten hospitals would have received reimbursement for 46.2 percent of their premium costs under the utilization method even though their patient utilization rate averaged 59.64 percent. The commenter concluded that the utilization method did not reimburse excessively premium costs.

Response: Because the utilization method is applied on a departmental basis, it would be merely coincidental for a provider's overall utilization rate to equal the percentage of its premium reimbursement under the pre-1979 apportionment method. In any event, assuming that the commenter's data are accurate, it clearly is unrepresentative of the universe of providers. Continuation of the pre-1979 utilization method is improper because, among other reasons, comparison of national loss data and utilization rates reveals that Medicare patients receive awards at a rate that is less than one-third of their utilization of patient services. While utilization will be an important factor in our new apportionment policy, this final rule will apportion the risk component of premium cost in a manner that accounts for the disproportionately small share of Medicare claims.

Comment: The HCRIS data file contains no information on average malpractice award size, but only aggregate premium cost and claims paid data. Average award size, not aggregate comparisons between loss data and the utilization rate, is relevant to the propriety of removing premium costs from the G&A pool.

Response: HCRIS contains premium cost information and paid claims data for individual hospitals. As explained above, the aggregate claims paid data reveal that Medicare patients are paid a disproportionately small share of awards relative to their overall utilization of hospital services. Since the issue is whether to remove premium costs from the G&A pool for all providers subject to the cost-based system, it is appropriate to base this decision on a comparison of aggregate data.

In addition, the NAIC data indicate that, as explained above, the average patient indemnity for Medicare patients is approximately one-half the average indemnity for non-Medicare patients. Thus, besides the disproportionality established by the aggregate HCRIS data, the NAIC data show that average Medicare malpractice award size is disproportionately small too.

Comment: Contrary to HCFA's claim in the preamble to the proposed rule, the Westat Study contradicts the agency's decision to remove malpractice costs from the G&A pool, for the following reasons: (1) HCFA's official synopsis of the Westat Study states that Medicare patients are more likely to be injured as a result of institutional errors, more likely to fall and more likely to be injured in their own rooms than non-Medicare patients. Because these kinds of injuries usually result in malpractice awards against hospitals, not physicians, the commenters concluded that the Study actually shows that the frequency of Medicare awards against hospitals is disproportionately high (while the frequency of Medicare awards against physicians is disproportionately low); (2) A consultant's reanalysis of the data used for the Westat Study showed that Medicare patients accounted for 19.9 percent of total claims filed and between 17.8 percent and 22.5 percent of total claims paid at a time when the average Medicare utilization rate was 21 percent.

Response: As indicated above, this final rule is not based in any way on the Westat Study. The court decisions on the 1979 malpractice rule, together with the comments submitted in this rulemaking, reject use of that Study as a basis for deciding whether to remove malpractice premium costs from the G&A pool because, for example, the Study did not carefully distinguish hospital and physician claims. As explained above, the disproportionalities established by the HCRIS and the NAIC data, among other reasons, justify our decision to remove malpractice insurance costs from the G&A cost center.

3. The Relative Importance of Malpractice Premium Costs in the G&A Pool

Comment: The HCRIS data file contains no historical information on malpractice insurance premium costs. HCFA used total malpractice insurance premium costs (Worksheet A, line 71, column 5) as its source of premium data. Along with premiums and self-insurance fund contributions, this figure included allowable uninsured loss payments (deductibles, copayments, and excess losses), associated direct costs, and non-reimbursable insurance premiums, fund contributions, and losses. Because this figure overstates the cost of insurance, it cannot be used appropriately to make judgments about premium cost. Thus, HCFA's assertions about the cost of malpractice insurance relative to the total G&A cost center are based on overstated costs and an overstated ratio.

Response: In the NPRM, we stated that the HCRIS data show that malpractice insurance costs are about $708 million annually, which constitutes 6.14 percent of the total costs in the G&A pool (including malpractice insurance costs). The more recent HCRIS data that underlies this final rule shows that malpractice insurance costs are about $847 million annually, which is about 6.1 percent of total G&A costs plus malpractice insurance expense. Because malpractice insurance costs have not been included in the G&A cost center since 1979, it was necessary to compare total malpractice insurance costs to the sum of total G&A costs plus total malpractice insurance costs. For this purpose, we included, besides malpractice insurance premiums and self-insurance fund contributions, other costs associated with malpractice insurance. It was necessary to include all of the costs from line 71 of worksheet A because this entry is the best available data from the Medicare cost report for total premium cost. While these associated costs were included in our calculations, malpractice premium cost (and self insurance fund contributions) is easily the largest of the costs that, taken together, are entered on line 71 of Worksheet A. Since malpractice insurance cost was defined identically in the numerator and denominator of the ratio from which the 6.14 percent figure was derived, the comparison made was valid in all relevant respects.

Comment: HCFA's claim in the NPRM that the different costs in the G&A cost center are not itemized on the providers' cost reports is erroneous.

Response: The NPRM statement referred to by the commenter was made in the context of our discussion of one of the alternatives to the proposed rule. (See, 50 FR 25187, column 2.) The alternative was to directly apportion other overhead costs in addition to malpractice premium costs. As explained above, we allow providers to report their G&A costs on an undifferentiated basis or to break them down into six component cost centers. Since none of the other overhead costs for which direct apportionment has been suggested (for example, Medicare billing costs) is the same as any of the component cost centers, we stated that the fiscal impact on this alternative could not be ascertained.

Comment: Even if the HCRIS data do show that malpractice premium costs constitute 6.14 percent of the total of the G&A cost center, this percentage is less than one sixteenth of the whole G&A pool. By contrast, other component costs in the G&A pool (for example, data processing costs and business office costs) are a much larger percentage of the G&A pool.

Response: When the NPRM was published, the HCRIS data showed that premium costs were 6.14 percent of the total G&A cost center plus total malpractice insurance costs. Since that time, additional cost reports have been added to HCRIS. As described above, the result is that HCRIS now indicates that premium costs are about 6.10 percent of the costs in the G&A pool. We recognize that other component cost centers in the G&A pool are a larger percentage of the G&A pool. For example, the HCRIS data base indicates that the cashiering and accounts component cost center is 13.07 percent of the total G&A pool while data processing is 11.37 percent of the whole cost center. Unlike malpractice insurance premium costs, however, these component cost centers include a myriad of discrete costs. For example, data processing may include the cost of software; the cost of magnetic tapes, discs, etc.; and costs associated with personnel. Similarly, cashiering and accounts could consist of personnel-related costs, supplies, and other items.

Moreover, we have no evidence that these component cost centers (or any of their significant constituent costs) are utilized disproportionately by Medicare. On the other hand, because malpractice insurance costs have increased extraordinarily, in addition to being a significant percentage of the G&A pool and greatly under-utilized by program beneficiaries, direct apportionment of these costs is proper.

Comment: HCFA possesses cost report information from which to make an empirical determination of the size of the different costs in the G&A pool. The agency's failure to analyze the constituents of the total cost center leaves unsupported its statement that direct apportionment of premium costs reinstated rather than upset the balance of the G&A pool.

Response: As explained below, we have two data sources pertaining to the relative size of the component cost centers of the total G&A pool. However, we know of no reliable data on the relative size of discrete costs within the G&A pool. In particular, the cost reports and worksheets contain no information on the discrete costs that constitute the different component cost centers. Also, while our data indicate that some of the other component cost centers in the G&A pool are larger than malpractice insurance costs, no data show that these component cost centers (or their significant constituents) are utilized disproportionately by program beneficiaries. By contrast, the extraordinary increase in and the significant size of malpractice insurance costs, together with their under utilization by Medicare patients, make it appropriate to directly apportion only these costs.

Comment: Several commenters submitted data from *ad hoc* samples of hospitals, which allegedly show that other G&A costs are a larger percentage of the whole pool than premium costs.

Response: As some of these commenters conceded, their data are derived from samples that are not representative of the universe of Medicare providers. We have more reliable data on this subject that show that some component cost centers are larger than premium costs. However, there is no evidence that Medicare disproportionately shares in these other component cost centers, or that these costs have increased dramatically in recent years.

Comment: The Department's 1978 internal study on the G&A pool indicates that several G&A costs are over-utilized by Medicare patients, including data processing costs and inpatient business office costs. Several commenters on the 1979 rule stated that Medicare paid less than its fair share of various G&A costs.

Response: As explained above, reliance on the 1978 study referred to by the commenter (Maher Study) is inappropriate because it is based on an unreliable sample and unverified data. We have no reliable data to support the contention that Medicare paid less than its fair share of other G&A costs (e.g., billing-related costs, cost report preparation and appeals, Medicare statistical recordkeeping, etc.). Indeed, credit and collection costs are, for the most part, utilized more heavily by non-Medicare patients because the underlying services are not covered by Medicare. Also, one mode of interim Medicare payments—the Periodic Interim Payment (PIP) system—provides for automatic payments to providers in a manner that does not require immediate submission of bills by the provider. Any differences in relative billing costs for different categories of payer are diluted by the advent of uniform billing systems and Medicare's recognition of such a system. Thus, we have determined that to the extent that discrete costs in the G&A pool might be over-utilized by Medicare beneficiaries, such costs would be more than offset by costs and considerations such as the ones described above.

4. Changes in Other Costs in the G&A Cost Center

Comment: HCFA has no evidence to support its claim that no other costs in the G&A pool increased significantly during the period in which malpractice premium costs increased so dramatically. In fact, other G&A costs have risen greatly in recent years. For example, the HAS/MONITREND data compiled by the American Hospital Association (AHA) indicate that data processing costs per adjusted occupied bed increased 132.3 percent between 1980 and 1984.

Response: The HCRIS data base is a limited source of historical information on increases in component cost centers of the G&A pool. As explained above, we allow providers to report their G&A costs on an undifferentiated basis or, as an alternative procedure, by breaking them down into six component cost centers. At one point, HCRIS showed that of the 5,162 hospitals with 1982 cost reports, 589 hospitals (11 percent) reported their G&A costs on a component basis. At that time, HCRIS showed further that of the 2,703 hospitals with 1983 cost reports in HCRIS, 578 hospitals (21 percent) elected to break down their G&A costs. The HCRIS data show that no component costs in the G&A pool increased significantly as a percentage of the total G&A pool during 1982 and 1983.

We also have roughly commensurable data derived from the American Hospital Association's "Hospital Administrative Services (HAS)/ MONITREND" program, which, besides HCRIS, is the only other pertinent available data source that we know of. The HAS/MONITREND data reveals that, for roughly similar component costs of a pool of G&A costs, no component G&A costs increased significantly as a percentage of the whole G&A pool between 1979 and 1984.

Even if it were assumed that data processing expense per adjusted occupied bed increased 132.3 percent between 1980 and 1984, this would not detract from the propriety of removing premium costs from the G&A pool. As explained above, malpractice insurance costs increased 66.7 percent during the same period. The data processing component cost center, unlike malpractice premium cost, includes numerous discrete costs. Most importantly, there is no evidence that data processing costs, or any of the

other component costs included in the G&A pool, are used disproportionately by Medicare patients.

Comment: The Department cannot establish that malpractice premium costs distorted the balance of the G&A pool without supplying data that compare the rate of increase of premium costs with the rate of increase of other constituents of the G&A pool. Due to the limited timeframe of the HCRIS data, such an analysis could not be based on that data. Thus, the agency should undertake a study of the cost reports in order to secure this comparative analysis.

Response: As explained above, HCRIS constitutes historical evidence on the relative rate of increase of premium costs and component cost centers from 1982 to 1983. The HAS/MONITREND data constitute evidence on this same issue for the period between 1979 and 1984. We know of no reliable data on relative rates of increase of discrete costs within component cost centers of the G&A center.

We do not believe that additional study of the cost reports would be fruitful. Since malpractice insurance costs were not reported separately until 1979, the cost reports would yield comparative data for only 1979 through 1985. Data for the 1979–1985 period would only enable comparisons between premium costs and component cost centers. Since discrete costs within a component center are not included in the cost reports or worksheets, premium costs could not be compared with constituent G&A costs. Thus, any study of the constituents of the G&A pool would be impossible.

Furthermore, the key issue regarding the propriety of removing premium costs from the G&A pool is whether those costs were under-utilized by Medicare patients. Even if it were assumed that other constituent G&A costs increased as fast or faster than malpractice costs, the under-utilization of premium costs would warrant—absent program over-utilization of another, equally significant and inflationary constituent G&A cost—removal of these costs from the G&A pool. We know of no countervailing G&A cost that would balance the disproportionality created by the extraordinary increase and under-utilization of premium costs.

Comment: There is no evidence that HCFA studied any other constituent G&A cost in order to determine whether it increased as much or more than malpractice insurance costs. Numerous other overhead costs (for example, energy costs), increased tremendously in recent years.

Response: Energy costs are not included in the G&A pool, but rather, are included in the cost center generally described as "Plant Operation." Also, there is no evidence that energy costs are used more by Medicare patients than by non-Medicare patients.

Comment: Several commenters submitted data from *ad hoc* samples of hospitals, which purportedly showed that other G&A costs increased at a greater rate than malpractice insurance costs.

Response: The *ad hoc* samples are statistically unrepresentative of the universe of providers. As explained above, the evidence indicates that no other component cost increased at a greater rate than malpractice insurance costs.

Comment: If malpractice insurance costs are to be directly apportioned, then costs uniquely attributable to Medicare patients (e.g., keeping billing records, preparing cost reports, and processing claims) also should be removed from the G&A pool.

Response: The costs referred to by the commenter would be reported in the Other General and Administrative component cost center of the G&A pool. (*See*, Provider Reimbursement Manual (HIM 15–1), section 2313.1.) Because constituent costs within a component cost center are not itemized on the cost report or worksheet, it is impossible to know the precise proportion the costs mentioned by the commenters represent in the Other General and Administrative component cost center. However, there is no evidence that these costs increased significantly during the period that malpractice insurance costs skyrocketed. Also, as discussed above, our programmatic experience suggests that some of these costs (e.g., credit and collection costs, billing costs, etc.) are not over-utilized by Medicare patients. Thus, there is no reason to believe that these costs distorted the presumed balance of the G&A pool.

Comment: The NPRM depicts the following worst-case scenario. Under the pre-1979 utilization method, Medicare was reimbursing 40 percent of premium costs, which constitute about 6 percent of the G&A pool, while the program should have been reimbursing only 11.6 percent of those costs. This disproportionality would distort the averaging of G&A costs by only 1.4 percent (.40 minus .116 times .06). If the utilization rate were only 30 percent during the relevant time period, then the distortion would be only 1.1 percent (.30 minus .116 times .06). Because the cost-finding process is so inherently imprecise, no attempt should be made to address such a small distortion. But if a distortion of 1 percent justifies direct apportionment of malpractice premium costs, then distortions stemming from other costs attributable exclusively or disproportionately to Medicare patients should be directly apportioned too.

Response: The commenter's calculations are correct. However, because HCRIS now shows that the whole G&A pool consists of about $14.0 billion in costs per annum, a distortion in that cost center of 1.4 percent would equal $196.0 million per annum. Similarly, a distortion of 1.1 percent would equal $154.0 million per annum. Based on the three parameters established on the basis of HCRIS for this final rule, the disproportionality would distort the G&A pool by 1.9 percent (.429 minus .118 times .061), which would equal $266.0 million per annum (1.9 percent times $14.0 billion). As explained above, we know of no other G&A cost that is over-utilized by the program, along with being sufficiently inflationary and large, to create a countervailing distortion in the G&A cost center.

Comment: In 1981, HCFA stated that hospital care costs for 1980 were $99.6 billion. (*See, Health Care Financing Review*, September 1981.) The agency estimated that the first-year savings from the 1979 malpractice rule would be $1.16 billion, which is only slightly more than 1 percent of total hospital costs. If, as was claimed by HCFA in 1979, Medicare utilization was 30 percent and the program should have been reimbursing only 5 percent of premium costs, then the G&A pool would have been distorted by only .25 percent (.30 minus .05 times 1 percent). The imprecise nature of the cost-finding process makes it absurd to discrete cost such a small part of the G&A pool.

Response: The commenter has mismatched statistics. Premium costs should be compared to the totality of costs in the G&A pool, not to the universe of hospital costs. The HCRIS data show that premiums account for 6.10 percent of total G&A costs. The utilization method would distort the G&A pool by 25 percent of 6.10, as implied by the commenter, only if premiums equaled 1 percent of total G&A cost (a statement not made by the commenter and one that is belied by the HCRIS data). As explained above, based on the 6.10 percentage relationship between malpractice insurance costs and total G&A costs, the utilization method would distort the G&A pool by 1.9 percent or $266.0 million per annum. This disproportionality in favor of non-Medicare patients is large enough to

warrant, absent a countervailing disproportionality in favor of the program, direct apportionment of premium costs.

D. Malpractice Loss Experience Is a Valid Basis for Partially Determining Medicare's Share of the Predominant Component of Malpractice Insurance Premium Cost

1. Relevance of Insurance Industry Practices

Comment: The claims-paid methodology is at variance with how the insurance industry establishes hospital malpractice insurance premiums. While section 1861(v)(1)(A) of the Act arguably affords the Secretary some discretion as to whether to follow insurance industry premium-setting practices, any deviations from these practices must have a rational basis. There is no evidence supporting the rationality of the claims-paid formula.

Response: The insurance industry does not employ a single premium-setting methodology. Rather, hospital malpractice insurance premiums are established on a variety of different bases. For example, coverage can be provided on an "occurrence" basis (i.e., a claim is covered under a policy if the underlying incident occurred when the policy was in effect) or on a "claims-made" basis (i.e., policy coverage depends on whether the claim was reported when the policy was in effect). Other differences between policies depend on the nature of the available experience data. While some actuaries use "paid losses" (e.g., closed claims) to calculate experience levels, the majority use an "incurred loss" approach in which calculations are based on both pending or open claims and closed claims.

The establishment of a typical hospital malpractice insurance premium includes three main steps. First, an overall state rate must be determined. The insurance company gathers statewide loss data from a past period, data which include allocated loss adjustment expenses (ALAE). Provision is then made for insurer expenses, including unallocated loss adjustment expenses (ULAE), and that amount is added to projected losses plus ALAE. The sum is then compared with the premium level that would be charged if current rates were to apply in the future, and any necessary adjustments are made.

Second, the insurer determines how any indicated change in the statewide rate should be divided between the class of insureds. For example, hospitals are categorized as for-profit or not-for-profit. "Rate relativities," which are based on nationally-derived loss ratios, are then applied to each category. Further distinctions may be made between geographical subdivisions on the basis of loss ratios.

Third, each hospital receives its own experience rating. That rating is based on an institutional size weight and a statewide or territorial weight. The experience data used are based on losses and ALAE.

In contrast to the insurance industry, which establishes malpractice insurance premiums, the Secretary is charged with the responsibility of ensuring that Medicare pays no more than its fair share of provider premium costs. While section 1861(v)(1)(A) of the Act requires the Secretary to consider insurance industry practice in the course of developing reasonable cost reimbursement principles, the statute affords broad discretion as to whether to apply specific *industry premium-setting practices* to *Medicare apportionment policy*. Obviously, industry premium-setting practices do not address—much less mandate a particular result as to—the proper methodology for apportioning premium costs.

Primarily because Medicare beneficiaries submit and are paid a disproportionately small share of malpractice claims, it is appropriate to apportion premium costs on a basis that accounts for this phenomenon. (See, section III.C., above.) As explained in the NPRM, we agree with the Court of Appeals for the District of Columbia Circuit that the 1979 malpractice rule's claims-paid formula satisfies the statutory requirements by definition, and that the formula is not arbitrary and capricious simply because it does not reimburse total premium cost in a manner that is tied explicitly to each component of total cost.

However, in response to criticisms raised in the litigation of the 1979 malpractice rule and in comments on the NPRM, we have decided to revise the claims-paid methodology in certain respects. The result is an apportionment policy that tracks more closely insurance industry premium-setting practices. Under this final rule, providers will be reimbursed on a separate basis for each main part of total premium cost. First, an administrative component of each provider's premium cost that is not identifiable to specific claims—including the insurer's fixed overhead expenses and a proportionate share of taxes and commissions—will be returned to the G&A pool and apportioned on a utilization basis. Although industry premium-setting practices do not bear on how premium costs should be apportioned, this method of reimbursing the administrative element of premium cost, which is consistent with the program's pre-1979 apportionment policy and with the policy preferred by the provider industry, is a fair and rational way of apportioning the administrative component because Medicare patients and non-Medicare patients proportionately utilize the services underlying this part of total cost. (See, section II.A., above.)

Second, each provider will be reimbursed separately for the risk component—including anticipated loss experience, ALAE, ULAE, and the remaining share of taxes and commissions—of total premium cost. The risk component will be apportioned on the basis of the adjusted national ratio and the individual hospital's utilization rate. This is a fair and rational apportionment method because the services underlying the risk component are affected by losses and related risk activities and Medicare patients submit and are paid a disproportionately small share of malpractice claims. (See, sections II.A. and III.C., above.)

The national ratio is an essential feature of the claims-paid methodology. While the insurance industry does not determine malpractice coverage on a claims-paid basis, it considers loss experience in each step of the premium-setting process. As explained above, experience data figure importantly in the determination of overall state rates. Nationally-derived loss ratios are used to determine the "rate relativities" that enable the insurer to distinguish categories of hospitals within a State and within geographical subdivisions of a state. Also, paid losses may be used to determine the experience rating of an individual provider.

While insurance industry practice does not address the apportionment issue, we believe that use of the national ratio for reimbursing the risk component is rational because, unlike the pre-1979 utilization method, it ensures that the program will pay only its fair share of this part of total premium cost. Moreover, our use of the national ratio for apportionment purposes is similar to the insurance industry's use of rate relativities in the premium-setting process. A rate relativity is that part of the premium rate that accounts for a specific characteristic of the class of insureds (e.g., whether hospitals are for-profit or non-profit). Similarly, the national ratio is that part of the hospitals' premium cost reimbursement

that accounts for the Medicare program's disproportionately small share of claims filed and loss experience. The national ratio, like rate relativities, is based on nationally-derived loss ratios.

The HCRIS data show that the ratio of Medicare losses to total losses is 11.8%. We have adjusted the national ratio to 13.2% in order to account for the allocated loss adjustment expenses (ALAE) associated with paid claims and to include a share of unallocated loss adjustment expenses (ULAE) for those claims. The inclusion of amounts for ALAE and ULAE in the risk portion is consistent with how the industry determines state rates. Also, the industry experience rates each hospital on the basis of its losses and ALAE.

Finally, use of the adjusted national ratio to scale the risk component to each hospital's own Medicare utilization rate ensures that Medicare will pay only its fair share of this part of total premium cost. Apportioning the risk element on a straight utilization basis is improper because the national ratio is more than three times lower than the national utilization rate and the average Medicare award is much lower than the average non-Medicare award. Also, ALAE is much lower for Medicare patients than non-Medicare patients and, relative to general hospital utilization, Medicare patients file fewer claims than non-Medicare patients. Scaling the risk component to each provider's utilization rate responds to this major disproportionality and ensures that Medicare providers will be reimbursed fairly for their premium costs.

Comment: The NPRM confuses the terms "loss experience," "risk-of-loss," and "paid claims." Paid claims represent the amounts paid to particular patients, which do not include administrative and other expenses associated with such claims. Loss experience includes paid claims and expenses allocated to such claims. Risk-of-loss is the prediction of future claims, which is not based on payment of past claims by patient type or facility.

Response: It was not necessarily our intention in the preamble to the proposed rule to use the terms "paid claims," "loss experience," and "risk-of-loss," in the manner used by actuaries. In fact, there is considerable variability in the insurance industry's use of these three terms. For example, the definition of "paid claims" suggested by the commenter is consistent with industry practice in New York but not in various other states where the term includes ALAE as well as amounts paid to specific claimants. Taking into account variations in use within the insurance industry and among actuaries, it is our understanding that "paid claims" (or "paid losses") means amounts paid to specific claimants and may or may not include associated administrative and other expenses. Similarly, "loss experience" typically means paid claims and open claims and may or may not include associated administrative and other expenses. And "risk-of-loss" usually means likelihood of future claims or losses. Unless otherwise indicated, we will use, in this final rule, the terms "paid claims," "paid losses," and "loss experience" interchangeably to refer to amounts paid to specific claimants. Our use of the term "risk-of-loss" will comport with the above-described definition used typically by the insurance industry and actuaries. Under this final rule, the risk component of total premium cost includes an amount for anticipated loss experience, in addition to amounts for the handling and defense of claims and losses.

Comment: The insurance law treatise cited in the NPRM does not establish that premiums are related significantly to paid losses during the preceding five year period. The treatise states that premiums are based on predicted costs of future claims, together with administrative and other expenses.

Response: As indicated in the NPRM, the treatise shows that premiums are significantly related to losses. The premium amount equals, in part, an amount proportionate to the expected cost of handling and meeting predicted future claims. This amount is determined partially on the basis of loss experience data at each step of the premium-setting process. As is also discussed in the NPRM, the remaining part of premium cost is an amount for administrative and other costs.

a. *Specific Alleged Deviations of the Claims-Paid Methodology from Insurance Industry Practices.*

Comment: The proposed rule ignores the fact that premium costs reflect expected costs in the upcoming period, not simply past costs. Premiums are calculated to be sufficient to cover future claims and related expenses. The claims-paid methodology mistakenly assumes that future malpractice losses may be determined by examining past malpractice claims.

Response: The Medicare statute limits cost-based reimbursement to, *inter alia*, costs actually incurred by the provider for the benefit of Medicare patients. We recognize that the cost of a premium for the current period is based, in part, on an estimation of the probable cost of future claims and related expenses. However, as explained above, experience loss data, which reflect past costs, are used in each step of the premium-setting process.

Under this final rule, the administrative component of total premium cost will be apportioned on a utilization basis because Medicare patients do not under-utilize the particular subcosts (e.g., insurer fixed overhead expenses) that constitute that part of the total cost. Because Medicare patients under-utilize the risk component of total cost, however, we will reimburse that element on the basis of the hospital's own utilization rate and the adjusted national ratio. The national ratio, like the experience loss data used in the rate-setting process, reflects past costs. Unlike the insurance industry, however, we must apportion premium costs as accurately as possible, rather than predict future losses. The special apportionment basis for the risk component established by this final rule will ensure that the applicable statutory requirements are satisfied. (See, Section III. G., below.)

Comment: The claims-paid methodology is irrational because, under insurance industry practices, an individual policyholder's loss experience over a five-year period is not a determinant of its own total premium cost or of parts of that cost (e.g., the anticipated future loss subcost).

Response: As explained above, experience rating of individual providers is one step in the premium-setting process. Under this final rule, however, an individual provider's loss experience will not determine the apportionment of premium cost. The national ratio of Medicare losses to total losses will partially determine reimbursement of the risk component of total premium cost. It is necessary to use the adjusted national ratio to scale each hospital's utilization rate because Medicare beneficiaries file and receive a disproportionately small share of awards. While insurance industry practices are not dispositive of the apportionment issue, the industry uses experience loss data throughout the premium-setting process. Loss data for between three and five years are used in the establishment of the statewide rate and the various rate relativities. Since our use of the adjusted national ratio in this final rule is most like the establishment of rate relativities, it is consistent with insurance industry practice to base the national ratio on five years of loss data. Contrary to the commenter's assertion, the insurance industry's experience rating of individual hospitals — invariably based

on loss data for a five year period—is one determinant of premium cost.

Comment: Premium rates are not based on the type of payor losses. Specifically, a provider's Medicare claims experience does not affect its premium costs. This explains why the HCRIS data show that similarly situated hospitals do not have lower premiums when Medicare utilization is higher. For the HCRIS data, the coefficient of correlation between Medicare utilization and premiums is positive, not negative.

Response: Under this final rule, a provider's own loss experience history will not materially determine any part of its reimbursement for premium costs. (We recognize that a hospital's loss experience may contribute to the establishment of the HCRIS-derived national ratio, which, under this final rule, partially determines apportionment of the risk component of total premium cost. However, because the national ratio is based on data for more than 5,000 hospitals for a five-year period, the experience of a specific hospital would have only a marginal affect on the national ratio.) Reimbursement for the risk component will be determined partially by the national ratio of Medicare losses to total losses. While insurers do not directly establish premiums on the basis of the age or type of insurance of claimants, they do experience rate each provider. Because Medicare beneficiaries submit and are paid fewer and smaller claims, the lower experience levels of providers with higher Medicare utilization rates will tend to be reflected in their experience rating plans and, ultimately, in their premium costs. Also, hospitals with higher Medicare utilization rates will receive greater rates of reimbursement under this final rule. Finally, we have responded in detail above (see, section III.B.) to the commenter's assertions regarding what HCRIS allegedly shows about the relationship between premiums and Medicare utilization.

Comment: The individual provider characteristics most directly relevant to hospital malpractice insurance premiums are overall annual bed occupancy and outpatient utilization—not the provider's loss experience history. Also, factors unrelated to policy holder characteristics (e.g., the extent to which investment income offsets underwriting losses) strongly influence premium levels. Because premiums are determined largely on a utilization basis, the pre-1979 utilization method is a better means of apportioning premium costs.

Response: The overall annual bed occupancy, outpatient utilization, and other characteristics (e.g., general liability) of the specific provider all figure in the "rating basis" used for the provider. But the rating basis is nothing more than a description of the data that are collected and used for rate-setting purposes. As explained above, experience loss data figure importantly in each step of the premium-setting process. The commenter's assertion that the individual hospital's loss experience is not directly relevant to premium cost is belied by the experience rating stage of the premium-setting process.

While the rating basis used by an insurer may be determined largely on a utilization basis, the rate-setting process is much more complicated. For example, once the statewide rate is determined, nationally-derived loss ratios are used to calculate rate relativities in order to account for specific characteristics of different categories of insureds. Due to the extraordinary disparity between the national Medicare utilization rate and the national claims-paid ratio, among other reasons, it is necessary to scale, for purposes of apportioning the risk component, the hospital's utilization rate by the national ratio. Thus, just as the largely utilization-derived rating basis is tempered in the rate-setting process, so it is necessary to scale the hospital's own Medicare utilization rate by the adjusted national ratio in the apportionment process. Moreover, the variables that underlie the utilization method of apportionment (i.e., principally, payer shares) are fundamentally different from the utilization variables (e.g., annual overall bed occupancy) that bear on the rating basis used for ratemaking purposes.

The extent to which investment income offsets underwriting losses is reflected in each stage of the rate-setting process. Although profit is attributable to risk-related activities, we have decided not to include an amount for profit in the premium breakdown established under this final rule. The profit derived from the investment of the premium precludes any need to include a subcost for profit in the premium breakdown.

Comment: Risk exposure should be measured in terms of criteria such as institutional size, complexity of services offered, skill of physician and other medical staff, and the provider's risk management activities instead of on the basis of patient indemnities.

Response: Measurement of the risk component of premium cost on the basis of the national ratio of Medicare losses to total losses and the hospital's own utilization rate enables us to accurately apportion this aspect of premium cost between program beneficiaries and non-Medicare patients. As explained above, the insurance industry uses loss data in establishing a statewide rate and various rate relativities, in addition to experience rating individual providers. Notably, the industry does not use the criteria suggested by the commenter to set premium rates and costs. To the extent that institutional size is reflective of annual bed occupancy, it is taken into account in the underlying rating basis instead of the rate-setting process itself. Except for institutional size, the criteria suggested by the commenter are too vague and subjective to use as a basis for apportionment policy. While larger institutions may have a somewhat greater exposure to risk (but not necessarily a greater exposure per unit of service), the lack of a proven connection between institutional size, risk exposure, and Medicare utilization, precludes reliance, for apportionment policy purposes, on an institutional size measure of risk exposure.

Comment: To set premiums for malpractice insurance, the insurer must assess two forms of risk that the insurer assumes by issuing the policy. Parameter risk is the risk that the ratesetter erroneously estimated either the likely number of occurrences or the average liability per occurrence. Process risk is the risk that, while the parameters were accurate, the actual number of occurrences and the average loss per occurrence during the policy period vary from the projection. The proposed rule assumes incorrectly that more than an insignificant portion of premium cost is attributable to the relative paid claims experience of Medicare and non-Medicare patients. In fact, because policies are not established on a claims-paid basis, such an apportionment could be effected only if separate policies were issued for the two groups of patients. This would require independent assessments of the parameter risk and process risk associated with each policy, and would result in an aggregate premium more costly than a single unified policy.

Response: The comment bears primarily on abstract actuarial principles that may underlie, from a theoretical standpoint, the rate-setting process. However, neither parameter risk nor process risk is assessed explicitly in the rate-setting process. The practical relevance of the comment is to the question of the necessary profit margin for premium rates. Contrary to the commenter's assertion, the use of separate insurance policies is not the only means by which the differential claims-paid experience of providers could be apportioned. (See, section

IV.E., below, for a discussion of our reasons for not adopting the alternative of requiring separate insurance policies for Medicare and non-Medicare patients.) Instead, rate relativities that distinguish hospitals on the basis of their Medicare populations could be used. If the insurance industry were to explicitly use such rate relativities in the premium-setting process, the probable result would be premiums, the investment of which would yield different profit margins per different hospital sizes. In any event, our concern is with the proper Medicare apportionment policy for premium costs, generally, and for the profit subcost, in particular. As explained above (see, section II.A.), we have determined that it is unnecessary to include a specific subcost for profit in the premium breakdown established under this final rule.

b. *The Relationship Between Insurance Industry Experience Rating Plans and the Claims-Paid Methodology.*

Comment: The most widely used experience rating techniques mitigate the influence of actual claims experience on premium cost. For example, insurance companies weight the amount of a given loss in accordance with the size of the institution. They also incorporate several years of experience in order to minimize the impact of claims fluctuations from year to year.

Response: As explained above, the experience rating of the individual hospital is the final step in the establishment of the provider's premium. By contrast, under this final rule, a hospital's premium cost reimbursement will be essentially unaffected by the provider's own loss experience. The adjusted national loss ratio will be the only claims-paid determinant of premium cost reimbursement. Similarly to how the industry uses rate relativities to modify the overall statewide rate, we will use the national ratio to scale the hospital's utilization rate in apportioning the risk component of premium cost. Because the national ratio is based on five years of experience for more than 5,000 hospitals, it will not be significantly affected by fluctuations in the loss history of a given provider from year to year. As explained in the NPRM, in determining the national ratio, we weighted each group of sample hospitals by the number of beds in the universe relative to the number of beds in the sample hospitals. Also, under this final rule, reimbursement of the risk component of premium depends importantly on the individual hospital's utilization rate, while the administrative element is determined exclusively on a utilization basis.

Comment: The insurance industry's use of experience rating plans to recognize past claims experience in premium-setting differs radically from the claims-paid apportionment methodology. Experience rating is made on an incurred loss basis, rather than a claims-paid basis, in order to use as much experience as possible in making the hospital-specific determination. In addition, an amount limitation is imposed, which is adjusted by a credibility factor that varies with hospital size.

Response: As explained above, the limited use of the claims-paid methodology in this final rule is more similar to the industry's use of rate relativities than experience rating. While it is true that most experience rating is done on an incurred loss basis, insurers may use a claims-paid approach. In any event, instead of setting insurance premiums, we are establishing an apportionment policy. The use of the claims-paid methodology is a preferable Medicare apportionment basis because there is no data base available on incurred losses that is comparable in relevance and reliability to HCRIS. It is unnecessary to introduce an amount limitation or a credibility factor because the national ratio is based on the loss experience of more than 5,000 hospitals over a five-year period. Also, we weighted each group of sample hospitals in HCRIS by the number of beds in the universe in calculating the national ratio.

c. *Other Specific Criticisms of the Claims-Paid Methodology.*

Comment: The claims-paid formula is irrational because it is based primarily on hospital-specific loss experience, which changes radically from year to year even though such changes are not reflected in premium rates.

Response: Under this final rule, premium costs will not be apportioned on the basis of a hospital's own loss experience history or the identity of any claimant. Thus, changes in an individual hospital's experience history from year to year will not affect its program reimbursement.

Comment: Malpractice insurance is written primarily on an occurrence basis. Thus, contrary to the claims-paid formula, a claim arising in 1979 that is paid in 1982 is indemnified by the 1979 policy—not the 1982 policy. Due to the long "claims tail" of malpractice claims, it makes no sense to apportion costs on a claims-paid basis when those costs are determined on the basis of occurrences in prior years. This mismatching of premiums and occurrences ignores the impact of rising Medicare utilization (and the related increasing risk of loss associated with Medicare patients) and results in cost-shifting to non-Medicare patients.

Response: We recognize that most malpractice insurance policies are written on an occurrence basis. However, the insurance industry uses experience loss information throughout the premium-setting process. We believe that it is preferable to use paid losses (i.e., the national ratio) for apportioning the risk element of total premium cost. The alternative of using incurred losses must be rejected due to the unavailability of a reliable source of incurred loss data that distinguishes incurred Medicare losses from incurred non-Medicare losses. By contrast, HCRIS constitutes a highly reliable source of paid loss data for Medicare and non-Medicare patients.

While there may be some difference of opinion within the insurance industry and among actuaries, our best information, based on the NAIC data, is that there is, on average, a 1.5 year claims tail of malpractice claims for Medicare patients and 2.5 year claims tail for non-Medicare patients. This final rule takes account of the claims tail by relating the adjusted national Medicare malpractice loss ratio (i.e., the "R" term in the scaling factor formula) to both the national Medicare utilization rate as adjusted for the claims tail for Medicare patients (i.e., the "U_1" term in the scaling factor formula) and to the national Medicare patient utilization rate as adjusted for the claims tail for non-Medicare patients (i.e., the "U_2" term in the scaling factor formula). By taking account in the formula of the different claims tails for Medicare and non-Medicare patients, the scaling factors, used to determine reimbursement of the risk component, will reflect the impact of rising Medicare utilization and the related increasing risk of loss associated with Medicare patients.

Comment: Hospital malpractice events are so rare and so variable that measures of average claims are a statistically unreliable basis for apportioning premium costs. With respect to frequency of claims, the National Association of Insurance Commissioners (NAIC) found that there was about one claim per hospital per year and that only about one in three hospitals per year paid an award. (See, NAIC, *Medical Malpractice Closed Claims, 1975–78, Final Compilation,* Table 2–3, p. 41. See also National Center for Health Statistics, "Utilization

of Short Stay Hospitals: Annual Summary for the United States, 1979," December 1981, p. 51.) Of course, if these results were limited to the number of claims paid to Medicare beneficiaries, then the incidence of malpractice events would be reduced much further. While hospitals average one claim per year, the frequency distribution of those claims over several years would be determinative of whether the proposed rule overstated or understated an individual hospital's loss experience.

The commenter stated further that the statistical problems caused by the rarity of malpractice episodes are compounded by the large variability of the amounts of paid claims. For example, 63% of hospital claims in the NAIC study resulted in no payment and another 8% resulted in awards of less than $1,000. The total indemnity of this 71% of total claims studied averaged $50 per claim or less than 1% of the hospitals' total indemnity. At the other extreme, 1% of the paid claims were for $100,000 or more each, averaging over $275,000 and accounting together for more than one-half of the hospitals' total indemnity. Thus, neither the average indemnity per claim ($6,180) nor the average for only paid claims ($16,438) is illustrative of the amount of awards at the extremes. (See, NAIC, *Medical Malpractice Closed Claims, 1975–78, Final Compilation*, p. 41.)

The commenter also asserted that while averaging awards over a five year period for providers throught the United States may attenuate some of this variability, it also introduces additional sources of variability. For example, there have been marked changes over time resulting from the trend toward larger and larger awards and from inflation. Similarly, there are great differences among the states regarding paid claims per 100 hospital beds (ranging from 0.03 to 0.66 over four years) and with respect to average indemnity (ranging from $1,647 to $224,000). (See, NAIC, *Medical Malpractice Closed Claims, 1975–78, Final Compilation*, p. 127.) If this kind of analysis were pursued separately for Medicare patients and for others, where the frequencies are smaller, the variability would be much greater. Thus, the commenter concluded, the effect of broadening of time and place, inherent in the proposed rule's national ratio, is to increase the danger of error and inequity in trying to infer an appropriate basis for apportioning the premium costs of a given hospital.

Response: Under this final rule, the loss experience history of a specific hospital will have no significant effect on its premium cost reimbursement. Thus, from the standpoint of the individual provider, the alleged infrequency and variability of malpractice claims do not detract from the validity of this final rule.

The adjusted national ratio will be one determinant of a hospital's reimbursement for the risk component of total premium cost. The other major factor will be the provider's Medicare utilization rate. While the relative frequency and variability of claims might pose problems in the rate-setting process, they do not do so in the apportionment context. For example, the differences in frequency and award size among the states cited by the commenter would be relevant to the establishment of overall statewide rates. But our use of the national ratio to scale the provider's utilization rate is similar to the modification of statewide rates through the use of rate relativities. Rate relativities are based on nationally derived loss ratios and do not take account of the relative frequency and variability of claims. Moreover, any significant disparities that might be caused by the national ratio will be ameliorated by the inclusion of the provider's utilization rate in the scaling factor formula, used for apportioning the risk component of total premium cost. In addition, as was shown in a table above (see, section III.C.), the year-by-year ratios of Medicare losses to total losses is very stable. This supports the credibility of the national ratio, even though malpractice claims may be relatively rare events for a given provider.

Comment: The claims-paid formula is irrational because the use of an individual hospital's five-year loss experience as the exclusive apportionment criterion violates three fundamental actuarial principles. First, the formula is not based on "credible" data insofar as one hospital's five-year loss experience is not a sufficiently large data base to make an accurate apportionment. (One commenter stated that at least 1,082 claims of relatively uniform size would be required for full credibility, while a much larger number of claims would be necessary given the great variability in award amounts. Another commenter indicated that 683 claims would be necessary, and that a much larger sample would be needed to ensure that claim dollars are within 7.5% of the true value.) Second, the formula's data base is not "mature" because it fails to reflect accurately the true conditions of the period from which the data are derived. For example, a 1983 report of 1982 loss data is not mature because very few of the claims from that period have been asserted, much less paid. Third, the formula's data base is not "accurate" because, for example, data on the 1976–80 period will partially reflect claims that arose well before 1976. Such pre-1976 claims would be inaccurate because they would fail to reflect the myriad of economic, medical, and legal changes that affect payment amounts in accordance with exactly when the incident arose and the claim was paid.

Response: Under this final rule, a hospital's own five-year loss experience will not be determinative of its reimbursement for premium costs. Thus, the commenter's assertions about the alleged lack of credibility, maturity, and accuracy of loss experience are largely irrelevant under this final rule. There simply is no need, under this rule, to collect the type or volume of hospital-specific data discussed by the commenter. While the risk component of total premium cost will be partially based on the national ratio of Medicare losses to total losses, the HCRIS data used to establish the revised national ratio clearly are a credible data base. The national ratio is based on the loss experience of more than 5000 hospitals over a five-year period. As explained above, the ratio of Medicare losses to total losses is approximately the same over the span of the HCRIS data.

We reject any suggestion that the data underlying the national ratio are not mature. The commenter assumes erroneously that the occurrence basis of insurance coverage is the sole proper means to evaluate the maturity of the data underlying the national ratio. We believe that the use of a claims-paid term in the scaling factor formula is, given the inclusion of a term representing the individual hospital's own utilization rate, a preferable basis for establishing this part of our apportionment policy. While the national ratio could theoretically be established on an incurred loss basis, there is no reliable data base available that distinguishes Medicare from non-Medicare experience on an incurred loss basis. Under the claims-paid approach, which underlies the national ratio, the fact that not all claims incidents were reported for a given period does not detract from the accuracy of the data underlying the new ratio. Since the national ratio is, by definition, the national average of Medicare losses to total losses, the maturity of the underlying data must be judged on a claims-paid basis.

Finally, for largely the reasons set forth above with respect to the maturity

issue, we reject the assertion that the data underlying the national ratio are not accurate. The commenter mistakenly assumes that the incurred loss approach is the only valid means of implementing an apportionment policy. Under the claims-paid approach, the fact that a claim arose during a period preceding the five-year period used to determine the national ratio does not detract from the accuracy of the data underlying the ratio. Moreover, the accuracy of our approach to apportioning the risk component is bolstered by the inclusion in the scaling factor formula of terms that represent the claims tails for Medicare and non-Medicare patients.

Comment: The tables produced by HCFA on May 7, 1985, which formed the basis for the revised national ratio, show that paid claims by individual providers are not a significant determinant of premium cost. Table 2 contains the number of beds by census divisions while Table 4 lists Medicare paid claims data and total paid claims data. The West South Central census division for 0–99 beds shows the average premium to be $50 per bed ($1,314,840/26,138). The Pacific census division for 500+ beds shows the average total premium to be $5,750 per bed ($51,047,245/8,878). These figures highlight the variation in premium cost per state. They also undermine the quality of the HCRIS data since such wide variations in insurance cost per bed are impossible, especially on a regional basis.

Response: We recognize that hospital malpractice insurance premiums vary significantly among states and geographical subdivisions of states. But our concern is with the proper Medicare apportionment policy for premium costs, and not with the premium-setting process itself. Moreover, the rate relativity and experience rating steps of the premium-setting process are not predicated on statewide rates or rates within states. Our use of the national ratio to apportion the risk component of premium cost is, as explained above, similar to the use of nationally-derived rate relativities and is necessary to account for the great disparity between, among other things, Medicare utilization and paid losses.

The commenter has incorrectly applied the tables prepared by HCFA and reached an erroneous conclusion. The commenter apparently calculated the value of total *paid claims* per bed for the HCRIS file, using two census division bed size categories from our Table 4, and presented the resulting values as average *premiums* per bed. The conclusion that the results undermine the value of the HCRIS data by showing implausible variation in premium cost is incorrect since the numbers calculated are not premium cost.

In fact, the HCRIS data on premium costs for the census division hospital size cells that are discussed by the commenter show quite plausible variation. Average malpractice expense per bed for West South Central census division hospitals of 0-99 beds equals $257 ($6,710,151/26,138). Average malpractice expense per bed for Pacific census division hospitals of 500+ beds equals $1,267 ($11,250,189/8,878). This is a plausible five-to-one variation in contrast to the commenter's incorrectly calculated one hundred-to-one variation.

Comment: Malpractice insurance premiums vary widely among states and within a state. Yet there is no direct correlation between premiums, paid losses, and Medicare utilization. For example, Florida has a very high patient utilization rate of approximately 70%, along with some of the highest premium rates in the country.

Response: There obviously are differences in malpractice premiums among states and within a state. Because premiums are based partially on the experience rating of individual hospitals, and on nationally-derived rate relativities, any attempt to compare a state's overall Medicare utilization rate with its overall premium levels is necessarily inconclusive. Due to the experience rating of individual providers, along with the fact that Medicare beneficiaries submit and are paid fewer and smaller claims than non-Medicare patients, providers with high utilization rates should incur premium costs that are proportionately lower. The level of experience and claims environment within a state can be so adverse that the overall state rate is much higher than in other jurisdictions. This does not mean, however, that within such a state a hospital with high Medicare utilization will not, on average, tend to have better rates than a hospital with a lower utilization rate. Also, providers with higher utilization rates will receive proportionately greater Medicare reimbursement under this final rule.

2. The Components of Malpractice Insurance Premium Cost

a. *The Risk Component of Total Premium Cost.*

Comment: HCFA states in the NPRM that loss experience is the largest single item in the total cost of the premium. The agency's discussion of this issue is, according to the commenters, erroneous in the following respects: (1) The data from A.M. Best, which is discussed in the NPRM, does not segregate hospital malpractice from all other types of medical malpractice insurance. (2) There is no evidence that loss payment as a percentage of total premium cost has increased between the 1979 rulemaking and the current rulemaking. (3) The A. M. Best data, along with the rate filings of the two Maryland insurers, treat losses (i.e., paid losses) and loss adjustment expenses as a single item, and thus are incommensurable with the proposed rule which is based solely on paid losses. (4) The HCRIS data show that paid losses (i.e., $167,811,969) are only 33.5 percent of total premiums (i.e., $500,672,422)—between one-half and two-thirds less than the estimates made in the NPRM. Thus, HCRIS confirms the findings of the Rand study, cited in comments on the 1979 rule, that claims payments account for only 35 percent of total premium cost. (5) It is probable that the HCRIS ratio of losses to premiums is even lower than 33.5 percent for the preceding four years. HCRIS shows that the total paid claims for the five-year period was $549.8 million, of which $167.8 million in losses stemmed from the final year—the only year for which there is HCRIS data on premiums. Thus, the annual average of paid claims for the four prior years was only $95.5 million, a figure low enough to suggest a ratio of paid claims to losses that is significantly below 33.5 percent. HCFA should review the cost reports for the prior four years in order to determine total premium costs for each year, along with the ratio of losses to premiums for each year.

Response: We continue to believe that the portion of total premium cost related to losses is the largest single part of total premium cost, and that claims handling expense (or "loss adjustment expense") is the second largest part of total cost. Under this final rule, the risk component—91.5 percent of total cost—includes amounts for losses (i.e., anticipated loss experience) and for claims handling expense (i.e., ALAE and ULAE), in addition to a share of taxes and commissions.

Our response to the commenter's specific criticisms of the NPRM discussion of the relationship between the risk component and total premium cost, is as follows: (1) As stated in the NPRM, the A.M. Best data are aggregate data for all types of malpractice coverage. The widely varying estimates of the relationship between the risk portion and total premium cost are attributable to the different types of insurers that write policies and to how different insurers define various

expenses. As explained above (see, section II.A.), our best estimate, which is not based on the A.M. Best data, is that the risk component is 91.5 percent of total premium cost. (2) The 1979 rulemaking included estimates that loss experience accounts for between 30 percent and 60 percent of total premium cost, whereas the sources cited in the current rulemaking suggested that losses were between 70 percent and over 100 percent of total cost. (3) Under this final rule, our calculation of the risk component of total premium cost includes ALAE and ULAE, in addition to anticipated loss experience, and a share of taxes and commissions. (4) The HCRIS malpractice loss data reflect reported paid or closed claims. In determining the proper amount for the anticipated loss subcost of the premium, most insurers consider reported open and closed claims. Our best information is that the subcost for anticipated loss experience is approximately 55 percent of total premium cost. (Because of profit generated by investment of the premium, the insurer generally makes provisions for losses in the amount of 55 percent of total cost even though losses may reach levels as high as 75 percent of total cost. The investment income, together with the anticipated loss subcost, enables the insurer to cover all losses and make a profit.) Any divergence between our determination about the percentage relationship between anticipated losses and total premium cost and what HCRIS shows about the ratio of paid losses to malpractice premium expense presumably stems from two facts. First, our determination of anticipated loss experience includes both open and closed claims whereas HCRIS includes only closed claims. (As explained above, the difference between the HCRIS claims-paid data and the incurred losses approach used by most insurers does not detract from our use of the HCRIS data to establish the national ratio. HCRIS is a highly reliable information source, which, in the absence of an equally reliable database for incurred losses, is a more than adequate basis for determining the national ratio of Medicare losses to total losses.) Second, as explained above (see, section III.C.3.), the HCRIS measure of malpractice premium expense contains costs (e.g., deductibles, copayments, excess losses, associated direct costs, and various non-reimbursable costs) in addition to what the insurance industry considers to be premium cost. While some of these excess costs (e.g., deductibles, copayments, and excess losses) would also be reported in HCRIS as a loss, other excess costs (e.g., associated direct costs and non-reimbursable premiums, self-insurance fund contributions, and losses) would be reported with malpractice insurance expense but not as a loss. Finally, this final rule reflects our determination that the risk portion of total premium cost is based on expenses (e.g., ALAE) other than loss experience. In calculating that the risk component is 91.5 percent of total cost, We have included these various risk-related expenses along with an amount for anticipated. (5) As explained in response to the immediately preceding paragraph of this comment, our determination of the ratio of anticipated losses to total premium cost is based on open and closed claims in comparison with the insurance industry's measure of premium cost. There is no need to examine the cost reports for prior years to determine the percentage relationship between paid losses and malpractice premium expense because we have been able to establish independently the proper breakdown between the administrative component and the risk component (including anticipated loss experience) of total premium cost.

Comment: The Department's assumption that the lower life expectancy and reduced earning power of Medicare beneficiaries results in lower average claim costs applies only to a segment of claim costs. While the assumption may be true with respect to *income* loss on permanent disabilities, it is not obvious that the *medical* costs associated with permanent disabilities will be lower. Moreover, any reduction in average claim costs for permanent disabilities would likely be offset by one of the following sources of higher claim costs for Medicare patients: (1) Temporary disabilities for Medicare claimants are likely to be more frequent, to be of longer duration, and to generate higher medical costs than for other claimants because recuperative powers decline with advancing age. (2) If average claim costs are lower, then claims likely will be settled more frequently and more quickly. Thus, Medicare claims would result in higher relative settlement expenses since insurers pay lawyers and claims adjusters by the hour, and not on a contingent fee basis. (3) The propensity of Medicare patients to settle their claims more quickly would leave the insurance company with less investment income. Thus, greater loss adjustment costs and lower investment income would tend to even out any differences in average claim amounts between the elderly and others.

Response: The commenter's hypotheses are not a sound basis for formulating apportionment policy because they are, for the most part, unsupported by empirical evidence. We know of no studies distinguishing the frequency, duration, and cost of temporary disabilities from permanent disabilities for Medicare claimants. Similarly, there is no evidence distinguishing income loss and medical costs associated with permanent disabilities for Medicare claimants. In any event, HCRIS shows that the national Medicare hospital patient utilization rate is more than three times greater than the national ratio of Medicare losses to total losses. Regardless of whether this extraordinary disparity is attributable to costs associated with permanent disabilities or temporary disabilities, or to income loss or medical costs associated with permanent disabilities, we must adopt an apportionment policy that takes into account the disparity. Similarly, our new policy must take account of the results of our analysis of the NAIC data, which shows that, relative to non-Medicare patients and the whole patient population, the average Medicare indemnity is much lower; that Medicare patients have lower average ALAE; and that Medicare patients file fewer claims relative to utilization.

While the evidence shows clearly that Medicare patients submit and are paid fewer and smaller claims than non-Medicare patients (see, section III.C., above), we agree that there may be a weak correlation between ALAE (including settlement expenses) and the amount of a given loss. Because of this weak correlation, the ALAE per paid claim, as contrasted with the average ALAE dollar amount, may be relatively higher for Medicare beneficiaries than for non-Medicare patients. As explained above (see, section II.A.), these considerations were taken into account when we adjusted, based primarily on the NAIC data, the national ratio to account for the greater ALAE and ULAE per claim that is incurred by Medicare patients.

Although the NAIC data indicate that Medicare claims are closed more quickly than non-Medicare claims, any relative decrease in investment income would be insignificant since the NAIC data also show that, as an offsetting factor, the average ALAE dollar amount is smaller for Medicare patients than non-Medicare patients. In any event, any arguable decrease in investment

income would be negated, for purposes of establishing the proper apportionment policy, by the greater than three-to-one ratio between Medicare utilization and paid losses.

Comment: The proposed rule is based on the unfounded and unsupported assumption that Medicare patients use malpractice insurance only to the extent that Medicare claims are paid.

Response: As explained in the preamble to the proposed rule and elucidated further in our response to comments, we have determined that Medicare patients under-utilize the major part of premium cost, a fact which necessitates that the risk component of total cost be apportioned on the special basis set forth in this final rule. By contrast, we will apportion on a utilization basis the general fixed insurer overhead expenses that constitute, along with a share of taxes and commissions, the administrative component of total premium cost, because Medicare patients do not under-utilize these subcosts. The final rule clearly assumes that Medicare patients use all of the services underlying premium cost since the rule explicitly reimburses all parts of that cost.

b. *The Administrative Component of Total Premium Cost.*

Comment: It is inappropriate to use paid claims ratios to directly apportion that part of the insurance premium that represents fixed administrative and other costs. These fixed costs are not directly related to losses incurred by a hospital due to claims attributable to particular patients.

Response: Under this final rule, the administrative component of total premium cost will be apportioned on a utilization basis instead of on a claims-paid basis. (See, section II.A., above.)

Comment: The large proportion of hospitals that self-insure is a reflection of the importance of non-claim costs in the premium breakdown. By making payments to reserves for possible claims in lieu of purchasing premiums from outside insurers, self-insured hospitals expect to reduce their non-claim costs. The rarity of malpractice claims, together with the self-insured's use of sophisticated risk management techniques, means that they can largely determine their own malpractice experience.

Response: We fully recognize that non-claim costs figure importantly in total premium cost. Under this final rule, the administrative part of total malpractice insurance cost (i.e., whether payments for the purchase of a premium or contributions to a self-insurance fund) is reimbursed on a utilization basis. The risk component includes non-claim costs that are related to risk activities and the national ratio has been adjusted to account for the non-claim costs represented by ALAE and ULAE.

Comment: The 1979 rulemaking record indicates that loss payment constitutes between 30 percent and 60 percent of total premium cost. Thus, the proposed rule would not reimburse between 40 percent and 70 percent of total cost, including, for example, the cost of successfully defending a claim. The proposed rule also ignores discrete costs for various administrative expenses that are part of total premium cost.

Response: Under this final rule, all hospitals will be reimbursed on a separate basis for the two main parts of total premium cost. For example, defense costs will be included in the risk component, which is apportioned in accordance with the provider's own utilization rate and the adjusted national ratio. Administrative expenses will be apportioned on a utilization basis.

Comment: Even if Medicare paid claims are disproportionately low, insurers incur other expenses besides claim costs that are not proportionately lower. Thus, the claims-paid apportionment ratio will be too low, even if it were correct with respect to claims cost. The Department's statement in the NPRM that Medicare beneficiaries under-utilize the other, non-loss elements of total premium cost (e.g., claims processing, risk management, legal fees, etc.) is based solely on the Westat Study, which is an unreliable data base.

Response: Under this final rule, the non-risk, administrative component of total premium cost is 8.5 percent of total cost while the risk component is 91.5 percent of total cost. The administrative component consists of the following discrete costs: general fixed overhead expenses of the insurer and a share of taxes and commissions. Because the administrative component of premium cost is at most, only slightly affected by losses and associated risk activities, we have decided to return this element of total cost to the G & A pool and apportion it on a utiization basis.

By contrast, the expenses that constitute the risk component (i.e., anticipated loss experience, ALAE, ULAE, and the remaining share of taxes and commissions), are significantly affected by losses and associated risk activities. Our analyses of HCRIS and the NAIC data, among other reasons, have convinced us that Medicare patients submit and are paid fewer and smaller claims than non-Medicare patients. (See, section III.C., above.) Thus, it is necessary to apportion the risk component on a special basis that accounts for: the greater than three-to-one disparity between the national Medicare utilization rate and the national Medicare loss ratio; the smaller average award size for Medicare patients; the lower rate of claims filed relative to utilization for Medicare patients; and the lower average ALAE for Medicare patients.

Comment: One commenter stated that there is no support for the statement in the preamble to the proposed rule that Medicare beneficiaries under-utilize the significant parts of premium cost besides loss experience, and that these other elements were over-reimbursed under the utilization method. Specifically, there is no support for the following NPRM statements about these other elements of premium cost: (1) The expense of claims handling increases with the number of claims rather than their amount. Proportionally, the claims handling expense may be higher if the amount is smaller. (2) Medicare claimants are less likely to litigate their relatively small claims, and thus their defense costs are lower.

Response: The term "claims handling expense" (or "loss adjustment expense") refers to ALAE and ULAE. In addition to defense costs attributable to specific claims (i.e., ALAE), claims handling expense includes the general overhead costs incurred in maintaining a claims department (i.e., ULAE). Various factors may affect claims handling expense. A higher incidence of claims filed requires more personnel to handle the claims. Typically, an insurer will spend more money to defend a large claim (e.g., $1 million) than a small one (e.g., $5,000). In general, the longer it takes to settle a claim, the greater the claims handling expense. The NAIC data show that defense costs (i.e., ALAE) per average Medicare claim are lower than for non-Medicare claims. These results may stem from a disinclination on the part of Medicare patients to litigate their relatively small claims. (By contrast, the NAIC data also show that the ratio of ALAE to losses for Medicare patients is higher than the corresponding ratio for non-Medicare patients. This fact, together with our determination that a similar relativity applies to ULAE, explains why we adjusted the national ratio from 11.8% to 13.2%.)

Comment: A study by the California Hospital Association and California Medical Association showed that the incidence of claims that would be reimbursed under a no-fault malpractice

system increased with advancing age. (See, *Report on the Medical Insurance Feasibility Study*, sponsored jointly by the California Medical Association and California Hospital Association (1977), p. 52.) Thus, even if there were a decline in severity of incident and cost per incident with advancing age, this may be offset by an increase in frequency of incidents.

Response: The study relied on by the commenter is not reliable because it fails to distinguish incidents involving hospitals from incidents involving physicians. As described above (see section III.C.), our analysis of the NAIC data shows that, measured against hospital utilization, Medicare patients submit fewer malpractice claims than non-Medicare patients.

3. The Purpose of Hospital Malpractice Insurance

Comment: Taken to an extreme, the claims-paid methodology would destroy the basic purpose of insurance, which is to protect the insured from catastrophic loss in a manner that does not require expensive actions, such as adopting highly unproductive and costly techniques to minimize exposure to loss and maintaining liquid contingency reserves to pay uninsured claims. If premiums were quickly and fully adjusted to reflect the insured's loss history, the policyholder would end up "reimbursing" the insurer for paid claims. Since policyholders would reject such an approach, industry premium-setting practices represent a middle ground between ignoring loss experience and fully adjusting premiums on that basis.

Response: We reject the commenter's assumption that Medicare apportionment must reflect exactly industry premium-setting practices. In any event, our apportionment policy will be based on the nationally-derived national ratio and the Medicare utilization rate of specific hospitals. This is similar to how premiums are based, in part, on nationally-derived rate relativities, and the experience rating of specific providers. Because this final rule does not make premium cost reimbursement contingent on a specific hospital's own loss experience history, the rule is in no way modelled on policyholder "reimbursement" to the insurer of paid losses. While the new rule takes loss experience (i.e., the national ratio) into account, it is not based exclusively on paid claims. Thus, there is no reason to believe that this policy will undermine the function of insurance.

Comment: The proposed rule obscures the crucial difference between the risk of loss and losses, and reveals a failure to understand the function of malpractice insurance. From the standpoint of the insurer and the hospital, malpractice insurance indemnifies the hospital against the risk of loss, which is an uncertain but current cost of patient care. The proposed rule is predicated solely on loss experience, which, by definition, occurred in the past. The importance of this error is highlighted by the fact that the recent increase in premiums stems from the lack of a sound basis for estimating the risk of loss—not from an increase in paid claims. Similarly, the proposed rule ignores the fact that insurance is an integral part of the hospital's overall risk management program, which is instituted to minimize the risk of loss and any actual losses, and which is undertaken on an institution-wide basis that benefits all patients equally.

Response: We recognize that malpractice insurance is a current cost of patient care. Under this final rule, the administrative component of this cost will be apportioned entirely on a utilization basis. Besides being tied to the individual hospital's utilization rate, the risk component will be reimbursed on the basis of the adjusted national ratio of Medicare losses to total losses. While the risk portion of total premium cost will include reimbursement for anticipated loss experience, it also will include amounts for other risk-related subcosts (e.g., ALAE and ULAE). These features of this final rule, together with the inclusion of utilization factors and the adjustment of the national ratio to account for ALAE and ULAE, mean that the new rule obviously is not predicated solely on past experience. Moreover, while malpractice insurance is a current cost incurred largely to indemnify future losses, that cost is based importantly on loss experience data at each step of the premium-setting process. Our use of the adjusted national ratio to partially determine Medicare program reimbursement enables us to distinguish the relative risk of loss of Medicare and non-Medicare patients, which is similar to insurance industry use of loss experience data to develop rate relativities.

Increases in losses, misestimations of prior premiums, and national trends in the frequency and severity of claims exemplify the factors that determine premium increases. The commenter's assertion that the lack of a sound basis for estimating future losses accounts for premium increases is contrary to accepted insurance industry practice and actuarial principles.

Of course, we recognize that malpractice insurance is but one part of an overall risk management program that is pursued by many hospitals. For example, besides purchasing insurance, a hospital might use non-slip wax in order to minimize the risk of future loss. But the fact that malpractice insurance may be only one part of a provider's comprehensive risk management program is not dispositive of the Medicare apportionment issue.

To the extent the commenter's assertion addresses our apportionment policy for specific risk management activities, two responses are in order. First, if an insurer's safety engineer visits a hospital in an attempt to help the provider minimize its risks, then the insurer's activities would be accounted for in its general fixed overhead expenses that, under this final rule, are recognized as part of the administrative component of total premium cost and apportioned on a utilization basis. Second, the cost of the hospital's own risk management activities will be put in the G & A pool and apportioned on a utilization basis.

Comment: While it is conceded in the NPRM that malpractice insurance is of general benefit to a provider and all of its patients, the agency concludes that this is irrelevant to the question of the proper policy for apportioning premium costs. This argument is circular because it assumes that there is some disproportion favoring non-Medicare patients in the general benefit of insurance.

Response: We do not believe that the general benefit theory of the purpose of malpractice insurance is irrelevant to the apportionment policy issue. Rather, our position is that general acceptance of the theory does not mean that a policy based partially on claims-paid experience violates the cross-subsidization proscription of section 1861(v)(1)(A) of the Act. Conversely, while malpractice insurance may generally benefit the provider and all of its patients (including Medicare patients), this does not mean that the utilization method by itself is the best means of apportioning premium costs.

Indeed, when a single enterprise conducts two activities, one of which creates a higher liability risk than the other, it is entirely appropriate to apportion the liability insurance premium among these activities according to the degree of risk that each creates—even though the entire enterprise benefits from the asset protection that liability insurance affords. For example, it has been held that where a single institution operates both a medical school and a hospital, the malpractice liability premiums must

be allocated solely to the hospital, even though the insurance benefits the school as well by protecting its assets and ability to function. *Chicago College of Osteopathic Medicine* v. *Heckler*, N.D. Ill. No. 82 C 398, May 29, 1984.

Primarily because Medicare patients submit and are paid fewer and smaller claims than non-Medicare patients, premium costs must be removed from the G&A pool and apportioned on a basis different from the pre-1979 utilization method. (See, section III.C., above.) Under this final rule, hospitals will be reimbursed on a utilization basis for the administrative component of total premium cost. The services underlying the subcosts that constitute the administrative portion are not attributable to specific patients or risk-related activities. Because these services benefit all patients proportionately, it is proper to apportion the administrative component on a utilization basis.

The risk component of total cost will be apportioned on the basis of the hospital's Medicare utilization rate and the adjusted national ratio. Reimbursement will not depend on the hospital's own loss experience history. The services underlying the subcosts that constitute the risk portion are identifiable to specific patients or risk-related activities. Since these services are significantly affected by the number and amount of claims, which Medicare patients submit and receive at disproportionately low levels, program beneficiaries do not benefit proportionately from these services. Thus, it is necessary to apportion the risk component on the special basis established in this final rule. In this way, the general purpose of insurance will be unaffected while hospital reimbursement for premium costs will reflect, as is required by statute, the extent to which premium costs are actually incurred for Medicare patients.

Comment: The Department's concession that malpractice insurance benefits all of a provider's patients is inconsistent with the claims-paid methodology, which predicates reimbursement on loss experience and claimant identity. Hospital malpractice insurance costs indirectly benefit patients even where no claims are paid. As an indirect cost incurred for the benefit of Medicare patients, it must be reimbursed regardless of the hospital's loss experience history.

Response: There is no inconsistency between the general benefit theory of insurance and our use under this final rule of a claims-paid determinant of program reimbursement (i.e., the national ratio). The Medicare statute requires that malpractice insurance costs—an indirect cost incurred in the delivery of care to Medicare patients—be apportioned in a manner that ensures that only costs actually incurred for beneficiaries are reimbursed. The utilization method will be applied to the administrative component of total premium cost because Medicare patients do not under-utilize the services underlying that part of total cost. Primarily because Medicare beneficiaries submit and are paid a disproportionately small share of claims, the risk component must be apportioned on a special basis, which includes a claims-paid factor and a utilization factor. The individual hospital's loss history will not affect its reimbursement. The fact that the new rule includes a claims-paid determinant, which is necessary to satisfy applicable statutory requirements, does not affect or detract from the general purpose of insurance.

Comment: Under principles of cost accounting, the allocation basis for indirect costs must constitute a rational method of relating the costs to the "cost objective" (i.e., the direct cost incurred for the exclusive benefit of one product or service). The two main criteria used are "benefits" (afforded by the cost center to be allocated and received by the cost centers to which the costs are to be allocated) and "cause" (allocation of costs from one cost center to other cost centers based upon the degree to which the latter cause the former to be incurred). The commenter claimed that these principles are applicable to the evaluation of Medicare cost apportionment bases too. Because the proposed rule would directly apportion only premium costs, the commenter asserted that it is critical that the claims-paid methodology satisfy these criteria since any over-apportionment or under-apportionment will not be offset by another cost.

According to the commenter, the proposed rule does not satisfy either of the criteria for an adequate apportionment basis. Accounting authorities use the term "cause" to refer either to the reason the cost is incurred or what brought about the specific amount of the expense. The Medicare program requirement of malpractice insurance, together with the hospital's responsibility to preserve and shelter its assets, is the reason why insurance coverage is purchased. While malpractice losses may affect the amount of the premium or self-insurance contribution, they are not the sole determinant of that specific amount. Other factors, (e.g., claims administration, risk management, legal fees, etc.) enter into the determination of the premium. An individual hospital's loss history figures little, if at all, in its premium rates. Even if it were assumed that Medicare patients "cause" fewer and smaller malpractice awards, the commenter continued, this is a superficial and improper application of the causal criterion.

According to the commenter, the claims-paid methodology also does not satisfy the benefits criterion. Even if none of a hospital's Medicare patients were involved in a malpractice claim, each patient benefitted from the use of the hospital, which could not have operated without malpractice insurance.

In this commenter's view, while the proposed rule fails to satisfy fundamental cost accounting principles, two alternatives would constitute adequate apportionment bases. First, the utilization method would suffice because it assumes that premiums are necessary to the overall operation of the provider. This method equitably allocates premium costs to all classes of patients, along with similar costs found in the G&A pool. Second, use of patient-days of exposure would accurately yield the relative percentage of Medicare premium cost.

Response: First, premium reimbursement under this final rule will be essentially unaffected by a hospital's own loss experience history. We recognize that malpractice loss experience is not the sole determinant of malpractice insurance cost. However, because loss experience figures importantly in each stage of the premium-setting process, it is a cause of the specific amount of the premium. Since Medicare patients file and receive fewer and smaller awards, they under-utilize the services underlying the subcosts that are significantly affected by the frequency and size of awards. Under this final rule, these subcosts constitute the risk component of total premium cost. Because Medicare beneficiaries effectively cause less of that element of total cost, it is appropriate to partially determine reimbursement of the risk component on the basis of the national ratio. Similarly, while malpractice insurance obviously benefits the provider and all of its patients, the under-utilization of the risk component of premium cost means that Medicare patients benefit less than non-Medicare patients from that part of total cost. This fact necessitates application of a special apportionment basis to that component in lieu of the pre-1979 utilization method. By contrast, because Medicare patients neither cause less of the administrative component of total premium cost, nor benefit less from that element, than non-Medicare patients, it

is proper to apportion that component on a utilization basis.

Comment: The purpose of cost accounting, like the statutory requirement that the program reimburse the reasonable costs of Medicare patients, is to assign an institution's costs to the services actually furnished by the institution so as to reflect the cost of those services. Malpractice insurance costs are a necessary cost because they are incurred as an incident of furnishing medical services. Specifically, these costs are an incident of ownership and use of the hospital's assets, and are required variously by state law, commercial lenders, and even the Medicare program. As a necessary condition for the provision of hospital services, the services underlying these costs must be apportioned accurately, under statutory requirements and the principles of cost accounting, between Medicare and non-Medicare patients. The commenter concluded that the proposed rule fails to satisfy these requirements because it would treat malpractice claims in themselves—instead of premium costs—as a patient service to be apportioned between the two classes of patients.

Response: This final rule treats malpractice insurance cost generally, not just malpractice claims, as a patient service to be apportioned between Medicare and non-Medicare patients. Under the new rule, the administrative component of total premium cost—which is unrelated to specific losses or risk activities—will be returned to the G&A pool and apportioned on a utilization basis. The risk component, which includes risk-related subcosts besides just anticipated loss experience, will be apportioned on the basis of the individual provider's Medicare utilization rate and the adjusted national ratio. The new rule will apportion accurately all of the services underlying total premium cost. (See, section III.G., below.)

Comment: The claims-paid methodology contradicts the principles of "responsibility accounting," which require that costs be assigned to services in order to identify the responsibility for controlling those costs. Responsibility for controlling malpractice insurance costs belongs to the whole institution and cannot be assigned on a patient-by-patient basis.

Response: Under this final rule, reimbursement for insurance costs will not depend on a hospital's malpractice loss experience history or the identity of any claimants. Rather, premium costs will be apportioned on the basis of the hospital's own Medicare utilization rate and the national ratio. The new rule in no way impedes the hospital's overall responsibility to control malpractice costs or the hospital's application, in the exercise of control over those costs, of the principles of "responsibility accounting."

Comment: Hospitals purchase malpractice insurance to protect against the risk of future claims. Insurance includes protection against random fluctuations in claims, regardless of whether any claims are paid.

Insurance companies, not hospitals, pay claims (excluding deductible payments) and incur costs defending against claims. Thus, it is irrational to apportion premium costs incurred by *providers* on the basis of losses paid by *insurers.*

Response: Under this final rule, a hospital's particular loss experience history will not significantly affect its Medicare cost reimbursement. Claims are paid by insurers with the following exceptions: payments by self-insured providers, deductible payments, and payments in excess of insurance coverage by insureds. But every paid claim is identifiable to a specific provider. As explained above, experience loss data are considered in each step of the premium-setting process. Our use of the adjusted national ratio to partially determine reimbursement of the risk component of total cost is similar to the insurance industry 's use of rate relativities in the premium-setting process.

Comment: Hospital malpractice insurance is an administrative expense of doing business that benefits the provider and all its patients. Insurance safeguards the class of insureds by pooling many similar risks, calculating the probabilities of loss, and indemnifying the few who incur losses out of the premium pool created by the many who are at risk. Since insurance is a means of risk management and not merely the paying of periodic sums by the hospital to be relieved of liability for rare actual claims, it makes no sense, according to the commenters, to base apportionment policy for premium costs on paid claims experience. The proposed rule is particularly unreasonable because about two-thirds of claims against hospitals result in no payment to the claimant, yet those claims must still be contested to settlement or to trial at very significant expense. (See, National Association of Insurance Commissioners, *Medical Malpractice Closed Claims, 1975-78, Final Compilation,* Table 2.3, p. 41.)

Response: Under this final rule, all providers will be reimbursed on a utilization basis for the administrative component of total premium cost. Because malpractice insurance is an administrative cost of doing business, it is reasonable to ensure that each hospital is reimbursed for the part of premium cost that is not directly related to risk activities or specific losses. However, the disproportionately small share of claims submitted by and paid to Medicare beneficiaries, among other reasons, requires that the risk component of total cost be apportioned on a special basis. By apportioning the risk element of premium cost on the basis of the adjusted national ratio and the individual hospital's utilization rate, our apportionment policy will take into account the major disparity between Medicare utilization and paid losses, in addition to the lower average award size for Medicare patients, the lower frequency of claims relative to utilization for Medicare beneficiaries, and the lower average ALAE for Medicare patients. Besides anticipated loss experience, the risk component includes various defense, settlement, and administrative costs that are associated with risk activities. Also, the national ratio has been adjusted to account for ALAE and ULAE. Thus, even though most claims against hospitals do not result in awards, this final rule ensures that hospitals will be reimbursed for Medicare's fair share of the non-risk administrative aspects of premium cost and for the non-loss risk facets of total cost.

4. Miscellaneous Comments on the Claims-Paid Methodology

Comment: The proposed rule is administratively burdensome because it requires hospitals and their insurance companies to identify each paid claim within the applicable five-year period as to date and amount paid, type of liability (malpractice or general), and patient classification (Medicare, Medicaid, or other). It is also burdensome to separate hospital professional liability or malpractice liability from general liability.

Response: Under this final rule, a hospital's reimbursement for malpractice insurance costs will be essentially unaffected by its particular loss experience history. While there will be no need for hospitals to identify their paid claims for purposes of determining their own reimbursement, we will continue to require separate reporting of paid claims for purposes of monitoring, and possibly revising in the future, the national ratio. The great importance of ensuring the continued accuracy of the national ratio far outweighs any incidental burden that may result from this reporting requirement. Also, since

providers have been reporting loss experience separately since 1979, they are well-accustomed to this requirement. Finally, hospitals and the insurance industry have long been reporting separately professional liability and general liability claims, in addition to keeping separate records for them.

Comment: The proposed rule assumes improperly that it is easy to distinguish professional liability claims from general liability claims. In fact, the two kinds of claims are difficult enough to distinguish in many cases (e.g., a slip and fall) that most insurance companies require professional and general liability coverage from the same company. Insurance companies also experience rate the two kinds of coverage together. The commenter concluded that the proposed rule creates an obvious incentive for assigning a Medicare claim to professional liability and a non-Medicare claim to general liability. Since insurance companies provide both coverages to the insured, they would be indifferent to this possible abuse by providers.

Response: Under this final rule, a hospital's particular loss experience history will not significantly affect its premium cost reimbursement. Thus, whether a claim is assigned to professional or general liability will not bear on the hospital's reimbursement. The fact that a hospital's own loss experience does not determine its reimbursement also obviates any practical incentive to assign specific claims to professional liability or general liability. We note further that it is the insurer—not the insured—that is primarily responsible for assigning claims to one policy or the other. Insurance companies assign claims to professional or general liability on the basis of objective criteria.

Comment: The proposed rule seriously weakens a hospital's financial planning process because a given hospital will not know until after the end of its cost year what proportion of its cost will be reimbursed by the program. Without this information, the hospital will be unable to set charges accurately for charge-paying patients or to predict accurately how much Medicare reimbursement to include in its budget.

Response: Any policy for apportioning malpractice insurance premium costs would leave the provider without full information as to its reimbursement for these costs until the end of the cost year in question. For example, under the pre-1979 utilization method, a hospital would have to await the end of the cost year and go through the whole cost-finding process before it could confidently determine its Medicare reimbursement for malpractice insurance costs. In any event, to the extent that it may be easier for the hospital to predict its probable utilization for a given year than its probable loss experience, this final rule addresses the commenters' concern because malpractice insurance reimbursement will be determined primarily by the hospital's utilization rate and will be essentially unaffected by its loss experience.

Comment: Whereas Medicare has always required accrual accounting, the proposed rule follows cash accounting in that it ties reimbursement to the time when an award is paid to a claimant. Accordingly, the proposal enables hospitals to manipulate outcomes in a manner that accrual accounting was designed to avoid.

Response: With some exceptions, we have generally required accrual accounting for claimed allowable costs. Because malpractice insurance reimbursement will not significantly depend, under this final rule, on a hospital's own loss experience, hospitals will not be able to manipulate outcomes in the manner suggested by the commenter.

Comment: Adding a Medicare variable to the premium-setting process is theoretically possible but ill-advised. State insurance departments, which oversee ratemaking changes, would oppose such a change. Also, the addition of a Medicare variable would require extensive data collection efforts and revisions to rating plans. The cost of these actions would exceed the minimal benefit to the insurance industry of effecting minor reallocations of premium costs among hospitals.

Response: As explained above, we are charged with establishing an apportionment policy for malpractice premium costs that satisfies all statutory requirements. Although our policy decision could indirectly affect insurance industry practices, this rulemaking is not directed at changing those practices. Since our adoption of the 1979 malpractice rule apparently did not affect industry premium-setting practices, we do not expect this final rule to do so either.

Comment: The proposed rule's reliance on the current and four preceding cost reporting periods for determining an individual provider's loss ratio and, where applicable, the national ratio, violates the basic cost accounting precept that a proper allocation basis must be selected from the data of the same period from which the costs to be allocated and apportioned were incurred. The use of loss history over a five-year period deviates from this principle, and causes the proposed rule to ignore relevant changes within the five-year period (e.g., significant changes in the percentage of Medicare/non-Medicare patient mix, expansion of patient services by the opening or closing of specialized units). This mismatching of accounting period statistics is exacerbated by the long "claims tail" of malpractice claims.

Response: There is no mismatching of premium costs and individual provider loss data because, under this final rule, a hospital's particular loss experience will not affect its reimbursement. Our use of the national ratio in this rule also does not mismatch accounting period statistics. The scaling factor formula, which will be used to scale the individual hospital's Medicare utilization rate to the adjusted national ratio takes account of the different claims tails for Medicare and non-Medicare patients by virtue of the inclusion of the U_1 and U_2 terms in the formula. (See, section II.A., above.) Thus, the hospital malpractice insurance policy established by this final rule reflects changes in utilization and the like that might be magnified by the claims tail and thereby affect insurance costs.

E. The National Ratio

Comment: The proposed rule shows how completely inadequate the data are on which HCFA bases its rule. HCFA is proposing a more than 100 percent increase in reimbursement to a hospital with no paid claims during the hospital's cost reporting period currently under consideration and the four previous cost reporting periods. This proposal is based on the total paid claims history of hospitals that will be reimbursed on an individual hospital basis.

The Medicare national ratio demonstrates that there is no validity to basing reimbursement on a hospital's own paid claims during a five-year period. Rather, reimbursement should be based on a hospital's Medicare utilization rate. The Medicare national ratio also shows the arbitrary and capricious nature of the 1979 malpractice rule.

Response: In applying, under the 1979 malpractice rule, the national Medicare ratio to hospitals without any losses in the applicable five-year period, we assumed that a hospital without any losses during that period would experience average losses over the long run. As explained above (see, section III.B.) the revised national ratio is based on the reliable HCRIS data.

However, under this final rule, the paid claims history of individual

hospitals is not relied upon as a basis for reimbursement of malpractice insurance costs. Rather, the adjusted national ratio is scaled to a hospital's own Medicare utilization and applied to the risk portion of the hospital's malpractice insurance costs. The use of scaling relative to a hospital's utilization responds to the commenter's statement that reimbursement of malpractice insurance costs should take into account a hospital's utilization. Similarly, the final rule also provides that apportionment of the administrative component of malpractice insurance costs is based totally on a hospital's Medicare utilization.

Comment: HCFA's reliance on the Westat Study, which includes physician data, to derive the national hospital malpractice claims-paid ratio is arbitrary and capricious.

Response: The final rule does not rely on the Westat Study for any purpose. The revision to the national ratio proposed in the NPRM and adopted in this final rule is based on the reliable HCRIS data.

Comment: In the description of the process used to estimate the Medicare national ratio for hospitals, the proposed rule (at 50 FR 25181) stated:

> Since a hospital's exposure to malpractice risk is related to the volume of services it provides, we decided it would be better to weigh the sample by the number of beds in each group rather than by the number of hospitals.

This is a direct acknowledgment that malpractice risk is based upon total volume. No distinction is made as to the types of patients occupying hospital beds. Since the proposed rule also made numerous assertions that malpractice costs are predicated upon risk, it is incongruous that, on the one hand, the HCRIS data, used as a justification for the rulemaking, is based upon a hospital's exposure to malpractice losses as related to the volume of services it provides, while the proposed apportionment formula ignores volume of services provided.

Response: This final rule addresses the commenter's concerns by taking into account in the apportionment methodology for both the administrative and the risk components of malpractice insurance cost, the individual hospital's Medicare utilization as a measure of the volume of services provided.

Comment: To be complete, the proposed rule should more fully explore malpractice insurance costs associated with SNFs and the Maternal and Child Health program.

Response: As discussed above (see, section II.B.), we will continue to study SNF malpractice loss experience. Until we decide to take further action, SNF costs of malpractice insurance are to be included in the G&A cost center and apportioned on a utilization basis. With respect to the Maternal and Child Health program, we are leaving this matter to the discretion of the states. (See, section II.D., above.)

Comment: Based on the Westat Study, the national ratio for SNFs should be 92.1 percent.

Response: As we have previously noted, HCFA is no longer using the Westat Study as a basis for any aspect of malpractice insurance apportionment policy.

Comment: The proposed rule should not be applied to the Medicaid program because the Medicaid program covers patients under 65 as well as those over 65.

Response: For the reasons described above (see, section II.C.), we have decided that the states should determine on an individual basis how best to reimburse providers under Medicaid for the cost of their malpractice insurance.

F. Alternative Methodologies Considered

In the Regulatory Impact Analysis (section IV of this preamble), we discuss alternatives considered in the development of this final rule. That discussion includes our response to comments received on the four alternatives discussed in the proposed rule. In addition, as a result of analysis of comments on the NPRM, we developed several other alternatives, which were considered in developing this final rule and which are described and discussed in the Regulatory Impact Analysis. Our response to comments on alternatives considered, which is contained in the impact analysis section, is included by reference in this part of the preamble.

G. This Final Rule Furthers the Statutory Interest in Reimbursing Only Actual Costs Necessary in the Efficient Delivery of Services and in Preventing Cost-Shifting Between Medicare Patients and Non-Medicare Patients

Comment: Different commenters submitted various exhibits that allegedly showed that the proposed rule produces bizarre and absurd reimbursement results. Other commenters described various hypotheticals about allegedly bizarre results or cited court decisions finding such results.

Response: As explained in the NPRM, whether particular reimbursement results are "bizarre" depends on the validity of background assumptions pertaining to the balance of the whole G&A pool and the "proper" apportionment policy. Moreover, the actual reimbursement results presented by the commenters are not a statistically valid sample. Most importantly, this final rule obviates the possibility of allegedly bizarre reimbursement results of the kind presented by the commenters and found by some courts.

Under the 1979 malpractice rule, reimbursement results were determined by malpractice loss experience during a five-year period. If a provider had no losses, then it was reimbursed on the basis of the national ratio. Otherwise, reimbursement was determined by the ratio of the hospital's Medicare losses to its total losses during the applicable period. For providers with losses, claimant identity determined reimbursement results. Patient utilization was not a directly related factor under the 1979 rule.

By contrast, this final rule makes premium cost reimbursement depend on the individual hospital's utilization rate and on the adjusted national ratio. The hospital's own loss experience history and the identity of any claimants are irrelevant under this rule. The allegedly bizarre results asserted by the commenters and found by some courts will be precluded by this final rule. For example, it will not be possible for a provider with a high utilization rate and a low ratio of Medicare losses to total losses to receive less reimbursement than a provider with a low utilization rate and a high claims-paid ratio. Providers with similar utilization rates and similar malpractice insurance costs cannot have dissimilar reimbursement results under this final rule. Furthermore, providers with no loss experience during the applicable period will be reimbursed on the same basis as providers with actual losses. To the extent that a hospital's utilization rate does not change drastically from year to year, that provider can expect consistent reimbursement of premium costs from year to year.

In essence, this final rule negates the very question of the "superficially peculiar results" generated by the 1979 malpractice rule. See, *Walter O. Boswell Memorial Hospital* v. *Heckler*, 749 F.2d 788, 802 (D.C. Cir. 1984). Conceivably, the hospital industry may complain that this final rule will produce reimbursement results that are bizarre simply because they diverge from what would stem from the pre-1979 utilization method. We would reject such an assertion as being unsupported by the statute or court decisions. Also, as explained in the NPRM, only the

assumptions underlying our initial adoption of the utilization method validate particular reimbursement results produced by that apportionment method. Our determination that malpractice insurance costs must be removed from the G&A pool undermines the applicability of these assumptions to these particular costs, and necessitates adoption of a rule which we believe will apportion premium costs in a manner that satisfies applicable statutory requirements.

Comment: The Department 's reliance on the opinion of the Court of Appeals for the District of Columbia Circuit in the *Boswell* case is mistaken. The court 's discussion of the consistency of the claims-paid methodology with the Medicare statute is dictum. Also, that discussion is erroneous because it conflates reimbursement of losses (which are paid by insurance companies and not hospitals) with reimbursement of the appropriate share of the malpractice insurance premium.

Response: While the Court of Appeals for District of Columbia Circuit did not decide the merits of the 1979 malpractice rule, the Court did remand the matter to the district court for decision consistent with the appellate court's opinion. The court of appeal's construction of section 1861(v)(1)(A) of the Act would appear to be binding in that circuit. As explained above (see, section III. D.), malpractice loss information figures importantly in all stages of the premium-setting process and is clearly relevant to the apportionment policy issue. The fact that insurers, not hospitals, typically pay losses is irrelevant because losses are attributed to specific providers and bear importantly on their premium rates. Scaling of the individual hospital's utilization rate on the basis of the adjusted national ratio—necessary to redress the disproportionately small share of Medicare malpractice claims submitted and paid—is clearly within the Secretary's broad discretion to determine reasonable costs and insure against cross-subsidization by Medicare and non-Medicare patients. The national ratio is an integral part of the claims-paid methodology, which satisfies applicable statutory requirements "by definition." (See, 749 F.2d at 802.)

Comment: The bizarre reimbursement results produced by the proposed rule will not even out over the long run because, with the advent of PPS, most hospitals would be subject to a new rule for no more than four or five years.

Response: As explained above, this final rule obviates the possibility of allegedly bizarre reimbursement results. Premium cost reimbursement will not depend on the individual hospital's loss experience history or the identity of any claimants. Rather, reimbursement will be determined by the hospital's own utilization rate and the adjusted national ratio. Since the difference between the hospital's utilization rate and the percentage of its premium reimbursement in any given year will stem solely from the adjusted national ratio—a result necessitated by the major underutilization by Medicare beneficiaries of services related to losses and risk activities— there will be no issue as to whether the reimbursement results of a specific hospital will "even out over the long run." Thus, the fact that most hospitals will be subject to the new rule for a limited period in no way undermines the consistency of the rule with applicable statutory requirements.

Comment: The proposed rule violates the cost-shifting proscription of the Medicare Act because the removal of premium costs from the G & A pool will distort the balance of the remaining G & A costs between Medicare and non-Medicare patients.

Response: As explained in the NPRM and elucidated further in our response to comments, we have determined that it is necessary to remove malpractice insurance premium costs from the G & A pool in order to restore the presumed balance of that cost center. (See, section III. C., above.) Because we have now concluded that Medicare patients do not disproportionately utilize the general fixed overhead expenses and other costs that constitute the administrative part of total premium cost, we have decided to return this portion to the G & A pool and apportion it on a utilization basis. Primarily because Medicare patients submit and receive fewer and smaller claims than non-Medicare patients, it is necessary to apportion the risk element of total premium cost on the special basis established by this final rule. Instead of causing cost-shifting, the special apportionment policy established by this final rule for premium costs is necessary to ensure compliance with the cost-shifting proscription of section 1861(v)(1)(A) of the Act.

Comment: In order to determine whether the proposed rule is consistent with the Medicare statute, hospitals with no claims in the applicable five-year period must be distinguished from hospitals with claims. For no-claim hospitals, the proposed rule would over-reimburse hospitals with a relatively small percentage of elderly patients and under-reimburse providers with a relatively high percentage of aged patients. Hospitals with high utilization rates would be forced to shift costs incurred for Medicare patients to non-Medicare patients. For hospitals with claims, there will be great reimbursement disparities among hospitals depending on claimant identity and the size of awards to specific claimants. Also, there will be great variations for a specific hospital from one period to another. These disparities and variations will be largely subject to chance. Hospitals that suffer a low ratio of Medicare claims to total claims in a specific year will be forced to shift premium costs to non-Medicare patients.

Response: Under this final rule, premium cost reimbursement will not depend on a specific provider's loss experience history or the identity of any claimant. The administrative part of total premium cost will be apportioned on a utilization basis. Reimbursement for the risk portion will be determined by the hospital's own utilization rate, as scaled in accordance with the adjusted national ratio. Since reimbursement results for all hospitals will be determined primarily by individual utilization rates, Medicare patient utilization and premium cost reimbursement will be directly proportional to one another. There will be no disparities among providers with identical utilization rates. Variations in reimbursement for a given provider will depend solely on the hospital's own utilization rate. Since reimbursement results will track utilization rates, as scaled by national ratio in order to account for the disproportionate use of the risk portion by Medicare patients, there will be no cost-shifting from the program to non-Medicare patients.

Comment: The proposed rule violates the requirement that "costs actually incurred" be reimbursed insofar as it ignores administrative or processing costs that are totally independent of a specific plaintiff's recovery.

Response: Under this final rule, the two main parts of total premium cost will be apportioned on different bases. (See, section I.A., above.) The administrative component will be returned to the G&A pool and apportioned on a utilization basis. The predominant risk element (including subcosts besides anticipated losses) will be apportioned on the basis of the specific hospital's utilization rate and the adjusted national ratio. Reimbursement will be unrelated to the specific recoveries of plaintiffs or other claimants. Since this final rule accounts specifically for all premium subcosts, it clearly ensures reimbursement for Medicare's share of the cost actually incurred by the hospital.

Comment: The proposed rule violates the Medicare statute because there is no general relationship between premium costs and an individual hospital's loss experience, and there is no specific relationship between a hospital's claims-paid ratio and its current malpractice costs.

Response: As explained above (see, section III. D.), section 1861(v)(1)(A) of the Act only requires the Secretary to consider insurance industry practices for purposes of establishing regulations for the determination of reasonable costs. Also, industry rate-setting practices do not apply directly to the question of the proper apportionment policy for premium costs.

Under this final rule, premium cost reimbursement is not directly related to a specific hospital's loss experience history or the ratio of its Medicare losses to total losses during the applicable five year period. The adjusted national ratio of Medicare losses to total losses is the sole aspect of the claims-paid methodology that is included in this final rule. The insurance industry's use of experience rating plans shows clearly that there is a relationship between premium costs and a specific hospital's loss experience history. While a hospital's claims-paid ratio does not directly affect its current premium costs, the underutilization of the services in the risk portion of total cost should result in lower premium costs. Also, loss data for classes of insureds is used to set and adjust the overall statewide rate in the form of rate relativities. As explained above (see, section III. D.), our use of the adjusted national ratio to scale the hospital's particular utilization rate is similar to the insurance industry's use of rate relativities. Thus, inclusion of the national ratio in this final rule comports fully with all statutory requirements.

Comment: The Medicare statute requires the Secretary to reimburse costs actually incurred by individual providers on behalf of Medicare beneficiaries. Evidence regarding the impact of loss experience on insurors in the aggregate cannot establish that individual provider malpractice insurance premiums are significantly affected by loss experience or paid claims. Similarly, reliance on the national ratio is a radical departure from past practice and is contrary to the statutory mandate to reimburse the costs actually incurred by the specific provider. The national average of the ratio of Medicare paid claims to total paid claims is unrelated to the individual hospital's current malpractice costs. The appropriate frame of reference is the individual hospital, not the totality of all hospitals. Use of a national ratio especially penalizes providers in states like Florida where Medicare hospital utilization rates frequently are 80 percent.

Response: Section 1861(v)(1)(A) of the Act provides generally that the reasonable cost of services "shall be the cost actually incurred" subject to certain limitations including the exclusion of incurred costs "found to be unnecessary in the efficient delivery of needed health services." As explained in the preamble to the proposed rule, section 1861(v)(1)(A) provides the Secretary with broad discretion to promulgate regulations for the determination of the reasonable cost of services. This wide-ranging discretion includes, *inter alia*, the authority to determine costs for various types or classes of institutions, agencies, and services through the use of estimates of costs of particular items or services. Evidence about the aggregate impact of loss experience and other premium subcosts on premium rates involves the estimation of the cost of a particular item or service for types of providers and services—a practice explicitly authorized by the statute. Since our use under this final rule of the adjusted national ratio is nothing more than a specific instance of this practice, the national ratio also is authorized by the statute. Moreover, because the adjusted national ratio will be used along with the individual hospital's own utilization rate in order to determine its reimbursement for the risk portion of premium cost, the national ratio will be related to a hospital's current costs through the mediation of its current utilization rate. Thus, there is no question that this final rule satisfies the applicable statutory requirements. Finally, hospitals with high utilization rates will correspondingly receive more reimbursement under this new rule.

Comment: Use of the national ratio for providers with no loss experience during the applicable five-year period contravenes the statutory requirement that a provider's reasonable costs be reimbursed. There is no rational basis between the national Medicare claims-paid ratio and the amount of malpractice insurance costs of a specific hospital that are attributable to the program. Even if there were a relationship between loss experience history and premium costs, the national ratio would violate the Medicare statute because there is no evidence that the risk of incurring a Medicare claim is the same for all hospitals with no loss experience, regardless of their size, complexity, and major health care activities.

Response: Under this final rule, the hospital's own utilization rate will fully determine reimbursement of the administrative part of premium cost and partially determine reimbursement of the risk element of total cost. The national ratio, as adjusted to account for ALAE and ULAE, will be the other main determinant of reimbursement of the risk portion of total premium cost. The national ratio will apply to all hospitals, regardless of their loss experience history. By basing much of the apportionment of premium cost on a hospital's own utilization rate, this final rule accounts partially for the risk of incurring a Medicare claim. For the risk portion of total premium cost, however, it is necessary to scale the utilization rate to the national ratio in order to account for the fact that Medicare patients under-utilize the services underlying that part of total cost.

Comment: The proposed rule creates incentives for hospitals to overpay Medicare claims if the provider is under a deductible or is self-insured. If a hospital is under a deductible and pays a Medicare claim, the deductible amount is fully reimbursed as an assigned loss. Also, the full amount of the claim is included in the calculation of the apportionment ratio, thereby increasing reimbursement of the premium amount in excess of the deductible. In the case of claims paid by a self-insured hospital, payment of a Medicare claim will increase the claims-paid ratio. But increases in the ratio will result in a proportionally greater increase in reimbursement. This is because the premium includes expenses and reserves (in addition to paid claims), and thus is higher than paid claims.

Response: Under this final rule, a provider's loss experience and the identity of any malpractice award recipient will have no effect on the hospital's premium cost reimbursement. Since the new rule will apportion costs solely on the basis of the individual hospital's utilization rate and the adjusted national ratio, there will be no incentive to treat Medicare and non-Medicare claims differently. Any attempt by a specific hospital to "game" the national ratio by assigning a borderline claim to Medicare or by inflating Medicare claims would be fruitless, as a statistical matter. Also, the lawyers, physicians, accountants, and other professionals involved in the reimbursement process would likely take action necessary to curb most possible abuses.

Comment: In a program validation report issued on January 19, 1983 by George R. Holland, Regional Administrator, Region IV, HCFA concluded that the claims-paid formula was inequitable, and that there was no valid correlation between premium costs and a provider's loss experience because there would not be sufficient data upon which to base a determination. The Region IV report states that HCFA's Central Office was preparing a national program validation study. However, HCFA has refused to produce the national validation report in response to FOIA requests.

Response: The Region IV report concluded that the claims-paid formula creates an incentive for providers to designate malpractice losses for Medicare/Medicaid patients in order to increase the percentage of their malpractice insurance costs paid by the programs. The Region generally recommended that HCFA should change the current apportionment policy so that malpractice insurance costs are paid on a more equitable and sound basis. The Region's specific recommendations included the following: (1) separate malpractice insurance premiums for Medicare/Medicaid patients should be actuarily determined based upon loss data for program patients with the hospital directly passing along the cost of those premiums; or (2) in the absence of actuarily determined Medicare/Medicaid premium rates, all providers should use a national ratio to apportion the cost of malpractice insurance premiums to Medicare and Medicaid. The Region also recommended that HCFA should re-evaluate the current national ratio of 12.6% (i.e., 5.1% for Medicare plus 7.5% for Medicaid) utilizing the loss experience data that intermediaries have now accumulated.

HCFA's position on the Region IV report was that the report was not sufficiently conclusive to warrant further study at that time. In fact, the report contains comments and opinions of the Region that do not reflect the official position of HCFA. It also contains information that has neither been verified by HCFA's national office nor placed in a national perspective. Therefore, the Region IV report does not represent an official statement of HCFA. Finally, no national HCFA report resulted from the Region IV report.

H. Program Treatment of Malpractice Insurance Costs Is Consistent With the Apportionment Policy for Other Costs

Comment: By retaining the utilization method of apportioning other overhead costs in the G & A pool, for which Medicare beneficiaries over-utilize the underlying services (e.g., accounting, house staff, workers' compensation, data processing, billing and collections, and consulting, accounting, and legal fees resulting from the Medicare reimbursement cost reporting and appeal system), the program violates the Medicare statute by shifting costs to non-Medicare patients. Combined with HCFA's proposal to directly apportion malpractice insurance costs, the agency clearly is concerned with minimizing Medicare expenditures instead of with apportioning costs as accurately as possible.

Response: Direct apportionment of premium costs is justified by the extraordinary increase in those costs, the major under-utilization of the related services by program beneficiaries, the size of premium costs relative to the G & A pool, and the absence of countervailing G & A costs that are over-utilized by Medicare patients. (See, section III.C., above.) For these reasons, we have determined that the presence of the entirety of premium cost in the G & A cost center has upset the presumed balance of the G & A pool and led to cost-shifting of the sort that is proscribed by section 1861(v)(1)(A) of the Act. By apportioning the risk element of premium cost, i.e., the component that is under-utilized by Medicare beneficiaries, on the special basis established by this final rule, we will restore the presumed balance of the G & A pool. Our use of this special reimbursement method is consistent with section 1861(v)(1)(A) of the Act, which explicitly authorizes the use of "different [reimbursement] methods in different circumstances", including the use of methods "on a per diem, per unit, per capita, or other basis."

Besides being explicitly authorized by statute, continuation of the utilization method of apportioning the other overhead costs mentioned by the commenter is proper. None of these other costs satisfy the criteria that make it necessary to remove malpractice costs from the G & A pool. Moreover, there is no empirical evidence that direct apportionment of these costs would result in greater or more accurate program reimbursement. Thus, there is no basis for the allegation that the absence of the direct apportionment of these costs violates the Medicare statute.

Comment: HCFA has undertaken no empirical analysis of other G&A costs, and thus the agency's decision to not directly apportion these costs is completely arbitrary. If malpractice insurance costs are to be directly apportioned, then direct apportionment of other G&A costs is necessary to produce an equitable result.

Response: In our response to comments on the decision to remove malpractice insurance costs from the G&A pool, we have described the available data on other G&A costs and explained why it would be fruitless to pursue a comprehensive study of the myriad discrete costs that constitute the G&A cost center. (See, section III.C., above.) There are good reasons why we must reject the commenter's suggestion that all other G&A costs be directly apportioned. First, none of the other G&A costs meets the criteria that have convinced us to remove malpractice insurance costs from the G&A pool. Since our decision to apportion malpractice costs on a special basis will restore the presumed balance of the G&A cost center, we have no reason to directly apportion other G&A costs. Notably, the commenters have submitted no reliable empirical evidence that other G&A costs have increased extraordinarily, are disproportionately utilized by the program, are a significant part of the G&A pool, and are not offset by other G&A costs.

Second, direct apportionment of all of the countless discrete costs in the G&A pool would be administratively infeasible for HCFA and providers and much too burdensome for hospitals. One complaint about the proposed rule—which would directly apportion only one overhead cost—was that it would impose unreasonable reporting requirements on providers. The reporting and verification requirements associated with direct apportionment of all of the countless costs in the G&A pool would far outstrip the resources of HCFA and providers. In the case of some discrete G&A costs (e.g., administrative salaries), it would be virtually impossible to directly apportion those costs. Even if it were assumed that direct apportionment of all G&A costs would more accurately apportion these costs than the utilization method, the cost of such a monumental change in policy would far outweigh any possible benefit.

The results of our determination on the relative cost and benefit of this alternative are buttressed further by the retroactive nature of this rulemaking. Since we will apply this final rule retroactively, some might suggest that it would be preferable to implement direct apportionment of all other G&A costs on the same basis. But the administrative costs for HCFA and the hospitals of reworking cost reports for past years for all G&A costs would be prohibitive.

Comment: A 1978 Departmental study (the Maher Study) showed that Medicare paid a disproportionately low share of total G&A costs, including malpractice costs, under the utilization method. In 1979, one senior HCFA official indicated that fairness required that other G&A costs be directly apportioned, in addition to premium costs. When the 1979 rule was transmitted to the Secretary, the Administrator of HCFA indicated that it would be too costly to directly apportion other G&A costs. The Department still has not come forward with a non-budgetary reason for deciding against direct apportionment of other G&A costs, in addition to malpractice costs.

Response: The cited events from 1978 and 1979 do not control our decision to forego direct apportionment of other G&A costs. Also, we believe that the commenter has mischaracterized those events. As explained above, the Maher Study is statistically unreliable and based on unverified data. (See, section III.C.) Moreover, the comment of a single HCFA official in 1979 is not representative of the Secretary's reasons for rejecting the policy option in question. Also, besides informing the Secretary of the probable budgetary impact of the alternative of directly apportioning other G&A costs, the Administrator recommended against that option in 1979 on the grounds that implementation would be too costly and burdensome. As explained above, the administrative cost and burden of direct apportionment of other G&A costs is only one reason why we have rejected this policy option.

I. Retroactivity

Comment: Retroactive application of the proposed rule would be unfair to affected providers.

Response: There is no unfairness in replacing the 1979 malpractice rule for cost reporting periods beginning on or after July 1, 1979 with this final rule. As explained above (see, section III.G.), this final rule ensures that providers will receive their fair share of Medicare payment for malpractice insurance costs. Retroactive application of this final rule will ensure that hospital reimbursement of malpractice insurance costs will take account of the factors held necessary by the courts and urged by the commenters on the NPRM. (See, section II.E., above.) Application of this rule to past years will have the effect of *increasing* Medicare reimbursement for many providers over that which was allowable under the 1979 malpractice rule. As explained above (see, section II.F.), no hospital will receive less reimbursement during the retroactive period under the new rule than was due under the 1979 rule.

Furthermore, no unfairness stems from the fact that some providers will receive less reimbursement under this final rule than they would have received under the pre-1979 utilization method. Providers received notice on March 15, 1979 of the Secretary's initial determination that continued application of the utilization method was contrary to section 1861(v)(1)(A) of the Act. This determination was finalized on June 1, 1979 with the promulgation of the 1979 malpractice rule. While some courts have invalidated the 1979 rule, we have consistently defended against reinstatement of the pre-1979 rule. As explained above (see, section III.C.), our reconsideration of current policy has confirmed our original determination that the pre-1979 utilization method over reimbursed malpractice insurance costs. For that reason, we have rejected the alternative of replacing the 1979 malpractice rule with the pre-1979 utilization method. (See, section IV.E., below.)

Rules are to be accorded retroactive effect when it is reasonable to do so and the public interest is served by retroactive application. *SEC* v. *Cheney Corp.*, 322 U.S. 194 (1947). In this case, retroactivity is reasonable because this final rule ensures that providers' malpractice insurance costs will be reimbursed in a manner that satisfies applicable statutory requirements. Also, providers were afforded notice of our intention to reconsider current apportionment policy and, as explained above, they can only be benefitted by the new policy established under this rule.

Retroactive application of this final rule also is in the public interest. The court decisions invalidating the 1979 malpractice rule necessitated our reconsideration of current policy. In the absence of an alternative apportionment methodology, some courts have, upon invalidating the 1979 rule, ordered reimbursement under the pre-1979 utilization method as relief for plaintiff hospitals. But, in addition to instituting the 1979 rule's claims-paid formula, the Secretary determined in 1979 that the utilization method reimbursed excessively malpractice insurance costs. Special circumstances obtained in a case like this where a public program is involved and the allocation of limited Trust Fund resources are at stake. Hospitals should not be allowed to reap a windfall stemming from the invalidation of the 1979 malpractice rule and the lack of an alternative to the 1979 rule that is both statutorily authorized and duly promulgated by the Secretary.

In deciding to apply this final rule retroactively, we are guided by the standard established by the Supreme Court in *SEC* v. *Cheney Corp.*, 322 U.S. 194, 203 (1947):

> [R]etroactivity must be balanced against the mischief of producing a result which is contrary to a statutory design or to legal or equitable principles. If that mischief is greater than the ill effect of the retroactive application of a new standard, it is not the type of retroactivity which is condemned by law.

Retroactive application of this final rule will produce no "ill effects" because, as explained above, hospitals can only benefit under this rule as compared to the 1979 malpractice rule. Moreover, retroactivity is fully consistent with applicable "legal and equitable principles" since the new rule satisfies applicable statutory requirements (see, section III.G., above) and will prevent hospitals from realizing a windfall stemming from invalidation of the 1979 rule and the imposition as relief of the utilization method.

Finally, retroactive application of this final rule is fully consistent with the "statutory design." Section 1861(v)(1)(A)(ii) of the Act authorizes the Secretary to adopt regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services *for any fiscal period*, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or *excessive*" (emphasis added). As explained above, the Secretary determined in 1979 that the utilization method of apportioning malpractice insurance costs produced excessive reimbursement of those costs. The 1979 malpractice rule was adopted to redress the problem, and this final rule will replace the 1979 rule. Our reexamination of current policy confirms the 1979 determination that the utilization method over-reimbursed malpractice costs. Thus, pursuant to sections 1861(v)(1)(A)(ii) and 1871 of the Act, the new rule will be applied retroactively to ensure that providers do not receive excess reimbursement for their malpractice insurance costs and that the program pays its fair share of those costs.

Comment: The reasons advanced in the NPRM in support of retroactivity are deficient. Retroactive application of the proposed rule would have a tremendous adverse impact on providers insofar as they would be reimbursed less than they would receive under the utilization method. Also, the Department's four

reasons for why any negative impact of retroactivity would be outweighed by the benefits of such implementation are unsound, as follows:

(1) *Relationship to Earlier Policies and the Current State of the Law.*— These commenters stated that the court decisions invalidating the 1979 malpractice rule leave the utilization method as the only operative Medicare apportionment policy for malpractice insurance costs. Retroactive application of a new rule would constitute a major departure from the utilization method that the courts have reinstated as Medicare policy. Also, the court decisions have effectively settled this area of the law.

(2) *Reliance Interests of Providers.*— According to these commenters, the Secretary's authority under section 1861(v)(1)(A)(ii) of the Act to promulgate retroactive regulations does not extend to undoing policy decisions that were within the permissible scope of the Secretary's discretion. Since the pre-1979 application of the utilization method to malpractice insurance costs was within the Secretary's discretion, section 1861(v)(1)(A)(ii) does not authorize the retroactive termination of the prior apportionment policy. Furthermore, the commenters stated that retroactivity would undermine the reliance interests of providers. When the 1979 malpractice rule was adopted, providers recognized that the rule was unlawful and challenged immediately its validity. The providers' behavioral response to the 1979 rule evidenced their well founded expectation that the utilization method would continue to govern Medicare apportionment of malpractice insurance costs. Moreover, providers had no notice that the Secretary would seek to implement retroactively this final rule. If providers had had such notice, they would have sought to maximize the percentage of non-Medicare patients in their total patient population and minimize the percentage of Medicare patients. In addition, providers have every reason to rely on compliance by the Department with court decisions invalidating the 1979 rule.

(3) *Burden on Providers.*— These commenters claimed that retroactive application of the proposed rule would exact a financial penalty of $200 million from providers with appeals pending. Some of this loss could have been averted if providers had known that the Secretary would try to implement retroactively a new rule. Also, providers have incurred major transaction costs in challenging the 1979 malpractice rule, and it is unfair to make them start their legal challenge anew. This unfairness is compounded by the possibility that the Department will pursue additional rulemaking if the current one does not achieve its goals.

(4) *Furtherance of Statutory Interests.*— Finally, the commenters contended that retroactive implementation of the new rule could not further the twin statutory objectives of reimbursing only actual necessary costs and preventing cost-shifting between Medicare and non-Medicare patients. These two objectives are in conflict and the claims-paid formula would be legal only if there is a sound basis for rejecting obvious alternatives that would harmonize the conflicting statutory goals.

Response: While providers typically will be reimbursed less for their malpractice insurance costs under this final rule than under the pre-1979 utilization method, continued application of the utilization method to these costs would reimburse hospitals for costs well beyond those actual and necessary for the efficient delivery of services, in contravention of section 1861(v)(1)(A) of the Act. (See, section III.C., above.) The mere fact that providers will be reimbursed no more than the statute permits does not give rise to a significant adverse impact on providers with respect to their participation in the Medicare program. Moreover, the commenters have assumed mistakenly that the appropriate comparison is between this final rule and the pre-1979 utilization method. Clearly, the new rule should be compared to the 1979 malpractice rule because the 1979 rule—was in effect during the retroactive period. This final rule will replace the 1979 rule -not the utilization method, which was eliminated for purposes of malpractice insurance cost apportionment in 1979. Since, as was explained above, hospitals can only benefit under this final rule relative to the 1979 malpractice rule, retroactivity will have no adverse impact on providers. Furthermore, as explained below, we adhere to the four general reasons advanced in the NPRM for why the benefits of retroactivity outweigh any possible negative effects:

(1) *Relationship to Earlier Policies and the Current State of the Law.*— The legal status of the 1979 malpractice rule is in a state of great flux. Some courts have rendered final, non-appealable decisions invalidating the 1979 rule, which, typically, invalidate action taken pursuant to the 1979 rule for specific cost reporting periods of particular providers. In addition, many adverse decisions are pending presently on appeal, as are some decisions which have upheld the validity of the 1979 malpractice rule. District court decisions have not yet been rendered in many cases, and several courts of appeals have yet to consider the validity of the 1979 malpractice rule.

Also not decided conclusively is the question of the proper relief to be granted in cases where the 1979 rule has been invalidated. While some courts have held that, absent a new regulation, the utilization method should be applied to the particular malpractice insurance costs in controversy, other courts have left open the possibility of new corrective rulemaking or have simply not addressed the relief issue. Thus, there is no basis for the assertion that the courts have reinstated the utilization method as the only operative apportionment policy for malpractice costs. On the contrary, the courts have not conclusively resolved the issues raised in the litigation of that rule.

Since this final rule includes elements of the pre-1979 utilization method and the 1979 rule's claims-paid formula, retroactive implementation would not result in an abrupt departure from earlier policies. The differences between this final rule and the 1979 malpractice rule stem primarily from the introduction of utilization factors into the new methodology, factors which, as explained above, can only benefit hospitals during the retroactive period. As under the pre-1979 utilization method, the administrative portion of total premium cost will be included in the G & A pool and apportioned entirely on the basis of each provider's Medicare utilization rate. The risk portion of premium cost will be apportioned on the basis of the individual provider's utilization rate as scaled in accordance with the adjusted national ratio. Of course, the national ratio is one of the essential features of the 1979 malpractice rule. While the scaling of the risk portion departs from the usual application of the utilization method, it is necessary because Medicare patients file and receive a disproportionately small share of malpractice claims.

Finally, the conflicting decisions and numerous pending appeals on the 1979 malpractice rule have created great uncertainty about the state of the law pertaining to Medicare malpractice insurance apportionment policy. This final rule will be applied retroactively in order to fill the void and restore order in this unsettled area of the law.

(2) *Reliance Interests of Providers.*— As explained above, this final rule will replace the 1979 malpractice rule—not

the pre-1979 utilization method, which was eliminated for malpractice insurance costs in 1979. As described above, sections 1861(v)(1)(A)(ii) and 1871 of the Act authorize the Secretary to make appropriate retroactive corrective adjustments to Medicare reimbursement regulations. Nothing in the language of these statutory provisions or their legislative history suggests that the Secretary's authority to apply new regulations retroactively is limited to revising policies that exceed the scope of the Secretary's discretion. Section 1861(v)(1)(A) provides no discretion to reimburse providers for costs which the Secretary determines are in excess of those actual and necessary in the efficient delivery of services to Medicare patients. Thus, the Secretary's determination that the utilization method would over-reimburse premium costs for the period in question and that this final rule will satisfy applicable statutory requirements justifies, given the necessity of replacing the 1979 malpractice rule, retroactive application of this final rule.

Furthermore, we reject any suggestion that providers have a reliance interest in continuation of the utilization method of apportioning malpractice insurance costs. On March 15, 1979, and June 1, 1979, the Secretary gave notice of his determination that the utilization method would no longer be applied to malpractice insurance costs because it resulted in excessive reimbursement for those costs. The providers' widespread legal challenge to the 1979 rule has no bearing on the fact that providers have long been on notice that these costs would no longer be apportioned on a strict utilization basis. Since the June 1, 1979 adoption of the malpractice rule, the Department has applied and defended that rule consistently. While many providers may have hoped to prevail in their challenges to the 1979 malpractice rule—and in some cases plaintiff hospitals did prevail—the existence of such lawsuits could not justify any alleged "reliance" on the continued application of the utilization method. Apart from establishing the 1979 rule's claims-paid formula, the Secretary determined in 1979 that the utilization method over-reimbursed malpractice insurance costs. Even if it were assumed that providers could have expected the claims-paid formula to be invalidated, such an expectation would not give rise to a reliance interest in continuation of the utilization method. Because the Secretary had eliminated independently the utilization method, providers should have expected the adoption of some other replacement methodology for apportioning malpractice insurance costs. While the 1979 **Federal Register** documents obviously did not address the possibility of retroactive rulemaking, sections 1861(v)(1)(A)(ii) and 1871 of the Act plainly authorize such agency action.

Since 1979, providers have had the option of taking action (e.g., by attempting, as the commenter suggested, to minimize Medicare utilization) to "ameliorate the effects" of our decision to discontinue apportioning malpractice costs on a utilization basis. Since this final rule is based largely on the 1979 malpractice rule and its predecessor, retroactive application of this rule does not change the fact that it was each provider's own decision as to whether to take such ameliorative action.

Finally, the adoption of this final rule does not constitute noncompliance with any court decision on the 1979 malpractice rule. In each instance where a court has entered a final, non-appealable judgment mandating application of the utilization method to the costs in controversy, such judgments will be complied with.

(3) *Burden on Providers.*— Retroactivity will impose no financial penalty on providers because no hospital will receive less reimbursement for malpractice costs under this final rule than it would have received under the 1979 malpractice rule. Furthermore, in comparison to the 1979 malpractice rule, this final rule will benefit greatly many hospitals. Hospitals will receive utilization-based reimbursement for the administrative portion of total premium cost. Reimbursement for the predominant risk portion will be based on each provider's utilization rate, as scaled in accordance with the adjusted national ratio. Thus, providers will receive some reimbursement for the administrative portion and for the predominant risk portion of premium cost. The fact that the final rule might not reimburse providers as much as they would have received under the pre-1979 utilization method is not of controlling importance because this rule will replace the 1979 malpractice rule—not the pre-1979 utilization method—and because providers could not, subsequent to the 1979 rule, reasonably expect to be reimbursed based upon a strict utilization method.

As explained above, providers could have acted to minimize the effects of our elimination of the utilization method at any time since 1979, and retroactive application of this final rule has no bearing on that fact. Similarly, the transaction costs incurred by providers in challenging the 1979 rule were undertaken voluntarily, as would be any additional costs that might be incurred in challenging this rule. These costs are largely reimbursable by Medicare for providers subject to cost reimbursement.

Finally, the possibility of undertaking additional rulemaking on this issue, although not presently contemplated, has no bearing on the validity of retroactive application of this final rule.

(4) *Furtherance of Statutory Objectives.*— Since this final rule includes features of the pre-1979 utilization method and the 1979 malpractice rule, we are convinced that it furthers the statutory objectives of reimbursing only actual, necessary costs incurred for Medicare patients and of preventing cost-shifting between Medicare beneficiaries and non-Medicare patients. The administrative portion of total premium cost will be reimbursed under the utilization method. The risk portion will be reimbursed on the basis of the adjusted national ratio and each provider's own patient utilization rate. As explained above (see, section III.G.), we believe that this final rule satisfies the applicable statutory requirements. Also, we believe that the new rule is preferable to all of the alternatives considered in this rulemaking. (*See,* sections III.G., IV.E., and IV.F.)

Comment: The new rule would be applied unlawfully to providers that receive final, non-appealable judgments invalidating the 1979 malpractice rule.

Response: Of course, we complied fully with all final, non-appealable judgments invalidating the 1979 malpractice rule, and we will continue to do so. We will not without court approval apply retroactively this final rule to any provider's claims that resulted in a final, non-appealable judgment invalidating the 1979 rule and ordering reimbursement under the pre-1979 utilization method.

Comment: Retroactive application of a new rule is grossly unfair because the new rule has little prospective effect, and thus its adoption is intended solely to deprive hospitals of their proper reimbursement.

Response: This final rule will apply prospectively to the more than 700 hospitals excluded from PPS. In addition, the new rule will have prospective applicability to an additional 1450 excluded units that are part of hospitals subject to the prospective payment system. Thus, the new rule will have some future application to inpatient services furnished by many of the hospitals participating in the program. The new rule also will apply prospectively to

outpatient Services furnished by all hospitals. (See, section IV.B., below.) Retroactive application of the new rule will not deprive hospitals of their proper reimbursmement; rather, it ensures that the program will pay its fair share of hospital malpractice insurance costs. As explained above, many hospitals will receive more reimbursement under the new rule than under the 1979 rule; and no hospital will receive less reimbursement for the retroactive period than it received under the 1979 rule.

Comment: Since the 1979 malpractice rule is invalid, any attempt to apply retroactively a new rule must fail for the same reasons.

Response: Even if the 1979 rule were finally held invalid, that would not obviate the possibility of applying this new rule retroactively. This final rule differs substantively from the current rule in important respects. (*See*, sections II.A. and II.E., above.) The new rule is based on different empirical data than the 1979 rule. (*See*. section III.B., above.) Also, the new rule is the result of the current notice-and-comment rulemaking, and not the 1979 rulemaking.

Moreover, if the 1979 malpractice rule were finally held invalid, there would be an even greater need to replace the 1979 rule with a new valid regulation for the retroactive period. Absent appropriate corrective action, the program might be constrained to reimburse malpractice insurance costs on a utilization basis, which would result in a windfall to providers. Instead, we have filled the void and restored order in this unsettled area of the law with a new rule that responds to the major criticisms of the 1979 rule.

Comment: Retroactive application of the new rule would violate the express mandate of several court decisions.

Response: Since this final rule will not be effective until May 1, 1986, no court has addressed its validity. The issue of the retroactive application of this new rule has therefore not been the subject of any court mandate either. Several courts, upon invalidating the 1979 malpractice rule, have ordered utilization-based reimbursement and denied motions to stay final relief or to remand to the agency for suitable corrective action. We believe that these decisions were based on the fact that the Secretary had not promulgated a new final rule as of the date of the courts' orders. In any event, these courts did not hold that, *in general*, the Secretary may not engage in retroactive rulemaking concerning malpractice insurance apportionment policy. They held only that, absent a new rule, utilization-based reimbursement was an appropriate *remedy* for specific plaintiffs challenging the 1979 rule for specific cost reporting periods. Adoption of this final rule is not unlawful since all final, non-appealable judgments mandating utilization-based reimbursement will be complied with fully.

Comment: Retroactive application of the new rule would violate the due process rights of providers.

Response: Providers are only entitled to receive those Medicare reimbursement amounts that are authorized by statute. Providers have no due process right to obtain a specific amount of Medicare reimbursement. Under this final rule, a hospital can only receive more reimbursement for a retroactive period than under the 1979 malpractice rule. Thus, retroactive application of the new rule could not give rise to a colorable constitutional claim.

Comment: In general, the Secretary lacks the authority to engage in retroactive rulemaking. Specifically, the Secretary cannot engage in retroactive rulemaking to overturn the decisions of the courts. Also, section 1861(v)(1)(A)(ii) of the Act authorizes adjustments in a provider's periodic interim payments, not the adoption of retroactive regulations.

Response: Sections 1861(v)(1)(A)(ii) and 1871 of the Act provide the Secretary with the authority to engage in retroactive rulemaking. Additionally, the common law supports this exercise of retroactive rulemaking. Section 1815(a) of the Act authorizes adjustments to a provider's periodic interim payments, not section 1861(v)(1)(A)(ii). Once this final rule becomes effective, malpractice insurance cost reimbursement appeals will be decided on the basis of the new rule. The courts may then decide the validity of this final rule and whether the new rule may be applied retroactively. Without court approval, this final rule will have no effect on a final, non-appealable judgment of a court in which utilization-based reimbursement was imposed as the only permissible relief. Rather, the new rule responds to the courts' criticisms of the 1979 rule and eliminates the shortcomings of the 1979 rule that were found by the courts.

J. Application and Implementation of This Final Rule

Comment: The proposed rule does not explain specifically how a provider subject to a new rule should file a claim for additional payment under the new rule.

Response: Procedures for filing a claim for payment under this final rule are explained in section II.F., above. Briefly, a provider may request, under this new rule, reopening of a cost report to claim additional reimbursement within the period specified in the reopening and finality regulations. All open cost reports, including cost reports with respect to which appeals have been filed and are pending, on the issue of reimbursement for malpractice insurance cost, will automatically be calculated by the intermediary on the basis of this final rule. However, the intermediary will not make adjustments to cost reports for periods beginning prior to May 1, 1986, where such an adjustment would result in less reimbursement to the provider for malpractice insurance costs than would have been payable under the 1979 malpractice rule.

Comment: If a new rule were to be applied retroactively, then retroactive application should be made to all providers instead of to only providers whose malpractice insurance costs are on appeal or subject to reopening.

Response: This final rule will be applied retroactively to all providers' malpractice insurance costs for cost reporting periods beginning on or after July 1, 1979. In implementing this final rule, however, the general importance of ensuring the finality of decisions on reimbursement issues outweighs whatever benefits might be received by providers whose malpractice insurance costs are outside the reopening period. Our rules of administrative finality and reopening protect both the Medicare Trust Funds and the provider community from unexpected contingencies that might arise long after a decision becomes final. For example, we might discover that a particular reimbursement methodology greatly over-reimbursed certain costs over a ten-year period. If we were to take retroactive corrective action, application of the rules of administrative finality and reopening would protect providers by limiting program recovery of overpayments to cost reports with respect to which the three-year reopening period had not yet expired. Similarly, the reopening and finality rules protect the Medicare program from the administrative and financial burden of processing claims filed long after the cost reporting period to which they relate. Regardless of whether our finality and reopening rules benefit or disadvantage providers in a specific case, their overall role of providing certainty in the administrative process is important enough to warrant their consistent application.

Comment: The proposed rule does not state whether closed cost reports will be

reopened officially in order to effectuate additional payments under a new rule. If reopening is required, no issues besides malpractice insurance costs should be considered. Also, if reopening is required, then the Department should state whether reopened cost reports for fiscal years 1982 and 1983 must be submitted through the Hospital Cost Report Information System (HCRIS).

Response: This final rule will be implemented for all cost reports that are not yet final (closed). The implementation of this final rule for closed cost reports will require a reopening and, with a revised determination, the issuance of a revised notice of amount of program reimbursement (NPR) by the intermediary. Only cost reports that are subject to reopening under §405.1885 may be reopened to consider implementation of this new rule. During the reopening, no issues other than reimbursement for the cost of malpractice insurance will be considered. Finally, reopened cost reports that result in a revised determination will not be submitted through HCRIS.

Comment: The proposed rule does not address the impact of additional payments under a new rule on the calculation of the lesser of cost or charges, and, in the case of proprietary providers, the return on equity capital. The proposed rule also does not clarify the impact of additional payments under a new rule on the TEFRA payment rates in fiscal years 1983 and 1984 for non-PPS hospitals whose base year costs are affected by an additional payment.

Response: All cost reporting periods are subject to regulations and program policies applicable to each period. However, retroactive application of this rule will not impact on the equity capital of proprietary providers. This means that an increase in a provider's equity capital cannot be recognized because there was no basis for the provider to anticipate an increase in its assets by application of this final rule. Moreover, the additional reimbursement to be made currently under this final rule for a prior period could not be assumed to be equity that was actually used in the provision of patient care during that prior period. Nevertheless, a change in the apportionment of a provider's return on equity capital to Medicare will occur to the extent that increased Medicare reimbursement for malpractice costs will serve to increase the Medicare apportionment ratio and thus increase the return on equity payable to the provider for each year. However, any additional reimbursement that might result from a change in the apportionment ratio for any of the retroactive periods will not serve to increase the equity capital base for the subsequent retroactive period.

These prior cost reporting periods (affected retroactively by this final rule) could be affected, under this new rule, by the lower of reasonable costs or customary charges principle under § 405.455; by the cost limits provision under § 405.460; and by the rate of increase provision under § 405.463. The lower of costs or charges principle at § 405.455 is fully applicable to payments made under this final rule. In addition, applicable cost limits under § 405.460 and applicable rate of increase limits under § 405.463 will be adjusted for the impact of this final rule.

Comment: The federal rates under PPS should be revised to reflect additional payments under a new rule for a hospital's base year. Also, the hospital-specific rates should be adjusted retroactively to take account of additional base year payments.

Response: The Social Security Amendments of 1983 (Pub. L. 98–21) radically altered Medicare's system for paying hospitals for the operating costs of inpatient services for payment years beginning on or after October 1, 1983. The "federal" and "hospital-specific" portions are part of a prospectively-determined payment rate based upon the best data available at the time the rates are established. Thus, as opposed to the retrospective cost reimbursement system addressed by this regulation, the PPS rates are not subject to retroactive change where the intermediary, on the basis of the best data available, made a good faith attempt to act in accordance with the law as it was understood when the rates were established. (See, section III.F, above.)

IV. Regulatory Impact Analysis

A. Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any major rule. A major rule is defined as any regulation that is likely to result in: (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, we prepare and publish a regulatory flexibility analysis consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that the rule will not have a significant economic impact on a substantial number of small entities. We determined that the proposed rule required a regulatory impact analysis under E.O. 12291, and we also decided to prepare a regulatory flexibility analysis. Therefore, we included in the preamble of that proposed rule an analysis satisfying the provisions of both E.O. 12291 and the RFA, which discussed the impacts of the proposal and certain alternatives.

We have reviewed certain issues raised by commenters concerning the alternatives discussed in the proposed rule, and, as a result of our review of those issues, we have reconsidered the methodology described in the proposed rule and developed additional alternatives to reflect the problems identified by the commenters. The most important potential alternatives and their impact are discussed below.

A final regulatory impact analysis under E.O. 12291 is needed for this final rule. We have also decided to prepare a final regulatory flexibility analysis. In these analyses, we consider the issues raised in response to the impact analysis published with the proposed rule, and we discuss additional alternatives considered as well as the impact of any changes from the proposed rule. This section, in combination with the other sections of this preamble, constitutes an analysis meeting the combined provisions of both E.O. 12291 and the RFA.

B. Effect on Medicare Payments to Hospitals

We will apply the new malpractice rule two ways: prospectively, and retroactively. Implementation of retroactive application is discussed above, in sections II.F. and III.J of this preamble, and will affect only those hospitals that are described there. We estimate that retroactive payments using the revised reimbursement formula will result in program expenditures of about $195 million. Although this revised methodology, if applied retroactively for certain providers, could result in smaller payments to those providers than the amounts paid to them under the 1979 malpractice rule, we will not recover any putative overpayments.

We expect that more than 2,200 hospitals will qualify for additional payments as a result of retroactive application of the new methodology. Some of these payments will be relatively small, but payments to the several hundred hospitals that were

paid little or nothing under the 1979 malpractice rule may be substantial. Based on rough estimates of numbers of hospital and total payments for retroactive applications, the average additional payment would be between $80 thousand and $90 thousand dollars.

—Prospective application of this new rule will affect:

• More than 700 children's, psychiatric, rehabilitation, alcohol/drug, and other long-term care hospitals excluded from the prospective payment system;

• Nearly 1,450 units that are excluded from the prospective payment system (755 psychiatric units, 377 rehabilitation units, and 316 alcohol/drug units) and are part of hospitals subject to PPS (about 1,100 PPS hospitals have one or more excluded units);

• Malpractice cost reimbursement related to outpatient services furnished by PPS hospitals;

• Hospitals subject to the prospective payment system that, as a result of retroactive application of this rule, receive additional payment for the base year used to determine their hospital-specific rates under $412.71; and

• Sole community hospitals paid under $412.92 that, as a result of retroactive application of this rule, receive additional payment for the base year used to determine their hospital-specific rates.

Total FY 1985 payments to hospitals and units excluded from the prospective payment system were about $500 million, or only about one percent of total Medicare payments for all covered inpatient hospital services. Further, malpractice insurance costs are less than one percent of the total costs for excluded hospitals. Therefore, we do not expect this regulation to result in a significant prospective increase in program expenditures for these excluded hospitals and units.

We do not have sufficient data to estimate how much the Medicare payments for malpractice costs related to outpatient services will increase under the new malpractice rule. Total FY 1985 payments for these services were about $3.8 billion. Again, assuming that malpractice insurance costs account for less than one percent of the total costs for these services, we do not expect a significant increase in expenditures, although we expect most hospitals under PPS will benefit from some increase in reimbursement for these expenses. However, a hospital that experienced relatively high Medicare claims loss experience in the 5-year period applicable under the 1979 malpractice rule could receive reduced payments as a result of prospective application of the new methodology for Medicare malpractice costs related to outpatient services and excluded units.

The prospective application of the new methodology will result in increased payments to some of the more than 5,400 hospitals currently paid under the prospective payment system for the greater part of their Medicare malpractice expenses. Prospective adjustment of the hospital-specific rates for hospitals that receive additional payments in their base years will increase payments under the prospective payment system by about $5 million for the transition period cost reporting periods, that is, for cost reporting periods beginning before October 1, 1986. Congressional action extending the prospective payment transition period would, of course, result in extended effect of any adjusted hospital-specific portion.

Prospective adjustment of the hospital-specific rates will have a significant impact on sole community hospitals that received an additional payment for their base period. Under section 1886(d)(5)(C)(ii) of the Act, and regulations at 42 CFR 412.92, sole community hospitals are paid a prospective rate on a per-discharge basis, 75 percent of which rate is determined on a hospital-specific basis using the base period specified in § 412.73. Thus, an additional payment for the base period of a sole community hospital would have a continuing effect on its payment under the prospective payment system, rather than ending with the close of the transition period.

Although many hospitals will benefit from the new methodology, not all hospitals will receive more under the new methodology than they would have received under the 1979 malpractice rule or the increased national ratio proposed in the NPRM. The relative benefit or disadvantage of each prospectively affected hospital will depend on the relative magnitude of that hospital's Medicare utilization and malpractice loss experience. We expect hospitals that had little or no Medicare malpractice claims loss experience to benefit from this methodology, since they could otherwise have received as little as zero reimbursement. Under this new rule, no hospital with Medicare patients will receive zero reimbursement for malpractice insurance costs; each hospital serving Medicare patients will receive reimbursement under this rule regardless of its particular malpractice claims-paid history. However, hospitals with Medicare claims loss experience will not always be paid as much as they could have been under the 1979 malpractice rule or the proposed rule.

Table 1, below, shows how much Medicare reimbursement under the new methodology will vary according to a hospital's ratio of Medicare utilization to total utilization.

TABLE 1.—EFFECT OF NEW METHODOLOGY ON MEDICARE REIMBURSEMENT FOR THE COST OF HOSPITAL MALPRACTICE INSURANCE

Hospital Medicare utilization rate (percent) [1]	Scaling factor [2]	Medicare share of premium (percent)		
		Risk component [3]	Administrative component [4]	Total [5]
0.00	0.000	0.00	0.00	0.00
1.00	0.002	0.22	0.09	0.31
2.00	0.005	0.45	0.17	0.62
3.00	0.007	0.68	0.26	0.94
4.00	0.010	0.92	0.34	1.26
5.00	0.013	1.15	0.43	1.58
6.00	0.015	1.40	0.51	1.91
7.00	0.018	1.64	0.60	2.24
8.00	0.021	1.89	0.68	2.57
9.00	0.023	2.14	0.77	2.91
10.00	0.026	2.40	0.85	3.25
11.00	0.029	2.66	0.94	3.60
12.00	0.032	2.93	1.02	3.95
13.00	0.035	3.20	1.11	4.31
14.00	0.038	3.48	1.19	4.67
15.00	0.041	3.76	1.28	5.03
16.00	0.044	4.04	1.36	5.40
17.00	0.047	4.33	1.45	5.78
18.00	0.051	4.63	1.53	6.16
19.00	0.054	4.93	1.62	6.54
20.00	0.057	5.23	1.70	6.93
21.00	0.061	5.54	1.79	7.33
22.00	0.064	5.86	1.87	7.73
23.00	0.068	6.18	1.96	8.14
24.00	0.071	6.51	2.04	8.55
25.00	0.075	6.85	2.13	8.97
26.00	0.079	7.19	2.21	9.40
27.00	0.082	7.53	2.30	9.83
28.00	0.086	7.89	2.38	10.27
29.00	0.090	8.25	2.47	10.71
30.00	0.094	8.62	2.55	11.17
31.00	0.098	8.99	2.64	11.63
32.00	0.102	9.38	2.72	12.10
33.00	0.107	9.77	2.81	12.57
34.00	0.111	10.16	2.89	13.05
35.00	0.116	10.57	2.98	13.55
36.00	0.120	10.99	3.06	14.05
37.00	0.125	11.41	3.15	14.56
38.00	0.129	11.84	3.23	15.07
39.00	0.134	12.29	3.32	15.60
40.00	0.139	12.74	3.40	16.14
41.00	0.144	13.20	3.49	16.69
42.00	0.149	13.67	3.57	17.24
43.00	0.155	14.16	3.66	17.81
44.00	0.160	14.65	3.74	18.39
45.00	0.166	15.15	3.83	18.98
46.00	0.171	15.67	3.91	19.58
47.00	0.177	16.20	4.00	20.19
48.00	0.183	16.74	4.08	20.82
49.00	0.189	17.30	4.17	21.46
50.00	0.195	17.86	4.25	22.11
51.00	0.202	18.45	4.34	22.78
52.00	0.208	19.04	4.42	23.46
53.00	0.215	19.65	4.51	24.16
54.00	0.222	20.28	4.59	24.87
55.00	0.229	20.93	4.68	25.60
56.00	0.236	21.59	4.76	26.35
57.00	0.243	22.26	4.85	27.11
58.00	0.251	22.96	4.93	27.89
59.00	0.259	23.68	5.02	28.69
60.00	0.267	24.41	5.10	29.51
61.00	0.275	25.17	5.19	30.35
62.00	0.284	25.95	5.27	31.22
63.00	0.292	26.75	5.36	32.10
64.00	0.301	27.57	5.44	33.01
65.00	0.311	28.42	5.53	33.95
66.00	0.320	29.29	5.61	34.90
67.00	0.330	30.20	5.70	35.89
68.00	0.340	31.12	5.78	36.90
69.00	0.351	32.08	5.87	37.95
70.00	0.361	33.07	5.95	39.02
71.00	0.373	34.10	6.04	40.13
72.00	0.384	35.15	6.12	41.27
73.00	0.396	36.24	6.21	42.45

TABLE 1.—EFFECT OF NEW METHODOLOGY ON MEDICARE REIMBURSEMENT FOR THE COST OF HOSPITAL MALPRACTICE INSURANCE—Continued

Hospital Medicare utilization rate (percent) [1]	Scaling factor [2]	Medicare share of premium (percent)		
		Risk component [3]	Administrative component [4]	Total [5]
74.00	0.408	37.37	6.29	43.66
75.00	0.421	38.54	6.38	44.92
76.00	0.434	39.75	6.46	46.21
77.00	0.448	41.01	6.55	47.55
78.00	0.462	42.31	6.63	48.94
79.00	0.477	43.66	6.72	50.38
80.00	0.492	45.06	6.80	51.86
81.00	0.508	46.52	6.89	53.41
82.00	0.525	48.04	6.97	55.01
83.00	0.542	49.61	7.06	56.67
84.00	0.560	51.26	7.14	58.40
85.00	0.579	52.97	7.23	60.19
86.00	0.598	54.76	7.31	62.07
87.00	0.619	56.62	7.40	64.02
88.00	0.640	58.58	7.48	66.06
89.00	0.662	60.62	7.57	68.18
90.00	0.686	62.76	7.65	70.41
91.00	0.710	65.00	7.74	72.74
92.00	0.736	67.36	7.82	75.18
93.00	0.763	69.83	7.91	77.74
94.00	0.792	72.44	7.99	80.43
95.00	0.822	75.19	8.08	83.26
96.00	0.853	78.09	8.16	86.25
97.00	0.887	81.15	8.25	89.40
98.00	0.922	84.40	8.33	92.73
99.00	0.960	87.84	8.42	96.26
100.00	1.000	91.50	8.50	100.00

[1] Hospital-specific utilization is shown in one percent increments only to illustrate the effects of the methodology. Actual reimbursement results will depend on the hospital's precise Medicare utilization rate in the various patient care departments.

[2] The scaling factor takes into consideration hospital-specific utilization, the adjusted national Medicare loss ratio, the corresponding national Medicare utilization rate, the national non-Medicare loss ratio, and the national non-Medicare utilization rate.

[3] The values in this column are the product of the scaling factor from column 2 and the risk component of premium (91.5%).

[4] This column is the product of hospital utilization from column 1 and the administrative component of premium (8.5%).

[5] This column is the sum of columns 3 and 4. Addition may appear to be inexact due to rounding.

Hospital-specific claims loss experience will not affect Medicare reimbursement under the new methodology. Therefore, a hospital with a very high Medicare malpractice loss ratio relative to its Medicare utilization rate may receive less reimbursement for its malpractice insurance costs under this new rule than it would have received under the 1979 rule. Similarly, a hospital with a relatively low Medicare utilization rate may be paid less under this rule than under the 1979 methodology. As illustrated in Table 1, under this rule a hospital with Medicare utilization of 15 percent or lower will be paid less than the 5.1 percent of its malpractice premiums that would have been paid by Medicare under the 1979 rule to any hospital that had no malpractice claims- paid experience. On the other hand, a hospital with a high Medicare utilization rate and relatively low Medicare malpractice claims-paid experience is likely to receive reimbursement for more of its malpractice insurance costs under this new rule than under the 1979 rule.

The different effects of the new methodology from those of the 1979 rule are illustrated by application of the two methodologies to four hypothetical hospitals (A, B, C, and D), each with 50 percent Medicare utilization. All four are excluded from the prospective payment system. For the relevant cost reporting periods, Hospital A has no malpractice claims loss experience at all. Hospital B has some Medicare claims loss experience, but no malpractice claims losses related to non-Medicare patients. Hospital C has no Medicare losses, but some non-Medicare claims loss experience. Its ratio of Medicare malpractice losses to its total malpractice losses is 0.2, or 20 percent.

Under the rule published July 1, 1979, Hospital A would be paid 5.1 percent of its malpractice insurance costs; that is, the current national ratio of Medicare losses to total losses. (Under the 1985 proposed rule methodology, the hospital would have received 11.6 percent of premium expense; that is, the proposed updated national ratio.) Under the 1979 malpractice rule and the 1985 proposed rule, hospital B would be paid 100 percent of its malpractice insurance costs, and Hospital C would receive no reimbursement for malpractice insurance. Under the 1979 rule and the 1985 NPRM, hospital D would be paid based on the ratio of its Medicare malpractice losses to all malpractice losses for the relevant cost reporting periods; that is, 20 percent of its insurance costs.

Under this final rule, 8.5 percent of each of the four hypothetical hospitals' malpractice insurance costs would be included in their G & A cost centers and reimbursed based on Medicare utilization. Each would be reimbursed comparable amounts (about 4.25 percent of total premium cost) for this administrative portion of their malpractice insurance costs. Medicare reimbursement for the remaining portion (that is, the risk portion, or 91.5 percent of the premium) will be determined based on the scaling factor formula, which takes into account the adjusted national ratio of Medicare malpractice loss experience, the national Medicare utilization rate, and the hospital's particular Medicare utilization rate. In this example, since all four hospitals have the same Medicare utilization rate, all would be reimbursed the same percentage of malpractice insurance costs; that is, 17.86 percent for the risk portion, and 4.25 percent for the administrative portion, or 22.11 percent of total premium cost. Hospitals A and C would thus receive more reimbursement under this final rule than under the 1979 malpractice rule and the 1985 NPRM; Hospital B would receive less.

Hospital D would receive slightly greater total reimbursement under the new rule; that is, 22.11 percent of malpractice costs under this new rule, as compared with 20 percent under the 1979 rule and the NPRM. However, if Hospital D had had a lower Medicare malpractice loss ratio (for example, 10 percent), it would receive significantly more under the new method than under the 1979 rule; and if it had had a higher Medicare malpractice loss ratio (for example, 50 percent), it would receive less under this rule than it would have received under the 1979 rule.

Because most hospitals in most cost reporting periods have little or no malpractice losses, and because Medicare losses generally are a relatively small portion of total losses, we expect that the majority of hospitals in the situation of Hospital D (that is, with both Medicare and non-Medicare loss experience) would be paid more under this final rule than under the previously applicable methodology. These hospitals generally will benefit from this methodology if they have low Medicare malpractice losses relative to their Medicare utilization. Since the national Medicare malpractice loss ratio is only 11.8 percent as compared with an average Medicare utilization rate of approximately 40 percent for 1983, this new rule will benefit most hospitals. Similarly, hospitals with no malpractice claims loss experience will usually benefit from application of the new methodology, since only those with around 15 percent or lower Medicare utilization will receive lower total reimbursement under this new rule than under the 1979 rule.

In summary, the shift from a provider-specific claims based methodology to a methodology that weighs provider-specific Medicare utilization heavily in determining the Medicare share of malpractice costs will benefit most hospitals. The greatest benefit will accrue to those with no or low Medicare malpractice claims losses and relatively higher Medicare utilization.

C. Effect on Medicare Payments to SNFs

As discussed above, due to lack of adequate data on the malpractice claims loss experience of skilled nursing facilities, we have decided to allow SNFs to include their malpractice costs in the G & A cost center for apportionment on a utilization basis. We expect that this change will result in higher reimbursement but we do not expect it to affect Medicare

reimbursement to SNFs significantly. We will continue to develop and analyze data on SNF malpractice costs.

D. Effect on Medicaid Payments to Hospitals and SNFs

Twelve states follow Medicare reimbursement principles for purposes of determining Medicaid payments to providers. Unless it acts to amend its state plan and adopt some other rules, each of these states will have to implement this rule; that is, pay SNFs for malpractice expense on a strict utilization basis, and pay hospitals based on the new Medicare methodology for hospitals (adjusted appropriately for Medicaid). In addition, a number of other states use Medicare definitions of allowable cost in their reimbursement systems, and may have to amend their state plans if they do not wish to treat malpractice costs similarly to Medicare. Furthermore, states that would not otherwise be affected could elect to adopt this methodology under the discretion afforded them under section 1902(a)(13) of the Act.

We expect few states to adopt the new methodology, since very few adopted the 1979 methodology as part of their Medicaid programs. Thus, although this rule will affect states by impelling them to amend their state plans, we anticipate that the direct effect of this rule on Medicaid payments to hospitals will be slight.

E. Alternatives Considered in the Proposed Rule

In the impact analysis published with the proposed rule, we discussed four major alternatives we had considered in addition to the proposal—

1. Take no action;
2. Reinstate the utilization method of apportionment;
3. Directly apportion other G&A costs in addition to malpractice insurance costs; and
4. Reimburse providers based on separate malpractice insurance premiums for Medicare and non-Medicare patients.

A number of commenters supported the second, third, and fourth of these alternatives, and disputed our reasons for rejecting them. For the most part, we have responded to these comments in section III of this preamble, above. However, certain comments, especially those concerned with the "separate policies" alternative, related directly to the impact analysis section in such a way that it is appropriate to discuss them here.

Comment: The most accurate way of determining the proper apportionment of costs is to allow hospitals to purchase separate malpractice insurance policies covering Medicare and non-Medicare patients. This commenter stated that the premiums would be virtually the same.

Response: For the reasons discussed below, we do not agree that separate policies would assure the proper apportionment of costs, or that the premiums of separate policies would, if accurate, be virtually the same. In addition, there are certain practical barriers to adopting a separate policies approach. First, as one commenter pointed out, even if a hospital wanted to purchase separate policies, insurance companies do not offer them. Second, it would not be possible to institute such policies on a retroactive basis, and, as previously explained, we have determined that a retroactive change in the Medicare rules for reimbursing the costs of malpractice insurance is appropriate.

The Medicare statute gives the Secretary the responsibility and authority to promulgate regulations prescribing the methods to be used to determine the reasonable costs of providing covered services to Medicare beneficiaries. To adopt the commenters' suggestion to reimburse providers based on separate malpractice insurance policies would be to inappropriately delegate to malpractice insurance carriers the Secretary's responsibilities to determine Medicare's share of costs. Of course, the Medicare statute does not authorize the Secretary to require malpractice insurance carriers to provide separate policies for Medicare patients. Moreover, we have no evidence that insurers have, at this time, either the inclination or the capability to accurately determine malpractice premiums separately for Medicare and non-Medicare patients.

If separate policies were issued, each insurer could be expected to use varying methods to calculate premiums covering Medicare and non-Medicare patients. Under a "separate policies" approach to Medicare reimbursement, we would be unable to determine whether the insurer had properly apportioned the insurance premiums between Medicare and non-Medicare. For example, it often would advantage a provider to select an insurer that charged the same for Medicare as non-Medicare. This would result in excessive Medicare reimbursement to the extent that the premium did not reflect the lower risk related to Medicare beneficiaries.

Furthermore, we believe that separate policies would likely result in Medicare premiums higher than justified. That is, if the malpractice insurance costs attributable to Medicare patients account for 10 percent of a total premium, a policy covering only Medicare patients probably would be more than 10 percent of the former combined premium. Our new reimbursement methodology will result in a more equitable and justifiable result than reliance on separate insurance policies.

Comment: HCFA mistakenly claims that separate policies would create artificially high premiums and increase the costs of administering the Medicare program. Mechanisms exist to prevent artificially high premiums on Medicare risk. To keep these costs low, HCFA could, for example—

(1) Limit reimbursement under separate policies to the lowest price per Medicare patient at which malpractice insurance coverage is widely available, similar to payment restrictions for drugs;

(2) Recognize separate policies only when written by limited purpose or commercial companies formed solely to insure this Medicare risk; or

(3) Recognize separate policies only if a hospital purchased its Medicare risk coverage from a company different from the company that provided the hospital's non-Medicare risk coverage.

Response: At this time, insurers cannot rate providers based on characteristics of the patient population because they have little patient-specific claims loss experience. Therefore, they would have to use some other basis to set premiums, initially. Based on comments we received, we expect they might use similar rates for Medicare and non-Medicare patients, which would be inappropriate for the reasons given above.

It would not be administratively feasible for the Medicare program to shop around for the lowest-priced malpractice insurer. The responsibility to select an insurer lies with each hospital, and although the hospital must select an insurer prudently, there is currently no explicit law or regulation that specifies that the cheapest malpractice insurer must be selected. A hospital must consider many factors in selecting among alternative insurers, and the premium rate is only one of them. Furthermore, in some states, only a single insurer is available to a hospital.

The suggestion that we should recognize separate policies only when written by limited purpose or commercial companies formed solely to insure this Medicare risk would not be possible in some states, due to existing laws and arrangements. In each state, the established insurance regulators would have to approve the proposed rate-making changes. Furthermore, we

are not convinced that limited purpose or commercial companies formed solely to handle this Medicare risk would be cost effective. We also doubt that many insurers would be willing to set up business based strictly on insuring Medicare malpractice risk.

Purchasing Medicare malpractice risk coverage from a company different from the company providing non-Medicare risk coverage still would not necessarily assure that the correct reimbursement would be paid to providers for Medicare beneficiaries. To require such an arrangement would also frustrate many established purchasing and insuring strategies. Many hospitals are accustomed, for good reasons, to purchase all their liability coverage from a single insurer. It would not always be to a hospital's advantage to have a unique insurer for its Medicare malpractice risk.

Comment: Separate policies would permit the identification of the insurance risk of all the elements of costs attributable to Medicare patients instead of using aggregate losses only to measure the costs.

Response: We assume that by "aggregate losses," the commenter meant the accumulation of costs based on claims-paid experience. We expect that insurers would vary in their approach to dealing with the insurance risk factors. There are presently no data to support the assumption that separate policies would appropriately identify all the elements of risk.

As previously stated, insurers cannot presently rate providers based on the characteristics of patient population, because they have little patient-specific claims loss data; therefore, they would probably use similar rates for Medicare and non-Medicare malpractice premiums. Furthermore, the new methodology established by this final rule does reflect other elements of cost in addition to claims paid. We believe this methodology accomplishes the same objective and is more administratively feasible than the "separate policies" approach.

Comment: Commercial insurance for malpractice exposures might not be available for individual hospitals, or if available, might only be available on a "claims-made" basis. Equitable treatment of both self-insured and commercially-insured providers, as well as providers with "claims-made" and "occurrence" insurance coverage, requires an independent assessment of cost not revealed by market prices.

Response: This observation is partially correct, but to date we do not know of such a validated independent assessment of cost comparison of both insurers and cost factors of malpractice insurance. As recognized by the commenter, malpractice insurance is not a classical "market" (because, e.g., premiums are based on rates approved by state insurance commissions), and prices (that is, premiums) often seem to be based on considerations in addition to cost factors. However, as far as the risk factor is concerned, we believe that the HCRIS data, and our new reimbursement methodology, obviate any need for insurance companies to ascertain the precise difference in risks between Medicare and non-Medicare patients.

Comment: HCFA could determine the costs that would be apportioned to Medicare under the utilization method of reimbursement and then weight the Medicare portion by some statistically valid factor to reflect any provable reduction in cost based on lower malpractice awards. (The commenter contends that, because awards are such a low portion of total malpractice premium costs and because indirect benefits from maintaining malpractice insurance would be allocable to the Medicare patients on the same basis as to non-Medicare patients, an appropriate weighting factor probably would be very close to 1.0.)

Response: We have considered all of the above factors as we developed our new reimbursement methodology, and we believe that our methodology responds to the commenter's concerns. However, as shown by Table 1, above, we believe the weighting factor generally would be significantly less than 1.0. The claims loss experience of individual hospitals would have no significant effect on Medicare reimbursement under the new methodology. Hospitals with the same Medicare utilization rate would be paid the same portion of expense regardless of their loss experience.

F. Alternatives Considered in Developing This Final Rule

As noted above, the comments we received on the proposed rule caused us to reconsider various factors related to payment for malpractice costs. As a result, we developed several new alternatives, including the revised methodology adopted in this final rule.

As shown by the comments received on the alternatives discussed in the proposed rule, numerous comments addressed the central issue of what portion of the malpractice costs should be reimbursed by Medicare, and there were several suggestions as to how this portion should be determined. The 1979 malpractice rule specified that providers' paid malpractice claims must be separately accumulated and used to directly apportion their malpractice insurance costs to Medicare. This apportionment was determined either by using the ratio of the provider's Medicare malpractice losses to its malpractice losses for all patients, or, if a provider had no malpractice loss experience, by reference to the national ratio of Medicare malpractice losses to all malpractice losses. Thus, the methodology of the 1979 rule takes into account a provider's loss experience, but not its Medicare utilization. It presumes that all premium cost may be considered to be related to risk.

As discussed in section III. of the preamble, a number of commenters advanced arguments that the proposed rule's methodology overlooked certain considerations:

- A portion of premium expense reflects the insurer's administrative expense not related to risk of loss.
- Some portion of the premium is related to loss adjustment expenses, which, though they are risk related, are not included in claims losses.
- Malpractice premium expense is a cost of doing business that, to some extent, benefits all patients even when there is no claims loss experience.
- Claims experience over a five-year period does not necessarily reflect a provider's Medicare utilization.

Despite these considerations, it remained clear to us that, as shown by the national Medicare loss ratio of 11.8 percent, Medicare beneficiaries did not account for a share of malpractice risk proportionate to their utilization of hospital services. Therefore, since the alternatives discussed and rejected in the proposed rule continued to be unacceptable, we developed several new alternatives in response to the comments, each addressing one or more of these considerations.

The principal new alternatives we considered were generated by considering whether or not to—

- Reflect loss adjustment expense in the calculation of the national ratio;
- Assign a portion of premium expense to the G&A cost center;
- Continue to use claims loss experience to determine the Medicare share of risk-related premium expense;
- Continue to use the national ratio directly to determine the Medicare share of malpractice insurance costs for hospitals with no claims loss experience; or
- Reflect each provider's Medicare utilization in determining the Medicare share of premium expense.

Because each of these factors may, to some extent, be considered

independently, a large number of potential alternatives are possible. However, we gave detailed consideration to five major combinations.

Alternative I was the proposed rule's methodology, using the most recent national Medicare loss ratio of 11.8 percent. If we chose this option, we would *not* assign any premium expense G&A, nor would we reflect loss adjustment expenses. We would continue to use hospital-specific claims loss experience, or direct application of the national ratio, as appropriate, in determining the Medicare share of malpractice insurance costs. Further, we would not consider hospital-specific Medicare utilization in determining the Medicare share.

Alternative 2 was to increase the national Medicare loss ratio from 11.8 percent to 13.2 percent to reflect loss adjustment expense (LAE), but otherwise to preserve the features of the proposed rule methodology.

Under Alternative 3, we would assign a portion of premium expense (8.5 percent) to the G&A cost center and also reflect LAE in adjusting the national ratio. Each hospital's Medicare utilization rate would thus be used to determine the Medicare share of the non-risk portion of the malpractice insurance premium. However, the Medicare share of the remaining portion of the premium expense (that is, the risk portion of 91.5 percent) would be determined based on hospital-specific claims loss experience (or, for a hospital with no claims loss experience, by direct application of the adjusted national ratio), as under both the 1979 malpractice rule and the proposed rule.

Alternative 4, like Alternative 3, included both assignment of an 8.5 percent portion of premium expense to G&A and reflection of LAE in an adjusted national ratio. In addition, for hospitals with no malpractice claims experience, Alternative 4 took the individual hospital's Medicare utilization rate into consideration by means of the scaling methodology discussed in section II.A. of the preamble. Alternatives 3 and 4 differed in that, under Alternative 4, scaling would be used (and, therefore, a hospital's own utilization taken into consideration) to determine Medicare's share of the risk portion of the malpractice insurance premium when a hospital had no claims loss experience. Otherwise, a hospital's specific ratio of Medicare malpractice claims to its total losses would be used to determine the Medicare share, just as under the 1979 and proposed rules.

Alternative 5, which is the selected alternative, differs from all other alternatives considered in that no recognition is given to an individual hospital's claims loss experience. It is the same as Alternative 4 in using a national ratio adjusted to reflect LAE, and the assignment of 8.5 percent of premium expense to G&A. It differs from Alternative 4 in that it applies the scaling methodology, and thereby reflects a hospital's Medicare utilization rate, to determine Medicare's share of the risk portion of malpractice premiums for all hospitals regardless of whether or not the hospital has had malpractice loss experience.

Table 2, below, provides a summary of these alternatives.

TABLE 2.—COMPARATIVE SUMMARY OF DECISION VARIABLES OF ALTERNATIVES CONSIDERED IN DEVELOPING THIS FINAL RULE

Decision Variable	Alternatives				
	1	2	3	4	5
Factor LAE into national ratio.	No	Yes	Yes	Yes	Yes
Assign a non risk portion of premium to G&A [1].	No	No	Yes	Yes	Yes
Use hospital-specific claims loss experience to determine medicare share of risk portion [2].	Yes	Yes	Yes	Yes [4]	No
Apply national ratio directly to risk portion when a hospital has no claims loss experience.	Yes	Yes	Yes	No	No
Use scaling methodology to determine medicare share of risk portion [3].	No	No	No	Yes [4]	Yes

[1] The Medicare share of this non-risk portion to be determined based on hospital-specific utilization.
[2] For alternatives that do not assign a portion of premium to G&A, the risk portion is 100 percent.
[3] The scaling methodology takes into account hospital-specific utilization, the national Medicare loss ratio, national Medicare utilization, and national non-Medicare utilization.
[4] Under Alternative 4, the scaling methodology would be applied to the risk portion only for hospitals with no claims loss experience.

Each of these alternatives would have substantially different impacts on affected hospitals. Much of the difference hinges on whether or not a hospital's specific claims loss experience is used in determining the Medicare share. To illustrate, compare the application of the various alternatives to several hypothetical hospitals like those discussed above, all with 50 percent Medicare utilization.

Hospital A—No malpractice claims loss experience.

Hospital B—Some Medicare-related malpractice loss, but no non-Medicare loss.

Hospital C—No Medicare-related malpractice loss, but some non-Medicare loss.

Hospital D1—Both Medicare and non-Medicare claims loss; hospital-specific Medicare malpractice loss ratio of 10 percent.

Hospital D2—Both Medicare and non-Medicare claims loss; hospital-specific Medicare malpractice loss ratio of 25 percent.

Hospital D3—Both Medicare and non-Medicare claims loss; hospital-specific Medicare malpractice loss ratio of 50 percent.

Table 3, below, summarizes the comparative impact the alternatives shown in Table 2 would have on Hospitals A, B, C, D1, D2, and D3.

TABLE 3.—COMPARATIVE MEDICARE MALPRACTICE REIMBURSEMENT IF ALTERNATIVES 1 THROUGH 5 WERE ADOPTED

[In percent]

Hypothetical Hospitals	Alternatives				
	1	2	3	4	5
A	11.8	13.2	16.33	22.11	22.11
B	100.0	100.0	95.75	95.75	22.11
C	0.0	0.0	4.25	4.25	22.1
D1	10.0	10.0	13.40	13.40	22.11
D2	25.0	25.0	27.13	27.13	22.11
D3	50.0	50.0	50.00	50.00	22.11

As indicated in this table, when hospital-specific claims loss experience is used, hospitals with comparable Medicare utilization may be paid widely varying shares of their malpractice insurance costs. This benefits some hospitals, but disadvantages hospitals with low Medicare malpractice losses, such as Hospitals C and D1.

The key decisions in selecting Alternative 5 were to—

- Assign a portion of premium expense to G&A. The reimbursement methodology thereby acknowledges that Medicare should share proportionately that portion of malpractice insurance cost that is unrelated to risk.
- Reflect loss adjustment expense in the national ratio. The upward adjustment of the national Medicare malpractice claims-paid ratio assures that claims handling costs are reflected in the ratio.
- Discontinue using hospital-specific claims loss experience to determine Medicare's share of the risk portion of malpractice premiums. The decision eliminates the so-called "anomalous results" of tying Medicare reimbursement to a hospital's particular malpractice loss history, under which a

single paid claim could conceivably cause a drastic difference in Medicare reimbursement.

• Use the utilization scaling methodology to determine Medicare's share of the risk portion, regardless of a hospital's loss experience. By relying on the adjusted national Medicare malpractice claims-paid ratio, and scaling that number upward or downward according to a hospital's Medicare utilization rate, reimbursement will reflect the proportion of services provided to Medicare patients at the hospital as well as the disproportionately low risk of malpractice claims loss attributable to Medicare patients.

Under this rule, we have attempted to develop a reimbursement methodology that responds to the greatest extent possible to the concerns of the courts and Medicare providers as discussed throughout this preamble. Alternative 5 was selected because it addressed most fully every major criticism of the 1979 malpractice rule and satisfied the applicable provisions of the Medicare statute (see section III.G of this preamble). The other alternatives were accordingly rejected because, while addressing certain aspects of the apportionment problem, each was less comprehensive than Alternative 5 in its approach.

Table 4 below summarizes the comparative impact the alternatives shown in Table 1 would have on aggregate Medicare program expenditures, both prospectively and in retroactive application.

TABLE 4.—COMPARATIVE DOLLAR IMPACTS OF ALTERNATIVES CONSIDERED IN DEVELOPING FINAL RULE

Estimated Medicare Reimbursement for Malpractice Expense [1]

Alternatives considered [2]	Cost ($millions)	
	Retroactive application [3]	Prospective application [4]
1	$20	Negligible.[5]
2	25	Negligible.
3	70	Negligible.
4	80	5.
5	195	5.

[1] These are our best estimates as of January 1986. All figures are rounded to the nearest $5 million.
[2] See the narrative preceding Table 2 for description of alternatives.
[3] Applied to pre-PPS cost reports beginning on or after July 1, 1979 and before October 1, 1983.
[4] Effect of prospective adjustment of HSP for cost reporting periods beginning on or after April 1, 1986. Assumes no extension of the prospective payment system transition period.
[5] Because all figures are rounded to the nearest $5 million, we consider estimated costs of less than $2.5 million to be negligible.

G. Conclusion

In summary, we have concluded that our final rule will substantially benefit both providers and the Medicare program. It will preserve the essential features of a policy that satisfies all applicable statutory requirements and that is necessary for the sound management of the program and the Medicare Trust Funds. Within the confines of the Medicare statute, the regulation fully responds to the concerns of Medicare providers and reviewing courts about the program's policy for apportioning malpractice insurance costs.

Under this final rule, we will always pay something for malpractice insurance. We may pay as high as 100 percent, but only if utilization is 100 percent, regardless of an individual hospital's Medicare malpractice loss experience. On the average, we will pay substantially more than under the existing rule. The new methodology will benefit most hospitals with high Medicare utilization and either no Medicare losses or a low Medicare/non-Medicare loss ratio. Those with low utilization and disproportionately high malpractice losses related to Medicare patients may, in some cases, receive less Medicare reimbursement for their malpractice expenses. (However, we will not recover overpayments resulting from retroactive application of this rule to cost reports already settled.) In view of the statutory requirements and the objectives of the Medicare program, this is the most supportable and cost-effective alternative available.

V. Circumstances Require Retroactive Application of This Final Rule

The Administrative Procedure Act, 5 U.S.C. 553(d)(3), provides that, for good cause shown, an agency may dispense with the normal requirement of a 30-day period between publication of a final rule and the effective date of the final rule. Because this final rule does not become effective until 30 days after publication, we do not believe that a "good cause statement" is necessary. As explained in the NPRM and in this final rule, we believe that retroactive application of this final rule is proper and necessary. In the event that it is deemed necessary to include a good cause statement for this final rule, we have determined that good cause exists for retroactive application of this final rule, and we hereby include by reference the discussion of those sections in the preamble of the NPRM and this final rule that address retroactive application and implementation of this rule.

VI. Opportunity for Comment

This interim final rule embodies certain changes from the proposal that were made to respond to the comments received. Although this rule will go into effect as stated above, public comment on these changes and on the factual information that we developed to implement the recommended revisions will be considered if received by May 1, 1986. Comments that merely reiterate issues dealt with in this document will not be considered. Because of the large number of items of correspondence that we typically receive on regulations, we cannot acknowledge or respond to them individually. However, after considering comments received timely on new issues bearing on this interim final rule, we will respond to the comments and include any further changes in the rule (including retroactive changes) which might be necessitated in light of those comments in a future **Federal Register** publication.

We voluntarily follow the notice and comment provisions of the Administrative Procedure Act (5 U.S.C. 553) in issuing Medicare rules. We believe that additional opportunity for comment is not necessary before this new rule goes into effect, since the changes are an outgrowth of the comments received. In the alternative, we find good cause to issue this interim final rule, because additional delay would be contrary to the public interest. Additional delay would result in the entry of further judicial judgments based on the prior rules at a cost to the Medicare Trust Funds of up to $180 million in the near term under circumstances that could make recovery of the funds difficult if this rule were to be issued at a later time. These sums do not include cases that are presently pending before the Provider Reimbursement Review Board, which shortly will be in the court system, and that involve approximately one hundred fifty million additional Trust Fund dollars. Moreover, since the pre-1979 utilization method clearly conflicts with the statutory requirements for proper allocation of costs to Medicare, any use of that method for hospitals still subject to cost reimbursement would also inappropriately disadvantage the Trust Funds. Administrative considerations and prompt statutory payment requirements necessitate that some reimbursement rule be in place. Accordingly, in light of the clear evidence that any payment under the pre-1979 utilization method violates the statute, and the need to have some alternative in place, it is appropriate to implement this regulation on an interim final basis. Medicare's need for adequate funding of future medical services requires strict conservation of program resources, and the

Department's fiduciary responsibility to protect the Trust Funds therefore warrants immediate issuance of this rule.

42 CFR Part 405 Subpart D, is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

1. The authority citation for Subpart D continues to read as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886 and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

2. The table of contents is amended by adding the title for a new § 405.457 to read as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

* * * * *

Additional General Rules On Reasonable Cost Reimbursement

* * * * *

§ 405.457 Malpractice insurance costs.

* * * * *

3. In section 405.452, paragraph (a)(1) is amended by changing the cross-reference from "paragraph (a)(1)(ii) of this section" to "§ 405.457" and the reference to "paragraph (a)(1)(iii)" to "paragraph (a)(1)(ii)"; by removing paragraph (a)(1)(ii); by redesignating paragraph (a)(1)(iii) as paragraph (a)(1)(ii); and by correctly designating paragraph (e)(9) as paragraph (e)(2).

4. A new §405.457 is added to appear just after § 405.456, to read as follows:

§ 405.457 Malpractice insurance costs.

(a) *Apportionment of malpractice insurance premiums and self-insurance fund contributions.* For cost reporting periods beginning on or after July 1, 1979, malpractice insurance costs must be apportioned as set forth in this section. Subject to the rules of administrative finality and reopening as set forth in Subpart R of this part, hospital malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare based on the methodology described in paragraph (b) of this section. Allowable malpractice insurance costs of SNFs must be apportioned to Medicare based on the methodology described in paragraph (c) of this section. For purposes of this section, "premium" includes contributions to malpractice self insurance funds.

(b) *Hospital malpractice insurance cost methodology.* (1) *Components of the premium.* The premium is divided into an administrative component and a risk component as follows:

(i) The administrative component consists of 8.5 percent of the total premium amount, and accounts for an insurer's fixed overhead expenses and a proportionate share of premium and payroll taxes and commissions paid to insurance agents.

(ii) The risk component consists of 91.5 percent of the total premium amount, and accounts for an insurer's anticipated loss experience, expenses associated with losses (including defense costs and claims department overhead costs), and the remaining share of taxes and commissions paid to insurance agents that are not included in the administrative component.

(2) *Apportionment of administrative component.* The administrative component of the premium is reported as an administrative and general cost and apportioned in accordance with § 405.452(a)(1).

(3) *Apportionment of risk component.* (i) The risk component of the premium is apportioned based on a scaling factor, derived from the scaling factor formula described in paragraph (b)(3)(ii) of this section, which accounts for the hospital's Medicare utilization rate and the disproportionately low national ratio of hospital malpractice losses paid to Medicare beneficiaries, as compared to losses paid to all patients. The scaling factor is multiplied by 91.5 percent of the hospital's malpractice insurance premium to determine Medicare's share of the risk component of the premium.

(ii) The scaling factor is derived from the following formula:

$$\frac{u \times (R/U_1)}{[u \times (R/U_1)] + [(1-u) \times (1-R)/(1-U_2)]}$$

U_1 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for Medicare patients.

U_2 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for non-Medicare patients.

R = The national Medicare malpractice loss ratio, as adjusted for associated claims handling expense.

u = The hospital's own Medicare utilization rate for the cost reporting period based on a ratio of the hospital's total Medicare-covered inpatient days of care to its total inpatient days of care.

R/U_1 = The national Medicare malpractice loss ratio compared to the national Medicare utilization rate.

$(1-R)/(1-U_2)$ = The national non-Medicare malpractice loss ratio compared to the national non-Medicare utilization rate.

(4) *Example:* Apportionment of Medicare's share of the malpractice insurance costs of a hospital that averages 75 percent Medicare utilization during the applicable cost reporting period is calculated as follows:

Step one—The administrative component of the premium (8.5 percent) is included in the administrative and general cost center of the hospital and is apportioned on a utilization basis. Thus, the hospital would be reimbursed approximately .085 times .75, or 6.38 percent of the administrative component of its premium. (This figure would vary slightly depending upon the hospital's specific Medicare utilization of its patient care departments.)

Step two—The risk component of the premium (91.5 percent) is apportioned on a basis which accounts for the hospital's own Medicare patient utilization rate and the adjusted national Medicare malpractice loss ratio by multiplying 91.5 percent by the .421 scaling factor derived from the scaling factor formula, as follows:

u = 75.0 percent
R = 13.2 percent
U_1 = 38.8 percent
U_2 = 38.1 percent

$$\frac{.75 \times (.132 / .388)}{[.75 \times (.132/.388)] + [(1-.75) \times (1-.132)/(1-.381)]} = .421$$

Thus, the hospital would be reimbursed .915 times .421, or 38.54 percent of the risk component of its premium. This means that Medicare reimbursement would account for 6.38 percent plus 38.54 percent, or 44.92 percent of this hospital's total malpractice insurance premium.

(5) *Updating of factors used in determining apportionment.* Based on actual cost report data, HCFA will periodically calculate the national average of Medicare utilization and the national ratio of hospital malpractice losses paid to Medicare beneficiaries to malpractice losses paid to all hospital patients. Periodically, as warranted by changes in these factors, HCFA will—

(i) Publish a notice in the **Federal Register** describing the proposed changes for public comment; and

(ii) In a subsequent **Federal Register**

notice, update the relevant factors and respond to comments.

(6) *Allowable uninsured malpractice losses and related direct costs incurred by a hospital.* If a hospital pays an allowable uninsured malpractice loss to or on behalf of a Medicare beneficiary in order to comply with a deductible or coinsurance provision of its malpractice insurance policy, or as a result of an award in excess of a reasonable coverage limit, or as a governmental provider, that loss and related direct costs must be directly assigned to Medicare for reimbursement. An uninsured malpractice loss paid to or on behalf of a non-Medicare patient is not an allowable cost.

(c) *SNF malpractice insurance cost methodology.* Costs of malpractice insurance premiums and self-insurance fund contributions, in addition to other allowable malpractice insurance costs of an SNF, are reported as an administrative and general cost and apportioned in accordance with § 405.452(a)(1).

(Catalog of Federal Domestic Assistance Programs: No 13.773, Medicare—Hospital Insurance; No. 13.774, Medicare — Supplementary Medical Insurance)

Dated: January 24, 1986.

C. McClain Haddow,

Acting Administrator, Health Care Financing Administration.

Approved: February 7, 1986.

Otis R. Bowen, M.D.,

Secretary.

[FR Doc. 86-6944 Filed 3-27-86; 8:45 am]

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Federal Register

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April 1, 1986

Part III

Department of Housing and Urban Development

Office of the Secretary

24 CFR Parts 200, 215, 235, 236, 247, 812, 880, 881, 882, 883, 884, 886 and 912

Restriction on Use of Assisted Housing; Final Rule

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Secretary

24 CFR Parts 200, 215, 235, 236, 247, 812, 880, 881, 882, 883, 884, 886 and 912

[Docket No. R-85-974; FR-1588]

Restriction on Use of Assisted Housing

AGENCY: Office of the Secretary, HUD.

ACTION: Final rule.

SUMMARY: This rule implements section 214 of the Housing and Community Development Act of 1980, as amended by section 329(a) of the Housing and Community Development Amendments of 1981. Section 214 prohibits the Secretary of HUD from making financial assistance available under the United States Housing Act of 1937 (Public Housing and section 8), sections 235 and 236 of the National Housing Act, or Section 101 of the Housing and Urban Development Act of 1965 (rent supplement), for the benefit of any alien who is not a lawful resident of the United States.

EFFECTIVE DATE: July 30, 1986.

FOR FURTHER INFORMATION CONTACT: For Parts 200, 215, 236, 247, 812, 880, 881, 883, 884 and 886: James Tahash, Program Planning Division, Office of Multifamily Housing Management, Department of Housing and Urban Development, Washington, DC 20410; telephone (202) 426-3944.

For Part 235: Brian Chappelle, Single Family Development Division, Office of Single Family Housing, Department of Housing and Urban Development, Washington, DC 20410; telephone (202) 755-6720.

For Part 912: Edward Whipple, Rental and Occupancy Branch, Office of Public Housing, Department of Housing and Urban Development, Washington, DC 20410; telephone (202) 426-0744.

For Part 882: Madeline Hastings, Room 6124, Existing Housing Division, (202) 755-6887, or Gerald Benoit, Room 6128, Existing Housing Branch, (202) 755-6477.

(These are not toll-free numbers.)

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VI. Prohibition of Assistance for Nonimmigrant Student Aliens

I. General

A. History of Rulemaking

By law, HUD housing subsidy may only be made available for American citizens, and for aliens who are legal residents of the United States. This prohibition applies to assistance for tenants in the form of rent supplement payments, section 236 interest reduction payments or rental assistance payments, section 8 housing assistance payments, and Public Housing. The prohibition also applies to assistance to homeowners through section 235 assistance payments.

The prohibition on assistance to aliens who are not legal residents of the United States is stated in section 214 of the Housing and Community Develoment Act of 1980, as amended in 1981 (section 329(a) of the Housing and Community Development Amendments of 1981, Pub. L. 97-35, August 13, 1981). The Conference Report on the 1981 amendment of Section 214 states that ". . . this section is intended to reserve scarce housing assistance resources for persons with the most legitimate claim—namely, citizens and other persons lawfully present in the United States" (House Report No. 97-208 at 697).

A proposed rule to implement the statutory prohibition enacted by the Congress in 1981 was published in the **Federal Register** for public comment on May 3, 1982 (47 FR 18914). A final rule for this purpose was published on October 4, 1982 (47 FR 43674), but has not been made effective.

In 1983 the Congress enacted a provision (section 474(e) of the Housing and Urban-Rural Recovery Act of 1983, Pub. L. 98-181, November 30, 1983) which barred HUD from implementing the prohibition on housing assistance to ineligible aliens for a one-year period. This bar to implementation expired at the end of November 1984.

B. Purpose and Organization of Rule

1. Purpose

In this revised final rule, HUD has made major technical improvements in the final rule text published in October 1982. By these changes, the Department hopes to minimize practical difficulties

and uncertainties inherent in the national implementation of the statutory prohibition on assistance for ineligible aliens across the spectrum of HUD subsidy programs. The Preamble to the October 1982 final rule. (47 FR 43674–43677) responded to public comments on the proposed rule. Except as noted below, these responses are hereby reaffirmed.

The revisions of the October 1982 final rule include procedures to facilitate an orderly transition to the enforcement of the alien restrictions for a current program participant, and temporarily preserving the waiting list position of an applicant who has not documented eligibility for admission. There is a more precise and complete statement of the circumstances when assistance must be denied or terminated. The rule provides that assistance payments continue during judicial eviction of an assisted tenant, that a PHA or owner may grant a limited extension of time for a participant to present evidence of citizenship or eligible alien status, and that failure to document eligible status is grounds for termination of an assisted tenancy. Procedures for submission of required documentation are expanded and clarified. Many changes clear up ambiguities in the rule, or help make the rule easier to understand.

2. Organization and Coverage of Rule

For all of the covered subsidy programs, the procedures to implement the prohibition of assistance for illegal aliens are contained in regulatory provisions which:

—Describe which aliens are eligible for assistance, and define necessary terms,
—Describe requirements to submit evidence of citizenship or eligible alien status,
—Describe requirements for notice to applicants and tennants, and
—Describe requirements for denial or termination of assistance.

Section 214 requirements are stated in three largely parallel sets of provisions for the programs subject to the alien restrictions:

(1) *For rent supplement payments, section 236 interest reduction payments or rental assistance payments, and section 235 interest reduction payments:* Part 200, Subpart G; plus, for section 235 only, § 235.13.

(2) *For the Section 8 Programs (including both project-based section 8, and the Section 8 Housing Certificate and Housing Voucher Programs):* Part 812: New definitions in § 812.2, plus new §§ 812.5 to 812.7.

(3) *For Public Housing (including Indian Housing and Turnkey III)) and Section 23 Leased Housing:* Part 912: New definitions in § 912.2, plus new §§ 912.5 to 912.7.

Alien regulations for the different programs are substantively and—so far as possible—textually identical. For example, requirements are substantively the same for the section 8 project-based subsidy programs as for the Rent Supplement Program and the Section 236 Rental Assistance Payments Program. However, there are necessarily some regulatory variations in the statement of section 214 requirements applicable for different subsidy programs, because of structural or legal differences between the programs, or to accommodate differences in the form of the program regulations).

The rule includes changes in existing program rules. These changes adapt the program rules as needed to enforce section 214 restrictions on assistance for ineligible aliens. Some of the changes clarify, at the relevant points in program regulations, how section 214 requirements relate to other program requirements. For example the rule states the new requirement to collect documentation of citizenship or eligible alien status at the time of the regular annual reexamination.

The statutory section 214 restrictions on assistance for ineligible aliens do not apply to financial assistance in the form of: (1) 221(d)(3) below market interest rate mortgages, or (2) direct Federal loans under section 202 of the Housing Act of 1959 (i.e., straight 202, without section 8). Therefore, this rulemaking does not affect such assistance. However, where such assistance is combined with other financial assistance, such as section 8, that is subject to the statutory restrictions, occupants of a dwelling unit must submit evidence of citizenship or eligible alien status in accordance with the regulations.

Section 214 is applicable to "financial assistance made available pursuant to the United States Housing Act of 1937" (section 214(b)). Section 17 of the United States Housing Act of 1937, which authorizes the Housing Development Grant Program and the Rental Rehabilitation Grant Program, was enacted in 1983 (section 301 of the Housing and Urban-Rural Recovery Act of 1983, which also contained the one-year bar on implementation of section 214 described in section I.A. of this Preamble). Section 17 was passed after publication of both the proposed rule, and the October 1982 final rule, for implementation of section 214. The present rule does not deal with either of the section 17 programs.

II. Evidence of Citizenship or Eligible Alien Status

A. Process for Documenting Eligibility: Nature of Revisions

Regulatory provisions which describe the process by which a family documents eligibility for assistance have been largely rewritten and reorganized. The changes are intended to make the rule more readable and precise, as well as to accomplish a number of specific purposes noted below.

Each of the three parallel sets of regulatory provisions on the covered programs are intended to provide clear answers to these basic questions:

—For whom must evidence of citizenship or eligible alien status be submitted?

Evidence must be submitted for the family head or spouse regardless of age, and for all other persons 18 years or older. The evidence must be submitted for each such person who is or will be an occupant of the assisted unit (§§ 200.182(a)(1), 812.5(a)(2), 912.5(a)(2)).

—Who is required to submit the evidence?

The evidence must be submitted by the applicant or participant family (§§ 200.182(a)(2), 812.5(a)(1), 912.5(a)(1)). The revised rule uses the existing vocabulary of the applicable program rules to designate the entity for which assistance is paid, and which must comply with program rules: applicant and "tenant" for section 236 and rent supplement, applicant and "mortgagor" for section 235, applicant and "Family" for section 8 and Public Housing assistance.

In § 200.181, the revised rule adds a definition of the term "tenant" for financial assistance in the form of rent supplement payments or section 236 interest reduction payments or rental assistance payments:

> An individual or a family renting a dwelling unit in a project owned by an eligible housing owner or occupying such a dwelling unit as a cooperative member.

This is essentially the same as existing regulatory language which describes a "qualified tenant" eligible for assistance under the rent supplement program (§ 215.20(b)(1)), or section 236 (§§ 236.2(a)(2), 236.710).

—To whom is the evidence submitted?

In each program, the party which determines whether a family is otherwise eligible for assistance also administers the restrictions on alien eligibility. Evidence of citizenship or eligible alien status is submitted by the family to this party:

—For financial assistance in the form of rent supplement payments, or of section 236 interest reduction payments or rental assistance payments, the required evidence is submitted to the *owner* of the assisted housing (§ 200.182(a)(4)(i)).

—Similarly, for project-based section 8 (other than Section 8 Moderate Rehabilitation under Part 882), the evidence is submitted to the section 8 *owner* (§812.5(a)(4)(i)(C)).

—In the Public Housing Program, the Section 8 Housing Certificate and Housing Voucher Programs, and the Section 8 Moderate Rehabilitation Program, the PHA determines eligibility for assistance. Evidence of citizenship or eligible alien status is therefore submitted by the Family to the PHA (§§ 812.5(a)(4)(i)(A) and (B), 912.5(a)(4)(i)).

—In the Section 235 Program, the evidence is submitted by the applicant or mortgagor to the mortgagee (§§ 235.13(a), 200.182(a)(4)(i)).

The revised rule (§ 812.2) adds the defined term "responsible entity" for precision and conciseness in designating the "entity responsible for administering the restrictions on providing assistance to ineligible aliens" in the different Section 8 Programs. In the Section 8 Housing Certificate and Housing Voucher Programs, and the Section 8 Moderate Rehabilitation Program, the responsible entity is the PHA (§§ 812.5(a)(4)(i)(A) and (B)). In the other Section 8 Programs, the responsible entity is the Owner (§ 812.5(a)(4)(i)(C)).

(For ease of exposition, the term "responsible entity" is used more broadly in this Preamble to refer to the entity which administers the section 214 restrictions in any of the covered programs.)

—*Does the responsible entity have to help the family obtain required evidence, or verify authenticity of evidence submitted?*

The revised final rule adds provisions which state that the responsible entity:

> is not required to assist the [Family] in obtaining the evidence to be submitted, and is not required to determine the validity or authenticity of evidence submitted. If the [responsible entity] suspects that a document submitted is not valid or authentic, or suspects misrepresentation, the [responsible entity] shall inform HUD.
>
> (§§ 200.182(a)(4)(ii)(B), 812.5(a)(4)(ii)(B), 912.5(a)(4)(ii))

The Preamble to the October 1982 final rule stated (47 FR 43674) that:

> The housing authority or owner is not required to verify the authenticity of the document [submitted by a family] but merely to note the type of document submitted, the issuing authority and the serial number if any.

The revised final rule incorporates in the regulation text the proposition that the responsible entity is not required to verify authenticity of documents submitted by the family. In addition, the owner is not required to verify "validity" of a document submitted. A document may be authentic, but not valid, for example if, the authorization for an alien to reside in the United States has been withdrawn or revoked.

In routine administration of the alien restrictions, the responsible entity is only expected to determine whether the family has submitted the type of document required by HUD, and that *on its face* the document appears to be valid and authentic evidence of the family's status. If there is no reason to doubt correctness of the document, or to suspect misrepresentation by the family, the responsible entity is not expected or required to undertake any investigation of the document, or of the family's status.

If, however, the responsible entity "suspects" that a document is not valid or authentic, or that there has been misrepresentation by the family, the owner or PHA must inform HUD. (Section III.B of this Preamble discusses the requirements for termination of financial assistance if the responsible entity determines that documents used to evidence citizenship or eligible alien status of a participant were fraudulently obtained or submitted, or are not valid or authentic evidence of such status.)

The reasons for not requiring that an owner, PHA or section 235 mortgage verify the authenticity of documents submitted by the family are the need for a uniform and objective process for determination of family eligibility, and more generally, practical administrative problems in implementing the statutory limitation.

The types of document which may be submitted are listed in the rule. The responsible entity is only required to determine if the family has or has not submitted the documents required. The responsible entity does not have to engage in a difficult or subjective examination of authenticity. HUD believes that this process will promote the maximum uniformity in administration of the section 214 requirements, with the least room for variation between different program administrators, or as between different applicants or participants subject to the statutory requirement. The purpose of the process is to determine a generally unambiguous legal issue—that an individual is or is not a citizen or a legal permanent resident of the United States. The Department seeks to resolve this issue in the most clearcut and mechanical manner: the submission by the family of specified legal documents which are evidence of eligible status.

The Department wishes to establish a procedure that will fully comply with the requirements of the law, but with the least demand on the administrative capacities and resources of program administrators. The character of the process required under the rule presents the least administrative burden for program administrators.

The revised rule also clarifies that the responsible entity has no regulatory duty to help the family obtain the documents to be submitted. While some program families may find it hard to come up with the documentation required, the legal duty to produce the documents rests solely with the family.

B. Documents Required

1. Evidence of Eligible Status: Definition

To establish eligibility for assistance, the family must submit the official documents which show that individual family members are either citizens or eligible aliens. The family must also submit a form of written consent by the family to use information submitted, which is called a "verification consent form". Regulatory provisions which describe the items a family must submit are reorganized and revised.

The revised final rule has added a new defined term which designates the set of documents which must be submitted by a family. "Evidence of citizenship or eligible alien status" or "evidence" is defined (§§ 200.181, 812.2, 912.2) to mean:

> the documents which must be submitted in accordance with [the regulation] to show citizenship or eligible alien status of occupants of an assisted dwelling unit. The evidence consists of both:
>
> (1) the documents described [in the rule as acceptable evidence of citizenship or eligible alien status], and
>
> (2) a verification consent form.

This definition permits precise and easy regulatory reference to the full package of documents which the family is required to submit.

2. List of Documents

The rule lists the documents accepted as evidence of citizenship or eligible alien status. This basic approach is the same in the October 1982 final rule and the revised final rule.

The list of documents which may be submitted to show *citizenship status* of an occupant has been amended by eliminating the following documents

previously listed in the 1982 final rule (e.g., § 200.182(b)(1) of 1982 rule): (1) Commuter Status Card (INS Form I–178), (2) Military Discharge Form (DD 214), (3) Selective Service Certificate of Registration (Form SSS 2), and (4) Voter registration card (compare revised final rule §§ 200.182(b)(1), 812.5(b)(1), 912.5(b)(1)). These deleted items do not evidence citizenship of the holder. A Commuter Status Card is a border-crossing permit, and may be issued to aliens. Military service is not limited to American citizens, and proof of citizenship is not required before issuance of a selective service registration or a voter identification form.

On advice of the Immigration and Naturalization Service (INS), the list of documents which may be submitted to evidence *eligible alien* status has been amended by adding:

> Passport stamped "processed for I–551, temporary evidence of lawful admission for permanent residence" (for permanent resident aliens.
>
> (§§ 200.182(c)(1)(iv), 12.5(c)(1)(iv), 912.5(c)(1)(iv))

INS forms and other types of documentation may change from time to time, and other forms of suitable documentation may have been omitted from the regulatory list. For this reason, the revised final rule has added authorization for submission by a family of "any other document designated by HUD" to evidence citizenship or eligible alien status (§§ 200.182(b)(1)(ix), 200.182(c)(1)(ix), 812.5(b)(1)(ix), 812.5(c)(1)(ix), 912.5(b)(1)(ix), 912.5(c)(1)(ix)).

3. When Documents Must Be Submitted

From the effective date of the rule evidence must be submitted before admission to a program (see section III.A.2 of Preamble).

For participants, evidence of eligibility for individual family members must be submitted at each regular annual reexamination of family income and composition (§§ 200.182(a)(5)(i)(A)(*1*), 812.5(a)(5)(i)(A)(*1*), 912.5(a)(5)(i)(A)(*1*); for discussion of transition requirements for current program participants see section IV.D of Preamble). In addition to the submission at annual reexamination, the family must submit evidence that a proposed new occupant of the unit is a citizen or eligible alien (see section III.A.5 of Preamble).

The October 1982 version of the final rule would have required submission of status documentation at "each recertification of income" (e.g., § 200.184(b)). The family would have been required to submit the documentation at any interim reexamination, as well as at the annual reexamination. Under the revised final rule, the family is not required to submit evidence of citizenship or eligible alien status at an interim reexamination.

The revised regulatory scheme is designed to fit the new documentation requirements under section 214 into the regular rhythm of the annual reexamination process for a participant family. Typically, the responsible entity conducts an interim reexamination because of special circumstances respecting an individual family—if there is a rise or fall in the family income used at the last annual reexamination to compute the rent. Whether the interim reexamination is performed at the initiative of the family (seeking a lower rent) or of the responsible entity (seeking an increased rent because of an increase in family resources), the reasons for the interim reexamination bear no clear or necessary relation to the statutory policies of section 214. A requirement for submission only at annual reexamination, and not at interim reexamination, will be more uniform in operation. In general, it will also be more administratively convenient.

However, nothing in this rule is intended to change or affect the schedule for the annual reexamination as determined under HUD regulations and requirements independent of this rule. In general, HUD program procedures require that reexaminations take place *at least* annually. In some cases, regular administration of the annual recertification requirement may result in an annual reexamination scheduled to fall less than one year after the preceding reexamination, for example, where there is a change in the responsible entity's regular reexamination schedule.

For any individual member of the family, the family is required to submit evidence supporting a claim of citizenship status only one time during continuous assisted occupancy by the citizen (§§ 200.182(a)(5)(i)(B), 812.5(a)(5)(i)(B), 912.5(a)(5)(i)(B)). However, a claim of eligible alien status for a family member must be re-documented at each successive annual reexamination. This distinction in treatment of documentation requirements for citizens and aliens is essentially unchanged from the prior versions of the rule. The single submission by a citizen is sufficient to show that the assisted individual is not an alien, and therefore not an ineligible alien. Status as a citizen is seldom lost. Legal status of an alien, on the other hand is likely to change from time to time. The Preamble to the original final rule (47 FR at 43675) noted that the Department is concerned:

> that an alien's status may be subject to change at any time. Moreover, . . . the Department does not believe that this requirement will be burdensome upon aliens who are required by law to carry their registrations in their possession at all times.

Although the family must submit required documentation at each annual reexamination, the set of family members for which evidence must be submitted may change from reexamination to reexamination. These changes may occur because of changes in the family configuration (where family members leave or join the family occupying the unit), because a family member for whom documentation was not previously required reaches the age of 18, or because documentation has been previously submitted for a citizen member.

4. Use and Release of Information

Provisions on use of status evidence submitted by the family are revised. The revisions are intended to express more comprehensively and clearly the purposes for which the information may be used by HUD or the responsible entity, and the parties to which the evidence may be released.

The revised final rule preserves the principle, as under the October 1982 final rule, that evidence submitted by the family to the responsible entity "shall be deemed to have been submitted in confidence" (revised final rule §§ 200.182(e), 812.5(e), 912.5(e)). Evidence submitted by the family in accordance with the rule may only be released by the responsible entity for the purposes stated in the rule.

The 1982 rule provided that information submitted by the family could be disclosed by a PHA, owner or mortgagee to persons "directly connected" with "verification" of status, or the "administration or enforcement" of the programs (e.g., § 200.182(e) of 1982 rule). If information furnished by the family was made available to HUD, HUD could in turn release the information to other agencies "for verification purposes" (e.g., § 200.181(e) of 1982 rule). On reconsideration, HUD believes that the 1982 regulatory formulation will present unnecessary difficulties and legal or factual issues as to what persons or agencies should be considered as "directly connected" with the stated purposes, and as to how the owner is to determine the existence of such a connection. The scope of allowable purposes for which the information can be used by the PHA or

owner is also too narrowly stated in the 1982 rule.

Under the revised final rule, the definition of "verification consent form" has been amended to include a more complete statement concerning release of evidence by the responsible entity or by HUD, and a consent to release of information held by governmental agencies (§§ 200.181, 812.2, 912.2).

Under the revised rule, the responsible entity which collects the evidence from the family, is flatly authorized to release evidence submitted by the family to HUD (§§ 200.181, 812.2, 912.2; §§ 200.182(e), 812.5(e), 912.5(e)).

It is not practical or necessary that the PHA or owner examine prospective uses by HUD of evidence submitted by the family, or determine whether the HUD officials to which the information is released are somehow "directly connected" with authorized uses of the information. As in the case of other documents relating to administration of the HUD assistance programs, HUD must have the right to require the release to HUD of information collected from the family (cf., § 814 of the Housing Act of 1954, 12 U.S.C. 1701n).

The purposes for which HUD may release the evidence submitted by the family or other information received by the Department bearing on the family's citizenship or eligible alien status, are, however, fully stated in the revised rule. HUD may release the information to any Federal, State or local government agency for the following purposes:

(1) Verification of citizenship or eligible alien status,

(2) Enforcement of restrictions on the availability of financial assistance because of such status;

(3) Investigation or prosecution of fraud in connection with any federal housing assistance program, and

(4) Other purposes connected with administration of HUD programs.

(See definition of "verification consent form" at §§ 200.181, 812.2 and 912.2)

Information submitted for enforcement of the section 214 restrictions may be relevant to a broader investigation of possible fraud by the family, or relevant for other purposes connected with HUD's statutory responsibilities. In submitting the information, the family should understand that the information may be released to HUD, and may be released by HUD for the full range of legitimate purposes connected with the mission of the Department. The information should not be artificially segregated or insulated from possible use by HUD for the full range of legitimate purposes defined by HUD's statutory responsibilities.

When releasing status evidence to HUD, the owner or PHA does not have to inquire as to the intended use of the information. However, where the information is released to a party other than HUD, the information may only be released for the following purposes:

(1) Verification of citizenship or eligible alien status,

(2) Enforcement of restrictions on the availability of financial assistance because of such status, or

(3) Investigation or prosecution of fraud in connection with any federal housing assistance program.

The explicit regulatory authority for HUD or the responsible entity to release the evidence for an investigation or prosecution of fraud is new in the revised final rule. HUD wants to permit and encourage the vigorous use of all available information for the prevention and prosecution of fraud, not solely for the enforcement of the statutory restrictions on occupancy by ineligible aliens.

The rule states the purposes for which evidence may be *released* by HUD or the responsible entity. However, the rule does not seek to regulate the further use of the information by the entity receiving the information, or to control any further release or transmission of the information. The Preamble to the October 1982 version of the final rule states that:

> the Department believes . . . that the Department is without authority or mandate to restrict other agencies charged with responsibility of enforcing other laws from utilizing information legitimately disclosed to them for such purposes.
>
> (47 FR 43676)

The "verification consent form" includes an authorization by the family for other Federal, state or local agencies to release information to HUD or to the responsible entity. The definition of verification consent form is amended to specify that a governmental agency may release any information which HUD or the responsible entity "determines to be necessary" for verification of citizenship or eligible alien status, or the enforcement of the restrictions on the availability of financial assistance because of such status. The regulatory language governing the family's consent to release of information bearing on enforcement of Section 214 is similar to existing regulatory language concerning the family's consent to release of information bearing on determination of family eligibility or rent (e.g., § 813.109(b) concerning the section 8 program).

III. Rental Programs: Denial or Termination of Assistance

Section 214 states that HUD may not "make financial assistance available for the benefit of " aliens not legally resident in the United States under the Immigration and Nationality Act.

The final rule text published in October 1982 provides that failure to document alien status shall result in denial or termination of the benefits of assistance (§§ 200.182(a), 812.5(a)). Regulatory provisions on the denial or termination of assistance in the rental subsidy programs are substantially revised in the present version of the final rule.

A. Rental Programs: Denial of Assistance

1. Purpose and Nature of Revisions

The October 1982 final rule provides (§§ 200.184(a), 812.7(a) that if required documentation is not presented "applications for the benefit of assistance shall not be approved" and "eligibility or income shall not be certified for initial occupancy." The October 1982 final rule also provides that after recertification an assisted lease may not be "renewed or extended" by an owner when the lease expires (§§ 215.20(b)(2)(i), 236.70(d)(i), 236.710(b)(1)(i), 812.8(b).)

This revised final rule contains a more complete and precise operational statement of the circumstances in which a new commitment for housing subsidy must be denied if a family does not document citizenship or eligible alien status. The specification of these cases includes both the denial of initial entry into a housing subsidy program, and the denial of a new assistance commitment on behalf of a current participant.

The rule does not change applicable procedures for denial or termination of assistance in the individual programs. In all cases, a denial or termination of assistance must be carried out in accordance with law and applicable rules and HUD requirements.

Transition provisions governing denial of assistance for families already participating in a program at the time of initial implementation, are discussed in section IV of this Preamble.

2. Admission

For the rental subsidy programs (other than the Housing Certificate and Housing Voucher Programs), the revised rule states that the entity which administers the prohibition on assistance to ineligible aliens may not "admit an applicant" to participation in the program unless the required

evidence has been submitted. (§§ 200.184(b)(1)(i), 812.7(a)(2)(i)(A), 812.7(a)(3)(i)(A), 912.7(a)(1)(i).)

The concept of "admission" is common to all of the programs, and is widely used in existing program regulations and handbooks. As used inthe context of the alien prohibition, the term is intended to denote the concrete administrative and contractual actions through which a family becomes a participant in a covered program.

Under the existing rule for the Housing Certificate Program, the point at which an applicant becomes as a participant is precisely defined as the point at which the PHA executes an assistance contract with an owner on behalf of the family (24 CFR 882.209(a)(1)). Otherwise stated, this is when the family is admitted to the program. This principle is also applicable to the Housing Voucher Program (under the **Federal Register** notices which currently control operation of the program). The revised rule provides (§ 812.7(a)(1)(i)(B)) that the PHA may not enter into an assistance contract for an applicant (i.e., may not admit an applicant) unless required evidence has been submitted.

Before admission, the responsible entity must receive evidence of citizenship or eligible alien status submitted by the family for the family head and spouse regardless of age, and for each person over 18 who will occupy the unit (§§ 200.182(a)(1), 812.5(a)(2), 912.5(a)(2)).

3. Housing Certificate and Housing Voucher Programs: Issuance of Certificate or Voucher

In the Housing Certificate and Housing Voucher Programs, the revised rule (section 812.7(a)(1)(i)(A)) provides that the PHA may not issue a Certificate or Voucher if the family has not submitted evidence of eligibility when required. This prohibition applies to both a family applying for participation in the program, and a participant family which wants to move to another dwelling unit.

4. Execution or Approval of Lease

In all of the rental subsidy programs, a dwelling is leased to a family. Under the revised final rule, execution or approval of an assisted lease is prohibited if the family has not submitted evidence of citizenship or eligible alien status when required.

In the Section 8 Housing Certificate and Housing Voucher Programs, subsidy is paid by the PHA to an owner only if the PHA has approved the *lease* between the family and the owner, and has executed an *assistance contract* (HAP Contract or Voucher Contract) with the owner. These two acts by the PHA are necessary as the statutory and programmatic basis for making housing assistance payments to an owner. Therefore, both contractual acts are necessary when the family enters the program, and also when a participant family wants to move.

For the Housing Certificate and Housing Voucher Programs, the revised rule provides (§ 812.7(a)(1)(i)(B)) that the PHA may not enter into an assistance contract or approve a lease for an applicant or participant family if required Section 214 documentation has not been submitted. This regulatory prohibition applies to the approval by the PHA of a lease extension or renewal for a participant family. The prohibition does not, however, affect an automatic extension of the tenancy under the terms of the lease originally approved by the PHA for the participant, since PHA approval is not required for continuance of the assisted tenancy under the lease originally approved by the PHA.

In the other Section 8 Programs (except Section 8 Moderate Rehabilitation under Part 882), the Rent Supplement Program, the Section 236 Interest Reduction Payments or Rental Assistance Payments Programs, and the Public Housing Program, the responsible entity is also the owner of the assisted unit. For these programs, the rule provides (§§ 200.184(b)(1)(ii), 812.7(a)(3)(i)(B), 912.7(a)(1)(ii)) that the owner may not "enter into" an assisted lease (including "entering into" any lease extension or lease renewal for a previously assisted family) unless the family has satisfied the documentation requirements. This prohibition against *entering into* an assisted lease applies only to the positive contractual act of the responsible entity to extend the subsidized tenancy, but does not affect the automatic extension of the tenancy by legal operation of the previously executed lease, and which does not require the agreement of the owner. In most cases, the forms of lease in use in these programs provide for automatic month-to-month extensions of the lease unless the owner acts to terminate the tenancy for cause (e.g., Model Lease for Subsidized Programs, in HUD Handbook 4350.3, Appendix 19a, section 2).

5. Approval of New Occupant

Before admission of a family, the responsible entity determines who may occupy the assisted unit. After initial admission, the family must also request approval for occupancy of the assisted dwelling unit by any additional person for whom submission of evidence of citizenship or eligible alien status is required (§§ 200.182(a)(5)(ii), 812.5(a)(5)(ii), 912.5(a)(5)(ii)). Until the family submits the evidence, the responsible entity may not approve occupancy of the assisted dwelling unit by the new person (§§ 200.182(a)(5)(ii), 200.184(b)(1)(iii), 812.5(a)(5)(ii), 812.7(a)(1)(i)(C), 812.7(a)(2)(i)(B), 812.7(a)(3)(i)(C), 912.5(a)(5)(ii), 912.7(a)(1)(iii)).

Assistance for the entire family is terminated if a participant family fails to get approval by the responsible entity for occupancy of the unit by a new person for whom submission of evidence of citizenship or alien status is required (§§ 200.184(c)(1)(ii), 812.7(b)(1)(i)(B), 812.7(b)(2)(i)(B), 912.7(b)(1)(ii)).

6. Rent Supplement and Section 236 Programs: Change in Form of Assistance

In some cases, assistance may be paid for a unit under more than one rental subsidy program under Part 200 (which covers rent supplement and Section 236): for example, a unit may be assisted with a combination of Section 236 interest reduction payments and rent supplement payments or Section 236 rental assistance payments. The configuration of assistance for a unit may change during the term of a tenant's lease. The revised rule prohibits the owner from starting a new form of financial assistance for the tenant family under a lease previously entered unless the family documents eligible status (section 200.184(b)(1)(iv)).

B. Rental Programs: Termination of Assistance

1. When Assistance Is Terminated, and by Whom

In the Section 8 Housing Certificate and Housing Voucher Programs and the Moderate Rehabilitation Program, eligiblity requirements are administered by the PHA. The October 1982 final rule (§ 812.8(b)(2)) requires the PHA to terminate housing assistance payments at the effective date of recertification "or as soon thereafter as permitted by the terms of the Housing Assistance Payment contract . . ." unless ineligible persons have vacated the unit.

In the Rent Supplement and section 236 (interest reduction payments or rental assistance payments) Programs, and in the other Section 8 Programs, the October 1982 final rule provides that if the lease can be terminated for failure to submit required documentation, assistance payments must be terminated at the effective date of the recertification unless ineligible persons

have vacated the unit. The owner of the project can enter into a new, unassisted lease with the family, or terminate tenancy in accordance with HUD rules §§ 215.20(b)(2)(i), 236.70(d)(1)(i), 236.710(b)(1)(i), 812.8(b)(3)). In Public Housing, the PHA must take action to terminate tenancy (§ 812.8(b)(1)). Unassisted occupancy of Public Housing is not allowed.

Under the revised final rule (§§ 200.184(c)(1), 812.7(b)(1)(i), 812.7(b)(2)(i), 912.7(b)(1)), in all of the tenant subsidy programs ongoing assistance for a family is terminated in three cases:

(1) If evidence of citizenship or eligible alien status is not submitted at reexamination when required.

(2) If the family fails to get approval by the responsible entity for occupancy of the assisted unit by a new person for whom section 214 status documentation is required. Approval is not given until evidence of citizenship or eligible alien status is submitted (see discussion at section III.A.5 of this Preamble).

(3) If a family is admitted with financial assistance, but the responsible entity is subsequently informed by HUD, or otherwise learns, that documents used by the family to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status.

Requirements for termination in cases (2) and (3) were added in the revised final rule.

Because of differences in the character of subsidy and the structure of the programs, there are differences between the programs as to what entity is responsible for acting to terminate the subsidy, and how the subsidy is terminated.

For all programs, the subsidy is terminated by the party responsible for enforcing the alien restrictions: (1) The PHA in Public Housing, the Section 8 Housing Certificate and House Voucher Programs, and the Section 8 Moderate Rehabilitation Program, and (2) the owner of the housing in the FHA subsidy programs and the other Section 8 Programs.

2. Section 8 Housing Certificate Program, Housing Voucher Program and Part 882 Moderate Rehabilitation Program: How Assistance is Terminated

In these programs, the PHA is not the landlord of the assisted unit. The PHA determines family eligibility and enters into an assistance contract (Housing Assistance Payments Contract or Voucher Contract) with the owner.

Under the revised final rule, each assisted family has the duty to submit to the PHA required evidence of citizenship or eligible alien status for unit occupants (§ 812.5(a); see also §§ 882.212(a) and 882.515(a)). The regulations for the Section 8 Certificate Program contain a complete list of the duties of a program family. In the revised final rule, the list of family duties has been amended to add an explicit statement of the family's duty to submit the evidence. (§ 882.118(a)(1)).

Principles governing operation of the demonstration Housing Voucher Program are currently stated in a 1985 Notice of Funding Availability (NOFA), which includes a specific statement of family obligations, modelled on requirements for the Housing Certificate Program (May 8, 1985, 50 FR 19475, 19486). While the NOFA is not being amended at this time to insert a reference to the requirement for submission of evidence under section 214, the duty to submit the evidence is included in the duty (section III.Q.(a)(1) of NOFA) to supply any information or documentation which the PHA or HUD determine to be necessary in administration of the Voucher Program at a regular or interim reexamination of family income and composition.

Under the revised final rule (§ 812.7(b)(1)(i)), if proper evidence of citizenship or eligible alien status has not been furnished, the PHA must "promptly terminate housing assistance payments" to the Section 8 owner on behalf of the family. The termination of subsidy must, however, be carried out "in accordance with HUD requirements."

In the Housing Certificate and Housing Voucher Programs, the HAP Contract is for a single unit, and for assistance on behalf of a specific family. The family is named in the assistance contract. Therefore when assistance payments for the family are terminated by the PHA, there are no further payments under the contract. However, in the Section 8 Moderate Rehabilitation Program, the PHA agrees to make housing assistance payments during the contract term for units occupied by eligible families referred to the owner by the PHA. Therefore assistance payments will continue for other contract units, and the owner can re-lease the contract unit previously occupied by the family found ineligible for continued assisted occupancy to another eligible family (which has presented the required evidence of citizenship or eligible alien status to the PHA).

3. Public Housing: Termination of Tenancy

In the Public Housing Program (including Indian Housing and the Public Housing homeownership programs), the PHA owns the assisted unit rented to the family. In the old Leased Housing Program, the PHA leases the unit from the owner. Because of the structure of these programs, Public Housing or Leased Housing assistance can only be terminated by eviction of a family that has not documented citizenship or eligible alien status for unit occupants.

Under the revised final rule, where termination of assistance is required, the PHA must promptly initiate and diligently pursue action to terminate the tenancy, and to evict the tenant by judicial action pursuant to State and local law (§ 912.7(b)(1)). PHA action to terminate tenancy and evict the tenant must be in accordance with Part 966, which contains both requirements for Public Housing leases (Subpart A) (including provisions which establish the family's duty to furnish information bearing on family eligibility, and grounds for termination of the lease); and for the PHA administrative grievance procedures (Subpart B).

HUD is amending Part 966 through a separate rulemaking in accordance with section 204 of the Housing and Urban-Rural Recovery Act of 1983 (HURRA), which states requirements for Public Housing leases and administrative grievance procedures (Pub. L. 98–181, November 30, 1983, amending section 6 of the U.S. Housing Act of 1937, 42 U.S.C. 1437d). Section 204 of the HURRA requires a PHA to implement an administrative grievance procedure for PHA adverse action, but allows a PHA to dispense with an administrative grievance hearing on an eviction or termination of tenancy if HUD has determined that State law mandates a judicial hearing which provides the basic elements of due process.

Until amendments of Part 966 become effective, initial implementation of the alien exclusion will be governed by the present lease and grievance procedure.

These points should be noted:

(1) Under present HUD requirements (at § 966.4(c)(2)), the lease must include an agreement by the tenant to furnish information and certifications on family composition which the PHA needs in order to determine family eligibility. Under the lease, therefore, the tenant must furnish the evidence of citizenship or alien status necessary for the PHA to determine eligibility for occupancy in accordance with section 214.

(2) Under the present HUD requirements (§ 966.4(l)(1) and section 6(l)(4) of the U.S. Housing Act of 1937), the PHA may not terminate tenancy except for serious or repeated violation of the lease or other good cause. Failure

to satisfy Section 214 documentation requirements is both a serious violation of the lease, and other good cause for termination.

(3) HUD has not yet implemented the statutory provision (section 6(k) of the U.S. Housing Act of 1937) that would allow a PHA to except an eviction or termination of tenancy from the administrative grievance process where *HUD determines* that State law requires a due process judicial hearing. Until HUD has implemented this provision (and made the necessary statutory determination for the PHA's jurisdiction), a PHA must give an opportunity for an administrative grievance hearing before evicting a tenant who has not presented required evidence of citizenship or eligible alien status.

The revised final rule (§ 912.7(b)(5)) provides that the PHA may halt action to terminate tenancy and evict the family if all required evidence is submitted by the Family to the PHA, and continuation of assistance is authorized in accordance with HUD requirements.

4. Rent Supplement and Section 236 Programs and Other Section 8 Programs (i.e., Other Than Part 882 Moderate Rehabilitation or the Section 8 Housing Certificate and Housing Voucher Programs): How Assistance Is Terminated

a. *Options for Termination of Assistance.* In the other Section 8 Programs and in the Rent Supplement and Section 236 Programs, the project owner enforces the restrictions on occupancy by ineligible aliens. The revised final rule provides that when the family is not eligible to continue assisted occupancy, the owner must "promptly" terminate financial assistance for the family (§§ 200.184(c)(1), 812.7(b)(2)(i)) Assistance is terminated either by the *commencement of an unassisted tenancy* or by *eviction* of the family from the unit. An unassisted tenancy can be created in either of two ways:

(1) By raising the lease rental to the unsubsidized market rent, if permitted by the lease.

(2) By entering into a new unassisted lease with the family.

(See §§ 200.184(c)(5) and 812.7(b)(2)(v).)

Thus, the owner has the choice of three ways of terminating assistance for the family: (1) Evict the family, (2) raise the rent to the HUD-approved market rent where permitted under terms of the lease, or (3) enter into a new unassisted lease with the family.

Under the rule, the choice between these alternatives is left to the management judgment of the owner. HUD believes that the discretion of the housing owner to make this choice should not be dictated by the Federal regulation. Section 214 requires termination of financial assistance if the unit is occupied by an ineligible alien, but does not specify the mechanics of termination in each program, or dictate the choice between available techniques for terminating subsidy in each program.

The extent of federal regulatory controls over the termination of assisted tenancy should be the minimum needed to accomplish the statutory objectives of section 214, with the minimum interference in the management practices and prerogatives of project owners. Implementation of the statutory requirement for termination of subsidy to families with ineligible members is not a reason for requiring the owner to accept a tenancy when assistance is no longer being paid for the family. Once the owner is confronted with the necessity of terminating subsidy on behalf of the family, then the owner should be free to make the ordinary business and management judgment of the acceptability of the tenant. The owner may have a legitimate concern not just with the tenant's ability to pay the rent with available income, but with the reliability and promptness of payment. Other business consequences may flow from the owner's choice.

If the owner chooses to evict the family, instead of offering an assisted lease or a market rate rental, the unit is available for rental to a new family, which is eligible for assistance. Conversely, if the owner decides to allow the original family to remain in the unit without assistance, the owner may be unable to make available for assisted families the full number of units for which assistance is committed under the assistance contract. Thus in some cases the owner's election to evict may promote the objective of assuring, in accordance with the objectives of section 214, that scare housing resources are preserved and used for eligible families.

The option to raise the family to market rent is only available to the owner if permitted under the lease. The option to enter a new unassisted lease with the family is available to the owner only if the family is willing to sign a new lease. Therefore the owner may not in a particular case have the practical option of choosing from the full menu of alternatives to eviction allowed under the rule.

Finally, even if the owner desires to evict the family, the family may only be evicted through judicial process, which gives the opportunity for a judicial hearing on the grounds for termination of tenancy (§§ 200.184(c)(6)(i), 812.7(b)(2)(vi)(A)).

b. *Commencement of Unassisted Tenancy.* If a tenant is not eligible for continued assisted occupancy, the owner does not have to evict the family from the dwelling unit so long as the assistance is terminated. Section 214 prohibits payment of housing subsidy for an ineligible alien, but does not, as such, prohibit unassisted occupancy of the unit by the alien. In public Housing, assistance is not separable from occupancy, and eviction of the family is the only way to terminate assistance. However, in the Section 8, Section 236 and Rent Supplement Programs financial assistance can be terminated without terminating occupancy by the family.

The revised rule provides that the owner may choose to do either of the following instead of proceeding to terminate the tenancy and evict the tenant:

(1) If permitted under the lease, the owner may notify the tenant that the tenant is required to pay the HUD-approved market rent for the dwelling unit.

(2) The owner may enter into a new lease without financial assistance. (See §§ 200.184(c)(5) and 812.7(b)(2)(v).)

Under either of these alternatives, assistance payments (rent supplement, section 236 rental assistance payments or section 80 stop. If section 236 interest reduction payments are being paid for a unit (a subsidized unit), after commencement of unassisted occupancy the tenant is required to pay the HUD-approved market rent.

Requiring Tenant to Pay Market Rent. The owner can increase the rent to the level of the HUD-approved market rent where permitted under the lease. For programs covered by the HUD model lease (HUD Handbook 4350.3, Appendix 19a), the lease provides (section 4) that the amount of rent paid by the tenant, and the assistance HUD pays on behalf of the tenant:

> *May be changed during the term of this Agreement* [i.e., the lease] if . . . changes in the Tenant's rent or assistance payment are required by HUD's *recertification or subsidy termination procedures* . . . .

The revised final rule requires termination of subsidy for an assisted tenant who fails to document citizenship or eligible alien status, including a failure to furnish the evidence at recertification. The regulatory procedures for termination require the owner to implement one of the three

available options for termination of subsidy, including raising the rent to the HUD-approved market rent.

The model lease also provides (section 15.a) that if the tenant does not timely submit at the annual reexamination information on family composition:

> Required by HUD for the purposes of determining the Tenant's rent and assistance payment [the owner may] . . . *require the Tenant to pay the higher, HUD-approved Market Rent for the unit.*

(In this case, the owner is not required to give 30 days notice of the rent increase.)

The model lease permits the owner to require the tenant to pay Market Rent after termination of the subsidy.

Entering Into an Unassisted Lease. The owner and tenant may enter into a new lease without financial assistance §§ 200.184(c)(5)(ii), 812.7(b)(2)(v)(B)). Unlike the other procedures for termination of subsidy, the creation of a new unassisted lease requires the agreement of the tenant.

c. *Process for Cutting Off Assistance.* In the revised rule, there are important changes in provisions which govern determination of the time when assistance for a family terminates. Under the revised rule the time at which assistance is terminated depends on these factors:

(1) The time of the *event which triggers the termination of assistance*—the family's failure to submit evidence at reexamination, the owner learning that documents submitted are not valid or authentic or that a new person is living in the unit without the owner's approval.

(2) The *owner's duty to terminate assistance "promptly"* after occurrence of the termination event. As discussed, assistance can be terminated by evicting the family, by charging market rent for the unit, or by entering a new lease. The time needed to terminate assistance my differ for these different termination procedures.

(3) The rule defining *how long assistance payments may continue.* Under the revised final rule, after occurrence of a termination event, assistance is terminated *in accordance with HUD requirements.* However, the rule allows continuation of assistance during the time needed for eviction of the family through judicial processes.

Continuation of Assistance During Eviction Process. Under the October 1982 version of the final rule, assistance payments halt immediately if a family does not submit required section 214 documentation at recertification (e.g., § 215.20(b)(2)(i)(A) on rent supplement assistance). This provision was severely criticized by owners and industry groups. The critics stated that abruptly cutting off subsidy revenues can cause large financial losses for a project. Even if an owner acts promptly to evict an ineligible tenant, a considerable time may be required before the tenant can be evicted through judicial action, and owners are prohibited by HUD regulations from using self-help remedies to evict a tenant.

The industry criticisms of this aspect of the original final rule are cogent and convincing. The rule has therefore been amended to authorize continuation of subsidy in the form of rent supplement payments, section 236 rental assistance payments and section 8 housing assistance payments during the time needed by the owner for eviction of a tenant occupying a unit under an assisted lease.

The revised final rule provides that after occurrence of the termination event, financial assistance terminates in accordance with HUD requirements:

> unless the owner shall *promptly initiate,* and shall *diligently pursue,* action to terminate the tenancy under an assisted lease in accordance with the terms of the lease, and to evict the tenant by judicial action pursuant to State and local law.

(§§ 200.184(c)(6)(i), 812.7(b)(2)(vi)(A).)

The owner must act in accordance with HUD regulations and other requirements for termination of tenancy. If the owner is taking the required actions to terminate the tenancy and evict the tenant, rent supplement payments, section 236 rental assistance payments or section 8 housing assistance payments:

> shall continue . . . in accordance with the applicable assistance contract during occupancy of the dwelling unit by the tenant under the lease. For any jurisdiction, HUD may prescribe a maximum period during which assistance payments may be continued during eviction proceedings, or may prescribe other standards of reasonable diligence for the prosecution of eviction proceedings.

(§§ 200.184(c)(6)(ii), 812.7(b)(2)(vi)(B).)

Thus, while the owner is under a broader regulatory obligation to proceed "promptly" with the termination of assistance (whether by eviction or termination of assisted occupancy), the regulation establishes a separate standard of diligence for the prosecution of eviction proceedings. As a condition for continuation of housing assistance, the owner must diligently pursue action for eviction in accordance with the regulatory standard.

The time an owner needs to evict a family is affected by a broad universe of legal requirements and practical contingencies. Eviction of the family requires satisfaction both of HUD requirements for termination of tenancy and of any additional procedures under State law, for example, any State law requirements for notice to quit, other State requirements for service of process on a tenant or governing notice or time of a judicial hearing, and any forms of process needed for execution of a decision by the State landlord-tenant court. The time needed to evict will reflect both procedural and other legal requirements in the State courts, and practical realities of the local court process, such as problems of scheduling a hearing on the local court calendar.

The language of the rule seeks to accommodate the variances of local law and practice, and the idiosyncrasies of individual cases. The rule establishes a basic regulatory standard of owner diligence, but does not impose a national regulatory formula setting a unform maximum period for eviction of a tenant or for continuating of subsidy. The rule requires the continuation of assistance payments if the owner shall "promptly initiate" and "diligently pursue" action to terminate the tenancy and evict the tenant.

However, the rule also permits the adaption of this national standard to the peculiarities of practice and experience in a locality. The rule provides that for any jurisdiction, HUD may prescribe a "maximum period" for continuation of assistance during the eviction process, or may prescribe "other standards of reasonable diligence for the prosecution of eviction proceedings." This regulatory authority for localization of the national standard will permit the local HUD offices to adapt the national standard in the light of knowledge of local conditions, and of practical problems in administering the regulatory standard. It may, for example, be very difficult to determine whether the time to evict results primarily from inherent delays and constraints of the local eviction process, or instead reflects the lack of effort to evict, or of genuine desire to evict. HUD offices may find that the best solution to such difficulties is the prescription of a maximum eviction period for a locality, based on information on local experience and practice.

The provision for continuation of assistance payments during eviction does not apply if the owner has not complied with the duty to obtain from the family the required evidence of citizenship or eligible alien status. The revised final rule states (§§ 200.184(b)(3), 812.7(a)(3)(iii)) that the owner may not receive or retain financial assistance paid for the benefit of a fmaily if the

owner admitted the family, entered into a lease for the family, or approved any additional person for occupancy of the assisted dwelling unit, when required evidence of citizenship or eligible alien status has not been submitted to the owner. (HUD may also take other remedial action against the owner for breach of the alien documentation requirements.)

The provision for continuance of assistance payments during the eviction process is intended only to cover a case where the family was properly admitted by the owner after submitting evidence of citizenship or alien status in the correct form, and where the family's ineligibility for assisted occupancy appears at a subsequent point in time (when the family fails to submit evidence at annual reexamination or to get the owner's approval for occupancy of the unit by a new person, or when the owner finds out that documentation originally submitted by the family was not valid or authentic).

Provision for Termination of Assistance "in accordance with HUD requirements". The revised final rule provides that upon occurrence of an event requiring termination of assistance for a program participant, financial assistance "shall terminate *in accordance with HUD requirements*" (§§ 200.184(c)(1), 812.7(b)(2)(i)).

Under this provision, termination of assistance will take place in accordance with HUD termination procedures under section 214, as well as any other HUD requirements which are applicable to the termination process. Moreover, the provision applies to the section 214 requirements stated in the revised final rule, as well as other requirements issued by HUD to implement the regulation. Owners of subsidized housing in the covered programs are contractually bound to comply with HUD regulations and other requirements for the subsidy programs.

d. *Termination of Tenancy*—(1) *Grounds.* As discussed above, the owner may elect to terminate the tenancy and evict a family which has not presented documentation of citizenship or eligible alien status, and the eviction process must be carried out in accordance with HUD requirements (Part 247, and similar provisions of Section 8 program regulations). Under existing regulatory and lease requirements for termination of tenancy, an owner may terminate the tenancy under an assisted lease for *"material non-compliance"* with the lease, or for *"other good cause"* (see, e.g., § 247.3(a) for the Rent Supplement and section 236 Programs and certain Section 8 Programs, and § 880.607(b)(1) for Section 8 New Construction; similar provisions in other Section 8 program rules). Under the HUD model lease (HUD Handbook 4350.3, Appendix 19a), the lease automatically renews for successive periodic terms unless the lease is terminated by the owner for material non-compliance or other good cause.

This rule does not change the regulatory grounds for termination of the assisted tenancy. Failure by the family to submit required evidence of citizenship or eligible alien status is a material violation of the assisted lease, and is also "other good cause" for termination of tenancy. The bases for this conclusion are discussed below.

(2) *Failure to Provide Evidence of Citizenship or Eligible Alien Status Is a Material Violation of the Assisted Lease.* The tenant is obliged to supply information to the owner bearing on family eligibility or family composition in accordance with HUD requirements. The HUD model lease provides that at the regular recertification the tenant must report "composition of the Tenant's household" and "supply any other information required by HUD" to set the amount of the assistance payment (section 15 of model lease). Similar provisions are contained in other program leases.

By this rule, the tenant is now required to supply evidence of citizenship or eligible alien status at annual reexamination (§§ 200.182(a), 812.5(a)). The failure to supply evidence of citizenship or eligible alien status is a material noncompliance with the tenant's duty under the lease to furnish information on family composition as required by HUD. The failure is material since the information is needed for the owner to determine statutory and regulatory eligibility for further assistance under the lease. The requirement for submission of the required documentation therefore goes to the heart of the assisted tenancy, the ability to continue the flow of subsidy for the family.

HUD has deleted those provisions of the October 1982 final rule (e.g., § 215.20(b)(2)(i)(B)) which purport to deal with a case where a lease does not permit termination of assistance during the term of the lease for failure to supply required documentation. All program families are required to submit evidence of family composition at reexamination. In practice program leases contain provisions obligating the family to submit information on family composition as required by HUD.

To emphasize the family's duty under the lease to furnish the evidence of family composition needed to show Section 214 eligibility, the revised final rule amends the termination of tenancy provisions to state explicitly that:

> Failure of the tenant to timely supply all required information on income and composition of the tenant household (*including required evidence of citizenship or eligible alien status*) shall constitute a substantial violation of the rental agreement. (§§ 247.3(c), 880.607(b)(3), 881.607(b)(3), 883.708(b)(3), 886.328(b)(3).) (Emphasis supplied.)

(3) *Failure to Provide Evidence of Citizenship or Eligible Alien Status Is "Other Good Cause" for Termination of Tenancy.* A family's failure to supply required evidence of eligibility is "other good cause" for termination of the tenancy under an assisted lease. As in the case of a failure to comply with the family's obligations under the lease, the inability or other failure to show eligibility for assistance is a non-compliance with a central requirement of the assisted tenancy, and the failure is therefore "other good cause" for termination.

(4) *Determination of Grounds for Termination of Tenancy.* The revised final rule deletes the provision that the regulation and lease should not be "construed to prevent the owner, at its election, from considering ineligible alien status to constitute 'good cause' for termination of the tenancy" (e.g., § 215.20(b)(2)(i) (A) and (B) of October 1982 final rule). HUD regulations only permit termination of an assisted tenancy by an owner for grounds stated in the regulation, including violation of the lease or other good cause. Failure to present evidence of citizenship or eligible alien status as required by HUD under section 214 is both a material violation of the assisted lease, and other good cause for termination of the assisted tenancy.

The owner must decide whether to evict a tenant on a given set of facts. This decision should be based on the owner's belief that the facts constitute grounds for termination of tenancy under the HUD regulations. However, the dispositive determination that grounds exist is made by the local landlord tenant court in the eviction proceeding.

In this proceeding, the landlord tenant court will decide whether the family has failed to satisfy the section 214 requirements. Where the owner seeks to evict a family for failure to document eligibility, the State court is bound to apply to standard for termination of tenancy under the HUD regulation and Federal law to the facts of the individual case.

5. Termination of Assistance After Persons for Whom Evidence Is Not Submitted Move From Unit

When the family does not submit evidence for all members at annual reexamination, or does not get approval of the responsible entity for occupancy by a new family member, the responsible entity is not required to proceed with the termination of financial assistance if "any person for whom required evidence has not been submitted by the tenant has moved from the assisted dwelling unit" (§§ 200.184(c)(2)(i), 812.7(b)(1)(ii)(A)(*1*), 812.7(b)(2)(ii)(A), 912.7(b)(2)(i)). In these circumstances, the responsible entity has discretion whether to proceed with the termination of assistance. However, where the responsible entity is required to terminate assistance because documents used to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status, the responsible entity must proceed with the termination of assistance in accordance with the rule even if all persons for which documentation has not been submitted have moved from the unit.

The Department considers that this distinction in the treatment of termination for submission of fraudulent or otherwise invalid documentation is necessary to preserve the integrity of the process for documentation of eligibility under this rule. The procedures for enforcement of section 214 depend on the submission of apparently correct and valid documentation by the families. The use of fraudulent or otherwise invalid evidence undercuts the basic enforcement mechanism used under the rule. For this reason, under the rule the submission of such evidence cannot be cured when ineligible persons move from the unit, and the responsible entity must proceed with the termination of assistance.

C. Conditions For Resumption of Assistance After Termination

The rule provides that if financial assistance for a tenant is terminated, the assistance shall not resume unless:

(1) all required evidence has been submitted by the tenant to the owner, and

(2) resumption of assistance is authorized in accordance with HUD requirements.

(§§ 200.184(c)(7), 812.7(b)(2)(vii).)

The October 1982 version of the final rule would have cut off assistance sharply after the effective date of recertification unless ineligible persons vacated the unit "on or before that date" (e.g., § 215.20(b)(2)(i)(A)). The rule did not provide for any subsequent restoration of assistance.

The Department now considers that this approach was excessively rigid, and that there should be leeway for justified resumption of assistance after termination if required evidence has been submitted for all family members. The rule requires submission of documents at specified times, and requires termination of assistance if the documents are not produced. There are cases when a resumption of assistance is appropriate, and there are other cases when it is not. The rule should not mechanically and uniformly bar a resumption of assistance once required evidence has been submitted. There should be regulatory flexibility for HUD to allow resumption of assistance inappropriate circumstances, but without allowing casual disregard for the deadlines established for submission of evidence. To accommodate both of these objectives, the revised final rule only permits resumption of assistance when "authorized in accordance with HUD requirements."

The rule will permit the development and evolution of HUD requirements for resumption of assistance in response to the Department's day by day experience in administration of the rule. The Department intends that these requirements be at once consistent with a tough and vigorous enforcement of the requirements of section 214, and the HUD regulations under section 214, and with compassionate and flexible application of the statutory requirements to the circumstances of individuals touched by the rule.

D. Section 8 New Construction and Substantial Rehabilitation Programs: Occupancy of Unit After Termination of Assistance

As discussed in section III.B.4.b of this Preamble, one of the acceptable modes of terminating assistance for an ineligible family is conversion to an unassisted tenancy. For Section 8 new construction and substantial rehabilitation, there is a statutory requirement (formerly at section 8(b)(2) of the U.S. Housing Act of 1937) that during the term of the assistance contract the owner must make available for occupancy by eligible families the number of units for which assistance is committed under the contract (Pub. L. 97-35, August 13, 1981, Housing and Community Development (HCD) Amendments of 1981, section 325(1); U.S. Housing Act of 1937, section 8(b)(2)). This requirement applies only for assistance contracts entered from October 1, 1981 (HCD Act of 1981, section 371(b)). (Although section 8(b)(2) of the U.S. Housing Act of 1937 was repealed in 1983, as part of a repealer of authorities for section 8 new construction and substantial rehabilitation, the provision repealed remains in effect for funds obligated prior to the repealer, and for a project financed with a Section 202 loan. (Pub. L. 98-181, November 30, 1983, Housing and Urban Rural Recovery Act of 1983, section 209).

The statutory requirement under former section 8(b)(2) of the U.S. Housing Act of 1937 to make new construction and substantial rehabilitation units available for eligible families has been implemented in the regulation provisions for the various Section 8 new construction and substantial rehabilitation programs (49 FR 31395, August 7, 1984). This revised final rule has added provisions on continued occupancy of an assisted unit after termination of housing assistance payments for failure to submit required evidence of citizenship or eligible alien status (§§ 880.504(e), 881.504(e), 883.605(e), 884.223(e), 886.129(e), 886.329(e)). Like the prior regulatory provisions governing continued occupancy by ineligible families, the new provisions apply only to HAP Contracts entered pursuant to Agreements executed on or after October 1, 1981.

The earlier regulatory provisions under section 8(b)(2) govern continued occupancy by a family which was ineligible for Section 8 assistance at the time the unit was leased. The new provisions govern continued occupancy of the unit by a family which was eligible for assistance at the time of leasing, but where assistance has been terminated in compliance with requirements of section 214. Once the Section 8 subsidy has been terminated, the new rule applies the same two basic regulatory policies as the existing rule under section 8(b)(2):

(1) The owner may allow continued occupancy of the unit by the family without Section 8 assistance;

(2) When the original family which is ineligible for assistance vacates the unit, the owner must make the unit available for occupancy by an eligible family. Now of course eligibility entails satisfaction of section 214 requirements, as well as the requirement for income eligibility.

The Department does not want to deny an ineligible family the opportunity to stay in the unit, so long as subsidy is not being paid. The regulatory policy in this context is consistent with the broader policy of this rule, which allows continued occupancy of a unit after

termination of assistance (see section III.B.4.b of Preamble). Neither section 214, nor the statutory requirement to make available the number of units for which assistance is committed under the assistance contract, mandate disturbing continued occupancy by families which were properly admitted in accordance with requirements in effect at the time of leasing.

E. Participants: Allowing Extention of Time to Submit Evidence

The revised final rule adds new provisions which give the responsible entity discretion to extend for up to 90 days the time for a participant family to submit evidence. During the extension, the responsible entity is not required to terminate financial assistance to the family, and may take other designated actions for continuation of assistance (e.g., execution or approval of a new lease). A family does not have any right to an extension. §§ 200.184(b)(2), 200.184(c) (2), (3) and (4), 812.7(a)(1)(ii), 812.7(a)(2)(ii), 812.7(a)(3)(ii), 812.7(b)(1)(ii), 812.7(b)(2) (ii), (iii) and (iv), 912.7(a)(2), 912.7(b) (2), (3) and (4).)

The new authority to grant an extension of the time to submit documents only applies to program participants. Applicants may not be admitted without submission of evidence of citizenship or eligible alien status.

A participant may not be able to secure and submit the required documents in time for submission at the annual reexamination, or when a new member begins occupancy of the unit. All members of the family may be citizens or lawful permanent residents of the United States. However, for a variety of justified reasons the family may need more time to obtain the documents. There may be unavoidable delays in getting officials in another State to send a copy of the birth certificate. Birth records may be lost or destroyed, and the family may need more time to locate a person who knows that a family member is a citizen, and will make the third party statement allowed under the rule as an alternative way to support a claim of citizenship status (§ 200.182(b)(2) and parallel rule provisions for Section 8 and Public Housing).

The new regulatory authority to extend time to produce required evidence is intended to accommodate enforcement of Section 214 with a recognition of the practical problems that participant families may meet in obtaining the requisite proof of eligibility. In this respect, the new provisions proceed from the same concern as the provisions allowing a third party statement as evidence of citizenship. The preamble to the October 1982 final rule (47 FR 43675) remarks that the allowance of a third party statement:

> is specifically designed to ease the difficulties faced by the elderly and others who either do not have any of the other documents or find it a hardship to obtain them.

The revised final rule provides that the responsible entity may allow an extension of time for a participant to submit required evidence only if:

(1) The family certifies that any person for whom required evidence has not yet been submitted by the family is a citizen or eligible alien, but shows that the family is temporarily unable to obtain evidence to support a claim of citizenship or eligible alien status, and needs additional time to obtain and submit the evidence.

(2) The family promises to make prompt and diligent efforts to obtain the evidence.

The PHA or owner may not excuse any family or family member from the duty to produce the required evidence. The discretion to issue an extension only covers a situation in which the family is "temporarily unable" to produce the documents, and "needs additional time to obtain and submit the evidence."

Corresponding to the purpose of the authority for extensions, an extension granted by the responsible entity "shall be for a specific period needed to obtain the evidence." Where the family is required to submit evidence at an annual reexamination, an extension or extensions may not allow submission of the evidences beyond *ninety days after the effective date of the reexamination.* Where the family is required to request approval for occupancy of the dwelling unit by an additional person, an extension or extensions shall not allow submission beyond *ninety days after occupancy by the additional person.*

The ninety day outer limit on extensions strikes a reasonable and generous balance between the problems of the family and HUD's duty to enforce section 214. Authority for indefinite extensions to participants would promote indefinite procrastination and abuse. The lack of a definite HUD-determined deadline for compliance would inevitably mean that both assisted families and the entities responsible for administration of the requirements would tend to drag out, or seek to avoid, compliance with the statutory conditions of eligibility.

For current participants when the rule is promulgated, notice of the requirement to produce evidence of eligibility is given at least 75 days before the effective date of the first reexamination at which the family has to produce the documentation (first regular reexamination after the first 90 days from the effective date of the rule). The extension authority allows the responsible entity to give a current participant family up to an additional 90 days, if the individual family needs more time to get the required documents. Thus, if necessary, a current participant may be granted up to 165 days (75 days notice plus 90 days extension) from the initial minimum notice to the family. (The actual period from initial notice to end of the maximum extension will be even longer if the PHA or owner gives the initial notice to a current participant more than 75 days before the reexamination.) (See discussion of transition provisions for current participants at section IV.B.5 of the Preamble.)

All new participant families are required to submit evidence before admission. Therefore the principal need for submissions after admission occurs if there are aliens in the family (who must be redocumented at each regular reexamination), or if another person wants to move into the unit. The demand for documentation, and consequently the need for more time to produce the documentation, is limited to these circumstances, and to the individual family members for whom additional documentation is required.

A decision to grant an extension of time for a family to submit the required evidence, and a determination of the length of the extension, must be made by the responsible entity on a case by case basis:

> In accordance with HUD requirements, and after considering the facts and circumstances of the individual case.

The issuance of an extension is not automatic or routine. The responsible entity may not avoid the responsibility to enforce section 214 requirements by the wholesale issuance of extensions.

The rule states that a family does not have any right to an extension, and that the owner or PHA may revoke an extension. Moreover, even after grant of an extension the owner or PHA:

> may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension.

If the family has not submitted the evidence by the end of the extension, the responsible entity must promptly take necessary action to terminate

financial assistance in accordance with HUD requirements for the program.

The Department recognizes that there is potential for abuse and overuse of the discretion to grant extensions. Some PHAs or owners may be unsympathetic with the objectives and requirements of section 214. Or they may desire to avoid cost or administrative problems. In order to minimize abuse of the discretion to grant extensions, and to maximize accountability for the exercise of this discretionary authority, the rule states for all the programs that a decision by the responsible entity to grant an extension:

> shall be in writing, and shall state the reasons for the . . . determination . . . [The responsible entity] shall provide information required by HUD concerning the [responsible entity's] policy and practice regarding extensions.

In addition, in the project-based subsidy programs, where eligibility requirements are generally administered by a private owner (Rent Supplement, section 236, and section 8 project-based assistance other than Part 882 Moderate Rehabilitation), the owner must notify HUD and the Contract Administrator (where HUD is not the Contract Administrator) of *each determination* to extend the time for submission of section 214 evidence. This requirement to notify HUD of each extension decision is not, however, applicable to the programs where eligibility is determined by a Public Housing Agency (PHA) under an Annual Contributions Contract with HUD: The Public Housing Program, the section 8 Part 882 Moderate Rehabilitation Program, and the section 8 Housing Certificate and Housing Voucher Programs.

HUD has made this distinction in treatment of the programs because of the difference in the character of the entities responsible for administration of section 214 eligibility requirements. For the programs where eligibility requirements are administered by a PHA, the PHA is by statutory definition a "governmental entity or public body" (U.S. Housing Act of 1937, section 3(b)[(6)] administering a governmental function. In the other program, the entities administering the requirements are usually private, and do not generally have a governmental character (although a Section 8 owner may be a PHA). HUD believes that a somewhat closer degree of oversight is required to assure that the discretion for grant of extensions is properly used by private owners. On the other hand, however, a greater latitude is appropriate for programs where eligibility requirements are administered by a PHA. This difference is also consistent with the statutory objective of vesting in PHAs "the maximum amount of responsibility in the administration of their programs" (U.S. Housing Act of 1937, section 2). It should be emphasized, however, that there is no difference between the programs in the basic authority for issuance of extensions to families (except for necessary adaptations dictated by differences in the structure of the different programs), and the difference stated pertains only to the requirement for the responsible entity to give notice to HUD or the Contract Administrator of each individual extension. In all programs the responsible entity must furnish information as required by HUD on the owner's policy and practice in granting extensions. This policy and practice is covered by normal review and audit of program performance.

The existence of a case-by-case discretionary authority to grant or deny an extension of time for an individual family departs from the general pattern of the section 214 requirements in this rule. For the most part, as previously discussed, the rule seeks to provide an objective procedure for the establishment of eligibility by submission of standard documentation, with a minimum of room for variance between individual PHAs or owners or in treatment of individual participant families. However, the Department believes that there should be some latitude for the responsible entity to respond to the very varied circumstances in which the family may need more time to submit evidence for an eligible member. These circumstances cannot be exhaustively formularized or specified in advance, and must therefore be left to the discretionary authority of the responsible entity as applied in individual cases. In the nature of this process, there cannot be perfect uniformity in these determinations. In addition, the responsible entity has a legitimate managerial interest in setting a policy for the grant of extensions in the light of experience, local practice and available administrative resources.

The grant of an extension suspends the duty of the responsible entity to terminate assistance for the family. However, the authority to grant an extension does not apply if the responsible entity learns that documents used by the family to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of eligibility. The authority to grant an extension only applies if the responsible entity would otherwise be required to terminate assistance because the family did not obtain approval for occupancy by a new person or because the family did not submit required evidence at reexamination.

IV. Transition

A. General

The rule includes revised provisions for the transition to full implementation of the statutory restrictions on housing assistance for ineligible aliens. The Conference Report on the 1981 amendment of section 214 (House Report No. 97-208 at 697) states that the Secretary should:

> . . . take steps to provide for an orderly transition which will satisfy the intent of the proposal to make assisted housing available to lawful residents exclusively. In undertaking this task, the Secretary is specifically directed to ensure that persons administering assisted housing programs deal fairly and humanely with all persons discovered to be occupying housing in violation of this section.

Although the Conference directive is not part of the law, the revisions of the final rule were written by HUD in the spirit of the Conference Report.

Section 214 restrictions affect two broad categories: *applicants* for assistance, and *tenants* already receiving the benefits of assistance. In general, the October 1982 final rule barred approval of new applications for rental subsidy assistance immediately after the "effective date" of the rule, but deferred enforcement of the alien restrictions for families "in occupancy at" the effective date (see, e.g., §§ 200.183(b)(1) and 200.184).

B. Timing of Transition Process: Effective Date of Initial Implementation Period

The timing of the transition process under the revised final rule is based on (1) timing of the "effective date," when the rule becomes legally binding; and (2) a defined transition period, called the "Initial Implementation Period."

The regulation effective date is stated at the beginning of the rule. This effective date allows time needed for HUD to develop, publish and distribute instructions and supporting materials to implement the regulation. The materials must be distributed to the owners and PHAs responsible for enforcing the alien restrictions in the programs.

The revised final rule adds a provision for a defined transition period commencing at the effective date. The "Initial Implementation Period" or "I.I.P." is defined as *the 90 day period beginning on the effective date of the rule* (§§200.181, 812.2, 912.2).

C. Applicants: Denial of Admission During I.I.P.—Preservation of Family's Position on Waiting List

Starting on the effective date of the rule, an applicant family may not be admitted until the family has submitted evidence of citizenship or eligible alien status for members of the family (§§ 200.184(b)(1), 812.7(a) (1)(i), (2)(i) and (3)(i), 912.7(a)(1)).

In the initial implementation of the rule, the prohibition on admission until the family has presented evidence of alien status could disrupt the ordinary flow of the admissions process. Families which come to the head of the waiting list may not be immediately ready to produce the required evidence. Some families may have the documentation ready at hand. Others may need more time to secure the documents.

HUD wishes to minimize the extent to which initial delays in securing the evidence affect a family's opportunity for admission. A family may have waited a long time for its application to come to the top of a waiting list for admission to an owner's project or a PHA program. During the initial period after the rule becomes effective, applicant families are less likely to have had enough time to obtain and submit the documents.

The rule therefore provides that during the I.I.P., an applicant shall not lose its position on the waiting list because of failure to submit required evidence of citizenship or eligible alien status (§§ 200.184(b)(4), 812.7(a)(1)(iii), 812.7(a)(2)(iii), 812.7(a)(3)(iv), 912.7(a)(3)). (It should be noted, however, that the rule does not require that an owner or PHA hold a unit open pending submission of the evidence.)

D. Transition Procedures for Current Participants

1. Protection of Current Participants

The revised final rule substantially alters and expands provisions on treatment of families who are already particpating in a program when the rule goes into effect. The changes concern description of the class of present program participants for whom special treatment is given, the time at which these families are required to document citizenship or eligible alien status, and the time at which these families must be notified of this requirement.

During the I.I.P., the owner or PHA may not terminate assistance to a participant for failure to submit evidence of citizenship or eligible alien status. At each regular reexamination after the I.I.P., participants are required to submit evidence of citizenship or eligible alien status.

A reasonable period for transition gives current participants time to obtain needed documents. If family members are not eligible for assistance, a family needs time to move, or make other changes in family living arrangements. By the decision of the Congress, subsidy for presently assisted families who are not eligible for continued assistance must be cut off. Inescapably, the termination of assistance will hurt the families affected. The opportunity for fair and humane administration of the transition to enforcement of the alien restrictions for occupants of assisted housing pertains principally to the timing of the transition process.

The Department intends that by giving time for national distribution of implementing instructions before the effective date, and by leaving a reasonable period after the effective date before the termination of assistance to current participants, the revised transition scheme will facilitate uniform and orderly implementation of the section 214 eligibility requirements in the HUD programs. HUD believes the revised transition scheme will foster maximum regulatory compliance with a minimum of unnecessary disruption.

2. Who Is Protected?: Definition of "Current Participant"

The October 1982 final rule contained special provisions for notice to families "*in occupancy at*" the effective date of the rule, and governing the time for submission of required documentation by these families (e.g., §§ 200.183 (a) and (b)(1), 200.184(b)). The revised final rule describes more clearly the class of present participants for which the rule gives special transition treatment.

For ease and economy of reference, the revised rule adds a defined term "Current Participant" (§§ 200.181, 812.2, 912.2) to designate a family included in this class. A Current Participant is defined as follows:

(1) In the section 8 housing certificate program or housing voucher program, a participant family for which *a lease for the family was approved by the PHA before the effective date of the rule.*

(2) In all other programs subject to the Section 214 requirements, a Family *for which an assisted lease was entered into for a lease term beginning before the effective date of the rule.*

3. Current Participants: When Required To Submit Evidence of Citizenship or Eligible Alien Status

In the original version of the final rule, notice of the requirements for documentation of eligible alien status was to be given by the owner of PHA to the family "within 30 days after receipt . . . of the Department's instructions regarding the form of such notice" (e.g., § 200.183(b)(1) of October 1982 final rule). The family would then be required to supply the required documentation for the first time at the first recertification falling at least sixty days after the notice to the family (e.g., § 200.184(b)). Thus the family would have at least 90 days (30 plus 60) from receipt of the HUD instructions by the PHA or owner to submit the documentation. The October 1982 final rule did not distinguish in this regard between the occurrence of an interim or regular reexamination falling after the prescribed period. The family would be required to produce the documentation in connection with either type of reexamination.

The revised final rule provides that Current Participant families must submit required evidence of citizenship or eligible alien status "*at the first annual reexamination effective after the end of the Initial Implementation Period, and at each subsequent annual reexamination* (§§ 200.182(a)(5)(i)(A)(2), 812.5(a)(5)(i)(A)(2), 912.5(a)(5)(i)(A)(2)).

In general, the responsible entity may not approve occupancy of an assisted unit by a new family member until evidence of citizenship or eligible alien status has been submitted (see discussion at section III.A.5 of Preamble). However, (as described in the preceding paragraph) a Current Participant is first required to submit evidence at the first annual reexamination after the I.I.P. Before the effective date of this reexamination, the responsible entity may not require the family to submit the evidence as a condition for approving an additional person for occupancy of the assisted unit (§§ 200.182(a)(5)(ii)(B), 812.5(a)(5)(ii)(B), 912.5(a)(5)(ii)(B)).

These points should be highlighted:

(1) For Current Participants, the family is never required to submit the evidence of citizenship or eligible alien status before the end of the I.I.P.

(2) After the I.I.P., a Current Participant does not have to submit the evidence of status at an interim reexamination. The family must submit the evidence at the annual reexamination required for all program families.

(3) Participant families not covered by the special transition rule (i.e., participants other than "Current Participants") are required to submit status evidence at each annual reexamination after admission.

The same 90-day grace period for initial implementation applies uniformly for all individual Current Participant

families and all programs. The time for submission does not vary, as under the original version of the final rule, depending on the promptness of the responsible entity in giving notice to the family.

Neither the original nor the revised version of the final rule accelerates the schedule for regular reexamination of a family. For this reason, even though the 90-day grace period is identical for all families, there can be up to a year's difference in the timing of the first submission requirement for individual families. The first regular annual reexamination after the I.I.P. could fall on the first day after the end of the I.I.P., or could fall up to a year after the end of the I.I.P. (where the last annual examination was at the end of the I.I.P.). The regulatory scheme folds the new requirements for submission of alien documentation into the pre-existing scheme for annual reexamination of family income and composition. It is the sense of the Department that the practical advantages of conforming the new requirement for production of the evidence to the regular rhythm of the reexamination process outweighs the benefits of demanding compliance by all families at a single time.

4. Current Participants: No Denial or Termination of Assistance During I.I.P.

Although the rule requires denial of *admission to applicants* during the I.I.P. for failure to submit section 214 documentation, the rule does not give a parallel authority to deny or terminate assistance to participants during this period. The responsible entity must deny or terminate assistance unless evidence is submitted when required under the rule (e.g., § 812.7(a)(1)(i) concerning denial of assistance under the section 8 Housing Certificate or Housing Voucher Program). Since a Current Participant is not required to submit, the evidence until the first post-I.I.P. regular reexamination, assistance may not be denied or terminated before this reexamination. Thus, for example, if a participant in the Housing Certificate Program wants to move to another unit during the I.I.P., The PHA may not deny issuance of a Certificate, or refuse to approve a lease for the new unit (see § 812.7(a)(1)). Similarly, in the case of project-based subsidy assistance, during the I.I.P. the owner may not refuse to enter a lease renewal or extension for an assisted family because of failure to submit alien documentation (see § 812.7(a)(3)).

The distinction in treatment of applicants and participants during the I.I.P. corresponds to a distinct difference in the interest and position of applicants and participants. A participant has a greater practical concern, namely disruption of an ongoing assisted occupancy.

5. Current Participant: Notice of Requirement To Submit Evidence of Status

The revised final rule provides that the responsible entity must notify a Current Participant family of the requirement to submit evidence of citizenship or eligible alien status "at least 75 days" before the effective date of the first annual reexamination at which the family is required to submit such evidence (§§ 200.183(a)(3), 812.6(b), 912.6(b)). As discussed above, the family is first required to document eligibility for assisted occupancy at the first regular reexamination after the I.I.P. In sum, therefore, the owner is required to give notice to the family at least 75 days before the family's first regular annual reexamination which fails after the 90-day period (the I.I.P.) beginning on the effective date of the rule.

Under the revised final rule, the time for notice to a Current Participant is no longer keyed to the time an owner or PHA receives HUD instructions on the form of notice. HUD intends to distribute instructions for implementation of the alien restrictions to the responsible entity before the effective date of the revised final rule. The rule effective date is the same for all purposes, and it will not be necessary to inquire in an individual case as to the date of "receipt" of the HUD instructions by a responsible entity.

Under the original version of the final rule, the family was required to produce status documentation sixty days after notice from the owner or PHA. Under the revised final rule, the time at which the family is initially required to produce evidence of citizenship or eligible alien status is not determined by the time at which the owner gives notice to the family. Instead, the time at which the responsible entity is required to give notice to the family depends on the time of the reexamination at which the family is required to produce the documentation. The owner is uniformly required to give the individual family at least 75 days notice before the effective date of reexamination. The revised notice requirement is designed to accommodate both the family's need to know what documentation will be required at reexamination, and the administrative problems in giving the notice.

The requirement for at least 75 days notice will generally make it possible to give the family notice of section 214 submission requirements at the same time as the regular notice to the family that recertification is due. The regular notice tells the family what information on family income and composition must be produced at reexamination. Giving the notices to a family at the same time avoids the need for a separate mailing or distribution of information to the family. In this way, the administrative complication and expense of the notice process can be considerably reduced.

The multifamily occupancy handbook provides that an owner should make a request to the family for recertification *between 75 and 90 days before the scheduled effective date* (Handbook 4350.3, section 5–4, page 5–3). For the programs covered by the handbook requirement, a notice within the 75–90 day range would also comply with the minimum notice under the present rule. The Public Housing Program, and the Section 8 Housing Certificate and Housing Voucher Programs, do not currently dictate the length of notice in connection with a regular reexamination. In practice most PHAs give more than 75 days notice before the effective date of the annual reexamination. Many PHAs apparently operate in accordance with a sixty day plus sixty day notice system: the family is given sixty days to submit the information, and the submission date is sixty days before the effective date of reexamination. For PHAs using this system, the family is thus given 120 days notice, and the section 214 notice could generally be given at the same time as the regular notice of reexamination.

The notice system in the October 1982 final rule would have required notice by a responsible entity to all families at the same time—within the 30 day period after receipt of HUD instructions. This system would not have allowed the PHA or owner to combine the section 214 notice with the notice otherwise required in connection with an annual reexamination. Instead, the original final rule would have mandated a large special mailing or other distribution. This requirement could have presented a particularly significant administrative problem and expense for large PHAs in the Public Housing Program, and especially in the Section 8 Housing Certificate and Housing Voucher Programs.

The system under the revised final rule permits staging of the section 214 notices to individual families at the same times as notices provided under the regular reexamination schedule. The revised rule also assures adequate notice to the individual family before the reexamination at which the evidence

must be submitted. While the original final rule required at least 60 days notice before the effective date of reexamination, the revised rule requires at least 75 days notice to a Current Participant.

Some PHAs or owners may choose to give general and simultaneous notice of section 214 requirements to current participants, accelerating notice to individual participants. Such notice may be given in addition to the individual 75-day notice required under the rule. If the general notice is given to an individual family at least 75 days before the effective date of reexamination (and otherwise meets the regulatory notice requirements), the general notice can substitute for the staged notice to individual families.

V. Section 235: Denial or Repayment of Assistance

A. Denial of Assistance

In the Section 235 Program, the applicant for mortgage insurance or mortgagor must present evidence of eligibility at the point of application for section 235 assistance, purchase of a cooperative membership, assumption of a mortgage, commencement of foreclosure relief, or request for reinstatement (§ 235.13(a)). Unless the evidence of citizenship or eligible alien status has been submitted, the applicant or mortgagor is not eligible for financial assistance payments under section 235. The mortgagee must certify to the Secretary that the required evidence of citizenship or eligible alien status has been submitted for all persons for whom such evidence is required (§ 235.13(b)).

As in the case of applicants for assistance in the tenant subsidy programs, the requirements for documentation of eligible status apply immediately at the effective date of the rule. The concept of an "Initial Implementation Period" (for participants in the tenant subsidy programs) does not apply for assistance under section 235.

B. Repayment of Section 235 Assistance

A new provision (§ 235.13(c)) is added in the revised final rule, which requires the mortgagor to repay the Secretary the full amount of the 235 assistance payments:

> If the mortgagee has certified to the Secretary . . . that required evidence of citizenship or eligible alien status was submitted, but the Secretary subsequently determines that documents submitted to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or were not valid or authentic evidence of such status.

VI. Prohibition of Assistance for Nonimmigrant Student Aliens

When originallly passed by the Congress (Pub. L. 96-399, October 8, 1980), section 214 only prohibited housing subsidy for a so-called "nonimmigrant student alien". In general, this term meant a person admitted to the United States as a bona fide student, rather than as an immigrant or permanent resident. In August 1981, this statutory limitation was succeeded by the broader statutory prohibition under the present language of section 214, which bars assistance to persons who are not legal residents of the United States. Although the law no longer contains any reference to nonimmigrant student aliens, they are not included in the statutory description of legal residents eligible for housing subsidy. The law and this rule therefore continue the bar on financial assistance for nonimmigrant student aliens.

On November 17, 1981, HUD published and made effective an interim rule implementing the prohibition of assistance for nonimmigrant student aliens (48 -FR 56421) in the various housing programs. The interim rule prohibited admission of such aliens for housing assistance under the programs covered by section 214. For families receiving assistance at the effective date of the rule under the rental subsidy programs, the interim rule allowed continuation of assistance until the end of the current lease term.

This rule systematically excises the prior regulatory provisions which bar assistance to a nonimmigrant student alien. From the effective date of this rule, denial and termination of assistance to a family with a nonimmigrant student alien member are governed by the broader procedures for denial or termination of assistance under section 214.

The October 1982 version of the final rule included separate transition provisions concerning assistance for nonimmigrant student aliens. The revised final rule does not include any separate mention or treatment of nonimmigrant student aliens. With the passage of approximately four years since promulgation of the November 1981 rule, there is now no longer a substantial need to deal with nonimmigrant student alien tenancies under leases in existence at that time. The Department also does not wish to complicate broader issues and problems in implementation of section 214 requirements with separate transitional requirements governing assistance for nonimmigrant student aliens, which would be of marginal practical application and significance.

Findings and Certifications

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations in 24 CFR Part 50 that implement section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332. The Finding of No Significant Impact is available for public inspection during regular business hours in the Office of General Counsel, Rules Docket Clerk, Room 10276, 451 7th Street SW., Washington, DC 20410.

This rule does not constitute a "major rule" as that term is defined in section 1(b) of Executive Order 12291 on Federal Regulation issued on February 17, 1981. Analysis of the rule indicates that it does not (1) have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geopraphic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Under the Regulatory Flexibility Act (5 U.S.C. 605(b)), the undersigned certifies that this rule does not have a significant economic impact on a substantial number of small entities because applicants and tenants who are deemed ineligible aliens will be replaced by others who are eligible. PHAs and owners will be able to rent units to these eligible individuals.

The Catalog of Federal Domestic Assistance numbers are: 14.103, Interest Reduction Payments-Rental and Cooperative Housing for Lower Income Families; 14.850, Public and Indian Housing; 14.851, Low Income Housing-Homeownership Opportunities for Low-Income Families; 14.149, Rent Supplements-Rental Housing for Lower Income Families; and 14.156, Lower-Income Housing Assistance Program (section 8).

Paperwork Reduction Act

Information collection requirements in §§ 200.182(a)(1), 812.5(a)(1) and 912.5(a)(1) are part of the application process and have already been approved by the Office of Management and Budget (OMB). For section 8, Rent Supplement and section 236 (interest subsidy and RAP), see OMB approval 2502-0204. For section 235, see OMB approvals 2502-0081 and 2502-0082. For

Public and Indian Housing, see OMB approval 2577-0083.

Information collection requirements in §§ 200.182(a)(3), 200.184, 812.5(a)(3) 812.7, 912.5(a)(3), 912.5(d), 912.6, and 912.7 have been submitted to OMB for approval under the provisions of the Paperwork Reduction Act of 1980 (Pub. L. 96-511). No person may be subjected to a penalty for failure to comply with these information collection requirements until they have been approved and assigned an OMB control number. The OMB control numbers will be announced by separate notice in the **Federal Register.**

Regulatory Agenda

This rule was listed at sequence number 772 (H 26-82, FR-1588) under listings for the Office of Housing in HUD's Semiannual Regulatory Agenda published on October 29, 1985 (50 FR 44166, 44178) under Executive Order 12291 and the Regulatory Flexibility Act.

List of Subjects

24 CFR Part 200

Administrative practice and procedure, Claims, Equal employment opportunity, Fair housing, Housing standards, Loan programs—housing and community development, Mortgage insurance, Organization and functions (Government agencies), Reporting and recordkeeping requirements, Minimum property standards.

24 CFR Part 215

Grant programs—housing and community development, Rent subsidies.

24 CFR Part 235

Condominiums, Cooperatives, Low and moderate income housing, Mortgage insurance, Homeownership, Grant programs—housing and community development.

24 CFR Part 236

Low and moderate income housing, Mortgage insurance, Rent subsidies.

24 CFR Part 247

Low and moderate income housing, Tenant eviction.

24 CFR Part 812

Low and moderate income housing, Rent subsidies.

24 CFR Part 880

Grant programs—housing and community development, Rent subsidies, Low and moderate income housing, New construction.

24 CFR Part 881

Grant programs—housing and community development, Rent subsidies, Low and moderate income housing, Substantial rehabilitation.

24 CFR Part 882

Grant programs—housing and community development, Low and moderate income housing, Rent subsidies.

24 CFR Part 883

Grant programs—housing and community development, Rent subsidies, Low and moderate income housing, New construction and substantial rehabilitation.

24 CFR Part 884

Grant programs—housing and community development, Rent subsidies, Rural areas, Low and moderate income housing, Substantial rehabilitation.

24 CFR Part 886

Grant programs—housing and community development, Rent subsidies, Low and moderate income housing, Substantial rehabilitation.

24 CFR Part 912

Low and moderate income housing.

Accordingly, 24 CFR Parts 200, 215, 235, 236, 247, 812, 880, 881, 882, 883, 884, 886 and 912 are amended as follows:

PART 200—INTRODUCTION

1. The authority citation for Part 200 is revised to read as follows:

Authority: Secs. 2, 211, and 807, National Housing Act (12 U.S.C. 1703, 1715b, and 1748f); sec. 7(d), Dept. of HUD Act (42 U.S.C. 3535(d)); Subpart G is also issued under sec. 214, Housing and Community Development Act of 1980, as amended by sec. 329, Housing and Community Development Amendments of 1981 (42 U.S.C. 1436a).

2. The title of Subpart G is revised to read "Restrictions on Use of Assisted Housing."

3. Subpart G consisting of §§ 200.180 through 200.184 is added to read as follows:

Subpart G—Restrictions on Use of Assisted Housing

Sec.

200.180 Restrictions on eligibility for financial assistance.
200.181 Definitions.
200.182 Evidence to citizenship or eligible alien status.
200.183 Notice to applicants and tenants.
200.184 Rent supplement and section 236—Denial or termination of assistance.

Subpart G—Restrictions on Use of Assisted Housing

§ 200.180 Restrictions on eligibility for financial assistance.

(a) This Subpart G is applicable to financial assistance under section 235 of the National Housing Act (12 U.S.C. 1715z), section 236 of the National Housing Act (12 U.S.C. 1715z-1), or section 101 of the Housing and Urban Development Act of 1965 (12 U.S.C. 1701s).

(b) Financial assistance may only be made available for the benefit of a citizen or eligible alien (see definition of "eligible alien" in § 200.181).

(c) "Financial assistance" is deemed to be paid for a dwelling unit:

(1) if assistance payments are paid for the dwelling unit under a contract between the mortgagee and the Secretary under section 235(b) of the National Housing Act, and the dwelling unit is subject to a mortgage insured under section 235 of the National Housing Act and Part 235 of this chapter;

(2) if the dwelling unit is in a rental or cooperative project subject to a mortgage for which interest reduction payments are paid under a contract between the mortgagee and the Secretary under section 236 of the National Housing Act, and the monthly rental charge paid to the owner for the dwelling unit is less than the HUD-approved market rent;

(3) if the dwelling unit is a rental or cooperative dwelling unit for which rental assistance payments are paid under a contract between the Secretary and the owner under section 236(f)(2) of the National Housing Act and Part 236, Subpart D, of this chapter; or

(4) if the dwelling unit is a rental or cooperative dwelling unit for which rent supplement payments are paid under a contract between the Secretary and the owner under section 101 of the Housing and Urban Development Act of 1965 and Part 215 of this chapter.

§ 200.181 Definitions.

Assisted dwelling unit. A dwelling unit for which financial assistance is deemed to be paid, as determined in accordance with § 200.180(c).

Citizen. A citizen of the United States.

Current Participant. A tenant for which an assisted lease was entered into for a lease term beginning before July 30, 1986.

Eligible alien. An alien who is a resident of the United States and is one of the following:

(1) An alien lawfully admitted for permanent residence as an immigrant as

defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15) and 1101(a)(20));

(2) An alien who entered the United States before June 30, 1948, or such later date as enacted by law, has continuously maintained residence in the United States since then, and is not ineligible for citizenship, but who is deemed to be lawfully admitted for permanent residence as a result of an exercise of discretion by the Attorney General under section 249 of the Immigration and Nationality Act (8 U.S.C. 1259);

(3) An alien who is lawfully present in the United States pursuant to an admission under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or pursuant to the granting of asylum (which has not been terminated) under section 208 of such Act (8 U.S.C. 1158);

(4) An alien who is lawfully present in the United States as a result of being granted conditional entry under section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity;

(5) An alien who is lawfully present in the United States as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest under section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. 1182(d)(5)); or

(6) An alien who is lawfully present in the United States as a result of the Attorney General's withholding deportation under section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)).

Evidence of citizenship or eligible alien status ("*evidence*"). The documents which must be submitted in accordance with § 200.182 to show citizenship or eligible alien status of occupants of an assisted dwelling unit. The evidence consists of both:

(1) The documents described in paragraphs (b) and (c) of § 200.182, and

(2) A verification consent form.

Financial assistance. See § 200.180(c).

HUD. The U.S. Department of Housing and Urban Development.

Initial Implementation Period. The 90 day period beginning on July 30, 1986.

Tenant. For financial assistance in the form of rent supplement payments, section 236 interest reduction payments or section 236 rental assistance payments: An individual or a family renting a dwelling unit in a project owned by an eligible housing owner or occupying such a dwelling unit as a cooperative member.

Verification consent form. A written agreement by an applicant or tenant, in the form prescribed by HUD, that:

(a) Any evidence submitted by the applicant or tenant may be released by the owner or mortgagee to HUD.

(b) Such evidence may also be released by the owner or mortgagee to a party other than HUD for the following purposes: Verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, or investigation or prosecution of fraud in connection with any Federal housing assistance program.

(c) HUD may release the evidence or other information to any Federal, State or local government agency (including the Social Security Administration and the Immigration and Naturalization Service) for the following purposes: Verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, investigation or prosecution of fraud in connection with any Federal housing assistance program, or other purposes connected with administration of HUD programs.

(d) Any Federal, State or local government agency may release to HUD, or to the owner or mortgagee, any information which HUD, or the owner or mortgagee, determines to be necessary for verification of citizenship or eligible alien status, or for enforcement of restrictions on the availability of assistance because of such status.

§ 200.182 Evidence of citizenship or eligible alien status.

(a) *Requirement for submission of evidence.* (1) Evidence of citizenship or eligible alien status shall be submitted in accordance with this section. The required evidence shall be submitted for the family head and spouse regardless of age, and for all other persons 18 years or older. The evidence shall be submitted for each such individual or family member who is or will be an occupant of the assisted dwelling unit.

(2) For financial assistance in the form of rent supplement payments, or of section 236 interest reduction payments or rental assistance payments, the evidence shall be submitted by each applicant and tenant. For financial assistance in the form of section 235 assistance payments, the evidence shall be submitted by each applicant and mortgagor.

(3) The verification consent form shall be signed by each person for whom the information is submitted. Failure to submit required evidence of citizenship or eligible alien status shall result in denial or termination of financial assistance in accordance with § 200.184 (for rent supplement and section 236) or § 235.13 (for section 235).

(4)(i) For financial assistance in the form of rent supplement payments, or of section 236 interest reduction payments or rental assistance payments, the required evidence shall be submitted by the applicant or tenant to the owner. For financial assistance in the form of section 235 assistance payments, the required evidence shall be submitted by the applicant or mortgagor to the mortgagee.

(ii)(A) The owner or mortgagee is responsible for administering the restrictions on providing assistance to persons who are not eligible aliens, and shall exercise this responsibility in accordance with HUD requirements.

(B) The owner or mortgagee is not required to assist the applicant, tenant or mortgagor in obtaining the evidence to be submitted, and is not required to determine the validity or authenticity of evidence submitted. If the owner or mortgagee suspects that a document submitted is not valid or authentic, or suspects misrepresentation, the owner or mortgagee shall inform HUD.

(5) For financial assistance in the form of rent supplement payments, or of section 236 interest reduction payments or rental assistance payments:

(i)(A)(*1*) A tenant shall (except as provided in § 200.182(a)(5)(B), which concerns continuous assisted occupancy by a citizen) submit the required evidence of citizenship or eligible alien status at each annual reexamination.

(*2*) In the case of a Current Participant, the tenant shall (except as provided in § 200.182(a)(5)(i)(B)) submit the required evidence of citizenship or eligible alien status at the first annual reexamination effective after the end of the Initial Implementation Period, and at each subsequent annual reexamination. (See provisions on notice to a Current Participant at § 200.182(a)(3).)

(B) Submission of evidence that an occupant of the assisted dwelling unit is a citizen is only required one time during continuous assisted occupancy of the project by the citizen.

(ii)(A) A tenant shall request the owner's approval for occupancy of the assisted dwelling unit by any additional person for whom submission of evidence of citizenship or eligible alien status is required. The owner shall not approve occupancy by the additional person until the evidence has been submitted.

(B) In the case of a Current Participant, § 200.182(a)(5)(ii)(A) is not applicable before the effective date of the first reexamination at which the Family is required to submit evidence of citizenship or eligible alien status pursuant to § 200.182(a)(5)(i)(A)(*2*).

(iii) When a member of the household (other than the head of household or spouse) reaches the age of 18, evidence of the person's citizenship or eligible alien status must be submitted at the next annual reexamination.

(6) For financial assistance in the form of section 235 assistance payments each applicant or mortgagor shall submit the required evidence upon occurrence of any of the events described in § 235.13(a).

(b) *Citizenship status.* (1) The original or a certified copy of one of the following documents must be submitted to support a claim of citizenship status:

(i) U.S. Passport,

(ii) Birth Certificate,

(iii) Consular Report of Birth,

(iv) Naturalization Certificate (original only),

(v) Certificate of Citizenship (original only),

(vi) U.S. Citizenship Identification Card (INS Form I–197),

(vii) Baptismal or other religious certificate which provides evidence of birth in the United States and which was created within one year of birth,

(viii) A document issued by the Bureau of Indian Affairs and which indicates membership in a federally recognized tribe, or

(ix) Any other document designated by HUD.

(2) If none of the above documents can be obtained, and a person claiming to be a U.S. citizen provides a reasonable explanation of inability to obtain the document, a signed statement from a third party may be submitted. The third party must produce one of the above documents to evidence that the third party is a citizen, and must state under penalty of perjury that the person for whom the document is not available is a citizen, and the basis of this statement.

(c) *Eligible alien status* (1) The original of one of the following documents must be submitted to support a claim of eligible alien status:

(i) Form I–151, Alien Registration Receipt Card (for permanent resident aliens);

(ii) Form I–551, Alien Registration Receipt Card (for permanent resident aliens);

(iii) Form I–181B, Processed for I–551, Temporary Evidence of Lawful Admission for Permanent Residence (for permanent resident aliens);

(iv) Passport stamped "processed for I–551, temporary evidence of lawful admission for permanent residence" (for permanent resident aliens);

(v) Form AR–3a, Alien Registration Receipt Card (Issued during 1941–1949 for permanent resident aliens);

(vi) Form I–94, Arrival-Departure Record (Annotated either "Section 207" or "Refugee," or "Section 208" or "Asylum");

(vii) Form I–94, Arrival-Departure Record—Parole Edition (Annotated "Section 212(d)(5)," or "Conditional Entry" or "Section 203(a)(7)");

(viii) Form I–94, Arrival-Departure Record (Annotated "Section 243(h)"); or

(ix) Any other document designated by HUD.

(2) A third party's statement or certification is not acceptable evidence of eligible alien status, and may not be submitted in lieu of the requirement to submit the documents listed in paragraph (c)(1) of this section.

(3) The following documents are not acceptable evidence of eligible alien status:

(i) Form I–94, Arrival-Departure Record: Annotated with any codes "A" through "L" for Non-Immigrants (for temporary resident aliens);

(ii) Form I–95A, Crewman's Landing Permits (for alien visitors);

(iii) Form I–144, Mexican Border Visitors Permit;

(iv) Form I–186, Nonresident Alien Mexican Border Crossing Card;

(v) Form I–185, Nonresident Alien Canadian Border Crossing Card;

(vi) Unnumbered form, Nonresident Alien Canadian Border Crossing Identification Card; or

(vii) Any Foreign issued Visa.

(d) *Retention of evidence.* A photocopy of each document (or original if released by the person submitting the document), and a signed verification consent form, shall be retained by the owner or mortgagee to whom the evidence is submitted. However, a photocopy need not be made or retained of any document bearing an identifying serial number if a record of the serial number and other necessary identifying information is made and retained in such manner as shall be prescribed by the Department.

(e) *Disclosure of evidence.* Evidence of citizenship or eligible alien status submitted to the owner or mortgagee shall be deemed to have been submitted in confidence. However, the evidence may be released by the owner or mortgagee to HUD. The evidence may also be released by the owner or mortgagee to a party other than HUD for these purposes:

(1) Verification of citizenship or eligible alien status,

(2) Enforcement of restrictions on the availability of assistance because of such status, or

(3) The investigation or prosecution of fraud in connection with any Federal housing assistance program.

(Information collection requirements in paragraph (a)(1) approved by the Office of Management and Budget under OMB control number 2502.0204)

§ 200.183 Notice to applicants and tenants.

(a) *The Rent Supplement and Section 236 Programs.* (1) This paragraph (a) is applicable to rent supplement payments and section 236 interest reduction payments or rental assistance payments.

(2) Before admission of an applicant, an owner shall notify the applicant that the applicant must submit evidence of citizenship or eligible alien status. An applicant may not be admitted unless the evidence has been submitted. See § 200.184(b).

(3) An owner shall notify a Current Participant of the requirement to submit evidence of citizenship or eligible alien status at least 75 days before the effective date of the first annual reexamination at which the tenant is required (under § 200.182(a)(5)(i)(A)(*2*)) to submit such evidence.

(b) *The Section 235 Program.* (1) This paragraph (b) is applicable to assistance payments under the section 235 program.

(2) Mortgagees shall give notice of the requirement to submit evidence of citizenship or eligible alien status in accordance with § 200.182 to each applicant for financial assistance under Section 235, and, upon the occurrence of any of the events described in § 235.13(a) to each mortgagor receiving the benefits of such assistance.

(c) *Form of notice.* A notice under this section of the requirement to submit evidence of citizenship or eligible alien status shall describe the evidence that must be submitted, and shall state when the evidence must be submitted. The notice shall be given in accordance with HUD requirements, and shall be in a form prescribed by HUD, or complying with HUD requirements.

§ 200.184 Rent Supplement and Section 236—Denial or termination of assistance.

(a) *Applicability.* This section is applicable to financial assistance in the form of rent supplement payments, or section 236 interest reduction payments or rental assistance payments.

(b) *Denial of Assistance.* (1) The owner shall not take any of the

following actions unless required evidence of citizenship or eligible alien status has been submitted to the owner in accordance with § 200.182:

(i) Admit an applicant with financial assistance,

(ii) Enter into an assisted lease (including entering into any lease extension or lease renewal for a tenant previously receiving financial assistance),

(iii) Approve any additional person for occupancy of an assisted dwelling unit, or

(iv) Commence any new form of financial assistance under an assisted lease previously entered (e.g., commencement of section 236 rental assistance payments for a tenant previously receiving only the benefit of section 236 interest reduction payments).

(2)(i) With respect to the tenant of an assisted dwelling unit, the owner may take actions described in paragraph (b)(1)(ii)(iii) or (iv) of this section although the tenant has not yet submitted evidence of citizenship or eligible alien status in accordance with § 200.182 if:

(A) The tenant certifies that any person for whom required evidence has not been submitted by the tenant is a citizen or eligible alien, but shows that the tenant is temporarily unable to obtain evidence to support a claim of citizenship status (under § 200.182(b) (1) or (2)), or a claim of eligible alien status (under § 200.182(c)), and needs additional time to obtain and submit the evidence,

(B) The tenant promises to make prompt and diligent efforts to obtain the evidence, and

(C) The owner decides, in the owner's managerial discretion, to grant an extension of time for the tenant to submit the evidence.

(ii) An extension under paragraph (b)(2)(i) shall be for a specific period needed to obtain the evidence. Where the tenant is required (under § 200.182) to submit the evidence at an annual reexamination, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the tenant is required (under § 200.182) to request the owner's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(iii) The owner's decision to grant an extension of the time for the tenant to submit the evidence, and the owner's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The tenant shall not have any right to an extension, and the owner may revoke an extension. The owner may only continue an extension if the tenant is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the tenant will be able to submit the evidence during the extension. If the tenant has not submitted the evidence by the end of the extension, the owner shall promptly terminate financial assistance for the tenant by terminating assisted occupancy in accordance with paragraph (c)(5) of this section, or by evicting the tenant in accordance with paragraph (c)(6) of this section. The owner's decision to grant an extension shall be in writing, and shall state the reasons for the owner determination. The owner shall notify HUD of each determination to extend the time for submission of the evidence, and shall provide other information required by HUD concerning the owner's policy and practice regarding such extensions.

(3) The owner may not receive or retain financial assistance paid for the benefit of a tenant if the owner takes any of the actions described in § 200.184(b)(1) when required evidence of citizenship or eligible alien status has not been submitted to the owner. HUD may take other appropriate remedial action.

(4) During the Initial Implementation Period, an applicant shall not lose its position on the owner's waiting list because of the applicant's failure to submit required evidence.

(c) *Termination of Financial Assistance (including Eviction).* (1) Upon the occurrence of any of the following events, financial assistance for the tenant shall terminate in accordance with HUD requirements. The owner must promptly terminate financial assistance for the tenant by terminating assisted occupancy in accordance with paragraph (c)(5) of this section, or by evicting the tenant in accordance with paragraph (c)(6) of this section:

(i) If evidence of citizenship or eligible alien status is not submitted by the tenant at annual reexamination when required,

(ii) If the tenant fails to obtain the owner's approval, in accordance with § 200.182(a)(5)(ii), for occupancy of the assisted dwelling unit by an additional person for whom submission of evidence of citizenship or eligible alien status is required, or

(iii) If the owner has admitted a tenant with financial assistance, but the owner is subsequently informed by HUD or otherwise learns, that documents used to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status.

(2) In the cases described in paragraphs (c)(1)(i) and (ii) of this section, the owner is not required to terminate financial assistance if:

(i) Any person for whom required evidence has not been submitted by the tenant has moved from the assisted dwelling unit, or

(ii)(A) The tenant certifies that any person for whom required evidence has not been submitted by the tenant is a citizen or eligible alien, but shows that the tenant is temporarily unable to obtain evidence to support a claim of citizenship status (under § 200.182(b)(1) or (2)), or a claim of eligible alien status (under § 200.182(c)), and needs additional time to obtain and submit the evidence,

(B) The tenant promises to make prompt and diligent efforts to obtain the evidence, and

(C) The owner decides, in the owner's managerial discretion, to grant an extension of time for the tenant to submit the evidence.

(3) An extension under paragraph (c)(2) shall be for a specific period needed to obtain the evidence. Where the tenant is required (under § 200.182) to submit the evidence at an annual reexamination, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the tenant is required (under § 200.182) to request the owner's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(4) The owner's decision to grant an extension of the time for the tenant to submit the evidence, and the owner's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of each individual case. The tenant shall not have any right to an extension of time to submit the evidence, and the owner may revoke an extension. The owner may only continue an extension if the tenant is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the tenant will be able to submit the evidence

during the extension. If the tenant has not submitted the evidence by the end of the extension, the owner shall promptly terminate financial assistance for the tenant by terminating assisted occupancy in accordance with paragraph (c)(5) of this section, or by evicting the tenant in accordance with paragraph (c)(6) of this section. The owner's decision to grant an extension shall be in writing, and shall state the reasons for the owner determination. The owner shall notify HUD of each determination to extend the time for submission of the evidence, and shall provide other information required by HUD concerning the owner's policy and practice regarding such extensions.

(5) Upon occurrence of any of the events described in paragraph (c)(1) of this section, assisted occupancy is terminated by doing either of the following:

(i) If permitted under the lease, the owner may notify the tenant that because of such occurrence the tenant is required to pay the HUD-approved market rent for the dwelling unit. The notice shall be given in accordance with HUD requirements.

(ii) The owner may enter into a new lease without financial assistance.

(6)(i) Upon occurrence of any of the events described in paragraph (c)(1) of this section, financial assistance on behalf of the tenant shall terminate in accordance with HUD requirements unless the owner shall promptly initiate, and shall diligently pursue, action to terminate the tenancy under an assisted lease in accordance with the terms of the lease, and to evict the tenant by judicial action pursuant to State and local law. Action by the owner to terminate the tenancy and evict the tenant must be in accordance with Part 247 and other HUD requirements.

(ii) If the owner is acting to evict the tenant in accordance with this paragraph (c)(6), rent supplement payments and section 236 rental assistance payments for the dwelling unit shall continue (subject to the provisions of § 200.184(b)(3)) in accordance with the applicable assistance contract during occupancy of the dwelling unit by the tenant under the lease. For any jurisdiction, HUD may prescribe a maximum period during which assistance payments may be continued during eviction proceedings, and may prescribe other standards of reasonable diligence for the prosecution of eviction proceedings.

(7) When financial assistance for the tenant has been terminated in accordance with § 200.184(c), financial assistance for the tenant shall not resume unless:

(i) All required evidence has been submitted by the tenant to the owner, and

(ii) Resumption of assistance is authorized in accordance with HUD requirements.

PART 215—RENT SUPPLEMENT PAYMENTS

4. The authority citation for Part 215 is revised to read as follows:

Authority: Sec. 101(g), HUD Act of 1965 (12 U.S.C. 1701s); section 7(d), Dept. of HUD Act (42 U.S.C. 3535(d)), unless otherwise noted.

§ 215.1 [Amended]

5. Section 215.1 is amended by removing the definition of Nonimmigrant Student-Alien.

6. Section 215.20(b)(2) is revised to read as follows:

§ 215.20 Qualified tenant.

* * * * *

(b) * * *

(2) For restrictions on eligibility for financial assistance of persons other than citizens and eligible aliens, see Part 200, Subpart G.

* * * * *

§ 215.55 [Amended]

7. Section 215.55(a) is amended by adding a new sentence after the words "at least once every 12 months.", to read as follows:

(a) * * * At reexamination the owner shall require the tenant to submit evidence of citizenship or eligible alien status in accordance with § 200.182.

* * * * *

PART 235—MORTGAGE INSURANCE AND ASSISTANCE PAYMENTS FOR HOME OWNERSHIP AND PROJECT REHABILITATION

8. The authority citation for Part 235 continues to read as follows:

Authority: Secs. 211 and 235, National Housing Act (12 U.S.C. 1715b, 1715z); Sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

9. Section 235.2 is amended by adding a new paragraph (f), to read as follows:

§ 235.2 Basic program outline.

* * * * *

(f) Evidence of citizenship or eligible alien status must be submitted by the applicant or mortgagor to the mortgagee in accordance with Part 200, Subpart G, and § 235.13 of this Part.

§ 235.5 [Amended]

10. Section 235.5 is amended by removing paragraph (g).

§ 235.10 [Amended]

11. Section 235.10 is amended by removing paragraph (e).

12. Section 235.13 is added, to read as follows:

§ 235.13 Ineligible alien applicant or mortgagor.

(a) Unless evidence of citizenship or eligible alien status has been submitted by the applicant or mortgagor to the mortgagee in accordance with § 200.182, a mortgagor shall not be eligible to receive assistance payments, as determined by the mortgagee at the time of: (1) Application for assistance, (2) purchase of a cooperative membership, (3) assumption of a mortgage, (4) commencement of foreclosure relief under the assignment program pursuant to § 203.650 (or under the temporary mortgage assistance program, when implemented) or (5) request for reinstatement of a mortgage under § 203.608.

(b) When any event specified in paragraph (a) of this section occurs, the mortgagee shall require the applicant or mortgagor to submit the evidence of citizenship or eligible alien status required under § 200.182. The mortgagee must certify to the Secretary that the required evidence of citizenship or eligible alien status has been submitted for all persons for whom such evidence is required. If the mortgagee cannot make such a certification, the mortgagee shall notify the applicant or mortgagor of its ineligibility for financial assistance payments under this Part.

(c) If the mortgagee has certified to the Secretary in accordance with § 235.13(b) that required evidence of citizenship or eligible alien status was submitted, but the Secretary subsequently determines that documents submitted to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or were not valid or authentic evidence of such status:

(1) The mortgagor shall repay to the Secretary the full amount of assistance payments made on behalf of the mortgagor under this Part. The Secretary's right to repayment from the mortgagor pursuant to this paragraph (c)(1) shall not affect or limit the Secretary's right to refund of overpaid assistance payments from the mortgagee as provided in § 235.361(b).

(2) No additional assistance payments may be made on behalf of the mortgagor. However, the Secretary may permit the resumption of assistance payments if all persons for whom required evidence of citizenship or eligible alien status has not been submitted by the mortgagor have moved

from the dwelling unit, or all required evidence has been submitted by the mortgagor.

(d) Commitments to insure mortgages under this Part will not be issued or extended unless the mortgagee has made the certification required under § 235.13(b).

(e) For other provisions concerning restrictions on eligibility for financial assistance of persons other than citizens and eligible aliens, see Part 200, Subpart G.

§ 235.325 [Amended]

13. Section 235.325 is amended by removing paragraph (c).

§ 235.375 [Amended]

14. Section 235.375 is amended by removing the second sentence of paragraph (a)(1), by removing paragraph (a)(5) in its entirety, and by removing the last sentence in paragraph (e).

PART 236—MORTGAGE INSURANCE AND INTEREST REDUCTION PAYMENTS FOR RENTAL PROJECTS

15. The authority citation for Part 236 continues to read as follows:

Authority: Secs. 211 and 236, National Housing Act (12 U.S.C. 1715b and 1715z–1); sec 7(d), Dept. of HUD Act (42 U.S.C. 3535 (d)).

§ 236.2 [Amended]

16. Section 236.2 is amended by removing the definition of Nonimmigrant Student-Alien.

17. The definition of Qualified Tenant in § 236.2 is amended by adding a paragraph (c) to read as follows:

§ 236.2 Definitions.

* * * * *

Qualified Tenant. * * *

(c) For restrictions on eligibility for financial assistance of persons other than citizens or eligible aliens, see Part 200, Subpart G.

§ 236.80 [Amended]

18. Section 236.80(a) is amended by adding a new sentence after the words "at least once every 12 months.", to read as follows:

(a) * * * At reexamination the owner shall require the tenant to submit evidence of citizenship or eligible alien status in accordance with § 200.182.

* * * * *

§ 236.710 [Amended]

19. A new sentence is added at the end of § 236.710, to read as follows:

* * * For restrictions on eligibility for financial assistance of persons other than citizens or eligible aliens, see Part 200, Subpart G.

PART 247—EVICTIONS FROM CERTAIN SUBSIDIZED AND HUD OWNED PROJECTS

20. The authority citation for Part 247 continues to read as follows:

Authority: Sec. 7(d), Department of H.U.D. Act (42 U.S.C. 3535(d)).

21. Section 247.3(c) is revised to read as follows:

§ 247.3 Entitlement of tenants to occupancy.

* * * * *

(c) *Material noncompliance.* The term "material noncompliance with the rental agreement" shall include: (1) One or more substantial violations of the rental agreement, or (2) repeated minor violations of the rental agreement that disrupt the livability of the project, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related project facilities, interfere with the management of the project or have an adverse financial effect on the project. Failure of the tenant to timely supply all required information on income and composition of the tenant household (including required evidence of citizenship or eligible alien status) shall constitute a substantial violation of the rental agreement. Nonpayment of rent or any other financial obligation due under the rental agreement (including any portion thereof) beyond any grace period permitted under state law shall constitute a substantial violation of the rental agreement. The payment of rent or any other financial obligation due under the rental agreement after the due date but within the grace period permitted under state law shall constitute a minor violation.

PART 812—DEFINITION OF FAMILY AND OTHER RELATED TERMS; OCCUPANCY BY SINGLE PERSONS

22. The authority citation for Part 812 is revised to read as follows:

Authority: Sec. 3, U.S. Housing Act of 1937 (42 U.S.C. 1437a); sec. 7(d), Dept. of H.U.D. Act (42 U.S.C. 3535(d)). Part 812 is also issued under sec. 214, Housing and Community Development Act of 1980, as amended by section 329, Housing and Community Development Amendments of 1981 (42 U.S.C. 1436a).

23. Section 812.1 is retitled and revised to read as follows:

§ 812.1 Purpose and applicability.

(a) This part:

(1) Defines the term Family and other related terms;

(2) Prescribes criteria and procedures for occupancy by Single Persons who are not otherwise eligible by reason of qualification as an Elderly Family or as a Displaced Person or as the remaining member of a tenant family, and incorporates the statutory 15 percent limitation on assistance for Single Persons; and

(3) Implements the statutory prohibition against making assistance under the U.S. Housing Act of 1937 ("Act") available for the benefit of ineligible aliens.

(b) This part is applicable to all housing assisted under section 8 of the Act, including section 8-assisted housing for which loans are made under section 202 of the Housing Act of 1959.

24. Section 812.2 is revised to read as follows:

§ 812.2 Definitions.

Act. The U.S. Housing Act of 1937.

Assisted Dwelling Unit. A dwelling unit assisted under the programs covered by this Part (see § 812.1(b)).

Citizen. A citizen of the United States.

Current Participant—(a) *For a participant under the Section 8 Housing Certificate Program or Housing Voucher Program:* A Family for which a lease was approved by the PHA before July 30, 1986.

(b) *For all other Section 8 assistance under this Part:* A Family for which an assisted lease was entered into for a lease term beginning before July 30, 1986.

Disabled person. A person who is under a disability as defined in section 223 of the Social Security Act or in section 102 of the Developmental Disabilities Services and Facilities Construction Amendments of 1970.

Displaced person. A person displaced by governmental action, or a person whose dwelling has been extensively damaged or destroyed as a result of a disaster declared or otherwise formally recognized pursuant to Federal disaster relief laws.

Elderly family. A Family whose head or spouse or whose sole member is at least sixty-two years of age, or a Disabled Person as defined in this section or a Handicapped Person as defined in this section, and may include two or more elderly, Disabled or Handicapped Persons living together, or one or more such persons living with another person who is determined to be essential to his or her care and well being.

Eligible alien. An alien who is a resident of the United States and is one of the following:

(1) An alien lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and

101(a)(20) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15) and 1101(a)(20));

(2) An alien who entered the United States before June 30, 1948, or such later date as enacted by law, has continuously maintained residence in the United States since then, and is not ineligible for citizenship, but who is deemed to be lawfully admitted for permanent residence as a result of an exercise of discretion by the Attorney General under section 249 of the Immigration and Nationality Act (8 U.S.C. 1259);

(3) An alien who is lawfully present in the United States pursuant to an admission under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or pursuant to the granting of asylum (which has not been terminated) under section 208 of such Act (8 U.S.C. 1158);

(4) An alien who is lawfully present in the United States as a result of being granted conditional entry under section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic natural calamity;

(5) An alien who is lawfully present in the United States as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest under section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. 1182(d)(5)); or

(6) An alien who is lawfully present in the United States as a result of the Attorney General's withholding deportation under section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)).

Evidence of citizenship or eligible alien status ("*evidence*"). The documents which must be submitted in accordance with § 812.5 to show citizenship or eligible alien status of occupants of an assisted dwelling unit. The evidence consists of both:

(1) The documents described in paragraphs (b) and (c) of §812.5, and

(2) A verification consent form.

Family. "Family" includes but is not limited to (1) an Elderly Family or Single Person as defined in this Part, (2) the remaining member of a tenant family, and (3) a Displaced Person.

Handicapped person. A person having a physical or mental impairment which (1) is expected to be of long-continued and indefinite duration, (2) substantially impedes the person's ability to live independently, and (3) is of such a nature that such ability could be improved by more suitable housing conditions.

HUD. The U.S. Department of Housing and Urban Development.

Initial Implementation Period. The 90 day period beginning on July 30, 1986.

Responsible Entity. The entity responsible for administering the restrictions on providing assistance to ineligible aliens (see § 812.5(a)(4)).

Single person. A person living alone or intending to live alone and who does not qualify as an Elderly Family or a Displaced Person as defined in this Part, or as the remaining member of a tenant family.

Verification consent form. A written agreement by a Family, in the form prescribed by HUD, that:

(a) Any evidence submitted by the Family to the Responsible Entity may be released by the Responsible Entity to HUD.

(b) Such evidence may also be released by the Responsible Entity to a party other than HUD for the following purposes: verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, or investigation or prosecution of fraud in connection with any Federal housing assistance program.

(c) HUD may release the evidence or other information to any Federal, State or local government agency (including the Social Security Administration and the Immigration and Naturalization Service) for the following purposes: verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, investigation or prosecution of fraud in connection with any Federal housing assistance program, or other purposes connected with administration of HUD programs.

(d) Any Federal, State or local government agency may release to HUD, or to the Responsible Entity, any information which HUD or the Responsible Entity determines to be necessary for verification of citizenship or eligible alien status, or enforcement of restrictions on the availability of financial assistance because of such status.

25. Sections 812.5 through 812.7 are added as follows:

§ 812.5 Evidence of citizenship or eligible alien status.

(a) *Requirement for submission of evidence.* (1) Evidence of citizenship or eligible alien status shall be submitted in accordance with this section by each applicant and participant Family.

(2) The required evidence of citizenship or eligible alien status shall be submitted by the Family for the Family head and spouse regardless of age, and for all other persons 18 years of age or older. The evidence shall be submitted for each Family member who is or will be an occupant of the assisted dwelling unit.

(3) The verification consent form shall be signed by each person for whom the information is submitted. Failure to submit required evidence of citizenship or eligible alien status shall result in denial or termination of assistance in accordance with § 812.7.

(4)(1) The Responsible Entity shall be as follows:

(A) For the Section 8 Certificate and Housing Voucher Programs: the PHA.g

(B) For the Section 8 Moderate Rehabilitation Program (under Part 882): the PHA

(C) For all other Section 8: the Section 8 Owner.

(ii)(A) The required evidence shall be submitted by the Family to the Responsible Entity. The Responsible Entity is responsible for administering the restrictions on providing assistance to ineligible aliens, and shall exercise this responsibility in accordance with HUD requirements.

(B) The Responsible Entity is not required to assist the Family in obtaining the evidence to be submitted, and is not required to determine the validity or authenticity of evidence submitted. If the Responsible Entity suspects that a document submitted is not valid or authentic, or suspects misrepresentation, the Responsible Entity shall inform HUD.

(5)(i)(A)*(1)* A Family shall (except as provided in § 812.5(a)(5)(i)(B), which concerns continuous assisted occupancy by a citizen) submit the required evidence of citizenship or eligible aliens status at each annual reexamination.

(2) A Current Participant shall (except as provided in § 812.5(a)(5)(i)(B)) submit the required evidence at the first annual reexamination effective after the end of the Initial Implementation Period, and at each subsequent annual reexamination. (See provisions concerning notice to a Current Participant at § 812.6(b).)

(B) Submission of evidence that an occupant of the assisted dwelling unit is a citizen is only required one time during continuous assisted occupancy by the citizen.

(ii)(A) A Family shall request the Responsible Entity's approval for occupancy of the assisted dwelling unit by any additional person for whom submission of evidence of citizenship or eligible alien status is required. The Responsible Entity shall not approve

occupancy by the additional person until the evidence has been submitted.

(B) In the case of a Current Participant, § 812.5(a)(5)(ii)(A) is not applicable before the effective date of the first reexamination at which the Family is required to submit evidence of citizenship or eligible alien status pursuant to § 812.5(a)(5)(i)(A).

(iii) When a member of the household (other than the head of household or spouse) reaches the age of 18, evidence of the person's citizenship or eligible alien status must be submitted at the next annual reexamination.

(b) *Citizenship status.* (1) The original or a certified copy of one of the following documents shall be submitted to support a claim of citizenship status:

(i) U.S. Passport,

(ii) Birth Certificate,

(iii) Consular Report of Birth,

(iv) Naturalization Certificate (original only),

(v) Certificate of Citizenship (original only),

(vi) U.S. Citizenship Identification Card (INS form I–197),

(vii) Baptismal or other religious certificate which provides evidence of birth in the United States and which was created within one year of birth,

(viii) A document issued by the Bureau of Indian Affairs and which indicates membership in a federally recognized tribe, or

(ix) Any other document designated by HUD.

(2) If none of the above documents can be obtained, and a person claiming to be a U.S. citizen provides a reasonable explanation of inability to obtain the document, a signed statement from a third party may be submitted. The third party must produce one of the above documents to evidence that the third party is a citizen, and must state under penalty of perjury that the person for whom the document is not available is a citizen, and the basis of this statement.

(c) *Eligible alien status.* (1) The original of one of the following documents shall be submitted to support a claim of eligible alien status:

(i) Form I–151, Alien Registration Receipt Card (for permanent resident aliens);

(ii) Form I–551, Alien Registration Receipt Card (for permanent resident aliens);

(iii) Form I–181B, Processed for I–551, Temporary Evidence of Lawful Admission for Permanent Residence (for permanent resident aliens);

(iv) Passport stamped "processed for I–551, temporary evidence of lawful admission for permanent residence" (for permanent resident aliens);

(v) Form AR–3a, Alien Registration Receipt Card (Issued during 1941–1949 for permanent resident aliens);

(vi) Form I–94, Arrival-Departure Record (Annotated either "Section 207" or "Refugee," or "Section 208" or "Asylum");

(vii) Form I–94, Arrival-Departure Record—Parole Edition (Annotated "Section 212(d)(5)," or "Conditional Entry" or "Section 203(a)(7)");

(viii) Form I–94, Arrival-Departure Record (Annotated "Section 243(h)"); or

(ix) Any other document designated by HUD.

(2) A third party's statement or certification is not acceptable evidence of eligible alien status, and may not be submitted in lieu of the requirement to submit the documents listed in paragraph (c)(1) of this section.

(3) The following documents are not acceptable evidence of eligible alien status:

(i) Form I–94, Arrival-Departure Record: Annotated with any codes "A" through "L" for Non-Immigrants (for temporary resident aliens);

(ii) Form I–95A, Crewman's Landing Permits (for alien visitors);

(iii) Form I–144, Mexican Border Visitors Permit;

(iv) Form I–186, Nonresident Alien Mexican Border Crossing Card;

(v) Form I–185, Nonresident Alien Canadian Border Crossing Card;

(vi) Unnumbered form, Nonresident Alien Canadian Border Crossing Identification Card; or

(vii) Any Foreign issued Visa.

(d) *Retention of evidence.* A photocopy of each document (or the original if released by the person submitting the document), and a signed verification consent form, shall be retained by the Responsible Entity. However, a photocopy need not be made or retained of any document bearing an identifying serial number if a record of such serial number and other necessary identifying information is made and retained in such manner as shall be prescribed by the Department.

(e) *Disclosure of evidence.* Evidence of citizenship or eligible alien status submitted to the Responsible Entity by the Family shall be deemed to have been submitted in confidence. However, the evidence may be released by the Responsible Entity to HUD. The evidence may also be released by the Responsible Entity to a party other than HUD for these purposes:

(1) Verification of citizenship or eligible alien status,

(2) Enforcement of restrictions on the availability of assistance because of such status, or

(3) The investigation or prosecution of fraud in connection with any Federal housing assistance program.

(Information collection requirements in paragraph (a)(1) approved by the Office of Management and Budget under OMB control number 250–0204.)

§ 812.6 Notice to applicants and participants.

(a) *Notice to Applicant.* Before admission of an applicant, the Responsible Entity shall notify the applicant that the applicant must submit evidence of citizenship or eligible alien status. An applicant may not be admitted unless the evidence has been submitted. See § 812.7(a).

(b) *Notice to Current Participant.* The Responsible Entity shall notify a Current Participant of the requirement to submit evidence of citizenship or eligible alien status at least 75 days before the effective date of the first annual reexamination at which the Family is required (under § 812.5(a)(5)(i)(A)(*2*)) to submit such evidence.

(c) *Form of Notice.* A notice under this section of the requirement to submit evidence of citizenship or eligible alien status shall describe the evidence that must be submitted, and shall state when the evidence must be submitted. The notice shall be given in accordance with HUD requirements, and shall be in a form prescribed by HUD, or complying with HUD requirements.

§ 812.7 Denial or termination of assistance.

(a) *Denial of Assistance*—(1) *For assistance under the Section 8 Housing Certificate Program or Housing Voucher Program:* (i) The PHA shall not take any of the following actions unless required evidence of citizenship or eligible alien status has been submitted to the PHA in accordance with § 812.5:

(A) Issue a Housing Certificate or Housing Voucher to an applicant, or to a participant who wants to move to another dwelling unit,

(B) Enter into an assistance contract or approve a lease on behalf of an applicant or participant (including approving a lease extension or lease renewal for a participant family),

(C) Approve any additional person for occupancy of an assisted dwelling unit.

(ii)(A) With respect to a participant, the PHA may take actions described in paragraph (a)(1)(i) of this section although the Family has not yet submitted evidence of citizenship or eligible alien status for a Family member to the PHA in accordance with § 812.5 if:

(*1*) The Family certifies that the Family member is a citizen or eligible

alien, but shows that the Family is temporarily unable to obtain evidence to support a claim of citizenship status (under § 812.5(b)(1) or (2)), or a claim of eligible alien status (under § 812.5(c)), and needs additional time to obtain and submit the evidence,

(2) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(3) The PHA decides, in the PHA's administrative discretion, to grant an extension of time for the Family to submit the evidence.

(B) An extension under paragraph (ii)(A) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 812.5) to submit the evidence at an annual reeaxmination, any extension or extensions granted by the PHA shall not follow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 812.5) to request the PHA's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(C) The PHA's decision to grant an extension of the time for the Family to submit the evidence, and the PHA's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension, and the PHA may revoke an extension. The PHA may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the PHA shall promptly terminate housing assistance payments for the Family in accordance with HUD requirements. The PHA's decision to grant an extension shall be in writing, and shall state the reasons for the PHA determination. The PHA shall provide information required by HUD concerning the PHA's policy and practice regarding extensions.

(iii) During the Initial Implementation Period, an applicant shall not lose its position on the PHA's waiting list because of the applicant's failure to submit required evidence.

(2) *For assistance under the Section 8 Part 882 Moderate Rehabilitation Program:* (i) The PHA shall not take either of the following actions unless required evidence of citizenship or eligible alien status has been submitted to the PHA in accordance with § 812.5:

(A) admit an applicant for participation in the program, or

(B) approve any additional person for occupancy of an assisted dwelling unit.

(ii)(A) With respect to a participant Family, the PHA may approve an additional person for occupancy of an assisted dwelling unit although the Family has not yet submitted required evidence of citizenship or eligible alien status for a Family member to the PHA in accordance with § 812.5 if:

(1) The Family certifies that the Family member is a citizen or eligible alien, but shows that the Family is temporarily unable to obtain evidence to support a claim of citizenship status (under § 812.5(b) (1) or (2)), or a claim of eligible alien status (under § 812.5(c)), and needs additional time to obtain and submit the evidence,

(2) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(3) The PHA decides, in the PHA's administrative discretion, to grant an extension of time for the Family to submit the evidence.

(B) An extension under paragraph (ii)(A) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 812.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 812.5) to request the PHA's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(C) The PHA's decision to grant an extension of the time for the Family to submit the evidence, and the PHA's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension, and the PHA may revoke an extension. The PHA may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the PHA shall promptly terminate housing assistance payments for the Family in accordance with HUD requirements. The PHA's decision to grant an extension shall be in writing, and shall state the reasons for the PHA determination. The PHA shall provide information required by HUD concerning the PHA's policy and practice regarding extensions.

(iii) During the Initial Implementation Period, an applicant shall not lose its position on the PHA's waiting list because of the applicant's failure to submit required evidence.

(3) *For all other Section 8 assistance under this part:* (i) The owner shall not take any of the following actions unless required evidence of citizenship or eligible alien status has been submitted to the owner in accordance with § 812.5:

(A) Admit an applicant with assistance,

(B) Enter into an assisted lease (including entering into any lease extension or lease renewal for a Family previously assisted), or

(C) Approve any additional person for occupancy of an assisted dwelling unit.

(ii)(A) With respect to a participant Family, the owner may take actions described in paragraph (a)(3)(i) (B) or (C) of this section although the Family has not yet submitted required evidence of citizenship or eligible alien status for a Family member to the owner in accordance with § 812.5 if:

(1) The Family certifies that the Family member is a citizen or eligible alien, but shows that the Family is temporarily unable to obtain evidence to support a claim of citizenship status (under § 812.5(b) (1) or (2)), or a claim of eligible alien status (under § 812.5(c)), and needs additional time to obtain and submit the evidence,

(2) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(3) The owner decides, in the owner's managerial discretion, to grant an extension of time for the Family to submit the evidence.

(B) An extension under paragraph (ii)(A) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 812.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 812.5) to request the owner's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(C) The owner's decision to grant an extension of the time for the Family to submit the evidence, and the owner's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. A Family shall not have any right to an extension, and the owner may revoke an extension. The owner may only continue an extension if the Family is making deligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the owner shall promptly terminate financial assistance for the Family by terminating assisted occupancy in accordance with paragraph (b)(2)(v) of this section, or by evicting the Family in accordance with paragraph (b)(2)(vi) of this section. The owner's decision to grant an extension shall be in writing, and shall state the reasons for the owner determination. The owner shall notify HUD and the Contract Administrator of each determination to extend the time for submission of the evidence, and shall provide other information required by HUD or the Contract Administrator concerning the owner's policy and practice regarding extensions.

(iii) The owner may not receive or retain a housing assistance payment paid for the benefit of a Family if the owner takes any of the actions described in paragraph (a)(3)(i) when the Family has not submitted required evidence of citizenship or eligible alien status. HUD may take other appropriate remedial action.

(iv) During the Initial Implementation Period, an applicant shall not lose its position on the owner's waiting list because of the applicant's failure to submit required evidence.

(b) *Termination of Assistance (including Termination of Tenancy)*—(1) *For assistance under the Section 8 Housing Certificate Program, the Housing Voucher Program, and the Section 8 Part 882 Moderate Rehabilitation Program:* (i) The PHA shall promptly terminate housing assistance payments for the Family in accordance with HUD requirements upon occurrence of any of the following events:

(A) If evidence of citizenship or eligible alien status is not submitted by the Family at annual reexamination when required,

(B) If the Family fails to obtain PHA approval, in accordance with § 812.5(a)(5)(ii), for occupancy of the assisted dwelling unit by an additional person for whom submission of evidence of citizenship or eligible alien status is required, or

(C) If the PHA is informed by HUD, or otherwise learns, that documents used to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status.

(ii)(A) In the cases described in paragraphs (b)(1)(i) (A) and (B) of this section, the PHA is not required to terminate housing assistance payments if:

(*1*) Any person for whom required evidence has not been submitted by the Family has moved from the assisted dwelling unit, or

(*2*)(*i*) The Family certifies that any person for whom required evidence has not been submitted by the Family is a citizen or eligible alien, but shows that the Family is temporarily unable to obtain evidence to support a claim of citizenship status (under § 812.5(b) (1) or (2)), or a claim of eligible alien status (under § 812.5(c)), and needs additional time to obtain and submit the evidence,

(*ii*) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(*iii*) The PHA decides, in the PHA's administrative discretion, to grant an extension of time for the Family to submit the evidence.

(B) An extension under paragraph (b)(ii)(A)(*2*) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 812.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 812.5) to request the PHA's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(C) The PHA's decision to grant an extension of the time for the Family to submit the evidence, and the PHA's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension of time to submit the evidence, and the PHA may revoke an extension. The PHA may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the PHA shall promptly terminate housing assistance payments for the Family in accordance with HUD requirements. The PHA's decision to grant an extension shall be in writing and shall state the reasons for the PHA determination. The PHA shall provide information required by HUD concerning the PHA's policy and practice regarding such extensions.

(iii) When housing assistance payments for the Family have been terminated in accordance with § 812.7(b)(1), assistance payments for the Family shall not resume unless:

(A) All persons for whom required evidence has not been submitted by the Family have moved from the assisted dwelling unit or all required evidence has been submitted by the Family to the Responsible Entity, and

(B) Resumption of assistance is authorized in accordance with HUD requirements.

(2) *For all other Section 8 assistance under this part:* (i) Upon the occurrence of any of the following events, financial assistance for the Family shall terminate in accordance with HUD requirements. The owner shall promptly terminate financial assistance for the Family by terminating assisted occupancy in accordance with paragraph (b)(2)(v) of this section, or by evicting the Family in accordance with paragraph (b)(2)(vi) of this section:

(A) If evidence of citizenship or eligible alien status is not submitted at annual reexamination when required,

(B) If the Family fails to obtain the owner's approval, in accordance with § 812.5(a)(5)(ii), for occupancy of the assisted dwelling unit by an additional person for whom submission of evidence of citizenship and alien status is required, or

(C) If the owner has admitted a Family with Section 8 assistance, but the owner is subsequently informed by HUD, or otherwise learns, that documents used to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status.

(ii) In the cases described in paragraphs (b)(2)(i) (A) and (B) of this section, the owner is not required to terminate financial assistance if:

(A) Any person for whom required evidence has not been submitted by the Family has moved from the assisted dwelling unit, or

(B) (*1*) The Family certifies that the Family member is a citizen or eligible alien, but shows that the Family is

temporarily unable to obtain evidence to support a claim of citizenship status (under § 812.5(b) (1) or (2)), or a claim of eligible alien status (under § 812.5(c)), and needs additional time to obtain and submit the evidence,

(2) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(3) The owner decides, in the owner's managerial discretion, to grant an extension of time for the Family to submit the evidence.

(iii) An extension under paragraph (b)(2)(ii)(B) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 812.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 812.5) to request the owner's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the owner shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(iv) The owner's decision to grant an extension of the time for the Family to submit the evidence, and the owner's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension, and the owner may revoke an extension. The owner may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the owner shall promptly terminate financial assistance for the Family by terminating assisted occupancy in accordance with paragraph (b)(2)(v) of this section, or by evicting the Family in accordance with paragraph (b)(2)(vi) of this section. An owner decision to grant an extension shall be made in writing, and shall state the reasons for the owner determination. The owner shall notify HUD and the Contract Administrator of each determination to extend the time for submission of the evidence, and shall provide other information required by HUD or the Contract Administrator concerning the owner's policy and practice regarding extensions.

(v) Upon the occurrence of any of the events described in paragraph (b)(2)(i) of this section, assisted occupancy is terminated by doing either of the following:

(A) If permitted under the lease, the owner may notify the Family that because of such occurrence the Family is required to pay the HUD-approved market rent for the dwelling unit. The notice shall be given in accordance with HUD requirements.

(B) The owner may enter into a new lease without section 8 assistance.

(vi) (A) Upon the occurrence of any of the events described in paragraph (b)(2)(i) of this section, housing assistance payments for the Family shall terminate in accordance with HUD requirements unless the owner shall promptly initiate, and shall diligently pursue, action to terminate the tenancy under an assisted lease in accordance with the terms of the lease, and to evict the Family by judicial action pursuant to State and local law. Action by the owner to terminate the tenancy and evict the Family must be in accordance with HUD regulations and other HUD requirements.

(B) If the owner is acting to evict the tenant in accordance with this paragraph (b)(2)(vi), section 8 housing assistance payments for the dwelling unit shall continue (subject to § 812.7(a)(3)(iii)) in accordance with the Housing Assistance Payments Contract during occupancy of the dwelling unit by the Family under the lease. For any jurisdiction, HUD may prescribe a maximum period during which assistance payments may be continued during eviction proceedings, and may prescribe other standards of reasonable diligence for the prosecution of eviction proceedings.

(vii) When financial assistance for the Family has been terminated in accordance with § 812.7(b)(2), housing assistance payments for the Family shall not resume unless:

(A) All required evidence has been submitted by the Family to the owner, and

(B) Resumption of assistance is authorized in accordance with HUD requirements.

PART 880—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM FOR NEW CONSTRUCTION

26. The authority citation for Part 880 continues to read as follows:

Authority: Secs. 3, 5 and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, 1437f); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

27. Section 880.504 is amended by adding a new paragraph (e) to read as follows:

§ 880.504 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased with Section 8 assistance at any time, in accordance with HUD regulations then in effect, but the owner is required to terminate housing assistance payments for the family in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), after termination of Section 8 assistance the owner may allow continued occupancy of the unit by the family without Section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

28. Section 880.601(b) is revised to read as follows:

§ 880.601 Responsibilities of owner.

* * * * *

(b) *Management and Maintenance.* The owner is responsible for all management functions. These functions include selection of tenants, obtaining evidence of citizenship or eligible alien status from the family, reexamination of family incomes, collection of rents, termination of tenancy and eviction, and all repair and maintenance functions (including ordinary and extraordinary maintenance and replacement of capital items). All functions must be performed in compliance with Equal Opportunity requirements.

* * * * *

§ 880.603 [Amended]

29. A new sentence is added at the end of § 880.603(c)(1) to read as follows:

* * * * *

(c) * * *

(1) * * * At the time of the annual reexamination of family income and composition, the owner shall require the family to submit evidence of citizenship or eligible alien status of family members in accordance with § 812.5.

* * * * *

30. A new sentence is added at the end of § 880.603(c)(3) to read as follows:

* * * * *

(c) * * *

(3) * * * For provisions requiring termination of assistance because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(2).

31. Section 880.607(b)(3) is revised to read as follows:

§ 880.607 Termination of tenancy and modification of lease.

* * * * *

(b) * * *

(3) *Material noncompliance.* Material noncompliance with the lease includes: (i) One or more substantial violations of the lease, or (ii) repeated minor violations of the lease that disrupt the livability of the building, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related facilities, interfere with the management of the building or have an adverse financial effect on the building. Failure of the family to timely submit all required information on family income and composition (including required evidence of citizenship or eligible alien status) will constitute a substantial violation of the lease. Nonpayment of rent or any other financial obligation due under the lease (including any portion thereof) beyond any grace period permitted under State law will constitute a substantial violation of the lease. The payment of rent or any other financial obligation due under the lease after the due date but within the grace period permitted under State law will constitute a minor violation.

* * * * *

PART 881—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM FOR SUBSTANTIAL REHABILITATION

32. The authority citation for Part 881 continues to read as follows:

Authority: Secs. 3, 5 and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, 1437f); sec. 7(d), Dept. of H.U.D. Act (42 U.S.C. 3535(d)).

33. Section 881.504 is amended by adding a new paragraph (e) to read as follows:

§ 881.504 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased with section 8 assistance at any time, in accordance with HUD requirements than in effect, but the owner is required to terminate financial assistance in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), after termination of section 8 assistance the owner may allow continued occupancy of the unit by the family without section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

34. Section 881.601(b) is revised to read as follows:

§ 881.601 Responsibilities of owner.

* * * * *

(b) *Management and Maintenance.* The owner is responsible for all management functions. These functions include selection of tenants, obtaining evidence of citizenship or eligible alien status from the family, reexamination of family incomes, collection of rents, termination of tenancy and eviction, and all repair and maintenance functions (including ordinary and extraordinary maintenance and replacement of capital items). All functions must be performed in compliance with Equal Opportunity requirements.

* * * * *

§ 881.603 [Amended]

35. A new sentence is added at the end of § 881.603(c)(1) to read as follows:

* * * * *

(c) * * *

(1) * * * At the time of the annual reexamination of family income and composition, the owner shall require the family to submit evidence of citizenship or eligible alien status of family members in accordance with § 812.5.

* * * * *

36. A new sentence is added at the end of § 881.603(c)(3) to read as follows:

* * * * *

(c) * * *

(3) * * * For provisions requiring termination of assistance because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(2).

37. Section 881.607(b)(3) is revised to read as follows:

§ 881.607 Termination of tenancy and modification of lease.

* * * * *

(b) * * *

(3) *Material noncompliance.* Material noncompliance with the lease includes: (i) One or more substantial violations of the lease, or (ii) repeated minor violations of the lease that disrupt the livability of the building, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related facilities, interfere with the management of the building or have an adverse financial effect on the building. Failure of the family to timely submit all required information on family income and composition (including required evidence of citizenship or eligible alien status) will constitute a substantial violation of the lease. Nonpayment of rent or any other financial obligation due under the lease (including any portion thereof) beyond any grace period permitted under State law will constitute a substantial violation of the lease. The payment of rent or any other financial obligation due under the lease after the due date but within the grace period permitted under State law will constitute a minor violation.

PART 882—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM—EXISTING HOUSING

38. The authority citation for Part 882 continues to read as follows:

Authority: Secs. 3, 5, and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, 1437f); sec. 7(d), Dept. of H.U.D. Act (42 U.S.C. 3535(d)).

39. Section 882.116(c) is revised to read as follows:

§ 882.116 Responsibilities of the PHA.

* * * * *

(c) Receipt and review of applications, determination of family eligibility for participation in accordance with HUD regulations (see Parts 812 and 813), and maintenance of a waiting list in accordance with this part. The PHA is responsible for obtaining evidence of citizenship or eligible alien status from a Family, and for verifying the sources and amount of the Family's income and other information necessary for determining income eligibility and the amount of the assistance payments.

* * * * *

§ 882.116 [Amended]

40. Section 882.116(m) is amended by removing the semicolon at the end of the paragraph and adding in its place: "* * *, and obtaining evidence of citizenship or eligible alien status from the Family in accordance with Part 812 of this chapter;".

41. Section 882.118(a)(1) is revised to read as follows:

§ 882.118 Obligations of the Family.

(a) * * *

(1) Supply such certification, release, information or documentation as the PHA or HUD determine to be necessary, including submission of required evidence of citizenship or eligible alien status, and submissions required for an annual or interim reexamination of Family income and composition.

* * * * *

42. Section 882.209 (a)(2), (a)(7) and (m)(1) are revised, and a new (k)(4) is added to read as follows:

§ 882.209 Selection and participation.

(a) * * *

(2) The PHA shall determine whether an applicant for participation (i) qualifies as a Family, (ii) has satisfied the requirement for submission of evidence of citizenship or eligible alien status of Family members, and (iii) is income eligible.

* * * * *

(7) The PHA shall maintain a waiting list of income eligible Families which have applied for participation in the PHA's Section 8 Certificate Program. The PHA shall not add a Family to the waiting list unless required evidence of citizenship or eligible alien status has been submitted to the PHA in accordance with § 812.5. The PHA shall select applicants for participation from the waiting list in accordance with policies and procedures (including any preferences) states in the administrative plan or equal opportunity plan.

* * * * *

(k) * * *

(4) The PHA shall not approve a Lease, and shall not execute a Contract, unless the Family has satisfied the requirements for submission of required evidence of citizenship or eligible alien status in accordance with § 812.5.

* * * * *

(m) * * *

(1) If a participant in the PHA's Section 8 Housing Certificate Program notifies the PHA that the Family wants another Certificate so that the Family can move to another dwelling unit within the area in which the PHA has determined that the PHA is not legally barred from entering into Contracts, the PHA shall (unless the PHA determines that the Family has not submitted required evidence of citizenship or eligible alien status, or determines it does not have sufficient funding for continued assistance for the Family, or is unable to get HUD approval if needed under § 813.105(c) to issue a Certificate to a Family that is not a Very Low-Income Family) either (i) issue another Certificate, or (ii) deny issuance of a Certificate in accordance with § 882.210.

* * * * *

43. Section 882.210 is amended by adding a new paragraph (e), to read as follows:

§ 882.210 Grounds for denial or termination of assistance.

* * * * *

(e) The Family's obligations as stated in § 882.118 include submission of required evidence of citizenship or eligible alien status. For a statement of circumstances in which the PHA is required to terminate housing assistance payments for the Family because of the Family's failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(1).

§ 882.212 [Amended]

44. A new sentence is added at the end of § 882.212(a), to read as follows:

(a) * * * At the time of the annual reexamination of family income and composition, the PHA shall require the family to submit evidence of citizenship or eligible alien status of Family members in accordance with § 812.5.

* * * * *

45. A new sentence is added at the end of § 882.212(c), to read as follows:

* * * * *

(c) * * * For provisions requiring termination of housing assistance payments because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(1).

46. Section 882.514(a)(1) is revised to read as follows:

§ 882.514 Family participation.

(a) *Initial Determination of Family Eligibility.* (1) The PHA is responsible for receipt and review of applications, and determination of Family eligibility for participation in accordance with HUD regulations (see Parts 812 and 813). The PHA is responsible for obtaining evidence of citizenship or eligible alien status from a Family, and for verifying the sources and amount of the Family's income and other information necessary for determining income eligibility and the amount of the assistance payments.

* * * * *

§ 882.515 [Amended]

47. A new sentence is added at the end of Section 882.515(a), to read as follows:

(a) * * * At the time of the annual reexamination of family income and composition, the owner shall require the family to submit evidence of citizenship or eligible alien status of family members in accordance with § 812.5.

* * * * *

48. A new sentence is added at the end of § 882.515(c), to read as follows:

* * * * *

(c) * * * For provisions requiring termination of assistance because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(1).

PART 883—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM—STATE HOUSING AGENCIES

49. The authority citation for Part 883 continues to read as follows:

Authority: Secs. 3, 5, and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, 1437f); sec. 7(d), Dept. of H.U.D. Act (42 U.S.C. 3535(d)).

50. Section 883.605 is amended by adding a new paragraph (e) to read as follows:

§ 882.605 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased with section 8 assistance at any time, in accordance with HUD regulations then in effect, but the owner is required to terminate financial assistance in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), after termination of Section 8 assistance the owner may allow continued occupancy of the unit by the family without Section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

51. Section 883.702(b) is revised to read as follows:

§ 883.702 Responsibilities of owner.

* * * * *

(b) *Management and Maintenance.* The owner is responsible for all management functions. These functions include selection of tenants, obtaining evidence of citizenship or eligible alien status from a family, reexamination of family incomes, collection of rents, termination of tenancy and eviction, and all repair and maintenance functions (including ordinary and extraordinary maintenance and replacement of capital items). All functions must be performed in compliance with Equal Opportunity requirements.

* * * * *

§ 883.704 [Amended]

52. A new sentence is added at the end of § 883.704(c)(1), to read as follows:

* * * * *

(c) * * *

(1) * * * At the time of the annual reexamination of family income and composition, the owner shall require the family to submit evidence of citizenship or eligible alien status of family members in accordance with § 812.5.

* * * * *

53. A new sentence is added at the end of Section 883.704(c)(3) to read as follows:

* * * * *

(c) * * *

(3) * * * For provisions requiring

termination of assistance because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(2).

54. Section 883.708(b)(3) is revised to read as follows:

§ 883.708 Termination of tenancy and modification of lease.

* * * * *

(b) * * *

(3) *Material noncompliance.* Material noncompliance with the lease includes: (i) One or more substantial violations of the lease, or (ii) repeated minor violations of the lease that disrupt the livability of the building, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related facilities, interfere with the management of the building or have an adverse financial effect on the building or project. Failure of the family to timely submit all required information on family income and composition (including required evidence of citizenship or eligible alien status) will constitute a substantial violation of the lease. Nonpayment of rent or any other financial obligation due under the lease (including any portion thereof) beyond any grace period permitted under State law will constitute a substantial violation of the lease. The payment of rent or any other financial obligation due under the lease after the due date but within the grace period permitted under State law will constitute a minor violation.

* * * * *

PART 884—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM, NEW CONSTRUCTION SET-ASIDE FOR SECTION 515 RURAL RENTAL HOUSING PROJECTS

53. The authority citation for Part 884 continues to read as follows:

Authority: Secs. 3, 5, and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, 1437f); sec. 7(d), Dept. of HUD Act (42 U.S.C. 3535(d))

55. Section 884.118(a)(3) and (a)(7) are revised to read as follows:

§ 884.118 Responsibilities of the owner.

(a) * * *

(3) Performance of all management functions. These functions include taking of applications, determination of eligibility (that the applicant is a Family, is income-eligible for admission, and has submitted required evidence of citizenship or eligible alien status in accordance with Part 812), selection of applicants, determination of the amount of Tenant Rent in accordance with Part 813, collection of rents.

* * * * *

(7) Reexamination of Family income and composition, and redetermination, as appropriate, of the amount of Tenant Rent and the amount of housing assistance payment in accordance with Part 813, and obtaining evidence of citizenship or eligible alien status from a Family at annual reexamination in accordance with Part 812.

* * * * *

§ 884.216 [Amended]

56. A new sentence is added at the end of § 884.216 to read as follows:

* * * Failure to submit evidence of citizenship or eligible alien status in accordance with Part 812 shall be grounds for termination of tenancy.

§ 884.218 [Amended]

57. A new sentence is added at the end of § 884.218(a), to read as follows:

(a) * * * At the time of the annual reexamination of family income and composition, the owner shall require the Family to submit evidence of citizenship or eligible alien status of Family members in accordance with § 812.5.

* * * * *

§ 884.218 [Amended]

58. A new sentence is added at the end of § 884.218(c), to read as follows:

* * * * *

(c) * * * For provisions requiring termination of assistance because of failure to submit evidence of citizenship or eligible alien status, see § 812.7(b)(2).

59. Section 884.223 is amended by adding, at the end of § 884.223, a new paragraph (e), to read as follows:

§ 884.223 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased at any time, in accordance with HUD regulations then in effect, but the owner is required to terminate housing assistance payments for the family in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), the owner may allow continued occupancy of the unit by the family without Section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

PART 886—SECTION 8 HOUSING ASSISTANCE PAYMENTS

Subpart A—Additional Assistance Program for Projects With HUD-Insured and HUD Held Mortgages

60. The authority citation for Part 886 continues to read as follows:

Authority: Secs. 3, 5, and 8, United States Housing Act of 1937 (42 U.S.C. 1437a, 1437c, and 1437f); sec. 7(d), Department of HUD Act (42 U.S.C. 3535(d)).

61. Section 886.119 (a)(3) and (a)(7) are revised to read as follows:

§ 886.119 Responsibilities of the owner.

(a) * * *

(3) Performance of all management functions. These functions include taking of applications, determination of eligibility (that the applicant is a Family, is income-eligible for admission, and has submitted required evidence of citizenship or eligible alien status in accordance with Part 812), selection of applicants, determination of the amount of Tenant Rent in accordance with Part 813, collection of rent.

* * * * *

(7) Reexamination of Family income and composition, and redetermination, as appropriate, of the amount of Tenant Rent and the amount of housing assistance payment in accordance with Part 813, collection of rent, and obtaining evidence of citizenship or eligible alien status from a Family at annual reexamination in accordance with Part 812.

* * * * *

62. Section 886.129 is amended by adding a new paragraph (e), to read as follows:

§ 886.129 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased with Section 8 assistance at any time, in accordance with HUD regulations then in effect, but the owner is required to terminate housing assistance payments for the family in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), after termination of section 8 assistance the owner may allow continued occupancy of the unit by the family without section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

Subpart C—Section 8 Housing Assistance Program for the Disposition of HUD-Owned Projects

63. Section 886.328(b)(3) is revised to read as follows:

§ 886.328 Termination of tenancy and modification of lease.

* * * * *

(b) * * *

(3) *Material noncompliance.* Material noncompliance with the lease includes: (i) One or more substantial violations of the lease, or (ii) repeated minor violations of the lease that disrupt the livability of the building, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related facilities, interfere with the management of the building or have an adverse financial effect on the building. Failure of the family to timely submit all required information on family income and composition (including required evidence of citizenship or eligible alien status) will constitute a substantial violation of the lease. Nonpayment of rent or any other financial obligation due under the lease (including any portion thereof) beyond any grace period permitted under State law will constitute a substantial violation of the lease. The payment of rent or any other financial obligation due under the lease after the due date but within the grace period permitted under State law will constitute a minor violation.

64. Section 886.329 is amended by adding a new paragraph (e), to read as follows:

§ 886.329 Leasing to eligible families.

* * * * *

(e) *Termination of Assistance for Failure to Submit Evidence of Citizenship or Eligible Alien Status.* If an owner is subject to paragraphs (a) and (b) of this section, and if an assisted unit was leased with Section 8 assistance at any time, in accordance with HUD regulations then in effect, but the owner is required to terminate housing assistance payments for the family in accordance with § 812.7 (for failure to submit required evidence of citizenship or eligible alien status), after termination of section 8 assistance the owner may allow continued occupancy of the unit by the family without section 8 assistance. The owner must make the unit available for occupancy by an eligible family when the original family vacates the unit.

PART 912—DEFINITION OF FAMILY AND OTHER RELATED TERMS; OCCUPANCY BY SINGLE PERSONS

65. The authority citation for Part 912 is revised to read as follows:

Authority: Sec. 3, U.S. Housing Act of 1937 (42 U.S.C. 1437a); sec. 7(d), Dept of H.U.D. Act (42 U.S.C. 3535(d)). Part 912 is also issued under sec. 214, Housing and Community Development Act of 1980, as amended by sec. 329, Housing and Community Development Amendments of 1981 (42 U.S.C. 1436a).

66. Section 912.1 is retitled and revised to read as follows:

§ 912.1 Purpose and applicability.

(a) This part:

(1) defines the term Family and other related terms;

(2) prescribes criteria and procedures for occupancy by Single Persons who are not otherwise eligible by reason of qualification as an Elderly Family or as a Displaced Person or as the remaining member of a tenant family, and incorporates the statutory 15 percent limitation on assistance for Single Persons; and

(3) implements the statutory prohibition against making assistance under the U.S. Housing Act of 1937 ("Act") available for the benefit of ineligible aliens.

(b) This part is applicable to:

(1) Public Housing, including rental housing, the Turnkey III Homeownership Opportunity Program and other Public Housing homeownership programs, and Indian Housing (including the Mutual Help Homeownership Opportunity Program).

(2) Leased Housing assisted under sections 10(c) or 23 of the Act as in effect before amendment by the Housing and Community Development Act of 1974.

67. Section § 912.2 is revised to read as follows:

§ 912.2 Definitions.

Act. The U.S. Housing Act of 1937.

Assisted Dwelling Unit. A dwelling unit assisted under the programs covered by this Part (see § 912.1(b)).

Citizen. A citizen of the United States.

Current Participant. A Family for which an assisted lease was entered into for a lease term beginning before July 30, 1986.

Disabled person. A person who is under a disability as defined in section 223 of the Social Security Act or in section 102 of the Developmental Disabilities Services and Facilities Construction Amendments of 1970.

Displaced person. A person displaced by governmental action, or a person whose dwelling has been extensively damaged or destroyed as a result of a disaster declared or otherwise formally recognized pursuant to Federal disaster relief laws.

Elderly family. A Family whose head or spouse or whose sole member is at least sixty-two years of age, or a Disabled Person as defined in this section or a Handicapped Person as defined in this section. An Elderly Family may include two or more elderly, Disabled or Handicapped Persons living together, or one or more such persons living with another person who is determined to be essential to his or her care and well being.

Eligible alien. An alien who is a resident of the United States and is one of the following:

(1) An alien lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15) and 1101(a)(20));

(2) An alien who entered the United States before June 30, 1948, or such later date as enacted by law, has continuously maintained residence in the United States since then, and is not ineligible for citizenship, but who is deemed to be lawfully admitted for permanent residence as a result of an excercise of discretion by the Attorney General under section 249 of the Immigration and Nationality Act (8 U.S.C. 1259);

(3) An alien who is lawfully present in the United States pursuant to an admission under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or pursuant to the granting of asylum (which has not been terminated) under section 208 of such Act (8 U.S.C. 1158);

(4) An alien who is lawfully present in the United States as a result of being granted conditional entry under section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by castastrophic natural calamity;

(5) An alien who is lawfully present in the United States as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest under section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. 1182(d)(5)); or

(6) An alien who is lawfully present in the United States as a result of the Attorney General's withholding deportation under section 243(h) of the

Immigration and Nationality Act (8 U.S.C. 1253(h)).

Evidence of citizenship or eligible alien status ("evidence"). The documents which must be submitted in accordance with § 912.5 to show citizenship or eligible alien status or occupants of an assisted dwelling unit. The evidence consists of both:

(1) The documents described in paragraphs (b) and (c) of § 912.5, and

(2) A verification consent form.

Family. "Family" includes but is not limited to (1) an Elderly Family or Single Person as defined in this Part, (2) the remaining member of a tenant family, and (3) a Displaced Person.

Handicapped person. A person having a physical or mental impairment which (1) is expected to be of long continued and indefinite duration, (2) substantially impedes his or her ability to live independently, and (3) is of such a nature that such ability could be improved by more suitable housing conditions.

HUD. The U.S. Department of Housing and Urban Development.

Initial Implementation Period. The 90 day period beginning on July 30, 1986.

Single person. A person living alone or intending to live alone and who does not qualify as an Elderly or a Displaced Person as defined in this part, or as the remaining member of a tenant family.

Verification consent form. A written agreement by a Family, in the form prescribed by HUD, that:

(a) Any evidence submitted by the Family to the PHA may be released to HUD.

(b) Such evidence may also be released by the PHA to a party other than HUD for the following purposes: verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, or investigation or prosecution of fraud in connection with any Federal housing assistance program.

(c) HUD may release the evidence or other information to any Federal, State or local government agency (including the Social Security Administration and the Immigration and Naturalization Service) for the following purposes: verification of citizenship or eligible alien status, enforcement of restrictions on the availability of assistance because of such status, investigation or prosecution of fraud in connection with any Federal housing assistance program, or other purposes connected with administration of HUD programs.

(d) Any Federal, State or local government agency may release to HUD, or to the PHA, any information which HUD or the PHA determines to be necessary for verification of citizenship or eligible alien status, or enforcement of restrictions on availability of financial assistance because of such status.

68. Sections 912.5 through 912.7 are added as follows:

§ 912.5 Evidence of citizenship or eligible alien status.

(a) *Requirement for submission of evidence.* (1) Evidence of citizenship or eligible alien status shall be submitted in accordance with this section by each Family applying for admission to an assisted dwelling unit, and by each Family residing in an assisted dwelling unit.

(2) The required evidence of citizenship or eligible alien status shall be submitted by the Family for the Family head and spouse regardless of age, and for all other persons 18 years of age or older. The evidence shall be submitted for each Family member who is or will be an occupant of the assisted dwelling unit.

(3) The verification consent form shall be signed by each person for whom the information is submitted. Failure to submit required evidence of citizenship or eligible alien status shall result in denial or termination of assistance in accordance with § 912.7.

(4)(i) The required evidence shall be submitted by the Family to the PHA. The PHA is responsible for administering the restrictions on providing assistance to ineligible aliens, and shall exercise this responsibility in accordance with HUD requirements.

(ii) The PHA is not required to assist the Family in obtaining the evidence to be submitted, and is not required to determine the validity or authenticity of evidence submitted. If the PHA suspects that a document submitted is not valid or authentic, or suspects misrepresentation, the PHA shall inform HUD.

(5)(i)(A)(*1*) A Family shall (except as provided in § 912.5(a)(5)(i)(B), which concerns continuous assisted occupancy by a citizen) submit the required evidence of citizenship or eligible alien status at each annual reexamination.

(*2*) In the case of a Current Participant, the Family shall (except as provided in § 912.5(a)(5)(i)(B)) submit the required evidence at the first annual reexamination effective after the end of the Initial Implementation Period, and at each subsequent annual reexamination. (See provisions concerning notice to a Current Participant at § 912.6(b).)

(B) Submission of evidence that an occupant of the assisted dwelling unit is a citizen is only required one time during continuous assisted occupancy by the citizen.

(ii)(A) The Family shall request PHA approval for occupancy of the dwelling unit by any additional person for whom submission of evidence of citizenship or eligible alien status is required. The PHA shall not approve occupancy by the additional person until the evidence has been submitted.

(B) In the case of a Current Participant, § 912.5(a)(5)(ii)(A) is not applicable before the effective date of the first reexamination at which the Family is required to submit evidence of citizenship or eligible alien status pursuant to § 912.5(a)(5)(i)(A)(*2*).

(iii) When a member of the household (other than the head of household or spouse) reaches age of 18, evidence of the person's citizenship or eligible alien status must be submitted at the next annual reexamination.

(6) The requirement to submit evidence of citizenship or eligible alien status under this section shall not apply to a homebuyer under the Homeownership Opportunity Agreement or Mutual Help and Occupancy Agreement entered into before July 30, 1986.

(b) *Citizenship status.* (1) The original or a certified copy of one of the following documents shall be submitted to support a claim of citizenship status:

(i) U.S. Passport,

(ii) Birth Certificate,

(iii) Consular Report of Birth,

(iv) Naturalization Certificate (original only),

(v) Certificate of Citizenship (original only),

(vi) U.S. Citizenship Identification Card (INS form I–197),

(vii) Baptismal or other religious certificate which provides evidence of birth in the United States and was created within one year of birth,

(viii) A document issued by the Bureau of Indian Affairs and which indicates membership in a federally recognized tribe, or

(ix) Any other document designated by HUD.

(2) If none of the above documents can be obtained, and a person claiming to be a U.S. citizen provides a reasonable explanation of inability to obtain the document, a signed statement from a third party may be submitted. The third party must produce one of the above documents to evidence that the third party is a citizen, and must state under penalty of perjury that the person for whom the document is not available is a citizen, and the basis of this statement.

(c) *Eligible alien status.* (1) The original of one of the following

documents shall be submitted to support a claim of eligible alien status:

(i) Form I–151, Alien Registration Receipt Card (for permanent resident aliens);

(ii) Form I–551, Alien Registration Receipt Card (for permanent resident aliens);

(iii) Form I–181B, Processed for I–551, Temporary Evidence of Lawful Admission for Permanent Residence (for permanent resident aliens);

(iv) Passport stamped "processed for I–551, temporary evidence of lawful admission for permanent residence" (for permanent resident aliens);

(v) Form AR–3a, Alien Registration Receipt Card (Issued during 1941–1949 for permanent resident aliens);

(vi) Form I–94, Arrival-Departure Record (Annotated either "Section 207" or "Refugee," or "Section 208" or "Asylum");

(vii) Form I–94, Arrival-Departure Record—Parole Edition (Annotated "Section 212(d)(5)," or "Conditional Entry" or "Section 203(a)(7)");

(viii) Form I–94, Arrival-Departure Record (Annotated "Section 243(h)"); or

(ix) Any other document designated by HUD.

(2) A third party's statement or certification is not acceptable evidence of eligible alien status, and may not be submitted in lieu of the requirement to submit the documents listed in paragraph (c)(1) of this section.

(3) The following documents are not acceptable evidence of eligible alien status:

(i) Form I–94, Arrival-Departure Record: Annotated with any codes "A" through "L" for Non-Immigrants (for temporary resident aliens);

(ii) Form I–95A, Crewman's Landing Permits (for alien visitors);

(iii) Form I–144, Mexican Border Visitors Permit;

(iv) Form I–186, Nonresident Alien Mexican Border Crossing Card;

(v) Form I–185, Nonresident Alien Canadian Border Crossing Card;

(vi) Unnumbered form, Nonresident Alien Canadian Border Crossing Identification Card; or

(vii) Any Foreign issued Visa.

(d) *Retention of evidence.* A photocopy of each document (or the original if released by the person submitting the document), and a signed verification consent form, shall be retained by the PHA. However, a photocopy need not be made or retained of any document bearing an identifying serial number if a record of such serial number and other necessary identifying information is made and retained in such manner as shall be prescribed by the Department.

(e) *Disclosure of evidence.* Evidence of citizenship or eligible alien status submitted to the PHA by the Family shall be deemed to have been submitted in confidence. However, the evidence may be released by the PHA to HUD. The evidence may also be released by the PHA to a party other than HUD for these purposes:

(1) Verification of citizenship or eligible alien status,

(2) Enforcement of restrictions on the availability of assistance because of such status, or

(3) The investigation or prosecution of fraud in connection with any Federal housing assistance program.

(Information collection requirements in paragraph (a)(1) approved by the Office of Management and Budget under OMB control number 2577–0083)

§ 912.6 Notice to Applicants and Tenants.

(a) *Notice to Applicant.* Before admission of an applicant, the PHA shall give notice to the applicant that the applicant must submit evidence of citizenship or eligible alien status. An applicant may not be admitted unless the evidence has been submitted. See § 912.7(a).

(b) *Notice to Current Participant.* The PHA shall notify a Current Participant of the requirement to submit evidence of citizenship or eligible alien status no later than 75 days before the effective date of the first annual reexamination at which the Family is required (under § 912.5(a)(5)(i)(A)(*2*)) to submit such evidence.

(c) *Form of Notice.* A notice under this section of the requirement to submit evidence of citizenship or eligible alien status shall describe the evidence that must be submitted, and shall state when the evidence must be submitted. The notice shall be given in accordance with HUD requirements, and shall be in a form prescribed by HUD, or complying with HUD requirements.

§ 912.7 Denial or termination of assistance.

(a) *Denial of Assistance.* (1) The PHA shall not take any of the following actions unless required evidence of citizenship or eligible alien status has been submitted to the PHA in accordance with § 912.5:

(i) Admit an applicant,

(ii) Enter into a lease for an assisted dwelling unit (including entering into a lease extension or lease renewal for a family residing in an assisted dwelling unit),

(iii) Approve any additional person for occupancy of a assisted dwelling unit, or

(iv) Enter into a Turnkey III or Mutual Help homeownership opportunity agreement, or into any other new contractual commitment for public housing homeownership assistance.

(2)(i) With respect to a participant, the PHA may take actions described in paragraph (a)(1) (ii) or (iii) of this section although the Family has not yet submitted required evidence of citizenship or eligible alien status for a Family member to the PHA in accordance with § 912.5 if:

(A) The Family certifies that any person for whom required evidence has not been submitted by the Family is a citizen or eligible alien, but shows that the Family is temporarily unable to obtain evidence to support a claim of citizenship status (under § 912.5(b) (1) or (2)), or a claim of eligible alien status (under § 912.5(c)), and needs additional time to obtain and submit the evidence,

(B) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(C) the PHA decides, in the PHA's administrative discretion, to grant an extension of time for the Family to submit the evidence.

(ii) An extension under paragraph (d)(2)(i) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 912.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 912.5) to request the PHA's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(iii) The PHA's decision to grant an extension of the time for the Family to submit the evidence, and the PHA's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension, and the PHA may revoke an extension. The PHA may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the PHA shall promptly take action in accordance with § 912.7(b) to terminate the tenancy and

evict the Family. The PHA's decision to grant an extension shall be in writing, and shall state the reasons for the PHA determination. The PHA shall provide information required by HUD concerning the PHA's policy and practice regarding extensions.

(3) During the Initial Implementation Period, an applicant shall not lose its position on the PHA's waiting list because of the applicant's failure to submit required evidence.

(b) *Termination of Tenancy.* (1) Upon the occurrence of any of the following events, the PHA shall initiate promptly, and shall diligently pursue, action in accordance with Part 966 to terminate the tenancy, and to evict the Family by judicial action pursuant to State and local law:

(i) If evidence of citizenship or eligible alien status is not submitted by the family at reexamination when required,

(ii) If the Family fails to obtain PHA approval in accordance with § 912.5(a)(5)(ii) for occupancy of the dwelling unit by an additional person for whom submission of evidence of citizenship or alien status is required, or

(iii) If the PHA has admitted a Family, but the PHA is subsequently informed by HUD, or otherwise learns, that documents used to evidence citizenship or eligible alien status were fraudulently obtained or submitted, or are otherwise not valid or authentic evidence of such status.

(2) In the cases described in paragraphs (b)(1) (i) and (ii) of this section, the PHA is not required to take action to terminate the tenancy and evict the Family if:

(i) any person for whom required evidence has not been submitted by the Family has moved from the assisted dwelling unit, or

(ii)(A) the Family certifies that any person for whom required evidence has not been submitted by the Family is a citizen or eligible alien, but shows that the Family is unable to obtain evidence to support a claim of citizenship status (under § 912.5(b) (1) or (2)), or a claim of eligible alien status (under § 912.5(c)), and needs additional time to obtain and submit the evidence,

(B) The Family promises to make prompt and diligent efforts to obtain the evidence, and

(C) The PHA decides, in the PHA's administrative discretion, to grant an extension of time for the Family to submit the evidence.

(3) An extension under paragraph (b)(2)(ii) shall be for a specific period needed to obtain the evidence. Where the Family is required (under § 912.5) to submit the evidence at an annual reexamination, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after the effective date of the reexamination. Where the Family is required (under § 912.5) to request the PHA's approval for occupancy of the dwelling unit by an additional person, any extension or extensions granted by the PHA shall not allow submission of the evidence beyond ninety days after occupancy by the additional person.

(4) The PHA's decision to grant an extension of the time for the Family to submit the evidence, and the PHA's determination of the length of the extension, shall be made in accordance with HUD requirements, and after considering the facts and circumstances of the individual case. The Family shall not have any right to an extension of time to submit the evidence, and the PHA may revoke an extension. The PHA may only continue an extension if the Family is making diligent efforts to obtain the evidence, and if there is a reasonable likelihood that the Family will be able to submit the evidence during the extension. If the Family has not submitted the evidence by the end of the extension, the PHA shall promptly take action in accordance with § 912.7(b)(1) to terminate the tenancy and evict the Family in accordance with HUD requirements. The PHA's decision to grant an extension shall be in writing and shall state the reasons for the PHA determination. The PHA shall provide information requried by HUD concerning the PHA's policy and practice regarding extensions.

(5) The PHA may halt action to terminate tenancy and evict the Family if:

(i) All required evidence has been submitted by the Family to the PHA, and

(ii) Continuation of assistance is authorized in accordance with HUD requirements.

Dated: March 12, 1986.

Samuel R. Pierce, Jr.,

Secretary.

[FR Doc. 86-7050 Filed 3-31-86; 8:45 am]

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Federal Register

Tuesday
April 1, 1986

Part IV

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Hospital-Based Skilled Nursing Facility Cost Limits Effective for Cost Reporting Periods Beginning October 1, 1982, and July 1, 1984; Final Notice

Medicare Program; Update to Freestanding and Hospital-Based Skilled Nursing Facility Cost Limits Effective for Cost Reporting Periods Starting May 1, 1986; Final Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[BERC-333-FN]

Medicare Program; Hospital-Based Skilled Nursing Facility Cost Limits Effective for Cost Reporting Periods Beginning October 1, 1982, and July 1, 1984.

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This schedule of limits revises the single Medicare reimbursement limit that was published in the **Federal Register** (47 FR 42894) on September 29, 1982 insofar as that notice applied to hospital-based skilled nursing facility (SNF) inpatient routine service costs. Freestanding SNF cost limits are not affected by this notice.

EFFECTIVE DATES: Under this notice different cost limit schedules apply to hospital-based SNFs for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, and for cost reporting periods beginning on or after July 1, 1984.

FOR FURTHER INFORMATION CONTACT: Steve Kirsh (301) 594-9465.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1861(v)(1) of the Social Security Act (the Act) authorizes the Secretary to set limits on allowable costs incurred by a provider of services that will be reimbursed under Medicare. These limits are based on estimates of the costs necessary for the efficient delivery of needed health services. Implementing regulations appear at 42 CFR 405.460.

Under this authority, we published in the **Federal Register** (47 FR 42894) on September 29, 1982, a schedule of limits applicable to cost reporting periods beginning on or after October 1, 1982. That schedule consists of a single set of cost limits for hospital-based and freestanding SNFs, as required by section 102 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). Section 102 added section 1861(v)(1)(E)(i) to the Act, which eliminated separate limits for hospital-based and freestanding SNFs for cost reporting periods beginning on or after October 1, 1982. Subsequently, section 605 of the Social Security Amendments of 1983 (Pub. L. 98-21, enacted on April 20, 1983) placed a one-year moratorium on the application of section 102 (that is, the single limits).

II. Deficit Reduction Act of 1984

Section 2319 of the Deficit Reduction Act of 1984 (Pub. L. 98-369), enacted on July 18, 1984, revised sections 1861(v)(1)(E) and (v)(7) of the Act and added a new section 1888 to the Act. This legislation provides new authority for the payment of routine service costs to SNFs and requires that separate limits apply to hospital-based and freestanding SNFs. Section 2319 of Pub. L. 98-369 also provides that, for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, the cost limits for routine services for urban and rural hospital-based SNFs must be 112 percent of the mean of the respective routine costs for urban and rural hospital-based skilled nursing facilities.

Prior to the September 29, 1982 schedule of single limits (required by Pub. L. 97-248), we published separate schedules. Under these schedules, the SNF cost limits for inpatient routine services were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs, respectively. Further, the routine costs considered for each comparison group were the routine costs attributable to the particular group, and these costs were divided between labor-related costs and nonlabor costs in urban and rural standard metropolitan statistical areas (SMSAs) (and New England County Metropolitan Areas (NECMAs)) as defined by the Bureau of Labor Statistics (BLS). The comparison groups were as follows:

- Hospital-based SNFs—SMSA (urban)
- Hospital-based SNFs—Non-SMSA (rural)
- Freestanding SNFs—SMSA (urban)
- Freestanding SNFs—Non-SMSA (rural)

Section 2319 of Pub. L. 98-369 also provides that for cost reporting periods beginning on or after July 1, 1984—

- Separate cost limits for hospital-based and freestanding SNFs must continue;
- Cost limits for freestanding SNFs must continue to be 112 percent of the mean freestanding inpatient routine service costs for SNFs in both urban and rural areas;
- Cost limits for hospital-based SNFs must be set at the appropriate freestanding limit plus 50 percent of the difference between the freestanding limit and 112 percent of mean hospital-based inpatient routine service costs for both urban and rural SNFs; and
- Cost differences between hospital-based and freestanding SNFs attributable to excess overhead allocations resulting from Medicare reimbursement principles are to be recognized as an add-on to the cost limit for hospital-based SNFs, as determined by the Secretary.

On November 22, 1985, we issued a proposed schedule of limits for public comment (50 FR 48313). This notice implements the changes for hospital-based SNF cost limits mandated by section 2319 of Pub. L. 98-369 for cost reporting periods beginning on or after October 1, 1982. The freestanding SNF cost limits remain the same as those published in the September 29, 1982 cost limits notice.

III. Tables and Appendices

This notice contains the following tables and appendices which are presented after section X. below:

Cost Reporting Periods Beginning on or After October 1, 1982 and before July 1, 1984

Table A-I—Hospital-based SNF Group Limits
Table A-II—Wage Index for Urban Areas
Table A-III—Wage Index for Rural Areas
Table A-IV—Cost Reporting Year Adjustment Factors
Appendix A-I—Derivation of Market Basket Index for SNF Routine Service Costs.
Appendix A-II—SMSA/NECMA Constituent Counties

Cost Reporting Periods Beginning on or After July 1, 1984

Table B-I—Hospital-based SNF Group Limits
Table B-II—Wage Index for Urban Areas
Table B-III—Wage Index for Rural Areas
Table B-IV—Cost Reporting Year Adjustment Factors
Appendix B-I—Derivation of Market Basket Index for SNF Routine Service Costs.

IV. Hospital-Based SNF Limits—Major Provisions

In this notice, there are two revised schedules of cost limits for hospital based SNFs. One schedule applies to cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984 (see table A-I). The other applies to cost reporting periods beginning on or after July 1, 1984 (see table B-I). These revised schedules of limits provide for the following:

A. Excluded Costs

For hospital-based SNFs, we are adjusting the limits on SNF per diem

inpatient routine services costs by excluding capital-related costs (see section IX. **Methodology for Determining Per Diem Routine Service Cost Limit**). We are also adjusting inpatient routine service costs in the data base to reflect the elimination of the inpatient routine nursing salary costs differential (see section V. **Summary of Changes in Methodology**).

B. Urban/Rural Location

We are using a classification system based on whether a SNF is located within an SMSA or metropolitan statistical area (MSA) (see section V.).

C. Data

We are using actual SNF routine service per diem cost data from Medicare cost reports to derive the limits (see section IX.).

D. Market Basket

We are using a market basket index that we developed to reflect changes in the prices of goods and services purchased by SNFs (see sections V. and VI. **Summary of Retained Methodology**; Appendix A–I for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984; and Appendix B–I for cost reporting periods beginning on or after July 1, 1984).

E. Wage Index

We are including a wage index for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984 (see Tables A–II and A–III) and an updated wage index for cost reporting periods beginning on or after July 1, 1984 (see Tables B–II and B–III). (See sections V. and VI. for discussions of the wage index.)

F. Cost of Living Adjustment

We are including a cost of living adjustment to the nonlabor component of the limits for SNFs located in Alaska, Hawaii, Puerto Rico and the Virgin Islands (See section VI.).

G. Computation of the Limits

For cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, we are setting the hospital-based SNF limits at 112 percent of the mean per diem routine service costs of each hospital-based group (that is, urban or rural).

Separate limits for hospital-based and freestanding SNFs continue for cost reporting periods beginning on or after July 1, 1984. The separate limit for freestanding SNFs in urban and rural areas continues to be 112 percent of the mean per diem routine service costs of urban and rural freestanding facilities, respectively. However, we are setting limits for urban and rural hospital-based SNFs at the appropriate limit applicable to freestanding facilities plus 50 percent of the difference between the limit for freestanding facilities and 112 percent of the mean per diem routine service costs for hospital-based facilities. We also provide for an amount for hospital-based SNFs to which we refer as the administrative and general (A&G) "add-on", as described in section V. below. The add-on adjustment is specifically related to the allocation of costs in the A&G cost center.

H. Schedule of Limits

Based on the methodology described above, we developed a revised schedule of per diem dollar limits (see Tables A–I and B–I).

V. Summary of Changes in Methodology

The revised schedules of limits incorporate the following changes in the methodology used to determine the cost limits (that is, changes from the previous methodology applicable to cost reporting periods beginning on or after October 1, 1981 and before October 1, 1982):

A. Changes Applicable to Cost Reporting Periods Beginning on or After October 1, 1982 and Before July 1, 1984

1. Statutory Change. We are using separate schedules of limits for hospital-based and freestanding SNFs and the SNFs are paid on the basis of the policy for calculating limits for reimbursement that was in effect prior to the passage of Pub. L. 98–369.

Under this system, the limits for freestanding facilities are set at 112 percent of the mean per diem routine service costs for freestanding urban and rural facilities, respectively. Similarly, the limits for hospital-based facilities are set at 112 percent of the mean per diem routine service costs for urban and rural hospital-based facilities, respectively.

2. Elimination of inpatient routine nursing salary cost differential. In the past, we recognize a per diem rate above the facility's average costs for all patients for inpatient routine nursing care furnished to aged Medicare patients. (The differential was also applied to pediatric and maternity patients, who also are assumed to require a greater amount of routine nursing services than other patients.) This was called the "nursing salary cost differential". The differential was not an add-on to the total routine nursing salary costs incurred by a provider, but rather a reallocation of the actual routine nursing salary costs between aged, pediatric, and maternity patients and all other classes of patients. It presumed that, on the average, aged pediatric and maternity patients receive more routine nursing services than do other patients.

The effect of the nursing differential was that the Medicare program recognized a higher than average routine per diem cost for aged, pediatric, and maternity patients and a lower than average per diem cost for all other classes of patients. (Disabled Medicare beneficiaries are counted in the "all other" category unless they are also pediatric or maternity patients, and the lower than average per diem is applicable to that class of patient.)

The total impact of the differential on a particular facility's Medicare reimbursement varied, depending on the provider's patient mix. If all of the provider's patients were aged, pediatric, and maternity, no differential was applicable.

We recognized a nursing salary differential equal to 8.5 percent of the provider's average per diem nursing salary for SNFs. In response to evidence indicating that the differential was not warranted, Congress enacted section 103 of Pub. L. 97–248 which amended section 1861(v)(1) of the Act to state that "regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities." According to its terms, section 103 is effective for all cost reporting periods subject to the cost limits provided in this notice. Therefore, the limits properly do not recognize any nursing salary cost differential.

Section 103 has also necessitated an adjustment of the cost limits because all of our current cost report data incorporates the inpatient routine nursing salary differential in Medicare costs. We are adjusting the SNF data to exclude the differential and the cost limits in this notice reflect this adjustment. Because the majority of days of care in a SNF are aged days, the effect of the adjustment on the limit is not significant.

3. Use of combined wage index. We are changing the methodology used to compute the limits to include a combined wage index. This change is purely technical and, as discussed further below, has no effect on the amount of the limit for any SNF.

In developing and applying the 1979, 1980, and 1981 cost limit schedules, we

used a hospital wage index to account for differences in the level of labor-related costs among the areas in which SNFs are located. To develop this wage index, we first calculated the national average wage for hospital workers in urban (SMSA or NECMA) areas, and a separate national average wage for hospital workers in nonurban (that is, non-SMSA and non-NECMA) areas. We then divided the average wage for each urban and nonurban area by the appropriate national average (urban and nonurban). This calculation resulted in a separate index value for each urban area that reflected the wage level for that area relative to the national average of all urban areas. The calculation also resulted in an index value for each nonurban area that reflected the wage level for that area relative to the national average for all nonurban areas. We call this type of index, which relates the average wage for each individual area to separate urban or nonurban national averages, a "split" index.

Because the wage index we used to calculate the September 30, 1981, limits is a split index, there are some cases in which the index value for an urban area is lower than the value for an adjacent nonurban area. The use of the split index has caused concern and confusion among SNFs in urban areas. To avoid further confusion on this point, we have, in developing the hospital-based SNF limits in this notice, used a "combined" wage index that relates the average area wages for both urban and nonurban areas to a single national average wage for all areas. Although the change from a split to a combined wage index has no effect on either the accuracy or the dollar amount of any SNF's limit, we believe use of a combined index will permit direct comparison of the index values for urban and rural, and thus make it easier for SNFs to understand how the wage index values for their areas were computed. The following example demonstrates that the final result using a split wage index, is identical.

Example

(1) *Split Wage Index* = .8824. Labor share = $44.33. Labor deflated costs: $44.33 divided by .8824 = $50.24. Mean labor deflated costs = $45.85. Area labor share limit: $45.85 times .8824 = $40.46.

(2) *Combined Wage Index* = .9894. Labor share = $44.33. Labor deflated costs: $44.33 divided by .9894 = $44.80. Mean labor deflated costs = $40.89. Area labor share limit: $40.89 times .9894 = $40.46.

The following hypothetical sample array is the source of the data used in this example. The split and combined wage index used in the hypothetical sample array were derived as shown below.

HYPOTHETICAL SAMPLE

Area	Average monthly hospital wage	Split wage index	Combined wage index
1	$900	0.7059	0.7916
2	1,050	0.8235	0.9235
3	1,125	0.8824	0.9894
4	1,500	1.1765	1.3193
5	1,800	1.4118	1.5831
Total	6,375		

Urban or rural national average monthly hospital wage equals total urban or rural average monthly hospital wage divided by number urban or rural areas equals—

$$\frac{6375}{5} = \$1,275$$

Combined national average monthly hospital wage equals total urban average monthly hospital wages plus total rural average monthly hospital wages* divided by number urban areas plus number rural areas equals—

$$\frac{6375 + 4990^*}{10} = \$1,137$$

*Total rural average monthly hospital wages are computed from average monthly hospital wages for five rural areas.

Example

(1) *Computation of Split Wage Index.* Area 1 average monthly hospital wage = $900. Urban or rural national average monthly hospital wage = $1275. Area 1 split wage index: $900 divided by $1275 = .7059.

(2) *Computation of Combined Wage Index.* Area 1 average monthly hospital wage = $900. Combined national average monthly hospital wage = $1137. Area 1 combined wage index: $900 divided by $1137 = .7916.

HYPOTHETICAL SAMPLE ARRAY

Area (1)	Labor Share 60.22 (2)	Wage index (3)		Labor deflated cost [1] using (4)	
		Split	Combined	Split wage index	Combined wage index
1	40.10	.7059	.7916	56.81	50.66
2	37.50	.8235	.9235	45.54	40.61
3	44.33	.8824	.9894	50.24	44.80
4	51.32	1.1765	1.3193	43.62	38.90
5	46.65	1.4118	1.5831	33.04	29.47
Mean labor deflated arrayed costs equal				$45.85	$40.89

[1] Column 2 divided by corresponding value in column 3.

Area (5)	Wage index (6)		Mean labor deflated cost (7)		Area limit (8)	
	Split	Combined	Split wage index	Combined wage index	(Labor share) [1] split wage index	Using combined wage index
1	.7059	.7916	45.85	40.89	32.37	32.37
2	.8235	.9235	45.85	40.89	37.76	37.76
3	.8824	.9894	45.85	40.89	40.46	40.46
4	1.1765	1.3193	45.85	40.89	53.94	53.94
5	1.4118	1.5831	45.85	40.89	64.73	64.73

[1] Column 7 multiplied by appropriate value in column 6.

In developing the wage index for the limits, we have also used approximate, rather than actual, index values for some areas. (These approximate values are identified by asterisks in Tables A–II, A–III, B–II, and B–III.) We have done this because the BLS, which supplies the data on wages and numbers of employees that we use to calculate the wage index, has informed us that its confidentiality requirements prohibit it from disclosing actual data for areas that include fewer than three reporting units. (A reporting unit need not be a single hospital. "Reporting unit" is defined by BLS as the smallest unit for which data are recorded on the employer's contribution report. For example, two facilities in the same area owned by one employer could appear as one reporting unit.) To make it possible to calculate limits for these areas, we asked the BLS to identify the areas having wage index values numerically closest to, but not less than, the areas for which it cannot supply actual data.

In the case of each area for which actual data are unavailable, we have substituted the wage index value identified by BLS as being closest to the actual value. We believe that the use of approximate rather than actual values for these areas will not affect the accuracy of the limits significantly, and will assure that no SNF's limit is reduced because actual data for its area are unavailable.

We have also, in developing the wage index used for the limits, excluded data for Federal government hospitals. Because these hospitals typically use national pay scales, the amounts they pay their employees do not necessarily reflect area wage levels. They also do not normally participate in the Medicare program and, therefore, excluding these data is appropriate. For cost reporting periods beginning on or after October 1, 1982 through June 30, 1984, we have included wage indexes in Table A–II for those newly designated SMSAs and NECMAs that were classified as such as a result of the 1980 census. (See appendix A–II for listing of newly designated SMSAs and NECMAs.) For cost reporting periods beginning on or after July 1, 1984, we have changed designations from SMSA to MSA as discussed in paragraph B.2. below. In addition, we now have wage indexes for Puerto Rico. This means that the hospital-based cost limits in this notice can now be applied to SNFs in Puerto Rico. (See Tables A–II, A–III, B–II and B–III.)

B. Changes Applicable To Cost Reporting Periods Beginning on or After July 1, 1984

1. Statutory Changes

a. We are using separate schedules of limits for hospital-based and freestanding SNFs.

b. The cost limits for hospital-based SNFs in *urban* areas is equal to the limit for freestanding SNFs located in urban areas plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs located in urban areas exceeds the limit for freestanding SNFs located in urban areas plus the A&G add-on.

c. The cost limits for hospital-based SNFs in *rural* areas is equal to the limit for freestanding SNFs located in rural areas plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs located in rural areas exceeds the limit for freestanding SNFs located in rural areas plus the A&G add-on.

The following illustration is provided for the calculations of the hospital-based SNF limits for cost reporting periods beginning on or after July 1, 1984 (Table B–I):

COST LIMIT DATA HOSPITAL-BASED SNFs

	Urban (MSA)	Rural (Non-MSA)
112% of hospital-based mean cost:		
Labor	$88.36	$76.13
Non-labor	22.22	15.18
Total	110.58	91.31

CALCULATION OF 50% DIFFERENCE BETWEEN 112% OF HOSPITAL-BASED MEAN COST AND THE FREESTANDING LIMIT

	Labor	Non-labor
Urban (MSA):		
112% of hospital-based mean cost	$88.36	$22.22
Freestanding SNF limit (47 FR 42894)*	−43.91	−12.09
Difference	44.45	10.13
50% of difference	22.23	5.07
plus Freestanding SNF limit (47 FR 42894)*	43.91	12.09
Hospital-based SNF limit	66.14	17.16
Rural (Non-MSA):		
112% of hospital-based mean cost	76.13	15.18
Freestanding SNF Limit (47 FR 42894)*	−46.61	−10.48
Difference	29.52	4.70
50% of difference	14.76	2.35
plus Freestanding SNF Limit (47 FR 42894)*	46.61	10.48
Hospital-based SNF limit	61.37	12.83

* Limit adjusted to July 1, 1984.

d. The A&G add-on is calculated by first determining the difference in average A&G per diem costs allocated directly to the inpatient routine SNF cost center between hospital-based and freestanding SNFs in MSA and non-MSA locations. This difference is then divided by the appropriate hospital-based SNF's average routine cost per diem to arrive at the percentage of A&G costs in routine cost per diem. The percentage is then multiplied by 50 percent of the amount that 112% of the hospital-based mean cost exceeds the freestanding limit, as described above.

The resulting amount is then subtracted from the A&G difference between hospital-based and freestanding SNFs. This adjustment is made so that the A&G add-on does not duplicate the portion of the dollar difference of A&G costs already contained in 50 percent of the amount by which 112% of the hospital-based mean cost exceeds the freestanding limits.

The resulting A&G amount is multiplied by the percentage of SNF costs attributable to wages, fringe benefits, health service costs, business service costs, and other miscellaneous expenses to arrive at the labor and nonlabor dollar amounts in Table B–I. The A&G add-on is then added to the hospital-based limits.

After examining the expenses that constitute the bulk of the cost differences between hospital-based and freestanding facilities, we have concluded that, apart from the A&G cost center, the allocation procedures are not the chief contributor to the cost difference between the two types of facilities. We note that hospitals and SNFs, regardless of type, use the same rules of allocation.

The following illustrates our calculation of the A&G add-on:

	Urban	Rural
A&G difference:		
1. Hospital-based SNF A&G mean*	$8.11	$6.46
2. Freestanding SNF A&G mean*	−3.63	−3.64
3. Difference	$4.48	$2.82
Amount of A&G included in the 50% difference between 112% of the hospital- based mean cost and the freestanding limit:		
4. A&G difference (from line 3)	$4.48	$2.82
5. Average Routine Cost (112% of the Hospital-based SNF mean cost equals $110.58 divided by 112% for urban area and $91.31 divided by 112% for rural area)*	$98.73	$81.53
6. Percent of A&G Difference to Routine Cost (line 4 divided by line 5)	4.54	3.46
7. Fifty percent of difference between 112% of the hospital-based SNF mean cost and freestanding SNF limit	$27.30	$17.11
8. Amount of A&G Difference included on line 7 (line 6 times line 7)	$1.24	$0.59
A&G Add-On:		
9. A&G difference from line 3	$4.48	$2.82
10. Less Amount from line 8	−1.24	−.59
11. A&G Add-on (line 9 less line 10)	$3.24	$2.23
	Labor	Non-labor
Urban A&G add-on = $3.24	$2.64	$0.60
Rural A&G add-on = $2.23	$1.82	$0.41

*Wage deflated means.
*See computation for total cost limit date for hospital-based SNFs in section VII.

2. Other Changes

a. The classification system used to develop the limits contains a technical change regarding the definition of urban and nonurban Areas. Schedules of limits previously published used SMSAs and non-SMSAs (and NECMAs and non-NECMAs in New England) to designate urban and nonurban locations.

On June 30, 1983, OMB implemented changes in the terminology and definitions that it uses to classify urban areas (OMB press release dated June 27, 1983, OMB–83–20). Effective June 30, 1983 the term "standard metropolitan statistical areas" was replaced by the

term "metropolitan statistical areas (MSAs)".

An MSA is a geographical area having a large population nucleus with adjacent communities that have a high degree of economic and social integration with the population nucleus. SMSA definitions were first developed and issued about 30 years ago.

Data available for metropolitan areas include statistics on population, housing, industry, trade, current employment and payroll data, local housing markets, and labor markets.

The changes in terminology and definitions implemented by OMB on June 30, 1983 resulted from a complete review of all metropolitan area data. OMB used commuting and other statistics from the 1980 census and new standards for establishing and defining MSAs. A comprehensive review and revision of metropolitan area definitions is undertaken every ten years following the completion of each decennial census.

MSAs are designated and defined following a set of standards prepared by the Federal Committee on MSAs, which advises OMB on metropolitan area definitions. Under the 1980 standards, an area qualifies for recognition as an MSA in one of two ways: (1) A city of at least 50,000 population, or (2) an urbanized area of at least 50,000 with a total metropolitan population of at least 100,000. In addition to the county containing the main city, an MSA may also include additional counties that have close economic and social ties to the central county. MSAs are defined in terms of entire counties, except in the six New England States. (OMB press release dated January 5, 1983, OMB–83–1.)

The MSA definitions and wage indexes are incorporated into the schedule of limits for cost reporting periods beginning on or after July 1, 1984.

b. For cost reporting periods beginning on or after July 1, 1984, we are making an adjustment to the limits if the estimated market basket index rate, as explained in section VI., differs from the actual rate by at least 3/10 of one percentage point. This is a change from the market basket adjustment used in the September 29, 1982 notice because in that notice the limits were adjusted to reflect the actual rate of increase in the market basket index only when the actual rate of increase exceeded the estimated rate by at least 3/10 of one percentage point. This schedule allows for an adjustment to the limits whenever the actual rate differs from the estimated rate by at least 3/10 of one percentage point (that is, higher or lower). This change will continue the protection afforded SNFs when the rate of increase in the prices of the goods and services they consume is greater than the estimated rate assumed by the limits. It also assures that expenditures are not in excess of a level appropriate to economic trends during the time the limits are in effect, thus moderating the financial pressures on the Medicare Trust Fund. This policy change allows the trust fund to benefit from any moderation in the rate of inflation, which is in the interest of current and future Medicare beneficiaries. By utilizing the actual rate in the market basket index, the limits more accurately reflect price changes that occur during the time the limits are in effect.

Following the end of each year that the limits are in effect, HCFA will determine the actual rate of increase or decrease in the market basket for the year. The data necessary to make this determination are usually available in the second quarter of the following year. This allows us to make the determination of the actual rate by June 30 of each year. If the actual rate differs from the estimated rate by at least 3/10 of one percentage point, the limits will be adjusted to reflect the actual rate of increase or decrease in the market basket for the preceding year. We will advise the intermediaries of these adjusted limits and publish them in the **Federal Register.** The adjusted limits will be used by the intermediaries to determine the amount of the final settlement for the cost reporting periods ending in the year for which the actual rate of increase or decrease has been determined.

VI. Summary of Retained Methodology

The following discussion summarizes the elments that we have retained for hospital-based SNFs from the methodology that was applicable to cost reporting periods beginning on or after October 1, 1981 and prior to October 1, 1982.

A. Separate Group Limits for Labor-Related and Nonlabor Components of Per Diem Routine Service Costs

We have retained separate group limits for the labor-related and nonlabor components of per diem routine service cost. We calculate these separate limits by first obtaining actual SNF per diem inpatient routine service cost data for each SNF. Next, to make the data reflect current conditions more accurately, we adjust the data from the midpoints of the cost reporting periods represented in the data collection to the midpoint of the initial cost reporting period to which the limits would apply. We then separate each SNF's per diem cost into labor-related and nonlabor portions, and divide the labor-related portion by the wage index for the SNF's location (see section B. below). We then compute separate group means for the labor-related and nonlabor components and multiply each group mean by 112 percent.

B. Adjustment of SNF Cost Data by Wage Index

We are again using a hospital industry wage index to account for area wage differences. Use of the hospital industry index is necessary since industry-specific data are not available on SNF wages. Because hospitals and SNFs generally compete in essentially the same labor market for employees, we believe an index based on geographic variations in hospital wages provides an accurate measure of geographic variations in wages paid by SNFs.

We developed the wage index from hospital wage data obtained from the BLS. The data used are those for the "hospital industry", a standard BLS reporting category. For cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, the wage indices are based on data for calendar year 1980 equivalent to those published in the **Federal Register** on September 29, 1982 (47 FR 42894) for freestanding SNFs. For cost reporting periods beginning on or after July 1, 1984, the wage indices are based on data for calendar year 1983.

We have been advised by the BLS that the wage index values for some areas are based on estimated 1983 data and may need to be revised based on actual data that were not available when we computed the wage index values shown in Tables B–II and B–III. If we receive additional 1983 data that require further changes in any wage index, we will notify the Medicare intermediaries of the corrected index and will direct them to recalculate the limits for the affected SNFs.

C. Use of SNF Market Basket

We have continued to base the cost limits on reported costs, adjusted for actual and projected cost increases by applying the SNF market basket index. This market basket is used to adjust the SNF cost data to reflect cost increases occurring between the cost reporting periods represented in the data collection to the midpoints of the cost reporting periods to which the limits would apply.

The market basket comprises the most commonly used categories of SNF routine service expenses. The categories

we are using are based primarily on those used by the National Center for Health Statistics in its National Nursing Home Surveys.

The categories of expenses are weighted according to the estimated proportion of SNF routine service costs attributable to each category (see appendices A–I and B–I). The weights for all major categories of SNF costs are based on the National Nursing Home Surveys for 1972 and 1976. These are the most current and comprehensive sources of national data on the distribution of costs in SNFs. (The second column of the appendices specifies the weights used for each category.)

In developing the market basket index, we obtained historical and projected rates of increase in the prices of goods and services in each category. The market basket index table, in the third and fourth columns, identifies the price variables used and the source of the forecast for calendar years 1980 through 1984 (Appendix A–1) and 1981 through 1986 (appendix B–1).

The market basket index also provides for adjustments to be made in the limits if our forecasts of economic trends prove erroneous. For cost reporting periods beginning on or after October 1, 1982 through June 30, 1984, if the final rate of increase in the market basket index for a year exceeds the estimated rate of increase by at least .3 of one percentage point the limits will be adjusted. For cost reporting periods beginning on or after July 1, 1984, if the final rate *differs* from the estimated rate of increase by at least .3 of one percentage point, the limits will be adjusted. We will advise the Medicare intermediaries to use the actual rate to adjust each SNF's limit at final settlement of the SNF's cost report.

D. Application of the Hospital Wage Index to Employee Benefits, Health Service Costs, Costs of Business Services, and Other Miscellaneous Expenses

In developing the current schedule, we applied the wage index discussed above to five categories of labor-related costs: Wages, employee benefits, health service costs, business service costs, and other miscellaneous costs.

We have retained this method in developing this revised schedule of limits. The proportion of adjusted routine service costs we adjust by the wage index is 80.22 percent for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, and 81.411 percent for cost reporting periods beginning on or after July 1, 1984.

For purposes of applying the wage index, employee benefits include such items as FICA tax, health insurance, life insurance, facility contributions to employee retirement funds, and all other compensation that the SNF records in the "employee health and welfare" cost center on its Medicare cost report. (The Medicare Provider Reimbursement Manual, HCFA-Pub. 15–I, Chapter 4, and the instructions to the HCFA cost reporting forms, HCFA-Pub. 15–II, describe the types of costs that are to be recorded in that cost center.)

Health service costs are a category used by the National Nursing Home Survey conducted in 1977 by the Office of Health Research, Statistics and Technology, National Center for Health Statistics of the Public Health Services. They include the costs of routine services that are purchased under arrangement from outside sources.

Business services costs include costs of banking, contract laundry, telephone, and other services SNFs purchase at retail from outside suppliers.

Other miscellaneous costs include various types of routine operating costs not allocated to any other category of the market basket.

Thus, we are applying the wage index to the total portion of cost (80.22 or 81.411 percent as appropriate) attributable to wages, fringe benefits, health service costs, business service costs, and other miscellaneous expenses rather than to the wage portion (61.26 percent for cost reporting periods beginning on or after October 1, 1982 through June 30, 1984 or 61.789 percent for cost reporting periods beginning on or after July 1, 1984) only. We are continuing this method because our analysis of the data shows that area variations in routine per diem costs in these additional categories are closely related to area variations in prevailing wage levels. We believe that applying the wage index to the other categories of labor-related costs specified above, rather than to wages only, results in individual limits that are more equitable and more appropriate to each SNF's actual market environment.

E. Limits Set at 112 Percent of Mean

For cost reporting periods beginning on or after October 1, 1982, through June 30, 1984, we are maintaining the revised limits at 112 percent of the average labor-related and average non-labor costs of each group.

F. Cost-of-Living Adjustment for Alaska, Hawaii, Puerto Rico, and the Virgin Islands

To avoid disadvantaging SNFs located in Alaska, Hawaii, Puerto Rico, and the Virgin Islands, we are continuing to provide a cost-of-living adjustment for these States. This is an adjustment of the nonlabor component of the limit that applies to these areas, based on the amount of the most recently determined cost-of-living differentials developed by the Office of Personnel Management. Since we adjust the labor-related component by the applicable wage index, this cost-of-living adjustment applies only to the nonlabor component.

G. Exception of Cost Limits

A provider can request an exception to the proposed cost limits under the provisions of 42 CFR 405.460(f). The request should be made to HCFA through the Medicare fiscal intermediary.

VII. Discussion of Public Comments

We received comments from one hospital association, one medical center, and one insurance association on the November 22, 1985 proposed SNF cost limits notice. A discussion of the comments and our responses to them are provided below.

Comment: Some commenters stated that the cost limits levels proposed for SNFs are inadequate. They believe that the levels are arbitrary and based on inappropriate data.

Response: Pub. L. 98–369 mandated the SNF cost limits levels for cost reporting periods beginning on or after October 1, 1982. The levels proposed for freestanding and hospital-based SNFs were proposed in accordance with that statute. We have no discretion regarding the levels at which the cost limits are set.

Comment: Some commenters believe that we should use the HCFA wage index developed for the prospective payment system in establishing the SNF cost limits. The wage index in the proposed notice was developed by using BLS hospital wage data.

Response: Implementation of the fiscal year 1986 prospective payment rate for hospitals based on the HCFA wage index has been postponed by Congressional action. We do not believe that it would be appropriate to use this wage index in the development of the SNF cost limits prior to its implementation in the prospective payment rate for hospitals. After implementation occurs in the prospective payment system, we will consider using the HCFA wage index in future cost limit notices.

Comment: Some commenters stated that the data used to develop the SNF cost limits was derived from cost reports prior to the implementation of the

prospective payment rates for hospitals, which are based on diagnostic related groups (DRGs). The commenters believe that the advent of DRG payment has resulted in SNFs having to furnish a more intensive level of care to beneficiaries, resulting in additional costs to the SNFs. These commenters do not believe that the additional costs are reflected in our proposed SNF cost limits. They suggested that the data used to develop the SNF cost limits be based on later cost years and the impact of the prospective payment system be considered.

Response: The data used to develop the cost limits are based on the latest cost report data available in the form required to develop the limits. Although we have received later cost reports, we have not been able to edit and analyze the data from these reports to the extent necessary, to ensure its accuracy and reliability in developing cost limits. We believe the data used in developing the limits must be the most accurate data available at the time the limits are developed.

The data used to develop the limits are based on pre-DRG data and any additional costs that may be incurred by SNFs due to the implementation of DRGs is not reflected in the cost data. However, the exceptions process is available to any SNF that incurs additional costs by furnishing markedly more intensive services (see 42 CFR 405.460). Further, a SNF need not wait until the end of its cost reporting period to apply for an exception. An exception may be requested before or during a cost reporting period.

VIII. Regulatory Impact Statement and Flexibility Analysis

A. Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for documents such as this that are likely to: (1) have an annual effect on the economy of $100 million or more, (2) cause a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or (3) result in significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We estimate that the revised limits for hospital-based SNFs results in a net loss of savings to the Medicare program of approximately $155 million through fiscal year 1986 and total of $165 million through fiscal year 1987. Since more than $90 million of the $165 million is paid in one year, there appears to be an effect on the economy that would require a regulatory impact analysis. However, the effect would be exclusively a result of the statutory requirement and not a result of this notice. Therefore, we have determined that this is not a major rule under Executive Order 12291 and that a regulatory impact analysis is not required.

In the proposed notice published November 22, 1985, we stated these reasons for determining that this notice was not a major rule under Executive order 12291. Nonetheless, we prepared and published estimates of the loss of savings that would result from the implementation of the proposed limits to affected cost reporting periods.

In preparing this final notice, we have reviewed and updated our earlier estimates. We estimate that the loss of savings would be distributed as follows:

[In millions of dollars]

Fiscal year—	Loss of savings from 1982 revised limits	Loss of savings from 1984 revised limits	Total loss of savings
1985	90		90
1985 and 1986		*65	65
1986			
Subtotal	90	65	155
1987		10	10
Total	90	75	165

*We cannot at this time distribute the savings for the 1984 schedule to particular fiscal years.

The above estimates were determined by calculating program savings as a result of the previous limits in effect and comparing these savings with the program savings that result from the revised limits. Program savings are the additional amounts that are reimbursable without the limits. Therefore, we are describing the net effect as a loss of savings. That is, we are paying hospital-based SNFs approximately $155 million more for fiscal years 1985 and 1986 and 10 million more for 1987, for a total of 165 million for the three years.

We issued an intermediary letter in February, 1985 (Transmittal No. A85–2) instructing intermediaries to begin making payments to affected SNFs based on interim cost limits. These payments represent tenative settlement. Final settlement will be made following publication of this notice.

B. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and publish an initial regulatory flexibility analysis for proposed regulations unless the Secretary certifies that the regulations would not have a significant economic impact on a substantial number of small entities. We consider all SNFs to be small entities under the RFA.

As we stated in the proposed notice published November 22, 1985, a substantial number of small entities will be affected by implementation of this rule, and the impact on these facilities will be significant if they take no major action to restrain costs. However, these effects are due to statutory changes, and alternatives are available because the method of computation is mandated by section 2319 of Pub. L. 98–369. Nonetheless, we voluntarily provided an initial regulatory flexibility analysis in the proposed notice.

Comment: One commenter stated the analysis we provided was inadequate, and requested that a deatailed regulatory flexibility analysis be performed, comparing provider cost behavior over the period of the limitations; providing a detailed comparison of costs, payments and benefits; and determining the extent to which penalties under these limits are due inefficiency and not differences in case mix or other factors unrelated to efficiency. This commenter particularly criticized our usual standard of analysis for focusing on incremental effects, comparing proposed payments to current payments.

Response: It is this Department's established practice to measure the effects attributable to a rule or notice by the difference between the situation that would occur as a result of the new action and that which would prevail in its absence. Further, because we believe it is good rulemaking practice, we often perform voluntary analyses even in cases in which it could be argued that the RFA requirements do not apply.

In this case, we provided a voluntary analysis even though the level of the limits being published were the results of a Congressional mandate. We believe we complied with the RFA requirements appropriately. The level and detail of analysis requested by the commenter substantially exceeds what is necessary for this notice.

The table below shows the estimated number of hospital-based SNFs that have costs in excess of, respectively, the single limits previously in effect, the revised limits effective for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, and the revised limits effective for cost reporting periods beginning on or after July 1, 1984.

	Single limits [1]	Revised limits [1] (1982–1984)	Revised limits [2] (1984–1985)
Number of hospital-based SNFs with costs in excess of limits	392	117	221
Total hospital-based SNFs in data base	488	488	417
Percent of hospital-based SNFs over limits	80	24	53

[1] Based on 1981 data.
[2] Based on 1982 data.

The above table does not include a small number of facilities that were too small in bedsize or had costs outside the normal cost range (that is, excessively high or low). Inclusion of cost data from these facilities in setting the limits would inappropriately skew the distribution of average costs and would result in limits that are not representative of normal operating costs.

As can be seen, approximately 80 percent of hospital-based SNFs had costs in excess of the single limits in 1982. Under the revised limits effective October 1, 1982, about 24 percent of these SNFs have costs in excess of the limits. From this data, we estimate that 117 hospital-based SNFs (24 percent of the total) are affected by the increased limits effective October 1, 1982. (Although freestanding SNFs are not affected by this proposed notice, for comparison purposes, approximately 30 percent of all freestanding SNFs had costs in excess of the limits in FY 1982.) As shown in the third column, 220 hospital-based SNFs (about 53 percent of total) are estimated to have costs in excess of the revised limits effective July 1, 1984.

In summary, the revised limits impact on approximately 200 to 300 hospital-based SNFs. In no case are the effects adverse. The affected SNFs each receive additional payments as a result of significantly higher limits. The amount of additional payment to a facility depends on the facility's costs as related to the limits.

We compared the relative impacts of the limits on urban and rural facilities. The findings are as follows:

PERCENT OF HOSPITAL-BASED SNFS WITH COSTS EXCEEDING THE LIMITS

[Rounded to nearest percentage]

	10/1/82 limits	7/1/84 limits
Urban	26	59
Rural	20	47

IX. Methodology for Determining Per Diem Routine Service Cost Limit

A. Development of Published Limits

1. Data

We have developed the limits by using actual SNF inpatient routine service cost data, less capital-related costs allocated to general inpatient routine services, obtained from Worksheet D–1 of the latest Medicare cost reports available as of November 15, 1981 for cost reporting periods beginning on or after October 1, 1982 through June 30, 1984 and November 1982 for cost reporting periods beginning on or after July 1, 1984. Capital-related costs include interest, depreciation, insurance, rent, and fixed asset related costs that are normally included in the depreciation accounts on the cost reporting form used for Medicare reimbursement purposes.

We have also adjusted the data from Worksheet D–1 to exclude the inpatient routine nursing salary cost differential.

We adjusted these data using the market basket index discussed above, to inflate costs from the cost reporting periods in the data base to the midpoint of the first cost reporting period to which the limits apply. The annual percentage increases in the market basket over the previous year that we used for this projection are:

	Cost reporting periods beginning on or after Oct. 1, 1982	Cost reporting periods beginning on or after July 1, 1984 *
1979	9.4	
1980	10.1	
1981	9.8	9.6
1982	** 6.9	7.3
1983	** 6.9	5.6
1984	** 7.0	4.1
1985		3.4
1986		** 4.0
1987		** 3.9

* These percentages have been updated from the proposed notice to reflect the most current market basket data available.
** Forecasted increase.

For cost reporting periods beginning on July 1, 1984 and later, an adjustment will be made to the limits if the estimated market basket rate differs from the actual rate by at least .3 of one percentage point. Should this occur, we will notify the Medicare intermediaries of the actual rate of increase and advise them to adjust each SNF cost limit at the time of final settlement.

2. Use of Wage Index to Adjust Cost Data

We devided each SNF's adjusted per diem routine service costs into labor-related and nonlabor portions. We determined the labor-related portion by multiplying each SNF's adjusted per diem routine service cost by 80.22 percent for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984 and 81.411 percent for cost reporting periods beginning on or after July 1, 1984, which is the labor-related portion of cost from the market basket. We then divided the labor-related portion of each SNF's per diem cost by the wage index applicable to the SNF's location (see Tables A–II, A–III, B–II, and B–III) to arrive at an adjusted labor-related portion of routine cost.

3. Group Means

We calculated separate means of labor-related and nonlabor adjusted routine service costs for each SNF group established in accordance with the SNF's SMSA(or MSA)/NECMA or non-SMSA(or non-MSA)/non-NECMA location.

4. Components of Limit

For cost reporting periods beginning on October 1, 1982 through June 30, 1984, for each SNF group, we multiplied the mean labor-related and mean nonlabor costs by 112 percent (see Table A–I).

For cost reporting periods beginning on or after July 1, 1984, the labor component and the nonlabor component of the freestanding SNF group limit (see 47 FR 42894) is inflated to July 1, 1984. We then subtracted the freestanding limit as of July 1, 1984 for each group from 112 percent of the hospital-based mean for each group and multiplied the result by 50 percent. The result is then added to the appropriate freestanding limit as of July 1, 1984 to arrive at the hospital-based limit in Table B–I.

B. Adjustment of Published Limits

1. Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984

a. *Adjustment of Labor-Related Component by Wage Index.* To arrive at a labor-adjusted limit for each SNF, we multiply the labor-related component of the limit for the SNF's group by the wage index developed from wage levels for hospital workers in the area in which the SNF is located. (See Tables A–II and A–III.) The adjusted limit that applies to a SNF is the sum of the nonlabor component,[1] plus the adjusted labor-related component, unless the SNF qualifies for the cost reporting year adjustment discussed in item b. below.

[1] The nonlabor component is further adjusted for cost of living if the SNF is located in Alaska, Hawaii, or Puerto Rico.

Example—Calculation of Adjusted Limit for Hospital-based SNF (A) Located in Dallas, Texas.

Labor-Related Component $79.99 (published in Table A–I); Nonlabor Component $22.17 (published in Table A–I; SMSA Wage Index 1.0222 (published in Table A–II).

Computation of Adjusted Limit

Labor-related component	$79.99
Wage index from Table A–II	x1.0222
Labor component	$81.77
Nonlabor component	+22.17
Adjusted limit	$103.94

b. *Adjustment for Cost Reporting Year.* If a SNF has a cost reporting period beginning after October 1, 1982, the intermediary will increase the limit that would otherwise apply to the SNF by the factor from Table IV that corresponds to the month and year in which the cost reporting period begins. Each factor represents the monthly increase that we derived by dividing the projected annual increase in the market basket by twelve. This adjustment is needed to account for price increases that occur after the date on which the limits are effective.

Example—SNF (A) has a cost reporting period that begins July 1, 1983.

The otherwise applicable limit for SNF (A) is $103.94.

Computation of Revised SNF Limit

Individual SNF adjusted limit	$103.94
Adjustment factor from Table A–IV	x1.05225
Revised limit	$109.37

If an SNF uses a cost reporting period that is not 12 months in duration, a special adjustment factor must be calculated. This results from the fact that projections are computed to the midpoint of a cost reporting period and the adjustment factors in Table IV are based on an assumed 12-month reporting period. For cost reporting periods of other than 12 months, the calculation must be done for the midpoint of the specific cost reporting period. The SNF's intermediary will obtain this adjustment factor from HCFA central office.

2. Cost reporting periods beginning on or after July 1, 1984

a. *Adjustment of Labor-Related Component by Wage Index.* To arrive at a labor-adjusted limit for each hospital-based SNF, we add the labor-related component of the limit and the labor-related component of the A&G add-on for the hospital-based SNF's group and multiply the sum by the wage index developed from wage levels for hospital workers in the area in which the hospital-based SNF is located. (See Tables B-II and B-III.) To arrive at the nonlabor limits, we then add the nonlabor component of the limit and the nonlabor component of the A&G add-on. The adjusted limit that applies to a hospital-based SNF is the sum of the labor-adjusted limit and add-on and the nonlabor limit and add-on unless the facility qualifies for the cost reporting year adjustment discussed in paragraph c. below.

Example—Calculation of Adjusted Limits for Hospital-Based SNF (B) located in rural Arkansas.

Labor-Related Component, (published in Table B-I); Nonlabor Component, (published in Table (B-I); Labor-Related Component, Hospital-Based SNF A&G "add-on", (published in Table B-I); Nonlabor Component, Hospital-Based SNF A&G "add-on" (published in Table B-I); Non-MSA Wage Index (published in Table B-II).

Computation of Adjusted Limit

Labor-related component	$61.37
A&G "add-on"	+1.82
	63.19
Wage Index from Table B–II	× .7800
Adjusted Labor Component	49.29
Nonlabor component	+12.83
Nonlabor component A&G add-on	+.41
Adjusted limit	62.53

b. *Adjustment for Cost Reporting Year.* If a facility has a cost reporting period beginning after July 1, 1984 the intermediary will increase the limit that would otherwise apply to the hospital-based SNF by the factor from Table B–IV that corresponds to the month and year in which the cost reporting period begins. Each factor represents the monthly increase that we derived by dividing the projected annual increase in the market basket by twelve. This adjustment is needed to account for price increases that occur after the date on which the limits are effective.

Example: The following is a computation of a revised hospital-based limit for SNF (B). Hospital-based SNF (B) has a cost reporting period that begins August 1, 1984. The otherwise applicable limit for SNF (B) is $62.53.

Individual SNF adjusted limit	$62.53
Adjustment factor from Table B–IV	× 1.00279
Revised Limit	62.70

If a facility uses a cost reporting period that is not 12 months in duration, a special adjustment factor must be calculated. This results from the fact that projections are computed to the midpoint of a cost reporting period and the adjustment factors in Table B–IV are based on an assumed 12-month reporting period. For cost reporting periods of other than 12 months, the calculation must be done for the midpoint of the specific cost reporting period. The hospital-based SNF's intermediary will obtain this adjustment factor from HCFA central office.

X. Schedule of Limits

Under the authority of section 1861(v) of the Social Security Act and section 2319 of Pub. L. 98–369, the following group per diem limits apply to the adjusted SNF inpatient routine service cost reimbursed under Medicare for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984 (see Table A–I) and cost reporting periods beginning on or after July 1, 1984 (see Table B–I). Medicare fiscal intermediaries will compute the adjusted limits for SNF's using the methodology set forth in this notice, and will notify each SNF of its applicable limit. These limits, as adjusted by the wage indexes in Tables A–II and A–III for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984 and Tables B–II and B–III for cost reporting periods beginning on or after July 1, 1984, and the cost reporting year adjustment factors in Tables A–IV and B–IV. Table B–IV will remain in effect until replaced by a revised schedule of limits published in final in a notice in the **Federal Register.**

Table A–I.—SNF Group Limits

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Location	Labor-related component	Nonlabor component [1]
HOSPITAL-BASED [2]		
SMSA	$79.99	$22.17
Non-SMSA	68.92	15.29

[1] The nonlabor portion of the limits for SNFs located in the States of Alaska and Hawaii and the commonwealth of Puerto Rico will be increased by the following cost-of-living adjustments:

	Factor
Alaska	1.225
Anchorage	1.225
All others	1.25
Hawaii (islands):	
Oahu	1.175
Kauai	1.175
Molokai	1.175
Maui and Lanai	1.175
Hawaii (island)	1.10
Puerto Rico	1.075

* The data used to develop the schedule of separate limits for hospital-based SNFs were obtained from the Medicare cost reports of hospital-based SNFs available as of November 15, 1981, just as was done for the freestanding limits. The basic limits methodology is now the same as that in force as of October 1, 1981 (46 FR-48026—September 30, 1981). These limits were derived using the same methodology as that used for determining the freestanding limits. This methodology is described in our **Federal Register** publication on September 29, 1982 (47 FR 42894).

Table A–II.—Wage Index for Urban Areas

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Urban area (SMSA)	Wage index
Abilene, TX	0.8360
Akron, OH	1.0997
Albany, GA	*.8712
Albany-Schenectady-Troy, NY	.9645
Albuquerque, NM	1.0380
Alexandria, LA	.9619
Allentown-Bethlehem-Easton, PA-NJ	1.0506
Altoona, PA	1.0463
Amarillo, TX	.9449
Anaheim-Santa Ana-Garden Grove, CA	1.2853
Anchorage, AK	1.5992
Anderson, IN	.9650
Anderson, SC	.8712
Ann Arbor, MI	1.2883
Anniston, AL	.8882
Appleton-Oshkosh, WI	.9620
Arecibo, PR	.6481
Asheville, NC	1.0033
Athens, GA	.8811
Atlanta, GA	.9418
Atlantic City, NJ	1.0417
Augusta, GA–SC	.9462
Austin, TX	1.0158
Bakersfield, CA	1.1813
Baltimore, MD	1.1352
Bangor, ME	.9421
Baton Rouge, LA	.9906
Battle Creek, MI	1.0366
Bay City, MI	*1.0658
Beaumont-Port Arthur-Orange, TX	.9407
Bellingham, WA	*.9181
Benton Harbor, MI	.8639
Billings, MT	.9762
Biloxi-Gulfport, MS	.8379
Binghamton, NY–PA	.9463
Birmingham, AL	1.0023
Bismarck, ND	.9430
Bloomington-Normal, IL	.9168
Bloomington, IN	*.9100
Boise City, ID	1.0585
Boston-Lowell-Brockton-Lawrence-Haverhill, MA–NH	1.1387
Bradenton, FL	*.9296
Bremerton, WA	*8993
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1904
Brownsville-Harlingen-San Benito, TX	.9764
Bryan-College Station, TX	.8228
Buffalo, NY	.9939
Burlington, NC	.8785
Burlington VT	*.9554
Caguas, PR	.6007
Canton, OH	.9637
Casper, WY	*1.0638
Cedar Rapids, IA	*.9418
Champaign-Urbana-Rantoul, IL	1.0359

Table A–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Urban area (SMSA)	Wage index
Charleston, SC	1.0333
Charleston, WV	1.0869
Charlotte-Gastonia, NC	.9767
Charlottesville, VA	1.0694
Chattanooga, TN–GA	.9985
Chicago, IL	1.2013
Chico, CA	1.0813
Cincinnati, OH–KY–IN	1.0959
Clarksville-Hopkinsville TN–KY	.8519
Cleveland, OH	1.2149
Colorado Springs, CO	1.0890
Columbia, MO	1.1961
Columbia, SC	.9874
Columbus, GA–AL	.9195
Columbus, OH	1.0803
Corpus Christi, TX	.9762
Cumberland, MD–WV	.9221
Dallas-Fort Worth, TX	1.0222
Danville, VA	*.8960
Davenport-Rock Island-Moline, IA–IL	.9812
Dayton, OH	1.1240
Daytona Beach, FL	.8804
Decatur, IL	*1.0023
Denver-Boulder, CO	1.1952
Des Moines, IA	1.0597
Detroit, MI	1.2516
Dubuque, IA	.9685
Duluth-Superior, MN–WI	.9252
Eau Claire, WI	.9102
El Paso, TX	.8765
Elkhart, IN	*.9100
Elmira, NY	1.0249
Enid, OK	.9247
Erie, PA	.9804
Eugene-Springfield, OR	.9554
Evansville, IN–KY	1.0438
Fargo-Moorhead, ND–MN	1.0057
Fayetteville, NC	*.8618
Fayetteville-Springdale, AR	.8155
Flint, MI	1.1849
Florence, AL	.8223
Florence, SC	.8445
Fort Collins, CO	.9121
Fort Lauderdale-Hollywood, FL	1.0830
Fort Myers, FL	.9389
Fort Smith, AR–OK	.9318
Fort Walton Beach, FL	*.7921
Fort Wayne, IN	.9222
Fresno, CA	1.2345
Gadsden, AL	.9316
Gainesville, FL	.9496
Galveston-Texas City, TX	1.0940
Gary-Hammond-East Chicago, IN	1.1438
Glens Falls, NY	.9078
Grand Forks, ND–MN	.8671
Grand Rapids, MI	.9905
Great Falls, MT	*.9406
Greeley, CO	*1.0158
Green Bay, WI	1.0100
Greensboro-Winston-Salem-High Point, NC	.9463
Greenville-Spartanburg, SC	.9802
Hagerstown, MD	1.0411
Hamilton-Middletown, OH	1.0706
Harrisburg, PA	1.0608
Hartford-New Britain-Bristol, CT	1.1760
Hickory, NC	.8509

Table A–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Urban area (SMSA)	Wage index
Honolulu, HI	1.1867
Houston, TX	1.1222
Huntington-Ashland, WV–KY–OH	.9534
Huntsville, AL	.8827
Indianapolis, IN	1.0551
Iowa City, IA	1.1812
Jackson, MI	*1.0561
Jackson, MS	.9192
Jacksonville, FL	.9777
Jacksonville, NC	*.9059
Janesville-Beloit, WI	.8912
Jersey City, NJ	1.1350
Johnson City-Kingsport-Bristol, TN-VA	.8975
Johnstown, PA	1.0642
Joplin, MO	.8965
Kalamazoo-Portage, MI	1.2181
Kankakee, IL	.9784
Kansas City, MO–KS	.9846
Kenosha, WI	*1.1136
Killeen-Temple, TX	.9185
Knoxville, TN	.9087
Kokomo, IN	1.0083
LaCrosse, WI	*.9406
Lafayette, LA	1.0077
Lafayette-West Lafayette, IN	.9257
Lake Charles, LA	.9204
Lakeland-Winter Haven, FL	.8993
Lancaster, PA	1.0762
Lansing-East Lansing, MI	1.0718
Laredo, TX	*.8631
Las Cruces, NM	*.7733
Las Vegas, NV	1.2134
Lawrence, KS	*.9678
Lawton, OK	*.9619
Lewiston-Auburn, ME	*.8879
Lexington-Fayette, KY	.9328
Lima, OH	1.0392
Lincoln, NE	.9347
Little Rock-North Little Rock, AR	1.0469
Long Branch-Asbury Park, NJ	1.0278
Longview, TX	.8757
Lorain-Elyria, OH	1.0438
Los Angeles-Long Beach, CA	1.3174
Louisville, KY–IN	1.0632
Lubbock, TX	.9036
Lynchburg, VA	.8747
Macon, GA	.9431
Madison, WI	1.0454
Manchester-Nashua, NH	.9762
Mansfield, OH	.9359
Mayaguez, PR	.5902
McAllen-Pharr-Edinburg, TX	.8269
Medford, OR	.9967
Melbourne-Titusville-Cocoa, FL	.9652
Memphis, TN–AR–MS	1.0594
Miami, FL	1.1623
Midland, TX	*1.0057
Milwaukee, WI	1.0561
Minneapolis-St. Paul, MN–WI	1.0099
Mobile, AL	.9490
Modesto, CA	1.0548
Monroe, LA	.9324
Montgomery, AL	.9885
Muncie, IN	*.9595
Muskegon-Muskegon Heights, MI	.9808
Nashville-Davidson, TN	1.0498
Nassau-Suffolk, NY	1.2886

Table A–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Urban area (SMSA)	Wage index
New Bedford-Fall River, MA	.9922
New Brunswick-Perth Amboy-Sayreville, NJ	1.0618
New Haven-Westhaven-Waterbury-Meriden, CT	1.0904
New London-Norwich, CT	1.0930
New Orleans, LA	.9842
New York, NY–NJ	1.3979
Newark, NJ	1.2061
Newark, OH	.9595
Newburgh-Middletown, NY	1.0483
Newport News-Hampton, VA	.9259
Norfolk-Virginia Beach-Portsmouth, VA–NC	1.0327
Northeast, Pennsylvania	1.0447
Ocala, FL	*.9418
Odessa, TX	*.9296
Oklahoma City, OK	1.0161
Olympia, WA	*1.0540
Omaha, NE–IA	.9859
Orlando, FL	.9890
Owensboro, KY	*.8803
Oxnard-Simi Valley-Ventura, CA	1.4050
Panama City, FL	*.8856
Parkersburg-Marietta, WV–OH	1.0064
Pascagoula-Moss Point, MS	*1.1283
Paterson-Clifton-Passaic, NJ	1.0829
Pensacola, FL	.9236
Peoria, IL	1.1136
Petersburg-Hopewell, VA	.9327
Philadelphia, PA–NJ	1.1941
Phoenix, AZ	1.1429
Pine Bluff, AR	*.7832
Pittsburgh, PA	1.1494
Pittsfield, MA	1.0335
Ponce, PR	.7832
Portland, ME	1.0113
Portland, OR–WA	1.1208
Portsmouth-Dover-Rochester, NH–ME	.8549
Poughkeepsie, NY	1.1148
Providence-Warwick-Pawtucket, RI	1.0384
Provo-Orem, UT	.9408
Pueblo, CO	1.0859
Racine, WI	.9504
Raleigh-Durham, NC	1.0364
Reading, PA	1.0092
Redding, CA	1.0671
Reno, NV	*1.3337
Richland-Kennewick, WA	.9678
Richmond, VA	.9379
Riverside-San Bernardino-Ontario, CA	1.2201
Roanoke, VA	.9948
Rochester, MN	1.0438
Rochester, NY	1.0571
Rockford, IL	1.0550
Rock Hill, SC	.9181
Sacramento, CA	1.2130
Saginaw, MI	1.1289
St. Cloud, MN	.8638
St. Joseph, MO	1.0264
St. Louis, MO–IL	1.0394
Salem, OR	1.0834
Salinas-Seaside-Monterey, CA	1.2317
Salisbury-Concord, NC	1.0402
Salt Lake City-Ogden, UT	.9370

Table A–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Urban area (SMSA)	Wage index
San Angelo, TX	.8521
San Antonio, TX	.9595
San Diego, CA	1.2334
San Francisco-Oakland, CA	1.3337
San Jose, CA	1.3264
San Juan, PR	.6806
Santa Barbara-Santa Maria-Lompoc, CA	1.1107
Santa Cruz, CA	1.1364
Santa Rosa, CA	1.4336
Sarasota, FL	1.0096
Savannah, GA	.9740
Seattle-Everett, WA	1.0487
Sharon, PA	1.0046
Sheboygan, WI	.8920
Sherman-Denison, TX	.8879
Shreveport, LA	1.0540
Sioux City, IA–NE	.9975
Sioux Falls, SD	.9242
South Bend, IN	.9157
Spokane, WA	1.1020
Springfield, IL	1.1235
Springfield, MO	.9079
Springfield, OH	1.0412
Springfield-Chicopee-Holyoke, MA	1.0298
State College, PA	*1.1383
Steubenville-Weirton, OH–WV	.9905
Stockton, CA	1.3466
Syracuse, NY	1.5182
Tacoma, WA	1.0720
Tallahasse, FL	*.9462
Tampa-St. Petersburg, FL	1.0066
Terre Haute, IN	.8856
Texarkana-TX-Texarkana, AR	1.1761
Toledo, OH–MI	1.1421
Topeka, KS	1.0783
Trenton, NJ	1.0906
Tucson, AZ	1.0495
Tulsa, OK	1.0220
Tuscaloosa, AL	1.0384
Tyler, TX	.9893
Utica-Rome, NY	.9977
Vallejo-Fairfield-Napa, CA	1.6758
Victoria, TX	.8608
Vineland-Millville-Bridgeton, NJ	1.0070
Visalia-Tulare-Porterville, CA	1.4467
Waco, TX	.8347
Washington, DC–MD–VA	1.1908
Waterloo-Cedar Falls, IA	.8884
Wausau, WI	*.9566
West Palm Beach-Boca Raton, FL	.9897
Wheeling, WV–OH	.9953
Wichita, KS	1.0412
Wichita Falls, TX	.8576
Williamsport, PA	.9890
Wilmington, DE–NJ–MD	1.1092
Wilmington, NC	.9005
Worcester-Fitchburg-Leominster, MA	.9943
Yakima, WA	.9682
York, PA	1.0110
Youngstown-Warren, OH	1.1351
Yuba City, CA	1.1283

* Approximate value for area.

Table A–III.—Wage Index for Rural Areas

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

Rural area (non-SMSA)	Wage index
Alabama	.8167
Alaska	1.4136
Arizona	.9100
Arkansas	.7921
California	1.0662
Colorado	.8515
Connecticut	1.0658
Delaware	.9406
Florida	.9059
Georgia	.8586
Hawaii	1.2652
Idaho	.8991
Illinois	.8965
Indiana	.8826
Iowa	.8290
Kansas	.8205
Kentucky	.8506
Louisiana	.8515
Maine	.8960
Maryland	.9928
Massachusetts	1.0870
Michigan	1.0471
Minnesota	.8275
Mississippi	.8118
Missouri	.8479
Montana	.8803
Nebraska	.7245
Nevada	.9741
New Hampshire	1.0452
New Jersey	.9559
New Mexico	.9235
New York	.9070
North Carolina	.8810
North Dakota	.8203
Ohio	.9305
Oklahoma	.8525
Oregon	.9566
Pennsylvania	1.0428
Puerto Rico	.6438
Rhode Island	*.9628
South Carolina	.8184
South Dakota	.7733
Tennessee	.7987
Texas	.8149
Utah	.8006
Vermont	.8808
Virginia	.8484
Washington	.9453
West Virginia	.9296
Wisconsin	.8291
Wyoming	.9782

*Approximate value for area.

Table A–IV.—Cost Reporting Year Adjustment Factors*

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

If a SNF cost reporting period begins	The adjustment factor is [1]
Nov. 1, 1982	1.00575
Dec. 1, 1982	1.01150
Jan. 1, 1983	1.01725
Feb. 1, 1983	1.02308
Mar. 1, 1983	1.02892

Table A–IV.—Cost Reporting Year Adjustment Factors*—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

If a SNF cost reporting period begins	The adjustment factor is [1]
Apr. 1, 1983	1.03475
May 1, 1983	1.04058
June 1, 1983	1.04642
July 1, 1983	1.05225
Aug. 1, 1983	1.05808
Sept. 1, 1983	1.06392

Table A–IV.—Cost Reporting Year Adjustment Factors*—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

If a SNF cost reporting period begins	The adjustment factor is [1]
Oct. 1, 1983	1.06975
Nov. 1, 1983	1.07558
Dec. 1, 1983	1.08141
Jan. 1, 1984	1.08724
Feb. 1, 1984	1.09307
Mar. 1, 1984	1.09890

Table A–IV.—Cost Reporting Year Adjustment Factors*—Continued

[Cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984]

If a SNF cost reporting period begins	The adjustment factor is [1]
Apr. 1, 1984	1.10473
May 1, 1984	1.11056
June 1, 1984	1.11639

[1] Based on projected market basket inflation rates of 6.9 percent and 7.0 percent for 1983 and 1984 respectively. These adjustment factors are subject to change based on later estimates of cost increases.

Appendix A–I.—*Derivation of "Market Basket" index for SNF routine service costs*

[Cost reporting periods beginning on or after Oct. 1, 1982 and before July 1, 1984]

Category of costs	Relative [1] importance 1980	Forecaster percent changes (1980–1984)	Price variable used
Payroll expenses	61.26	DRI–CFS [2]	Percentage changes in average hourly earnings of employees in nursing and personal care facility. (SIC 805) Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly).
Food	9.71	DRI–MM [3]	Processed foods and feeds component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
		DRI–MM	Food and beverage component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Employee benefits	7.92	DRI–MM	Supplements to wages and salaries per worker in nonagricultural establishments. For supplements to wages: Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business.* For total employment: Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly).
Fuel and other utilities	5.26	DRI–MM	A. Implicit price deflator-consumption of fuel oil and coal (derived from fuel oil component of Consumer Price Index). Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (monthly).
		DRI–MM	B. Implicit price deflator-consumer of electricity (derived from electricity component of Consumer Price Index). Source: U.S. Dept. of Commerce, Bureau of Economic Analysis.
		DRI–MM	C. Implicit price deflator for natural gas (derived from utility (piped) gas component of Consumer Price Index). Source: Same as electricity above.
		DRI–CFS	D. Water and sewage maintenance component of the Consumer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Miscellaneous	4.97	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Other business services	4.87	DRI–MM	Services component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Supplies	3.40	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Drugs	1.40	DRI–CFS	Pharmaceutical preparations, ethical component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Producer Prices and Price Indexes* (monthly).
Health services	1.21	DRI–CFS	Physician services component of Consumer Price Index for all urban consumers. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

[1] The basic weights for all major categories of skilled nursing home costs were obtained from the DHEW-National Center for Health Statistics (NCHS) National Nursing Home Surveys (NNHS) for 1972 and 1976 for homes certified for participation in the Medicare program. See *Nursing Home Costs 1972, United States: National Nursing Home Survey, August 1973–April 1974, DHEW, NCHS: National Nursing Home Survey: 1977 Summary for the United States, Vital and Health Statistics, Series 13, Number 43.*

A Laspeyres price index was constructed using 1977 weights and price variables indicated in this table. In calendar year 1977 each "price" variable has an index of 100.0. The relative routine service cost weights change each period in accordance with price changes for each price variable. Cost categories with relatively higher "price" increases get relatively higher cost weights and vice versa.

[2] DRI–CFS refers to Data Resources, Inc., Cost Forecasting Service (CFS 823), 1750 K Street, N.W., Washington, D.C. 20006.

[3] DRI–MM refers to Data Resources, Inc., Trendlong (782), 29 Hartwell Avenue, Lexington, Massachusetts 02173.

Appendix A–II.—SMSA/NECMA Constituent Counties

[Cost Reporting Periods Beginning on or after October 1, 1982 and before July 1, 1984]

Areas No Longer Qualifying as SMSAs

SMSA area	*Constituent counties*
Rapid City, SD	Meade Pennington

Areas Qualifying for Recognition as New SMSAs

SMSA area	*Constituent counties*
Anderson, SC	Anderson
Arecibo, PR	Arecibo Municipio Camuy Municipio Hatillo Municipio

Areas Qualifying for Recognition as New SMSAs—Continued

SMSA area	*Constituent counties*
Athens, GA	Clarke Jackson Madison Oconee
Bellingham, WA	Whatcom
Benton Harbor, MI	Berrien
Bremerton, WA	Kitsap
Casper, WY	Natrona
Charlottesville, VA	Albemarle Fluvanna Greene Charlottesville City
Chico, CA	Butte
Cumberland, MD–WV.	Allegany (MD) Mineral (WV)
Danville, VA	Pittsylvania Danville City

Areas Qualifying for Recognition as New SMSAs—Continued

SMSA area	*Constituent counties*
Florence, SC	Florence
Fort Walton Beach, FL.	Okaloosa
Glens Falls, NY	Warren Washington
Hagerstown, MD	Washington
Hickory, NC	Alexander Catawba
Jacksonville, NC	Onslow
Joplin, MO	Jasper Newton
Medford, OR	Jackson
Newark, OH	Licking
Newburgh-Middletown, NY.	Orange
Ocala, FL	Marion
Olympia, WA	Thurston

Areas Qualifying for Recognition as New SMSAs—Continued

SMSA area	*Constituent counties*
Redding, CA	Shasta
Rock Hill, SC	York
Salisbury-Concord, NC.	Cabarrus
	Rowan
Sharon, PA	Mercer
Sheboygan, WI	Sheboygan
State College, PA	Centre
Victoria TX,	Victoria
Visalia-Tulare-Porterville, CA.	Tulare
Wausau, WI	Marathon
Yuba City, CA	Sutter
	Yuba

New NECMAs

NECMA	*Constituent counties*
Bangor, ME	Penobscot
Burlington, VT	Chittenden
Portsmouth-Dover-Rochester, NH–ME.	Rockingham (NH)
	Strafford (NH)
	York (ME)

Revised NECMA Definitions

NECMA	*Constituent counties*
Boston-Lowell-Brockton-Lawrence-Haverhill, MA.	Essex (MA)
	Middlesex (MA)
	Norfolk (MA)
	Suffolk (MA)
	Plymouth (MA)
Hartford-New Britain-Bristol, CT.	Hartford
	Middlesex
	Tolland
Manchester-Nashua, NH.	Hillsborough
Portland, ME	Cumberland
	Sagadahoc
Providence-Warwick-Pawtucket, RI.	Bristol
	Kent
	Providence
	Washington

Table B–I.—SNF Group Limits

[Cost reporting periods beginning on or after July 1, 1984]

Location	Labor-related component	Nonlabor component [1]
HOSPITAL-BASED		
MSA:		
Limit	$66.14	$17.16
A&G add-on	2.64	.60
Non-MSA:		
Limit	$61.37	$12.83
A&G add-on	1.82	.41

[1] The nonlabor portion of the limits for SNFs located in the States of Alaska and Hawaii, the Commonwealth of Puerto Rico, and the Virgin Islands will be increased by the following cost-of-living adjustments:

Location	Adjustment factor
Alaska: All locations	1.250
Hawaii:	
Oahu	1.200
Kauai	1.175
Maui and Lanai	1.200
Malokai	1.200
Hawaii (island)	1.100
Puerto Rico	1.100
Virgin Islands:	
St. Croix	1.100
St. Thomas and St. John	1.100

Table B–II.—Wage Index for Urban Areas

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) [constituent counties or county equivalents]	Wage index
Abilene, TX	.9133
Taylor, TX	
Aguadilla, PR	.5539
Aguada, PR	
Aguadilla, PR	
Isabella, RP	
Moca, Pr	
Akron, OH	1.0600
Portage, OH	
Summit, OH	
Albany, GA	*.9206
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.9035
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.0727
Bernalillo, NM	
Alexandria, LA	1.0018
Rapides, LA	
Allentown-Bethlehem, PA–NJ	1.0617
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	1.1005
Blair, PA	
Amarillo, TX	1.0400
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2360
Orange, CA	
Anchorage, AK	1.5702
Anchorage, AK	
Anderson, IN	.9666
Madison, IN	
Anderson, SC	.8852
Anderson, SC	
Ann Arbor, MI	1.2703
Washtenaw, MI	
Anniston, AL	.8675
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	.9826
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	.6036
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	.9343
Buncombe, NC	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) [constituent counties or county equivalents]	Wage index
Athens, GA	.8343
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	.9728
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	1.0988
Atlantic, NJ	
Cape May, NJ	
Augusta, GA–SC	.9826
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.0210
Kane, IL	
Kendall, Il	
Austin, TX	1.1068
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.1867
Kern, CA	
Baltimore, MD	1.0325
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, Md	
Hartford, MD	
Howard, MD	
Queen Anne's, MD	
Bangor, ME	.9476
Penobscot, ME	
Baton Rouge, LA	1.0477
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	1.0131
Calhoun, MI	
Beaumont-Port Arthur, TX	1.0920
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.1631
Beaver, PA	
Bellingham, WA	* 1.0600
Whatcom, WA	
Benton Harbor, MI	.8716
Berrien, MI	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Bergen-Passaic, NJ	1.0184
Bergen, NJ	
Passsaic, NJ	
Billings, MT	*1.0268
Yellowstone, MT	
Biloxi-Gulfport, MS	.8701
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9500
Broome, NY	
Tigoa, NY	
Birmingham, AL	1.0028
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	.9900
Burleigh, ND	
Morton, ND	
Bloomington, IN	.9171
Monroe, IN	
Bloomington-Normal, IL	.9404
McLean, IL	
Boise City, ID	1.0414
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1312
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	.9902
Boulder, CO	
Bradenton, FL	*.9513
Manatee, FL	
Brazoria, TX	.8775
Brazoria, TX	
Bremerton, WA	*9562
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1497
Fairfield, CT	
Brownsville-Harlingen, TX	.9250
Cameron, TX	
Bryan-College Station, TX	1.0513
Brazos, TX	
Buffalo, NY	.9933
Erie, NY	
Burlington, NC	.8514
Alamance, NC	
Burlington, VT	*1.0053
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	.6232
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Aguas Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	.9697
Carroll, OH	
Stark, OH	
Casper, WY	*1.0104
Natrona, WY	
Cedar Rapids, IA	*.9185
Linn, IA	
Champaign-Urbana-Rantoul, IL	1.0274
Champaign, IL	
Charleston, SC	1.0127
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	1.1369
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC–SC	.9480
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	1.0144
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN–GA	.9667
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	.9914
Laramie, Wy	
Chicago, IL	1.1729
Cook, IL	
McHenry, IL	
Chico, CA	1.0344
Butte, CA	
Cincinnati, OH–KY–IN	1.0330
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN–KY	.8386
Christian, KY	
Montgomery, TN	
Cleveland, OH	1.2337
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Media, OH	
Colorado Springs, CO	1.0966
El Paso, CO	
Columbia, MO	1.0069
Boone, MO	
Columbia, SC	.9390
Lexington, SC	
Richland, SC	
Columbus, GA-AL	.8823
Russell, AL	
Chattanoochee, GA	
Muscogee, GA	
Columbus, OH	1.0530
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.9328
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.8925
Allegany, MD	
Mineral, WV	
Dallas, TX	1.0969
Collins, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	*.8823
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	.9928
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0928
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	1.1875
Volusia, FL	
Decatur, IL	1.0025
Macon, IL	
Denver, CO	1.1875
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	1.0632
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.1681
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.9092
Dale, AL	
Houston, AL	
Dubuque, IA	.9486
Dubuque, IA	
Duluth, MN-WI	.9437
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	.9942
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.9419
El Paso, TX	
Elkhardt-Goshen, IN	*9185

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Elkhart, IN	
Elmira, NY	1.0350
Chemung, NY	
Enid, OK	.9777
Garfield, OK	
Erie, PA	1.0215
Erie, PA	
Eugene-Springfield, OR	.9799
Lane, OR	
Evansville, IN-KY	1.0336
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0219
Clay, MN	
Cass, ND	
Fayetteville, NC	*.9472
Cumberland, NC	
Fayetteville-Springdale, AR	.8180
Washington, AR	
Flint, MI	1.2322
Genesee, MI	
Florence, AL	.8168
Colbert, AL	
Lauderdale, AL	
Florence, SC	.8723
Florence, SC	
Fort Collins-Loveland, CO	1.0065
Larimor, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0986
Broward, FL	
Fort Myers-Cape Coral, FL	.9797
Lee, FL	
Fort Pierce, FL	1.0200
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	.9592
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	
Okaloosa, FL	
Fort Wayne, IN	.9281
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	1.0223
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.1791
Fresno, CA	
Gadsden, AL	.9247
Etowah, AL	
Gainesville, FL	.9676
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.1360
Galveston, TX	
Gary-Hammond, IN	1.1581
Lake, IN	
Porter, IN	
Glens Falls, NY	.8287
Warren, NY	
Washington, NY	
Grand Forks, ND	.9796

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Grand Forks, ND	
Grand Rapids, MI	1.0030
Kent, MI	
Ottawa, MI	
Great Falls, MT	*1.0969
Cascade, MT	
Greeley, CO	*1.0412
Weld, CO	
Green Bay, WI	.9974
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9478
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartansburg, SC	.9013
Greenville, SC	
Pickens, SC	
Spartansburg, SC	
Hagerstown, MD	.9388
Washington, MD	
Hamilton-Middletown, OH	1.0187
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	1.0705
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-New Middleton-Britain-Bristol, CT	1.1460
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.9146
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1217
Honolulu, HI	
Houma-Thibodaux, LA	.9209
Lafourche, LA	
Terrebonne, LA	
Houston, TX	1.1473
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	1.0289
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.9248
Madison, AL	
Indianapolis, IN	1.0760
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.0946
Johnson, IA	
Jackson, MI	*1.0400
Jackson, MI	
Jackson, MS	.8769
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	.8180
Madison, TN	
Jacksonville, FL	1.0197
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	*.7823
Onslow, NC	
Janesville-Beloit, WI	.9042
Rock, WI	
Jersey City, NJ	1.0558
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	.9308
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	1.0247
Cambria, PA	
Somerset, PA	
Joliet, IL	1.1197
Grundy, IL	
Will, IL	
Joplin, MO	1.0228
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.2477
Kalamazoo, MI	
Kankakee, IL	1.0117
Kankakee, IL	
Kansas City, MO-KS	1.0451
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	*1.0144
Kenosha, WI	
Killeen-Temple, TX	.9766
Bell, TX	
Coryell, TX	
Knoxville, TN	.9193
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9984
Howard, IN	
Tipton, IN	
LaCrosse, WI	*.9796
LaCrosse, WI	
Lafayette, LA	1.0085
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	.9018
Tippecanoe, IN	
Lake Charles, LA	1.0512
Calcasieu, LA	
Lake County, IL	1.0853
Lake, IL	
Lakeland-Winter Haven, FL	.9716
Polk, FL	
Lancaster, PA	1.0776
Lancaster, PA	
Lansing-East Lansing, MI	1.0460
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	*.8542
Webb, TX	
Las Cruces, NM	*.8423
Dona Ana, NM	
Las Vegas, NV	1.2618
Clark, NV	
Lawrence, KS	*.9404
Douglas, KS	
Lawton, OK	*1.0286
Comanche, OK	
Lewiston-Auburn, ME	*.9666
Lexington-Fayette, KY	.9808
Androscoggin, ME	
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	1.0035
Allen, OH	
Auglaize, OH	
Lincoln, NE	.9171
Lancaster, NE	
Little Rock-North Little Rock, AR	1.0491
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	.8700
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	1.0104
Lorain, OH	
Los Angeles-Long Beach, CA	1.3166
Los Angeles, CA	
Louisville, KY-IN	1.1027
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	1.0152
Lubbock, TX	
Lynchburg, VA	.8955
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	1.0467
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0893
Dane, WI	
Manchester-Nashua, NH	.9613
Hillsboro, NH	
Merrimack, NH	
Mansfield, OH	.9240
Richland, OH	
Mayaguez, PR	.5689
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	.8980
Hidalgo, TX	
Medford, OR	.9923
Jackson, OR	
Melbourne-Titusville, FL	.9814
Brevard, FL	
Memphis, TN-AR-MS	1.0492
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Miami-Hialeah, FL	1.1602
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	1.0492
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.1919
Midland, TX	
Milwaukee, WI	1.0306
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.0722
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.9336
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.1590
Stanislaus, CA	
Monmouth-Ocean, NJ	.9713
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.9265
Ouachita, LA	
Montgomery, AL	.9534
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	*.9923
Delaware, IN	
Muskegon, MI	*.9589
Muskegon, MI	
Naples, FL	*1.1559
Collier, FL	
Nashville, TN	1.1642
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.2360
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9641
Bristol, MA	
New Haven-West Haven-Waterbury-Meriden, CT	1.0952
New Haven, CT	
New London-Norwich, CT	1.0517
New London, CT	
New Orleans, LA	1.0184
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3378
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.1801
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	.8665
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	.9730
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Williamsburg City, VA	
York, VA	
Oakland, CA	1.3334
Alameda, CA	
Contra Costa, CA	
Ocala, FL	*.9666
Marion, FL	
Odessa, TX	*1.0451
Ector, TX	
Oklahoma City, OK	1.0480
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	*1.0758
Thurston, WA	
Omaha, NE-IA	.9667
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	1.0286
Orange, NY	
Orlando, FL	1.0135
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	*.9013
Daviess, KY	
Oxnard-Ventura, CA	1.1859
Ventura, CA	
Panama City, FL	*.8955
Bay, FL	
Parkersburg-Marietta, WV-OH	1.0302
Washington, OH	
Wood, WV	
Pascagoula, MS	*1.1340
Jackson, MS	
Pensacola, FL	.9063
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	1.1391
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.1796
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.0869
Maricopa, AZ	
Pine Bluff, AR	*.9092
Jefferson, AR	
Pittsburgh, PA	1.1529
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	1.0278
Berkshire, MA	
Ponce, PR	.6883

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Juana Diaz, PR	
Ponce, PR	
Portland, ME	.9892
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1393
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	.9132
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.1219
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	.9991
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Statewide, RI	
Washington, RI	
Provo-Orem, UT	.9243
Utah, UT	
Pueblo, CO	1.1232
Pueblo, CO	
Racine, WI	1.0078
Racine, WI	
Raleigh-Durham, NC	1.0295
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	.8823
Pennington, SD	
Reading, PA	1.0412
Berks, PA	
Redding, CA	1.0444
Shasta, CA	
Reno, NV	1.2472
Washoe, NV	
Richland-Kennewick, WA	.9749
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.9472
Charles City Co., VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.1300
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	.9796
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Rochester, MN	1.0277
Olmsted, MN	
Rochester, NY	1.0207
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0479
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.2022
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.1053
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	.9117
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9937
Buchanan, MO	
St. Louis, MO–IL	1.0653
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0268
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.3264
Monterey, CA	
Salt Lake City-Ogden, UT	.9409
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.9599
Tom Green, TX	
San Antonio, TX	.9518
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.1559
San Diego, CA	
San Francisco, CA	1.3993
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.3538
Santa Clara, CA	
San Juan, PR	.6151
Barcelona, PR	
Bayoman, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	
Dorado, PR	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trojillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1123
Santa Barbara, CA	
Santa Cruz, CA	1.2056
Santa Cruz, CA	
Santa Fe, NM	1.0716
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.1632
Sonoma, CA	
Sarasota, FL	1.0007
Sarasota, FL	
Savannah, GA	.9861
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	1.0020
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.1388
King, WA	
Snohomish, WA	
Sharon, PA	1.0431
Mercer, PA	
Sheboygan, WI	.8771
Sheboygan, WI	
Sherman-Denison, TX	.8107
Grayson, TX	
Shreveport, LA	1.0931
Bossier, LA	
Caddo, LA	
Sioux City, IA–NE	1.0034
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	.9779
Minnehaha, SD	
South Bend-Mishawaka, IN	.9756
St. Joseph, IN	
Spokane, WA	1.0916
Spokane, WA	
Springfield, IL	1.1340
Menard, IL	
Sangamon, IL	
Springfield, MO	.9380
Christian, MO	
Greene, MO	
Springfield, MA	1.0331
Hampden, MA	
Hampshire, MA	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
State College, PA	1.0972
Centre, PA	
Steubenville-Weirton, OH–WV	.9624
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1738
San Joaquin, CA	
Syracuse, NY	1.0457
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0683
Pierce, WA	
Tallahassee, FL	.9041
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	1.0189
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8955
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	1.0994
Miller, AR	
Bowie, TX	
Toledo, OH	1.1218
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	1.1129
Shawnee, KS	
Trenton, NJ	1.0465
Mercer, NJ	
Tucson, AZ	1.0502
Pima, AZ	
Tulsa, OK	1.0490
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	1.0315
Tuscaloosa, AL	
Tyler, TX	1.0381
Smith, TX	
Utica-Rome, NY	.9690
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.2754
Napa, CA	
Solano, CA	
Vancouver, WA	* 1.0617
Clark, WA	
Victoria, TX	*.9265
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9914
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.0758
Tulare, CA	
Waco, TX	.8914
McLennan, TX	
Washington, DC–MD–VA	1.1678
District of Columbia, DC	
Calvert, MD	

Table B–II.—Wage Index for Urban Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

Urban area (MSA) (constituent counties or county equivalents)	Wage index
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	.9206
Black Hawk, IA	
Bremer, IA	
Wausau, WI	*.9362
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	1.0331
Palm Beach, FL	
Wheeling, WV–OH	.9869
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.1190
Butler, KS	
Sedgwick, KS	
Wichita, Falls, TX	.8979
Wichita, TX	
Williamsport, PA	.9930
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0866
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.9193
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	.9489
Worcester, MA	
Yakima, WA	.9926
Yakima, WA	
York, PA	.9973
Adams, PA	
York, PA	
Youngstown-Warren, OH	1.1231
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0610
Sutter, CA	
Yuba, CA	

* Approximate value for area.

Table B–III.—Wage Index for Rural Areas

[Cost reporting periods beginning on or after July 1, 1984]

	Wage index
Rural area (non-MSA):	
Alabama	0.7767
Alaska	1.4473
Arizona	.9268
Arkansas	.7800
California	1.017

Table B–III.—Wage Index for Rural Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

	Wage index
Colorado	.8619
Connecticut	1.0053
Delaware	.9116
Florida	.8840
Georgia	.8305
Hawaii	1.1584
Idaho	.8728
Illinois	.8911
Indiana	.8458
Iowa	.8092
Kansas	.8321
Kentucky	.8542
Louisiana	.8626
Maine	.8785
Maryland	.9185
Massachusetts	1.0305
Michigan	.9349
Minnesota	.8892
Mississippi	.8016
Missouri	.8261
Montana	.8775
Nebraska	.7345
Nevada	1.0113
New Hampshire	1.0080
New Jersey	NA
New Mexico	.9719
New York	.8747
North Carolina	.8568
North Dakota	.8309
Ohio	.9192
Oklahoma	.8776

Table B–III.—Wage Index for Rural Areas—Continued

[Cost reporting periods beginning on or after July 1, 1984]

	Wage index
Oregon	.9513
Pennsylvania	1.0442
Puerto Rico	.5693
Rhode Island	*.9308
South Carolina	.8031
South Dakota	.7437
Tennessee	.7709
Texas	.8423
Utah	.7823
Vermont	.8846
Virginia	.8641
Virgin Islands	*1.0000
Washington	.9562
West Virginia	.9855
Wisconsin	.8314
Wyoming	.9613

*Approximate value for area.

Table B–IV.—Cost Reporting Year Adjustment Factors [1]

[Cost reporting periods beginning on or after July 1, 1984]

If a SNF cost reporting period begins—	The adjustment factor is—
Aug. 1, 1984	1.00279
Sept. 1, 1984	1.00559
Oct. 1, 1984	1.00839
Nov. 1, 1984	1.01121
Dec. 1, 1984	1.01403

Table B–IV.—Cost Reporting Year Adjustment Factors [1]—Continued

[Cost reporting periods beginning on or after July 1, 1984]

If a SNF cost reporting period begins—	The adjustment factor is—
Jan. 1, 1985	1.01686
Feb. 1, 1985	1.02019
Mar. 1, 1985	1.02353
Apr. 1, 1985	1.02688
May 1, 1985	1.03024
June 1, 1985	1.03361
July 1, 1985	1.03700
Aug. 1, 1985	1.04039
Sept. 1, 1985	1.04380
Oct. 1, 1985	1.04722
Nov. 1, 1985	1.05064
Dec. 1, 1985	1.05408
Jan. 1, 1986	1.05753
Feb. 1, 1986	1.06091
Mar. 1, 1986	1.06429
Apr. 1, 1986	1.06769

[1] Based on compounded projected market basket inflation rates of 3.4, 4.0, and 3.9 percent for 1985, 1986, and 1987 respectively. These adjustment factors are subject to change based on later estimates of cost increases or decreases.

If, for any reason, we do not publish a new schedule of limits to be effective on May 1, 1986 or do not announce other changes in the current schedule by that date, the current limits will continue in effect, with the last adjustment factor above multiplied by 1.00319 once for each month between April 1, 1986 and the month in which the cost reporting period begins, until a new schedule of limits or other provision is issued. For example, if a cost reporting period begins on June 1, 1986, 1.06769 would be multiplied by 1.00319 (twice and the resulting factor would equal 1.07451 (1.06769 x 1.00319 x 1.00319 = 1.07451).

Appendix B–I.—Derivation of "Market Basket" Index for SNF Routine Service Costs

[Cost reporting periods beginning on on or after July 1, 1984]

Category of costs	Relative [1] importance 1985	Forecaster percent changes (1981–1986)	Price variable used
Payroll expenses	61.789	DRI–CFS [2]	Percentage changes in average hourly earnings of employees in nursing and personal care facility. (SIC 805) Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly), Table C–2.
Food	8.356	DRI–MM [3]	Processed foods and feeds component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
		DRI–MM	Food and beverage component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthy Labor Review*, Table 22.
Employee benefits	8.279	DRI–MM	Supplements to wages and salaries per worker in nonagricultural establishments. For supplements to wages: Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, Table 1.11. For total employment: Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly), Table B–4.
Fuel and other utilities	5.188	DRI–MM	A. Implicit price deflator-consumption of fuel oil and coal (derived from fuel oil component of Consumer Price Index) Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (monthly), Table 7.11.
		DRI–MM	B. Implicit price deflator-consumer of electricity (derived from electricity component of Consumer Price Index). Source: U.S. Dept. of Commerce, Bureau of Economic Analysis.
		DRI–MM	C. Implicit price deflator for natural gas (derived from utility (piped) gas component of Consumper Price Index) Source: Same as electricity above.
		DRI–CFS	D. Water and sewage maintenance component of the Consumer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Miscellaneous	4.856	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Other business services	5.148	DRI–MM	Services component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Supplies	3.325	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Drugs	1.720	DRI–CFS	Pharmaceutical preparations, ethical component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Producer Prices and Price Indexes* (monthly), Table 6.
Health services	1.339	DRI–CFS	Physician services component of Consumer Price Index for all urban consumers. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.

[1] The basic weights for all major categories of skilled nursing home costs were obtained from the DHEW-National Center for Health Statistics (NCHS) National Nursing Home Survey (NNHS) for 1972 and 1976 for homes certified for participation in the Medicare program. See *Nursing Home Costs 1972, United States: National Nursing Home Survey, August 1973–April 1974 DHEW, NCHS: National Nursing Home Survey: 1977 Summary for the United States, Vital and Health Statistics, Series 13, Number 43.*

A Laspeyres price index was constructed using 1977 weights and price variables indicated in this table. In calendar year 1977 each "price" variable has an index of 100.0. The relative routine service cost weights change each period in accordance with price changes for each price variable. Cost categories with relatively higher "price" increases get relatively higher cost weights and vice versa.

[2] DRI–CFS refers to Data Resources, Inc., Cost Forecasting Service (CFS 861), 1750 K Street, N.W., Washington, D.C. 20006.

[3] DRI–MM refers to data Resources, Inc., Trendlong (186), 29 Hartwell Avenue, Lexington, Massachusetts 02173.

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), 1871 and 1888 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a), 1395hh, and 1395yy)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program)

Dated: February 4, 1986.

Henry R. Desmarais,

Acting Administrator, Health Care Financing Administration.

Approved: March 11, 1986.

Otis R. Bowen,

Secretary.

[FR Doc. 86-7132 Filed 3-31-86; 8:45 am]

BILLING CODE 4120-01-M

[BERC-335-FN]

Medicare Program; Update to Freestanding and Hospital-Based Skilled Nursing Facility Cost Limits Effective for Cost Reporting Periods Starting May 1, 1986

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This notice sets forth a revised schedule of limits on skilled nursing facility inpatient routine service costs that are reimbursed under Medicare. This schedule applies to cost reporting periods beginning on or after May 1, 1986.

EFFECTIVE DATE: May 1, 1986.

FOR FURTHER INFORMATION CONTACT: Steve Kirsh, (301) 594-9465.

SUPPLEMENTARY INFORMATION:

I. Background

Sections 1861(v)(1) and 1888 of the Social Security Act (the Act) authorize the Secretary to set prospective limits on allowable costs incurred by a provider of services that will be reimbursed under Medicare. These limits are based on estimates of the costs necessary for the efficient delivery of needed health services. Implementing regulations appear at 42 CFR 405.460. Section 1888 of the Act directs the Secretary to set limits on per diem inpatient routine service costs for hospital-based and freestanding skilled nursing facilities (SNFs) by urban or rural area location.

Under the authority of section 1861(v)(1) of the Act, we published limits on September 29, 1982 (47 FR 42894) that continue to apply to freestanding SNFs. Under the authority of Section 1888 of the Act, we published new limits elsewhere in this issue of the **Federal Register** that apply to hospital-based SNFs for cost reporting periods beginning October 1, 1982 through June 30, 1984 and cost reporting periods beginning on or after July 1, 1984 (see BERC-333-FN).

Those limits contain provisions relating to: (1) Limits on adjusted SNF per diem inpatient routine service costs, (2) a "market basket" index developed to reflect changes in the price of goods and services purchased by SNFs, (3) adjustments to the cost limits by an area wage index developed from hospital industry wages, (4) a classification system based on whether the SNF is hospital-based or freestanding and whether it is located in an urban or rural area, (5) a cost-of-living adjustment for the nonlabor portion of the limits for SNFs located in Alaska, Hawaii, Puerto Rico, and the Virgin Islands, (6) freestanding SNF cost limits set at 112 percent of the average per diem labor-related and nonlabor costs, (7) hospital-based SNF cost limits set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the average per diem routine service costs of hospital based SNFs, and (8) an administrative and general (A&G) add-on for hospital-based SNFs.

We proposed revised SNF cost limits for cost reporting periods beginning on or after January 1, 1986 in the **Federal Register** (50 FR 48304) on November 22, 1985 and solicited comments on the proposal. This final notice discusses the comments received and implements revised SNF cost limits for cost reporting periods beginning on or after May 1, 1986.

In developing the revised limits, we have retained essentially the same provisions as in the limits currently applicable, which are published elsewhere in this issue of the **Federal Register** (BERC-333-FN). We have, however, used the most recent SNF cost data for calculating the limits, as well as the most recent hospital industry wage data and projections of the rates of increases in the costs included in the SNF market basket.

II. Discussion of Revised SNF Cost Limits

The schedule of limits on SNF inpatient routine service costs applies to cost reporting periods beginning on or after May 1, 1986 and provides for the following:

A. Separate Group Limits for Labor-Related and Nonlabor Components of Per Diem Routine Service Costs

We retained separate group limits for the labor-related and nonlabor components of per diem routine service cost. We calculate these separate limits as follows:

1. Actual SNF per diem inpatient routine service cost data are obtained for each SNF.

2. To make the data reflect current conditions more accurately, the data are adjusted from the midpoints of the cost reporting periods represented in the data collection to the midpoint of the initial cost reporting period to which the limits apply.

3. Each SNF's per diem cost is separated into labor-related and nonlabor portions. The labor-related portion is divided by the wage index for the SNF's location (see Tables II and III).

4. Finally, separate group means are computed for the labor-related and nonlabor components. Each group mean is multiplied by 112 percent.

B. Adjustment of SNF Cost Data by Wage Index

We are continuing to use a hospital industry wage index to account for area wage differences. This is necessary because industry-specific data are not available on SNF wages. Since hospitals and SNFs generally compete in essentially the same labor market for employees, we believe an index based on geographic variations in hospital wages provides an accurate measure of geographic variations in wages paid by SNFs. We developed the wage index from a survey of hospital salary data and data on paid hours worked. This index, unlike the Bureau of Labor Statistics (BLS) index used in the proposed notice, distinguishes between full-time and part-time employees. Therefore, it measures geographic variations in prevailing wage levels more accurately, and its use in these cost limits results in a more accurate limit for each provider.

As we noted in the proposed notice, the HCFA survey-based hospital wage index was proposed for use in the hospital prospective payment system in a proposed rule published in the **Federal Register** on June 10, 1985 (50 FR 24377) and was later adopted in our final rule that was published in the **Federal Register** on September 3, 1985 (50 FR 35646). We stated in the proposed SNF cost limits notice that we were considering the use of the HCFA survey-based index in this final notice and solicited comments on this proposed change. After considering the comments received, we decided to use the HCFA survey-based wage index for the limits in this notice.

The wage index values in this notice differ slightly from those published in the final rule for hospital prospective payment (50 FR 35715, September 3,

1985). This difference is due to the inclusion of index values for Puerto Rico. We derived the Puerto Rico index values by first applying the relationship between the average monthly wage for each Puerto Rico locale and the BLS national average monthly wage to the national average hourly wage from the HCFA survey-based wage index. Then, we incorporated the estimated average hourly wages for each Puerto Rico locale into the survey-based wage index data base. Finally, we calculated wage index values for all areas.

C. Use of SNF Market Basket

We are continuing to base the cost limits on reported costs, adjusted for actual and projected cost increases by applying the SNF market basket index. This market basket is used to adjust the SNF cost data to reflect cost increases occurring between the cost reporting periods represented in the data collection to the midpoints of the cost reporting periods to which the limits apply.

The market basket comprises the most commonly used categories of SNF routine service expenses. The categories we are using are based primarily on those used by the National Center for Health Statistics in its National Nursing Home Surveys.

The categories of expenses are weighted according to the estimated proportion of SNF routine services costs attributable to each category (see Appendix). The weights for all major categories of SNF costs are based on the National Nursing Home Surveys of 1973/1974 and 1977. (As noted in footnote [1] at the end of the appendix, the 1973/1974 survey obtained 1972 cost data and the 1977 survey obtained 1976 cost data.) These are the most current and comprehensive sources of national data on the distribution of costs in SNFs. (The second column of the appendix specifies the weights used for each category.)

In developing the market basket index, we obtained historical and projected rates of increase in the price of goods and services in each category. The market basket index table, in the third and fourth columns, identifies the price variables used and the source of the forecast for calendar years 1981 through 1987 (Appendix).

The market basket index also provides for adjustments in the limits if our forecasts of economic trends prove erroneous. For cost reporting periods beginning on or after May 1, 1986, if the final rate of change in the market basket index for a year differs from the estimated rate of change by at least .3 of one percentage point, the limits will be adjusted. We will advise the Medicare intermediaries to use the actual rate to adjust each SNF's limit retroactively at final settlement of the SNF's cost report. This approach is the same as that used for the current limits and is explained, in detail, elsewhere in this issue of the **Federal Register** (BERC–333–FN).

D. Application of the Hospital Wage Index to Employee Benefits, Health Service Costs, Costs of Business Services, and Other Miscellaneous Expenses

In developing the current hospital-based schedule, we applied the wage index discussed above to five categories of labor-related costs: wages, employee benefits, health service costs, business service costs, and other miscellaneous costs. We have retained this method in developing this revised schedule of limits. The proportion of adjusted routine service costs that we adjust by the wage index is 81.765 percent for cost reporting periods beginning on or after May 1, 1986.

For purposes of applying the wage index, employee benefits include such items as FICA tax, health insurance, life insurance, facility contributions to employee retirement funds, and all other compensation that the SNF records in the "employee health and welfare" cost center on its Medicare cost report.

Health service costs are a category used by the National Nursing Home Survey conducted in 1977 by the Office of Health Research, Statistics and Technology, National Center for Health Statistics of the Public Health Service. They include the costs of routine services that are purchased under arrangement from outside sources.

Business services costs include costs of banking, contract laundry, telephone, and other services that SNFs purchase at retail from outside suppliers.

Other miscellaneous costs include various types of routine operating costs not allocated to any other category of the market basket.

Thus, we are applying the wage index to the total portion of cost (81.765 percent attributable to wages, fringe benefits, health service costs, business service costs, and other miscellaneous expenses) rather than to the wage portion (62.239 percent for cost reporting periods beginning on or after May 1, 1986) only. We are continuing this method because our analysis of the data shows that area variations in routine per diem costs in these additional categories are closely related to area variations in prevailing wage levels. We believe that applying the wage index to the other categories of labor-related costs specified above, rather than to wages only, results in individual limits that are more equitable and more appropriate to each SNF's actual market environment.

E. Freestanding Limits Set at 112 Percent of Mean

For cost reporting periods beginning on or after May 1, 1986, we are maintaining the revised limits at 112 percent of the average labor-related and average nonlabor-related costs of each group. With the exception of the HCFA survey-based hospital wage index, we are continuing to use the same methodology for freestanding SNFs as described in the September 29, 1982 **Federal Register** notice (47 FR 42894).

F. Hospital Based Limits

For cost reporting periods beginning on or after May 1, 1986, the revised hospital-based limit equals the revised freestanding limit plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per diem routine service costs of hospital-based SNFs. The methodology for hospital-based SNFs (with the exception of the HCFA survey-based hospital wage index) is the same as the one described elsewhere in this issue of the **Federal Register** (BERC–333–FN). We are continuing to provide an add-on adjustment for A & G costs. The purpose of this add-on is to make an adjustment for the allocation of costs in the A & G cost center.

G. Cost-of-Living Adjustment for Alaska, Hawaii, Puerto Rico, and the Virgin Islands

To avoid disadvantaging SNFs located in Alaska, Hawaii, Puerto Rico, and the Virgin Islands, we are continuing to provide a cost-of-living adjustment for these areas. This is an adjustment of the nonlabor component of the limit that applies to these areas based on the amount of the most recently determined cost-of-living differentials developed by the Office of Personnel Management. Since we adjust the labor-related component by the applicable wage index, this cost-of-living adjustment applies only to the nonlabor component.

H. Exception to Cost Limits

A provider can request an exception to the proposed cost limits under the provisions of 42 CFR 405.460(f). The request is made to HCFA central office through the Medicare fiscal intermediary.

I. Classification System

We are retaining the classification

system based on whether an SNF is located within a metropolitan statistical area (MSA), as defined by the Office of Management and Budget (OMB). A discussion of OMB's MSA designations appears elsewhere in this issue of the **Federal Register** (BERC–33–FN).

The MSA and non-MSA designations in this notice are the same as those for hospital-based SNF cost limits for cost reporting periods beginning on or after July 1, 1984 (see BERC–333–FN published elsewhere in this issue of the **Federal Register**) except for the following:

- The Alton-Granite City, IL, the East St. Louis-Belleville, IL, and the St. Louis, MO-IL urban areas have been combined into one urban area, the St. Louis, MO-IL area.
- Cheyenne, Wyoming, Jackson, Tennessee, and Rapid City, South Dakota have been added as new MSAs.

III. Methodology for Determining Per Diem Routine Service Cost Limit

A. Development of Published Limits

1. Data

As previously mentioned, we are using actual freestanding and hospital-based SNF inpatient routine service cost data, less capital-related costs allocated to general inpatient routine services, obtained from Worksheet D–1 of the latest Medicare cost reports available as of November 1982. The data have been adjusted to exclude the inpatient routine nursing salary cost differential.

We adjusted these data using the market basket index discussed above, to inflate costs from the cost reporting periods in the data base to the midpoint of the first cost reporting period to which the limits apply. The annual percentage increases* in the market basket over the previous year that we used for this projection are:

1981	9.6
1982	7.3
1983	5.6
1984	4.1
1985	3.4
1986	**4.0
1987	**3.9
1988	**4.6

*These percentages have been updated from the proposed notice to reflect the most current market basket data available.
**Forecasted increase.

An adjustment is made to the limits if the forecasted market basket rate differs from the actual rate by at least .3 of one percentage point. Following the end of each year that the limits are in effect, we will determine the actual rate of increase or decrease in the market basket for that year. The data necessary to make this determination are usually available in the second quarter of the following year. This allows us to make the determination of the actual rate by June 30 of each year.

If the forecasted market basket rate differs from the actual rate by at least .3 of one percentage point, we will notify the Medicare intermediaries of the actual rate of increase or decrease and advise them to adjust each SNF cost limit at the time of final settlement.

2. Use of Wage Index to Adjust Cost Data

We divided each SNF's adjusted per diem routine service costs into labor-related and nonlabor portions. We determined the labor-related portion by multiplying each SNF's adjusted per diem routine service cost by 81.765 percent, which is the labor-related portion of cost from the market basket. We then divided the labor-related portion of each SNF's per diem cost by the wage index applicable to the SNF's location (see Tables II and III) to arrive at an adjusted labor-related portion of routine cost.

3. Group Means

We calculated separate means of labor-related and nonlabor adjusted routine service costs for each SNF group established in accordance with the SNF's MSA or non-MSA location.

4. Components of Limit

For each freestanding group, we multiplied the mean labor-related and mean nonlabor costs by 112 percent to arrive at the freestanding limits (Table I).

We then subtracted the freestanding limit for each group from 112 percent of the hospital-based mean for each group and multiplied the result by 50 percent. To arrive at the hospital-based limit (Table I), the 50 percent described above is added to the appropriate freestanding limit.

Cost Limit Data—Hospital-Based SNFs

	Urban (MSA)	Rural (Non-MSA)
112% of hospital-based mean cost:		
Labor	$93.90	$82.68
Non-labor	23.29	16.00
Total	117.19	98.68

Calculation of 50% Difference Between 112% of Hospital-Based Mean Cost and Freestanding Limit

	Labor	Non-labor
Urban (MSA)		
112% of hospital-based mean cost	$93.90	$23.29
Freestanding limit (table I)	47.64	11.74
Difference	46.26	11.55
50% of difference	23.13	5.78
Plus freestanding limit	47.64	11.74
Hospital-based limit (MSA)	70.77	17.52
Rural (Non-MSA)		
112% of hospital-based mean cost	82.68	16.00
Freestanding limit (table I)	−50.19	−9.92
Difference	32.49	6.08
50% of difference	16.25	3.04
Plus freestanding limit	50.19	9.92
Hospital-based limit (Non-MSA)	66.44	12.96

5. A & G Add-on—

We then calculate the A & G add-on for the hospital-based limits (see Table I).

	Urban	Rural
A&G difference:		
1. Hospital-based SNF A&G mean*	$8.69	$6.95
2. Freestanding SNF A&G mean*	−3.89	−3.94
3. Difference	$4.80	$3.01
Amount of A&G included in the 50% difference between 112% of the hospital-based mean costs and the freestanding limit:		
4. A&G difference (line 3)	$4.80	$3.01
5. Average rountine cost (average routine hospital-based SNF mean cost equals $117.19 and $98.68 divided by 112%)	104.63	88.11
6. Percent of A&G difference to average routine cost (line 4 divided by line 5)	4.59	3.42

	Urban	Rural
7. 50% of difference between 112% of hospital-based SNF mean cost and freestanding SNF limit	$28.91	$19.29
8. Amount of A&G difference included on line 7 (line 6 times line 7)	$1.33	$0.66
A&G add-on:		
9. A&G difference from line 3	$4.80	$3.01
10. Less amount from line 8	1.33	0.66
11. A&G add-on (line 9 less 10)	3.47	2.35
	Labor [1]	Nonlabor [2]
Urban A&G add-on=$3.47	$2.84	$0.63
Rural A&G add-on=$2.35	$1.92	$0.43

*Wage deflated means.
[1] 81.765 percent.
[2] 18.235 percent.

B. Adjustment of Published Limits

1. Adjustment of Labor-Related Component by Wage Index

a. Freestanding SNFs. To arrive at a labor-adjusted limit for each SNF, we multiply the labor-related component of the limit for the SNF's group by the wage index developed from wage levels for hospital workers in the area in which the SNF is located (see Tables II and III). The adjusted limit that applies to an SNF is the sum of the nonlabor component, plus the adjusted labor-related component, unless the SNF qualifies for the cost reporting year adjustment discussed in paragraph 2, below.

Example—Calculation of Adjusted Limit for Freestanding SNF (A) Located in Dallas, Texas:

Labor-Related Component $47.64 (Table I); Nonlabor Component $11.74 (Table I); MSA Wage Index 1.0758 (Table II).

Computation of Adjusted Limit

Labor-related component	$47.64
Wage index	×1.0758
Adjusted labor component	51.25
Nonlabor component	+11.74
Adjusted limit	62.99

b. Hospital-Based SNFs. To arrive at a labor-adjusted limit for each hospital-based SNF, we add the labor-related component of the limit and the labor-related component of the A&G add-on for the hospital-based SNF's group and multiply the sum by the wage index developed from wage levels for hospital workers in the area in which the hospital-based SNF is located (see Tables II and III). We then add the nonlabor component of the limit and the nonlabor component of the A&G add-on. The adjusted limit that applies to a hospital-based SNF is the sum of the adjusted labor component and add-on and the nonlabor component and add-on unless the facility qualifies for the cost reporting year adjustment discussed in paragraph 2 below.

Example: Calculation of Adjusted Limits for Hospital-Based SNF (B) Located in Scranton-Wilkes-Barre, Pennsylvania.

Labor Related Component: Limit $70.77 (Table I); Add-on $2.84 (Table I).

Nonlabor Component: Limit $17.52 (Table I); Add-on $0.63 (Table I).

MSA Wage Index: 0.9982 (Table II).

Computation of Adjusted Limit

Labor-related component:	
Limit	$70.77
Add-on	+2.84
	73.61
Wage index	×.9982
Adjusted Labor Component	73.48
Nonlabor component	
Limit	+17.52
Add-on	+0.63
Adjusted limit	91.63

2. Adjustment for Cost Reporting Year

If a facility has a cost reporting period beginning after May 1, 1986, the intermediary will increase the limit that otherwise applies to the SNF by the factor from Table IV that corresponds to the month and year in which the cost reporting period begins. Each factor represents the compounded monthly increase derived from the projected annual increase in the market basket index, and is used to account for inflation in costs that will occur after the date on which the limits are effective.

Example: The following is a computation of a revised hospital-based limit for previously cited SNF (B). Hospital-based SNF (B) has a cost reporting period that begins June 1, 1986. The otherwise applicable limit for SNF (B) is $91.63.

Individual SNF adjusted limit	$91.63
Adjustment factor from table IV	×1.00319
Revised limit	91.92

If a facility uses a cost reporting period that is not 12 months in duration, a special adjustment factor must be calculated. This is necessary because projections are computed to the midpoint of a cost reporting period and the adjustment factors in Table IV are based on an assumed 12-month reporting period. For cost reporting periods of other than 12 months, the calculation must be done for the midpoint of the specific cost reporting period. The SNF's intermediary will obtain this adjustment factor from our central office.

IV. Discussion of Public Comments

We received comments from two senior citizen organizations, one medical center, and one insurance association on our proposed SNF cost limits notice. A discussion of the comments and our responses to them are provided below.

Comment: Some commenters stated that the cost limits levels proposed for SNFs are inadequate. They believe that the levels are arbitrary and based on inappropriate data.

Response: Section 2319 of Pub. L. 98-369 governs the methodology for computing the SNF cost limits for cost reporting periods beginning on or after October 1, 1982. The methodology proposed for freestanding and hospital-based SNFs was in accordance with that statute. The cost limits are based on the most recent and accurate data available, which should, in turn, yield the most appropriate cost limit levels.

Comment: Some commenters believe that we should use the HCFA wage index, which was developed for the prospective payment system, to establish the SNF cost limits. The wage index in the November 22, 1985 proposed notice was developed by using BLS hospital wage data.

Response: We agree and have incorporated the HCFA survey-based wage index into the methodology in this final notice.

Comment: Some commenters stated that the data used to develop the SNF cost limits were derived from cost reports prior to the implementation of the prospective payment rates for hospitals, which are based on diagnostic related groups (DRGs). The commenters believe that the advent of DRG payment has resulted in SNFs having to furnish a more intensive level of care to

beneficiaries, resulting in additional costs to the SNFs. These commenters do not believe that the additional costs are reflected in our proposed SNF cost limits. They suggested that the data used to develop the SNF cost limits be based on later cost years and the impact of the prospective payment system be considered.

Response: The data used to develop the cost limits are based on the latest cost report data available in the form required to develop the limits. Although we have received later cost reports, we have not been able to edit and analyze the data from these reports to the extent necessary, to ensure its accuracy and reliability in developing cost limits. We believe the data used in developing the limits must be the most accurate data available at the time the limits are developed.

The data used to develop the limits are based on pre-DRG data. However, the exceptions process is available to any SNF that incurs additional costs by furnishing markedly more intensive services (see 42 CFR 405.460). Further, a SNF need not wait until the end of its cost reporting period to apply for an exception. An exception may be requested before or during a cost reporting period.

Comment: One commenter stated that the line descriptions of the labor and nonlabor components under "COST LIMIT DATA—HOSPITAL-BASED SNFs" in section III.A.4. of the proposed notice (50 FR 48306) are misleading. The commenter believes that these line descriptions imply that the labor and nonlabor components for urban and rural areas are 81.62 percent and 18.38 percent of the totals respectively. The commenter suggested changing the line descriptions by deleting the percentages so that the lines read only "Labor" and "Nonlabor".

Response: We agree and have changed the line descriptions as suggested. The percentages were erroneously inserted in the proposed notice as part of the line descriptions and are actually used to determine the labor and nonlabor portions of each SNF's total routine service costs (see section III.A.2. of this final notice).

V. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 requires us to prepare and publish an initial regulatory impact analysis for any major rule. A major rule is defined as any document such as this, that is likely to: (1) have an annual effect on the economy of $100 million or more, (2) cause a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or (3) result in significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We estimate that the revised limits will result in a net savings to the Medicare program of approximately $15 million through FY 1988, compared to expenditures under the prior limits.

The following table projects cost savings of the revised limits for cost reporting periods beginning on or after May 1, 1986 and before May 1, 1987:

Cost reporting periods	Fiscal Years (Rounded to the nearest $5 million)			
	1986	1987	1988	Total
Apr. 1 through Dec. 31, 1986	*	5	*	5
Jan. 1, through Mar. 31, 1987		5	5	10
Total	*	10	5	15

*Negligible; that is, less than $2.5 million.

Because the impact does not exceed $100 million annually, or any other threshold criterion under Executive Order 12291, we have determined that this is not a major rule and an initial regulatory impact analysis is not required.

B. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and publish an initial regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations do not have a significant economic impact on a substantial number of small entities. We consider all SNFs to be small entities under the RFA.

The table below shows the estimated number of hospital-based and freestanding SNFs that are estimated to have costs in excess of these revised limits applicable to cost reporting periods beginning on or after May 1, 1986, if they do not change their spending patterns. These figures include SNFs for cost reporting periods that begin on or after May 1, 1986, and before May 1, 1987.

Number of hospital-based SNFs in data base	417
Number of hospital/based SNFs with costs estimated to be in excess of limits	251
Number of freestanding SNFs in data base	2,780
Number of freestanding SNFs with costs estimated to be in excess of limits	1,068

In addition, many SNFs will be affected by the adoption of the HCFA wage index. The limits applicable to a given facility may be either increased or decreased by a change in the index value for the area.

As can be seen, a substantial number of SNFs are affected by this rule. However, it is our practice not to consider an economic impact on small entities to be significant unless the annual total costs or revenues of a substantial number of entities would be increased or decreased by at least three percent.

Neither the revised limits nor the HCFA wage index will result in facility total revenues being reduced by three percent or more over the limits that would otherwise apply. Medicare does not account for a high proportion of SNF utilization or revenue. In 1983, for example, Medicare SNF expenditures accounted for only 1.8 percent of total national nursing home expenditures. Therefore, we have determined, and the Secretary certifies, that this notice does not have a significant economic impact on a substantial number of small entities. We have not prepared a regulatory flexibility analysis.

Comment: One commenter stated that we should have performed a detailed regulatory flexibility analysis in the proposed notice. The commenter argued that incremental analysis (that is, determining impact based on a comparison of proposed payments to current payments) is inappropriate. The commenter wanted us to: (1) Compare provider cost behavior over the period of the limits;

(2) provide a detailed comparison of costs, payments, and benefits; and (3) determine the extent to which penalties under the limits would be due to inefficiency and not differences in case mix or other factors unrelated to efficiency.

Response: It is this Department's established practice to measure the effects attributable to a rule or notice by the difference between the situation that would occur as a result of the new action and that which would prevail in its absence. Using this standard, we have determined that a regulatory flexibility analysis is not required. In addition, the level of these limits is the result of a congressional mandate. We believe we have determined appropriately that a regulatory

flexibility analysis is not necessary for this notice.

VI. Schedule of Limits

Under the authority of sections 1861(v) and 1888 of the Social Security Act, the following group per diem limits apply to the adjusted SNF inpatient routine service costs reimbursed under Medicare for cost reporting periods beginning on of after May 1, 1986. Medicare fiscal intermediaries compute the adjusted limits for SNFs using the methodology set forth in this notice and notify each SNF of its applicable limit. These limits, as adjusted by the wage indexes in Tables II and III, and the cost reporting year adjustment factors in Table IV, remain in effect for cost reporting periods beginning on or after May 1, 1986.

Table I.—SNF Group Limits

Location	Labor related component	Nonlabor component [1]
Freestanding:		
MSA	$47.64	$11.74
Non-MSA	50.19	9.92
Hospital-Based:		
MSA:		
Limit	70.77	17.52
Add-on	2.84	0.63
Non-MSA		
Limit	66.44	12.96
Add-on	1.92	0.43

[1] The nonlabor portion of the limits for SNFs located in the States of Alaska and Hawaii, the commonwealth of Puerto Rico, and the Virgin Islands will be increased by the following cost-of-living adjustments:

	Adjustment factor
Alaska	1.250
Hawaii:	
Oahu	1.225
Kauai	1.150
Maui, Lanai and Molokai	1.200
Hawaii (island)	1.125
Puerto Rico	1.075
Virgin Islands	1.125

Table II.—Wage Index for Urban Areas

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX	0.9003
Taylor, TX	
Aguadilla, PR	*.5581
Aguada, PR	
Aguadilla, PR	
Isabella, PR	
Moca, PR	
Akron, OH	1.1080
Portage, OH	
Summit, OH	
Albany, GA	.8183
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.9248
Albany, NY	
Greene, NY	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.1078
Bernalillo, NM	
Alexandria, LA	.9169
Rapides, LA	
Allentown-Bethlehem, PA–NJ	1.0454
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	1.0022
Blair, PA	
Amarillo, TX	.9595
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2616
Orange, CA	
Anchorage, AK	1.5849
Anchorage, AK	
Anderson, IN	.9882
Madison, IN	
Anderson, SC	.8369
Anderson, SC	
Ann Arbor, MI	1.2607
Washtenaw, MI	
Anniston, AL	.8519
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	1.0666
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	*.6081
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	.8844
Buncombe, NC	
Athens, GA	.8179
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	.9663
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	1.0566
Atlantic, NJ	
Cape May, NJ	
Augusta, GA–SC	.9602

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.1015
Kane, IL	
Kendall, IL	
Austin, TX	1.1177
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.2059
Kern, CA	
Baltimore, MD	1.1150
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
Bangor, ME	.9285
Penobscot, ME	
Baton Rouge, LA	.9825
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	1.0302
Calhoun, MI	
Beaumont-Port Arthur, TX	1.0082
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0919
Beaver, PA	
Bellingham, WA	1.1471
Whatcom, WA	
Benton Harbor, MI	.8911
Berrien, MI	
Bergen-Passaic, NJ	1.0748
Bergen, NJ	
Passaic, NJ	
Billings, MT	1.0226
Yellowstone, MT	
Biloxi-Gulfport, MS	.8489
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9558
Broome, NY	
Tioga, NY	
Birmingham, AL	.9663
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	.9943
Burleigh, ND	
Morton, ND	
Bloomington, IN	.9899
Monroe, IN	
Bloomington-Normal, IL	.9844
McLean, IL	
Boise City, ID	1.0584
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1560
Essex, MA	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Middlesex, MA	
Norfolk, MA	
Plymount, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.1326
Boulder, CO	
Bradenton, FL	.9196
Manatee, FL	
Brazoria, TX	.8742
Brazoria, TX	
Bremerton, WA	.9813
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1846
Fairfield, CT	
Brownsville-Harlingen, TX	.8977
Cameron, TX	
Bryan-College Station, TX	.9569
Brazos, TX	
Buffalo, NY	1.0687
Erie, NY	
Burlington, NC	.7926
Alamance, NC	
Burlington, VT	1.0131
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	*.6279
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Aguas Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	1.0080
Carroll, OH	
Stark, OH	
Casper, WY	1.1063
Natrona, WY	
Cedar Rapids, IA	1.0174
Linn, IA	
Champaign-Urbana-Rantoul, IL	.9965
Champaign, IL	
Charleston, SC	.8912
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	1.0482
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	.8991
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	.9345
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	1.0041
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	.9702
Laramie, WY	
Chicago, IL	1.2351
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.2463
Butte, CA	
Cincinnati, OH-KY-IN	1.1050
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	.8183
Christian, KY	
Montgomery, TN	
Cleveland, OH	1.1565
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.0439
El Paso, CO	
Columbia, MO	1.1022
Boone, MO	
Columbia, SC	.9168
Lexington, SC	
Richland, SC	
Columbus, GA-AL	.7929
Russell, AL	
Chattanoochee, GA	
Muscogee, GA	
Columbus, OH	.9684
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.9899
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.8996
Allegany, MD	
Mineral, WV	
Dallas, TX	1.0758
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	.8087
Danville, City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	1.0660
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0939
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	.9139
Volusia, FL	
Decatur, IL	.9592
Macon, IL	
Denver, CO	1.2865
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	1.0556
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.1725
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.8457
Dale, AL	
Houston, Al	
Dubuque, IA	1.0590
Dubuque, IA	
Duluth, MN–WI	.9930
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	.9498
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.9437
El Paso, TX	
Elkhart-Goshen, IN	.9650
Elkhart, IN	
Elmira, NY	.9741
Chemung, NY	
Enid, OK	.9626
Garfield, OK	
Erie, PA	.9991
Erie, PA	
Eugene-Springfield, OR	1.1163
Lane, OR	
Evansville, IN–KY	1.0217
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0644
Clay, MN	
Cass, ND	
Fayetteville, NC	.8330
Cumberland, NC	
Fayetteville-Springdale, AR	.8078
Washington, AR	
Flint, MI	1.2104
Genesee, MI	
Florence, AL	.7889
Colbert, AL	
Lauderdale, AL	
Florence, SC	.7686
Florence, SC	
Fort Collins-Loveland, CO	1.0846
Larimor, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.1249

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Fort Myers-Cape Coral, FL	.9533
Broward, FL	
Fort Myers-Cape Coral, FL	.9533
Lee, FL	
Fort Pierce, FL	1.0215
Martin, FL	
St. Lucie, FL	
Fort Smith, AR–OK	.9243
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	.8751
Okaloosa, FL	
Fort Wayne, IN	.9568
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	.9990
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.1490
Fresno, CA	
Gadsden, AL	.8777
Etowah, AL	
Gainesville, FL	.9642
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.1412
Galveston, TX	
Gary-Hammond, IN	1.0978
Lake, IN	
Porter, IN	
Glens Falls, NY	.9607
Warren, NY	
Washington, NY	
Grand Forks, ND	.9871
Grand Forks, ND	
Grand Rapids, MI	1.0663
Kent, MI	
Ottawa, MI	
Great Falls, MT	1.0722
Cascade, MT	
Greeley, CO	1.0763
Weld, CO	
Green Bay, WI	1.0326
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9388
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	.9130
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	.9585
Washington, MD	
Hamilton-Middletown, OH	1.0214
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	.9868
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Hartford-New Middletown-Britain-Bristol, CT	1.1486
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.8982
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.2022
Honolulu, HI	
Houma-Thibodaux, LA	.9229
Lafourche, LA	
Terrebonne, LA	
Houston, TX	1.0668
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV–KY–OH	.9509
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.8661
Madison, Al	
Indianapolis, IN	1.0594
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.3084
Johnson, IA	
Jackson, MI	1.0206
Jackson, MI	
Jackson, MS	.9354
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	.7916
Madison, TN	
Jacksonville, FL	.9481
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	.7966
Onslow, NC	
Janesville-Beloit, WI	.9422
Rock, WI	
Jersey City, NJ	1.1108
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN–VA	.8617
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Washington, VA	
Johnstown, PA	.9526
Cambria, PA	
Somerset, PA	
Joliet, IL	1.1253
Grundy, IL	
Will, IL	
Joplin, MO	.9202
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.2341
Kalamazoo, MI	
Kankakee, IL	.9510
Kankakee, IL	
Kansas City, MO–KS	1.0660
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	1.0875
Kenosha, WI	
Killeen-Temple, TX	.8849
Bell, TX	
Coryell, TX	
Knoxville, TN	.8996
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9870
Howard, IN	
Tipton, IN	
La Crosse, WI	1.0167
LaCrosse, WI	
Lafayette, LA	1.0114
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	.9163
Tippecanoe, IN	
Lake Charles, LA	1.0036
Calcasieu, LA	
Lake County, IL	1.1637
Lake, IL	
Lakeland-Winter Haven, FL	.8851
Polk, FL	
Lancaster, PA	1.0396
Lancaster, PA	
Lansing-East Lansing, MI	1.0769
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	.8163
Webb, TX	
Las Cruces, NM	.8767
Dona Ana, NM	
Las Vegas, NV	1.1254
Clark , NV	
Lawrence, KS	1.0180
Douglas, KS	
Lawton, OK	.9469

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Comanche, OK	
Lewiston-Auburn, ME	.9426
Androscoggin, ME	
Lexington-Fayette, KY	.9873
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	.9866
Allen, OH	
Auglaize, OH	
Lincoln, NE	.9710
Lancaster, NE	
Little Rock-North Little Rock, AR	1.1135
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, Ar	
Longview-Marshall, TX	.8410
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	1.0280
Lorain, OH	
Los Angeles-Long Beach, CA	1.3290
Los Angeles, CA	
Louisville, KY-IN	1.0081
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	1.0128
Lubbock, TX	
Lynchburg, VA	.9215
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	.9325
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0902
Dane, WI	
Manchester-Nashua, NH	.9724
Hillsboro, NH	
Merrimack, NH	
Mansfield, OH	.9919
Richland, OH	
Mayaguez, PR	*.5732
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	.8105
Hidalgo, TX	
Medford, OR	1.0356
Jackson, OR	
Melbourne-Titusville, FL	.9378
Brevard, FL	
Memphis, TN-AR-MS	1.0494
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Miami-Hialeah, FL	1.0703
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	1.0349
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.1305
Midland, TX	
Milwaukee, WI	1.1411
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.1772
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.8927
Baldwin, Al	
Mobile, AL	
Modesto, GA	1.2103
Stanislaus, CA	
Monmouth-Ocean, NJ	.9924
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.9343
Ouachita, LA	
Montgomery, AL	.8876
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	1.0065
Delaware, IN	
Muskegon, MI	.9912
Muskegon, MI	
Naples, FL	1.0448
Collier, FL	
Nashville, TN	.9414
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.3143
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9795
Bristol, MA	
New Haven-West Haven-Waterbury-Meriden, CT	1.1276
New Haven, CT	
New London-Norwich, CT	1.1103
New London, CT	
New Orleans, LA	.9344
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3859
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.1404
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	8963
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	.9692
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
Oakland, CA	1.4893
Alameda, CA	
Contra Costa, CA	
Ocala, FL	.8735
Marion, FL	
Odessa, TX	.9619
Ector, TX	
Oklahoma City, OK	1.0930
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	1.0787
Thurston, WA	
Omaha, NE-IA	1.0509
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	.9299
Orange, NY	
Orlando, FL	1.0188
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	.8243
Daviess, KY	
Oxnard-Ventura, CA	1.2851
Ventura, CA	
Panama City, FL	.8354
Bay, FL	
Parkersburg-Marietta, WV-OH	.9121
Washington, OH	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Wood, WV	
Pascagoula, MS	.9678
Jackson, MS	
Pensacola, FL	.8742
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	1.0584
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA–NJ	1.1793
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.0801
Maricopa, AZ	
Pine Bluff, AR	.8009
Jefferson, AR	
Pittsburgh, PA	1.1008
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	1.0246
Berkshire, MA	
Ponce, PR	*.6935
Juana Diaz, PR	
Ponce, PR	
Portland, ME	1.0114
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.2074
Clackamas, OR	
Multhnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	.9373
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.0052
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	1.0553
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Statewide, RI	
Washington, RI	
Provo-Orem, UT	.9858
Utah, UT	
Pueblo, CO	1.1210
Pueblo, CO	
Racine, WI	1.0002
Racine, WI	
Raleigh-Durham, NC	.9720
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	.9623
Pennington, SD	
Reading, PA	1.0248

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Berks, PA	
Redding, CA	1.2396
Shasta, CA	
Reno, NV	1.1839
Washoe, NV	
Richland-Kennewick, WA	1.0256
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.9564
Charles City Co., VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.2517
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	.8997
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0284
Olmsted, MN	
Rochester, NY	1.0226
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.1354
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.2969
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.1070
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	1.0018
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9487
Buchanan, MO	
St. Louis, MO-IL	1.0827
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0971
Marion, OR	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2571
Monterey, CA	
Salt Lake City-Ogden, UT	1.0354
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.8719
Tom Green, TX	
San Antonio, TX	.8943
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.3104
San Diego, CA	
San Francisco, CA	1.6517
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.4805
Santa Clara, CA	
San Juan, PR	*.6197
Barcelona, PR	
Bayoman, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trojillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1822
Santa Barbara, CA	
Santa Cruz, CA	1.2432
Santa Cruz, CA	
Sante Fe, NM	.9809
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.3112
Sonoma, CA	
Sarasota, FL	.9639
Sarasota, FL	
Savannah, GA	.8917
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	.9962
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.1579
King, WA	

Table II.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Snohomish, WA	
Sharon, PA	.9757
Mercer, PA	
Sheboygan, WI	.9885
Sheboygan, WI	
Sherman-Denison, TX	.8619
Grayson, TX	
Shreveport, LA	.9613
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	1.0062
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	1.0211
Minnehaha, SD	
South Bend-Mishawaka, IN	1.0087
St. Joseph, IN	
Spokane, WA	1.1559
Spokane, WA	
Springfield IL	1.0664
Mengard, IL	
Sangamon, IL	
Springfield, MO	.9863
Christian, MO	
Greene, MO	
Springfield, MA	1.0060
Hampden, MA	
Hampshire, MA	
State College, PA	1.0772
Centre, PA	
Steubenville-Weirton, OH-WV	.9655
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.2871
San Joaquin, CA	
Syracuse, NY	1.0301
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.1052
Pierce, WA	
Tallahassee, FL	.9509
Gadsen, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	.9830
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8456
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	.8650
Miller, AR	
Bowie, TX	
Toledo, OH	1.2267
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	1.0632
Shawnee, KS	
Trenton, NJ	1.0317
Mercer, NJ	
Tucson, AZ	1.0090
Pima, AZ	
Tulsa, OK	1.0131
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	1.0172
Tuscaloosa, AL	
Tyler, TX	1.0035
Smith, TX	
Utica-Rome, NY	.8840
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.3397
Napa, CA	
Solano, CA	
Vancouver, WA	1.1659
Clark, WA	
Victoria, TX	.8205
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9929
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.0643
Tulare, CA	
Waco, TX	.9117
McLennan, TX	
Washington, DC-MD-VA	1.1965
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	.9993
Black Hawk, IA	
Bremer, IA	
Wausau, WI	.9871
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	.9972
Palm Beach, FL	
Wheeling, WV-OH	.9771
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.1589
Butler, KS	
Sedgwick, KS	
Wichita Falls, TX	.8776
Wichita, TX	
Williamsport, PA	.9048
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0588
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.9591
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	1.0094
Worcester, MA	
Yakima, WA	1.0389
Yakima, WA	
York, PA	.9853
Adams, PA	
York, PA	
Youngstown-Warren, OH	1.0480
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0460
Sutter, CA	
Yuba, CA	

* Approximate value for area.

Table III.—Wage Index for Rural Areas

	Wage index
Nonurban area:	
Alabama	0.7466
Alaska	1.4989
Arizona	.9323
Arkansas	.7703
California	1.1457
Colorado	.9326
Connecticut	1.0880
Delaware	.8645
Florida	.8815
Georgia	.7779
Hawaii	1.0157
Idaho	.9130
Illinois	.8917
Indiana	.8685
Iowa	.8719
Kansas	.8481
Kentucky	.8036
Louisiana	.8605
Maine	.8701
Maryland	.8773
Massachusetts	1.0548
Michigan	.9589
Minnesota	.8788
Mississippi	.7705
Missouri	.8325
Montana	.9154
Nebraska	.8310
Nevada	1.0799
New Hampshire	.9234
New Jersey	NA
New Mexico	.9213
New York	.8730
North Carolina	.8130
North Dakota	.9061
Ohio	.9100
Oklahoma	.8462
Oregon	1.0782
Pennsylvania	.9427
Puerto Rico	*.5736
Rhode Island	.9553
South Carolina	.7827
South Dakota	.8263
Tennessee	.7733
Texas	.8180
Utah	.9505
Vermont	.8888
Virginia	.8194
Virgin Islands	*1.0000
Washington	1.0273
West Virginia	.8816

Table III.—Wage Index for Rural Areas—Continued

	Wage index
Wisconsin	.8995
Wyoming	.9745

*Approximate value for area.

Table IV.—Cost Reporting Year Adjustment Factors [1]

If a SNF cost reporting period begins:	*The adjustment factor is:*
June 1, 1986	1.00319
July 1, 1986	1.00640
Aug. 1, 1986	1.00961
Sept. 1, 1986	1.01283
Oct. 1, 1986	1.01607
Nov. 1, 1986	1.01931
Dec. 1, 1986	1.02257
Jan. 1, 1987	1.02583

[1] Based on compounded projected market basket inflation rates of 3.9 percent for 1987 and 4.6 percent for 1988. These adjustment factors are subject to change based on later estimates of cost increases or decreases.

If, for any reason, we do not publish a new schedule of limits to be effective on February 1, 1987 or do not announce other changes in the current schedule by that date, the current limits will continue in effect, with the last adjustment factor above multiplied by 1.00375 once for each month between January 1, 1987 and the month in which the cost reporting period begins, until a new schedule of limits or other provision is issued. For example, if a cost reporting period begins on March 1, 1987, 1.02583 would be multiplied by 1.00375 twice and the resulting factor would equal 1.03354 (1.02583 × 1.00375 × 1.00375 = 1.03354).

APPENDIX.—DERIVATION OF "MARKET BASKET" INDEX FOR SNF ROUTINE SERVICE COSTS

[Cost reporting periods beginning on or after May 1, 1986]

Category of costs	Relative [1] importance 1986	Forecaster percent changes (1981–1987)	Price variable used
Payroll expenses	62.239	DRI–CFS [2]	Percentage changes in average hourly earnings of employees in nursing and personal care facility. (SIC 805) Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly), Table C–2.
Food	8.199	DRI–MM [3]	Processed foods and feeds component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
		DRI–MM	Food and beverage component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 22.
Employee benefits	8.124	DRI–MM	Supplements to wages and salaries per worker in nonagricultural establishments. For supplements to wages: Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, Table 1.11 For total employment: Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings* (monthly), Table B–4.
Fuel and other utilities	4.984	DRI–MM	A. Implicit price deflator-consumption of fuel oil and coal (derived from fuel oil component of Consumer Price Index). Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, (monthly)*, Table 7.11.
		DRI–MM	B. Implicit price deflator-consumption of electricity (derived from electricity component of Consumer Price Index). Source: U.S. Dept. of Commerce, Bureau of Economic Analysis.
		DRI–MM	C. Implicit price deflator for natural gas (derived from utility (piped) gas component of Consumer Price Index). Source: Same as electricity above.
		DRI–CFS	D. Water and sewage maintenance component of the Consumer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Miscellaneous	4.835	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Other business services	5.199	DRI–MM	Services component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Supplies	3.311	DRI–MM	All Item Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Drugs	1.741	DRI–CFS	Pharmaceutical preparations, ethical component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Producer Prices and Price Indexes*, (monthly), Table 6.
Health services	1.368	DRI–CFS	Physician services component of Consumer Price Index for all urban consumers. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.

[1] The basic weights for all major categories of skilled nursing home costs were obtained from the DHEW-National Center for Health Statistics (NCHS) National Nursing Home Surveys (NNHS) for 1972 and 1976 for homes certified for participation in the Medicare program. See *Nursing Home Costs 1972, United States: National Nursing Home Survey, August 1973–April 1974, DHEW, MCHS: National Nursing Home Survey: 1977 Summary of the United States, Vital and Health Statistics, Series 13, Number 43.*

A Laspeyres price index was constructed using 1977 weights and price variables indicated in this table. In calendar year 1977 each "price" variable has an index of 100.0. The relative routine service cost weights change each period in accordance with price changes for each price variable. Cost categories with relatively higher "price" increases get relatively higher cost weights and vice versa.

[2] DRI–CFS refers to Data Resources, Inc., Cost Forecasting Service (CFS 861), 1750 K Street, N.W., Washington D.C. 20006.

[3] DRI–MM refers to Data Resources, Inc., Trendlong (186), 29 Hartwell Avenue, Lexington, Massachusetts 02173.

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), 1871, and 1888 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a), 1395hh, and 1395yy)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program)

Dated: February 13, 1986.

Henry R. Desmarais,

Acting Administrator, Health Care Financing Administration.

Approved: March 11, 1986.

Otis R. Bowen,

Secretary.

[FR Doc. 86–7131 Filed 3–31–86; 8:45 am]

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Federal Register

Tuesday
April 1, 1986

Part V

Department of Health and Human Services

Food and Drug Administration

21 CFR Part 812

The American Society of Artificial Internal Organs Petition To Amend Investigational Device Exemption Regulations; Request for Comment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 812

[Docket No. 84P-0387]

The American Society of Artificial Internal Organs Petition To Amend Investigational Device Exemption Regulations; Request for Comment

AGENCY: Food and Drug Administration.

ACTION: Notice of citizen petition.

SUMMARY: The Food and Drug Administration (FDA) is soliciting comments on a citizen petition, submitted by the American Society of Artificial Internal Organs (ASAIO), requesting FDA to amend its regulations governing investigational device exemptions (IDE's) to allow certain limited investigations of significant risk medical devices to be subject to abbreviated IDE requirements.

DATE: Comments by June 30, 1986.

ADDRESS: Written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Les Weinstein, Center for Devices and Radiological Health (HFZ-84), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD. 20857, 301-443-4874.

SUPPLEMENTARY INFORMATION: Section 520(g) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 360j(g)) authorizes the exemption of devices from provisions of the act relating to misbranding, registration, premarket notification, performance standards, premarket approval, banned devices, recordkeeping and reporting requirements, restrictions on distribution of devices, good manufacturing practice requirements, and use of color additives, to permit devices to be used for clinical investigations to determine their safety and effectiveness. Section 520(g)(2)(A) of the act requires FDA to promulgate regulations prescribing procedures and conditions under which devices may be granted exemptions, known as investigational device exemptions (IDE's), from these provisions. Section 520(g)(2)(C) of the act permits FDA to vary the procedures and conditions under which investigations may be conducted depending upon the scope and duration of clinical testing, the number of human subjects involved in such testing, the need to permit changes to be made in the device subject to the testing, and whether the clinical testing is for the purpose of developing data to obtain approval for commercial distribution of the device.

To carry out the purpose of section 520(g)(2) of the act, and as a result of comments that FDA received on the proposal (41 FR 35282, 35284; August 20, 1976) and the reproposal (43 FR 20726, 20727; May 12, 1978), the final rule on IDE's (21 CFR Part 812) varies the amount of regulatory control over clinical investigations of devices depending on the degree of risk presented to subjects by use of the device. Accordingly, Part 812 currently provides that an investigation of any device that meets the definition in § 812.3(m) of a "significant risk device" is subject to detailed regulatory control and requires IRB and FDA approval. A sponsor of such an investigation must submit an investigational plan and report of prior investigations to an IRB and an IDE application to FDA.

Less regulatory control is exercised over investigations of devices other than significant risk devices. Such devices include articles such as crutches, elastic knee braces, bedboards, bedpans, medical chairs, and tongue depressors, as ordinarily used. A sponsor of an investigation that does not involve a significant risk device does not need to submit an IDE application to FDA or obtain FDA approval before beginning an investigation, unless FDA notifies the sponsor that approval is required. The sponsor must, however, properly label the device, obtain and maintain IRB approval, ensure that investigators document informed consent, maintain certain basic records, evaluate and submit reports concerning unanticipated adverse device effects, and comply with requirements for monitoring studies, prohibitions against commercialization, and undue prolonging of investigations.

FDA established the distinction between significant and other than significant risk devices and the system of review of investigations of each type of device in the belief that the distinction and the system carry out the purpose of section 520(g)(2) of the act in accordance with the congressional policy set forth in section 520(g)(1). That purpose is "to encourage, to the extent consistent with the protection of the public health and safety and with ethical standards, the discovery and development of useful devices intended for human use and to that end to maintain optimum freedom for scientific investigators in their pursuit of that purpose."

On November 21, 1984, ASAIO, P.O. Box C, Boca Raton, FL 33429, filed a citizen petition with FDA requesting that the agency amend Part 812 to allow "limited" investigations, or "feasibility" studies, involving significant risk devices after providing the agency with a "Notice of Limited Investigation." The petition also requests that FDA amend Part 812 to make such limited investigations subject only to abbreviated requirements, proposed in the petition, rather than the full requirements of the IDE regulations. The agency is publishing this notice to solicit information and views in accordance with 21 CFR 10.30(h)(3) to assist FDA in deciding whether to grant or deny the petition.

As described in the petition, a limited investigation of a device is a study intended to determine the feasibility of using the device for clinical diagnosis or treatment. The petition requests that "limited investigations" be permitted only where the investigation will be conducted at a single institution and will involve no more than 10 human subjects. The data from such investigations would not be used as primary support of a premarket approval application or a premarket notification submission. The petition proposes that sponsors of limited investigations submit to FDA, in lieu of the IDE application now required under Part 812, a "Notice of Limited Investigation." The notice would include, among other things, a description of the device, a summary of the purposes, objectives, and plan of the investigation, a sample of the informed consent form to be used in the investigation, and a certification of approval by the responsible IRB. FDA would have 14 days in which to review the "Notice of Limited Investigation" before the investigation could begin. The petition outlines the circumstances under which FDA could require additional information, require the submission of a full IDE application, or suspend the investigation. The intent of the petition is to place primary emphasis on IRB prior approval, while providing FDA with prompt notification of a proposed investigation and the opportunity to review and to act upon that investigation.

ASAIO argues that Congress intended the act to provide flexibility to investigators of innovative devices. ASAIO believes, however, that the current regulatory process provided by FDA in Part 812, especially as it pertains to the feasibility stages of medical device investigations, creates an imbalance that impedes or, in some cases, effectively prevents the development of important medical devices in the United States. ASAIO

argues that the petition is consistent with FDA's regulation of investigational drug studies, exemplified in the proposed changes to the regulations governing new drugs for investigational use (IND regulations) (see June 9, 1983; 48 FR 26720).

As discussed above, section 520(g)(1) of the act directs FDA to encourage the discovery and development of useful medical devices without compromising ethical principles or patients' health or safety. Abbreviated requirements in the current IDE regulations (§ 812.2) provide flexibility for investigations of other than significant risk devices. Additional flexibility for investigations of devices is provided through provisions in Part 812 that allow for waivers from some IDE requirements. These waivers are granted on a case-by-case basis.

An internal FDA task force established to review criticisms of the IDE program conducted a preliminary review of the ASAIO petition. The task force also considered whether it would be possible to establish criteria to identify device investigations, other than feasibility studies as described in the petition, that could be subject to lesser regulatory requirements, without compromising ethical principles or jeopardizing patients rights, welfare, or safety.

After a preliminary review of the petition, the task force met with representatives of ASAIO on February 14, 1985, to discuss the petition. On April 17, 1985, FDA received from ASAIO a supplement to its petition with a chart detailing the intended effect on the IDE regulations of the changes the petition proposes. The original petition, the minutes of the meeting, and the supplement are on file in the Dockets Management Branch (address above) under the docket number in the heading of this notice and are available for public review between 9 a.m. and 4 p.m., Monday through Friday. On June 7, 1985, FDA sent a tentative response to the petitioner stating that the agency was reviewing the additional information together with the petition.

After reviewing criticisms of the IDE program and the ASAIO petition, the task force recommended to the agency that it solicit comments on the issues presented by the petitioner. Accordingly, under § 10.30(h)(3) of FDA's administrative practices and procedures regulations (21 CFR 10.30(h)(3)), FDA is issuing this notice to request comments from interested persons to help the agency in its evaluation of the petition and of the effect that granting or denying the petition, in whole or in part, might have on the public health.

Coincidentally, FDA is also beginning a retrospective review of the IDE regulations in accordance with the Regulatory Flexibility Act (5 U.S.C.601) and Executive Order 12291. The purpose of the review is to examine whether the regulatory requirements are justified considering the need for public health protection. The review may result in FDA's proposing to change the IDE regulations. Even though this review may consider some of the same issues the ASAIO petition raises, FDA does not want to unduly delay the public's opportunity to examine and comment upon the ASAIO petition until the agency, sometime in the future, solicits comments on a proposed revision of the entire IDF regulations. FDA will consider any comments received in response to this notice in its review of the IDE regulations.

The original petition is being published below:

Citizen Petition

The American Society for Artifical Internal Organs (ASAIO or petitioner) submits this petition under sections 501, 502, 520(g)(2) and 701 (21 U.S.C. 351, 352, 360j(g)(2), and 371) of the Food, Drug, and Cosmetic Act, 5 U.S.C. 553(e), and 21 CFR 10.30, to request the Commissioner of Food and Drugs (Commissioner) to amend regulations in various sections of 21 CFR Part 812. The regulations relevant to this petition address the application requirements for an investigational device exemption (IDE) for significant risk devices under specified circumstances. In addition, regulations governing Food and Drug Administration (FDA) and Institutional Review Board (IRB) approval of changes in an investigational plan under these same circumstances are also relevant to this petition.

A. Action Requested

In this petition, ASAIO is requesting the FDA to implement Congress' intent, as evidenced in sections 520(g)(1) and 520(g)(2)(C) of the Food, Drug, and Cosmetic Act (Act), that scientists be provided with optimum freedom in conducting limited medical device investigations without compromising patient safety, and that procedures and conditions for obtaining an IDE be appropriately tailed for an investigator working with a small number of subjects at a single institution to determine the feasibility of a medical device. Congress recognized that the requirements for this type of limited investigation should be different from the requirements for a large-scale, multi-institutional clinical trial designed to serve as a precursor for the commercialization of a medical device. Current IDE regulations, however, do not take adequate account of these factors.

In essence, ASAIO is requesting the FDA to amend its IDE regulations to afford an additional degree of flexibility in investigations of the clinical feasibility of a medical device for use in diagnosis or treatment. The proposed changes would apply only to investigations involving a small number of human subjects in a single institution, when the data from such testing will not be used as primary support to obtain approval for the commercial distribution of the device. ASAIO requests that, under these limited circumstances, an investigator be permitted to conduct an investigation involving a significant risk device after providing the FDA with a Notice of Limited Investigation that would include, among other things, a sample of the subject's informed consent and certification of approval by the responsible IRB.

Under ASAIO's proposal, the Notice of Limited Investigation and accompanying documentation could be submitted to the FDA in lieu of an application for an IDE in the narrow circumstances described above, with the express understanding that clinical data generated by such an investigation will not be used as primary support of a premarket approval application or a premarket notification (*i.e.*, 510(k) submission). After receiving the Notice, the FDA would have fourteen (14) days in which to review it before the investigation could commence. Moreover, when warranted by the circumstances, the FDA would retain express authority to require additional information, to require submission of a formal application, or to suspend the investigation.

Specifically, the following amendments to existing regulations are requested:

1a. The present regulations that would be directly affected by the amendments proposed in this petition are 21 CFR 812.2 (Applicability), § 812.20 (Application) and § 812.42 (FDA and IRB Approval). Since these regulations are lengthy and would be cumbersome to reproduce in their entirety in this petition, petitioner incorporates by reference the text of these regulations, as set forth in the applicable sections of the Code of Federal Regulations.

1b. The petitioner requests that 21 CFR 812.2 be amended as follows:[1]

Section 812.2 Applicability.

* * * * *

(d)(1) ♦ Limited investigations. The application requirements of this part do

not apply to limited investigations of a device, including a significant risk device, in the following circumstances: (i) The investigation is conducted only in a single institution; (ii) the investigation involves no more than 10 human subjects (as defined in 21 CFR 50.3(g)); (iii) the data generated by the investigation will be used to demonstrate the feasibility of using a medical device for diagnosis or treatment; and (iv) such data will not be used as primary support of a premarket approval application or a premarket notification submission. An investigation conforming to these requirements may proceed in accordance with this section, without submitting an IDE application, provided that the sponsor submits to the FDA a Notice of Limited Investigation that includes the following information: [2]

(A) The name, address, and telephone number of the sponsor and of the investigator(s);

(B) A brief description of the medical device to be used in the investigation;

(C) The number of subjects to be involved in the investigation;

(D) The actual or anticipated beginning date of the investigation and its expected duration;

(E) A brief summary statement of the purposes, objectives, and plan of the investigation and a statement of how subject risks will be minimized;

(F) Assurances that no subject will participate in the investigation until that person has given his or her informed consent;

(G) A sample of the patient's informed consent form; and

(H) Certification of approval by the responsible IRB.

(2)(A) A limited investigation conforming to the requirements of this section may proceed fourteen (14) days after the FDA's receipt of the Notice of Limited Investigation.

(B) If, upon receipt of Notice of Limited Investigation, the FDA determines, based on specific and articulated concerns, that further inquiry into the investigation is necessary in order to protect the rights, safety, or welfare of subjects or to ensure compliance with ethical standards of scientific practice, the FDA shall make further inquiry into the investigation (either orally or in writing) and, based on the results of such inquiry, (i) may require the sponsor to submit additional information to the FDA or, in extraordinary and unusual circumstances, (ii) may require the sponsor to submit an application in conformity with 21 CFR 812.20. The FDA shall not routinely require the sponsor of an otherwise qualified limited investigation to take these additional steps, nor shall the fact that the proposed investigation involves significant risk be a factor in determining whether additional information or a full IDE application is required. If additional information is required, the limited investigation may proceed fourteen (14) days after the FDA's receipt of such information unless notification is received from the FDA prior to that time that a full IDE application is required.

(3)(A) In a limited investigation conforming to the requirements of this section, an investigator shall be required to prepare and submit to the IRB the reports described in § 812.150(a). Notwithstanding § 812.150(a)(4), an investigator shall not be required to secure FDA approval of a deviation from the investigational plan if such deviation has been approved by the reviewing IRB.

(B) In a limited investigation conforming to the requirements of this section, the sponsor shall be required to prepare and submit to the IRB the reports described in § 812.150(b). Notwithstanding any provisions of § 812.150(b) to the contrary, the only reports the sponsor shall be required to submit to the FDA are reports of unanticipated adverse device effects (see § 812.150(b)(1)), reports of withdrawal of IRB approval (see § 812.150(b)(2)), and a final report (see § 812.150(b)(7)).◆

◆(e)◆ Limit on certain exemptions.

* * * * *

◆(f)◆ Investigations subject to IND's.

* * * * *

1c. The petition further requests that, in order to be consistent with the amendment to § 812.2(d), 21 CFR 812.20 be amended as follows:

Section 812.20 Application.

(a) Submission. (1) A sponsor shall submit an application to FDA if the sponsor intends to use a significant risk device in an investigation, ◆unless otherwise provided by § 812.2(d)◆, or if FDA notifies the sponsor that an application is required for an investigation.

1d. The petitioner further requests that, in order to be consistent with the amendment to § 812.2(d), 21 CFR 812.42 be amended as follows:

Section 812.42 FDA and IRB approval.

A sponsor shall not begin an investigation or part of an investigation until an IRB and FDA have both approved the application ◆(when an application is required to be submitted to the FDA)◆ or supplemental application relating to the investigation or part of an investigation. ◆In the case of a limited investigation as described in § 812.2(d), such investigation may begin without filing an application with the FDA, provided that the sponsor has complied with the requirements of § 812.2(d).◆

B. Statement of Grounds

Congress' express purpose for including an exemption for otherwise applicable statutory requirements of the Act for devices intended for investigational use was:

> to encourage, to the extent consistent with the protection of the public health and safety and with ethical standards, the discovery and development of useful devices intended for human use and to that end to maintain optimum freedom for scientific investigators in their pursuit of that purpose.[3]

This laudable goal recognizes that a delicate yet workable balance must exist between protection of the public through a regulatory structure, and encouragement of responsible and independent scientific investigation designed to produce and refine medical devices with enormous potential benefits to humans. Such a balance is not easily achieved. It is ASAIO's view that the present regulatory process, especially as it pertains to the feasibility stages of medical device investigations, creates an imbalance that impedes or, in some cases, effectively prevents the development of important medical devices in this country. An increasing number of device investigations that otherwise would have been conducted in the United States are instead being conducted abroad where investigators may proceed in some cases in accordance with only the standards required under the Declaration of Helsinki. This petition proposes a simplification of the regulatory process in the early stages of certain limited investigations in order to encourage respected and innovative investigators to conduct their work on medical devices in this country rather than abroad.

ASAIO believes that compelling legal and policy grounds support its request to afford investigators a critically-needed degree of increased flexibility in limited circumstances through the introduction of changes to the regulatory scheme. Such changes would encourage responsible device investigation in this country while maintaining the standards of public safety and ethical responsibility that Congress has demanded and to which ASAIO wholeheartedly subscribes.

In support of its petition, ASAIO will illustrate the types of device investigations to which the proposed regulatory changes could aptly be applied and will attach statements by respected scientists attesting to the need for such changes. In addition, ASAIO will demonstrate that the changes suggested herein are fully consistent with the applicable statutory requirements and are similar, from both a policy and practical standpoint, to the FDA's refined administrative approach presently under consideration for the investigation of new drugs under the Food, Drug, and Cosmetic Act.

I. Illustrations of Potential Applicability and Statements in Support of Limited Investigations

By way of illustration only, ASAIO submits that the limited investigation proposal set forth in this petition would be appropriate for feasibility-type investigations of the following nature:

1. Investigations involving temporary extracorporeal therapeutic devices, such as a short-term artificial pancreas for stable and unstable diabetic patients, and new applications of existing devices, such as the use of a heart-lung machine for perfusion of limbs during cancer chemotherapy.

2. Investigations involving temporary or permanent implants during the early developmental stages, such as artificial skin and implanted sensors for uses such as glucose management in diabetics.

3. Investigations involving modification of an existing device, such as the binding of an antibiotic substance to a blood access device to reduce infection.

In these types of investigations, IRB approval and oversight will adequately safeguard subjects. Under such circumstances, an investigator should be allowed to proceed pursuant to the proposed regulations after providing the FDA with a Notice of Limited Investigation and certification of IRB approval. This procedure would help reduce unnecessary paperwork for the FDA, allowing the agency to allocate its resources more efficiently, while relieving the regulatory burden on researchers under limited circumstances.

ASAIO has received letters of support for its proposal from respected scientists who have witnessed the discouraging effect that the IDE regulations have had on the development of medical devices in the United States.[4] These scientists believe that the proposal for streamlined regulatory procedures in limited investigations, as described herein, would represent an important, positive step toward reestablishing this country's preeminence in the medical device field.

II. Legal Grounds for the Proposed Amendments

a. *Support from Legislative History.* The regulatory amendments proposed herein are fully consonant with the statutory framework supporting investigational device exemptions. As noted earlier on page 7, section 520(g) of the Medical Device Amendments of 1976 [5] introduced a statutory scheme to fulfill the following purposes: (1) Encourage discovery and development of useful devices; (2) maintain standards of public health, safety, and ethical investigatory practice; and (3) provide optimum freedom for scientific investigators. Congress acted to ensure the safety and protection of human subjects by defining the boundaries within which medical device investigations must proceed. ASAIO's proposal would clearly fall within such boundaries.

The proposed amendment to the IDE application process described in this petition places primary emphasis on IRB prior approval, while providing the FDA with prompt notification of a proposed investigation and the opportunity to review and to act upon that investigation. This alignment of approval responsibility is consistent with congressional intent under the Medical Device Amendments of 1976. In its explanation of the oversight responsibilities contained in the statutory provisions addressing exemptions for devices for investigational use, the House Committee Report states:

> The bill contains special requirements with respect to exemptions for devices intended to be tested using human subjects.
>
> *First, the Committee believes it to be appropriate in most instances to rely upon qualified investigational review committees rather than governmental officials to supervise the clinical testing of devices.* Such committees . . . are comprised of persons with diversified backgrounds who are competent to judge the acceptability of proposed research . . . .

H.R. Rep. No. 94-853, 94th Cong., 2d Sess. 43 (1976) (emphasis supplied).

b. *Support from Regulatory History.*— 1. Medical Device Regulation. As the FDA recognized in developing regulations to implement Congress' design for investigational device exemptions, the statutory "requirements that are critical to protection of subjects in all investigations [are] . . . informed consent, institutional review, and reporting of unanticipated adverse device effects." [6] These critical protections would be retained under the proposed amendments.

In addition to delineating the mandatory procedures that an investigator must follow on the "protection" side of the scale, Congress also specified the factors to be considered in weighing the appropriations of permitting various degrees of scientific freedom and flexibility on the "encouragement of discovery and development" side of the scale. Section 520(g)(2)(C) provides that procedures and conditions for granting an investigational use exemption for a device should be crafted in consideration of the following factors:

(1) The scope and duration of clinical testing to be conducted under the exemption;

(2) The number of human subjects involved;

(3) The need to permit changes to be made in the device subject to the exemption during testing conducted in accordance with a clinical testing plan; and

(4) Whether the clinical testing of a device is for the purpose of developing data to obtain approval for the device's commercial distribution.

Application of each of these factors to the present request for a measure of increased flexibility in the regulatory process strongly supports ASAIO's position that such changes are appropriate. In limiting the applicability of the amendment to a clinical investigation (including deviations approved by the IRB) involving a maximum of 10 or fewer human subjects conducted in a single institution, the testing would be well-controlled and subject to close and informed scrutiny by the responsible IRB. Under such circumstances, the necessity of prior FDA approval of an application would be deemed to have been complied with by the IRB's approval, as a surrogate for the Secretary, of the application submitted to it. Thus, the oversight function contemplated by Congress would be performed by a committee qualified to evaluate the proposed investigation without delaying unnecessarily the investigator's authority to proceed.

The proposal for allowing a limited investigation to proceed, under narrowly defined circumstances that include approval by the IRB and submission of a Notice of Limited Investigation to the FDA followed by a fourteen (14) day waiting period, is consistent with present regulations at 21 CFR 812.2 (b) and (ions from the full IDE process, relying primarily on IRB approval, while

providing the FDA with a prompt and accurate summary of important information concerning the planned investigation.

As in the case of investigations that "are considered to have approved applications for IDE's" under § 812.2(b) (*i.e.*, investigations of devices other than significant risk devices), the limited investigation described herein could proceed based on approval by the IRB of submissions made to it.[7] In addition, because it would encompass investigations involving significant risk devices, the proposed amendment would require submission to the FDA of a Notice of Limited Investigation which would contain, in abbreviated form, much of the same information that would have appeared in a formal application.

In light of the narrow scope of the investigations at issue in this petition, the guarantee of patient-safety protections inherent in the IRB approval process, the requirement of informed consent, and the non-commercial use of the data generated by this type of investigation, these amendments should be approved as being consistent with the Act's purposes of encouraging basic medical device development while ensuring the preservation of standards governing public health, safety, and ethical scientific practices.

2. Drug Regulation. In addition to finding support for this approach in the present IDE regulations themselves, the proposed amendment is also supported by the approach presently being developed for review of investigational new drug (IND) applications.[8] The proposed changes for INDs are designed "to assist sponsors of clinical investigations to prepare and submit high quality applications and to permit FDA to review them efficiently and with minimal delay. This action is one part of a larger effort to review and improve all aspects of FDA's drug regulatory process." The effort to streamline the regulatory process on the drug side is intended to "give sponsors greater freedom to design and implement clinical research studies" and to encourage innovation without compromising the safety of test subjects.[9] For INDs, this is being accomplished by, among other things, streamlining the application process, emphasizing that small, well-controlled investigations should be afforded greater flexibility, and requiring fewer supplements to approved applications.

To the extent the FDA has parallel responsibilities in monitoring scientific investigations of new medical devices, the FDA's regulatory revisions of the IND regulations should provide guidance to the agency in acting upon this petition. Problems are quickly emerging in device development that have already necessitated corrective action in the drug field.[10]

An administrative procedure analogous to the one being proposed in this petition already exists for IND amendments. In the context of supplemental applications, after reiterating that it is interested in learning contemporaneously only about the kinds of changes in an IND plan that would bear directly on its review and monitoring responsibilities (*i.e.*, new protocols or major changes in existing protocols), the FDA described the procedures to be followed in submitting any required IND amendments:

> The proposal would also clarify the proper timing of submissions. The current IND regulations require the sponsor to notify FDA before beginning a substantially modified protocol or a new protocol, but do not require sponsors to pause before proceeding, so long as local IRB approval has been obtained. The IND Rewrite would explicitly retain this current process.[11]

It is respectfully submitted that use of the Notice of Limited Investigation procedure, including certification of IRB approval, as an option under the IDE application process would evidence a desirable responsiveness to congressional intent and represent a prudent step as a matter of public policy.

c. *Summary.* When the FDA promulgated final IDE regulations in January, 1980, it addressed comments expressing apprehension that the regulations "would drive device research and development abroad" and would "discourage noncommercial research (that is, much of the research conducted at universities)," in the following fashion:

> FDA believes that the implementation of the final IDE regulations will not discourage medical device research and development in the United States . . . [T]here should be little, if any, change in the willingness of investigators and IRB's to participate in medical device research and little, if any, reduction in sponsors' incentives to develop devices of limited commercial value or to make improvements in already-marketed devices.[12]

Unfortunately, this optimistic assessment of the regulations' impact has proved inaccurate. Evidence from the scientific community is beginning to demonstrate that the IDE regulations have become a significant impediment to effective medical device research and are, in fact, influencing some prominent researchers in this country to abandon their projects or to conduct their medical device investigations in another country.

The proposed amendments for a limited investigation of medical devices would facilitate research by reducing paperwork, both for the researcher and the FDA in narrowly defined investigations, and by requiring only IRB approval of the proposal. This expedited research approval procedure, however, would not precipitate a compromise of subject safety. The FDA would continue to receive adequate notice of the investigation and would have a period in which to make further inquiries. Moreover, the IRB would continue to receive all the information required for a standard IDE and would review this information carefully, with a view toward minimizing subject risk.

Adoption of the limited amendments contained herein will simplify administrative procedures in appropriately narrow circumstances and, thus, improve a serious problem for researchers in the important field of medical devices. The proposed changes are supported by statutory authority and simply make good sense. Since persuasive legal and policy grounds exist in support of these proposed changes, ASAIO urges the FDA to adopt these amendments.

C. Environmental Impact

Enactment of the amendments to 21 CFR Part 812 suggested herein will have no significant impact on the human environment and an environmental impact statement is not required. 21 CFR 25.1(d)(5) (1983).

D. Certification

The undersigned certifies that, to the best knowledge and belief of the undersigned, this petition includes representative data and information known to the petitioner which are unfavorable to the petition.

Respectfully submitted,

Robert H. Bartlett, M.D., *President, American Society for Artificial Internal Organs.*

William A. Morton, *Chairman, ASAIO Regulatory Affairs Committee.*

Footnotes

1. Proposed amendments are in arrows.

2. The IRB will continue to receive all the information necessary for it to carry out its research approval duties as required by 21 CFR 56.109, 56.111 (1983).

3. Section 520(g)(1) of the Food, Drug, and Cosmetic Act.

4. Attached are letters from Dr. Pierre M. Galletti of Brown University, Dr. Yukihiko Nose of the Cleveland Clinic Foundation, Dr. George E. Schriener of the University of Washington, and Dr. Willem J. Kolff of the University of Utah.

5. Pub. L. 94–295, section 2, 90 Stat. 565 (codified at 21 U.S.C. § 360j(g)).

6. Preamble to final rule for Investigational Device Exemptions, 45 FR 3732, 3733 (1980).

7. The preamble to the final rule for Investigational Device Exemptions, 45 FR 3732, 3735 (1980), explained this approach: FDA believes that the provisions in the final IDE regulation concerning investigations of devices that do not present a significant risk satisfy this statutory requirement [that an application be submitted to the Secretary before an exemption may be granted]. Under § 812.2 (b)(1)(ii), the sponsor must obtain an IRB's approval of an investigation of such a device. *Thus, the IRB serves as the surrogate for the Secretary with respect to the receipt and approval of the application.* The IRB functions in this capacity under regulations issued by FDA. (Emphasis supplied).

8. See Proposed New Drug, Antibiotic, and Biologic Drug Product Regulations, 48 FR 26,720 (1983).

9. 48 FR at 26,720.

10. See letters attached to this petition.

11. 48 FR at 26,727.

12. Preamble to final IDE regulations, 45 FR 3732, 3734 (1980).

Request for Additional Information

In addition to requesting comments on the ASAIO petition itself, FDA is requesting comments on the following IDE-related questions:

1. In terms of achieving the objectives of section 520(g) of the act and § 812.1(a) of the IDE regulations, what if anything would be gained or lost by adopting ASAIO's proposed amendments to the regulations?

2. Are the IDE regulations an impediment to conducting limited investigations, as defined in the petition, in the United States? What devices have not been, or will not be, developed in the United States because of regulatory controls? What parts of the IDE regulations are most burdensome to the conduct of limited investigations?

3. Would IRB's be willing to assume additional responsibilities and authorities for reviewing, approving, and monitoring investigations of medical devices? If not, what changes need to be made so that IRB's would be willing?

4. Would IRB's, currently constituted and operating in conformance with FDA's IRB regulations (21 CFR Part 56), be competent to assess the scientific merit and general safety of limited investigations to the greater extent that the IRB regulations now require? What changes in IRB composition, functions, or operations would be necessary and feasible to enable IRB's to assume the additional responsibilities? What would be the implications of any such changes to current IRB responsibilities?

5. What other alternatives to IRB or FDA review and approval exist? How would these alternatives lessen the regulatory burden and, at the same time, fulfill the statutory mandate for study review and approval?

6. What criteria should be used to identify limited investigations, i.e., those subject to the abbreviated requirements proposed by the petition?

7. Which requirements of the IDE regulations should apply to limited investigations? For example, should information other than that proposed by ASAIO be included in a "Notice of Limited Investigation? Should FDA evaluate such a notice against the standards set out in § 812.30(b)? Against different standards?

8. What is the advisability of having abbreviated requirements for limited investigations of significant risk devices, as described in the ASAIO petition? What is the advisability of having the same or similar abbreviated requirements for the following types of investigations:

a. Sponsor/investigator studies which are clinical investigations sponsored and conducted by a single investigator, designed to evaluate certain treatment parameters, and not intended to gather data to be used to obtain approval for the commercial distribution of the device.

b. Investigations designed to evaluate new indications of a marketed device when the device is used in the same or similar manner as for the approved indication.

c. Investigations designed to evaluate whether minor changes to a marketed device improve the device's safety or effectiveness, when the modified device would be used in accordance with the approved labeling.

FDA is particularly interested in comments from members of the clinical community, e.g., clinical investigators, sponsors, research and academic institutions, and IRB chairpersons and members. Comments from other interested individuals or groups are also welcome. FDA advises that under § 10.30(d), any comments submitted in response to this notice will be included in Docket No. 84P–0387. Such comments may support or oppose the petition in whole or in part. A request for alternative or different administrative action, however, may be submitted only as a separate petition.

Interested persons may, on or before June 30, 1986, submit to the Dockets Management Branch (HFA–305), Food and Drug Administration, Rm. 4–62, 5600 Fishers Lane, Rockville, MD 20857, written comments regarding this notice. Two copies of any comments should be submitted, except that individuals may submit one copy. Comments should be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

Dated March 24, 1986.

Frank E. Young,

Commissioner of Food and Drugs.

[FR Doc. 86–7083 Filed 3–31–86; 8:45 am]

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Federal Register

Tuesday
April 1, 1986

Part VI

Department of Agriculture

Agricultural Stabilization and Conservation Service

7 CFR Part 729

Poundage Quota Regulations for the 1986 Through 1990 Crops of Peanuts; Proposed Rule

DEPARTMENT OF AGRICULTURE

Agricultural Stabilization and Conservation Service

7 CFR Part 729

Poundage Quota Regulations for the 1986 Through 1990 Crops of Peanuts

AGENCY: Agricultural Stabilization and Conservation Service, USDA.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth regulations for the 1986-1990 crops of peanuts regarding the allocation of farm poundage peanut quotas and related matters. Among other provisions, the proposed regulations address: (1) Establishment of farm quotas; (2) quota adjustments due to changes in the national quota; (3) reductions in quota for nonproduction; and (4) reallocation of quotas reduced for nonproduction or permanently released.

DATE: Comments must be received on or before April 16, 1986, in order to be assured of consideration.

ADDRESS: Send comments to the Director, Tobacco and Peanuts Division, ASCS, Department of Agriculture, P.O. Box 2415, Washington, DC 20013. All written submissions made pursuant to this notice will be made available for public inspection in Room 5750 South Building, USDA, between the hours of 8:15 and 4:45, Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Paul P. Kume (ASCS) 202-447-9003. The Preliminary Impact Analysis describing the options considered in developing this proposed rule is available upon request.

SUPPLEMENTARY INFORMATION: This proposed rule has been reviewed under USDA procedures established in accordance with Executive Order 12291 and Departmental Regulation No. 1512–1 and has been classified "not major". It has been determined that this rule will not result in: (1) An annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, Federal, State or local governments, or geographical regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The title and number of the Federal assistance program to which this proposed rule applies are: Commodity Loans and Purchases; 10.051, as found in the Catalog of Federal Domestic Assistance.

It has been determined that the Regulatory Flexibility Act is not applicable to this proposed rule since the Agricultural Stabilization and Conservation Service is not required by 5 U.S.C. 553 or any other provision of law to publish a notice of proposed rulemaking with respect to the subject matter of this rule.

This program/activity is not subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. See the notice related to 7 CFR Part 3015, Subpart V, published at 48 FR 29115 (June 24, 1983).

The Food Security Act of 1985 (Pub. L. 99–198) (the "1985 Act") amended the Agricultural Adjustment Act of 1938 (the "1938 Act") with regard to the establishment of peanut quotas for the 1986–1990 crop years. The proposed regulations issued with this notice implement those provisions.

Specifically, the proposed regulations cover the establishment of individual farm poundage quotas and the transfer of quotas between farms. Because the planting season is about to begin, and the proposed regulations could affect planting decisions, the period for comment on the proposed regulations has been limited to 15 days.

The regulations proposed in this notice are subject to change upon consideration of the comments. The most salient provisions of the proposed regulations are set forth below.

A—Adjustments to farm poundage quotas due to changes in the national poundage quota.

Statutory Provisions.

Section 358 of the 1938 Act, as amended, provides that the national poundage quota for peanuts for each of the 1986-1990 marketing years shall be established by the Secretary at a level that is equal to the quantity of peanuts, in tons, that the Secretary estimates will be devoted in each such marketing year to domestic edible, seed, and related uses except that the national poundage quota for any such marketing year shall not be less than 1,100,000 tons. The Secretary has previously announced that the 1986 national poundage quota shall be 1,355,500 tons.

Section 358 of the 1938 Act, as amended, provides that the national poundage quota shall be apportioned among the States so that the poundage quota allocated to each State shall be equal to the percentage of the national poundage quota allocated to farms in the State for 1985. Since the 1986 national poundage quota is increased by 255,500 tons over the 1985 national poundage quota, the 1986 poundage quota apportioned to each State will be increased over the State's 1985 poundage quota. Section 358 further provides that in such circumstances such increase shall be allocated equally among:

(i) All farms in the State for each of which a farm poundage quota was established for the marketing year immediately preceding the marketing year for which the allocation is being made; and

(ii) All other farms in the State on each of which peanuts were produced in at least two of the three immediately preceding crop years, as determined by the Secretary.

Proposed Regulations

The proposed regulations provide that, after adjustments in the quota or production history of farms resulting from permanent transfers of quota or permanent releases of a quota, if the poundage quota allocated to a State is greater than the poundage quota allocated to such State for the immediately preceding marketing year, the amount of the increase shall be allocated to: (1) Farms in the State which had a basic farm poundage quota greater than zero for the year immediately preceding the crop year for which the determination is being made ("eligible quota farms") and (2) all other farms in the State on which peanuts were produced in at least two of the three years preceding the year for which the determination is being made ("eligible nonquota farms").

For purposes of making allocations to individual farms, the amount by which a State's quota was increased from the preceding year will, under the proposed regulations, be divided by the total number of eligible quota and nonquota farms and that result shall be multiplied (1) by the number of eligible quota farms in the State to arrive at the total allocation for quota farms, and (2) by the total number of eligible nonquota farms in the State to arrive at the total allocation for nonquota farms.

The total number of pounds available for quota farms shall be prorated among eligible quota farms based upon the larger of the basic quota established for each such farm for the year preceding the year for which the determination is being made or the average of the highest quantities of peanuts produced on each such farm in the two years of the three year period preceding the year for which the determination is being made, in which the highest production occurred.

The total number of pounds available for nonquota farms in the State shall be

prorated among eligible nonquota farms based upon the average of the highest quantities of peanuts produced on each such farm in the two years, of the three year period preceding the year for which the determination is being made, in which the highest production occurred.

Farms on which not more than one acre of peanuts were produced will not be considered to have produced peanuts for purposes of allocating increases in State poundage quotas or allocating quotas that have not been produced or permanently released (see below). In addition, no quota will be established for a farm, under any circumstances, which exceeds the quantity which can be produced on the tillable cropland of the farm. The restriction concerning tillable cropland comports with the provisions contained in Section 358a of the 1938 Act, as amended, which provide that, with respect to transfers of quotas between farms, no transfer of the farm poundage quota from a farm shall be permitted if a county Agricultural Stabilization and Conservation Service committee determines that the receiving farm does not have adequate tillable cropland to produce the farm poundage quota.

The proposed regulations provide that, in making determinations concerning farm poundage quotas, farms shall be considered as being constituted the same as they were for the preceding marketing year. That provision is believed to comport with the intent of the statute which in connection with changes in farm poundage quotas refers repeatedly to farms for which a farm poundage quota was established for the immediately preceding marketing year. Also, it avoids farm divisions which might otherwise be undertaken solely for quota purposes.

Some farms eligible for a quota increase due to an increase in the State's poundage quota will also be subject to a reduction for previous nonproduction of quota. The proposed regulations provide in such cases that the increase will be redistributed in accordance with the rules applicable to the reallocation of reduced quotas.

B—Reductions in farm poundage quotas for nonproduction.

Statutory Provisions.

Section 358 of the 1938 Act, as amended, provides that, insofar as practicable and on such fair and equitable basis as the Secretary may by regulation prescribe, the farm poundage quota established for a farm for any of the 1986-1990 marketing years shall be reduced to the extent that the Secretary determines that the farm poundage quota established for the farm for any two of the three marketing years preceding the marketing year for which the determination is being made was not produced, or considered produced, on the farm.

Section 358 of the 1938 Act further specifies that, for the purposes of such reductions, the farm poundage quota for any such preceding marketing year shall not include (1) any increases for undermarketings for quota peanuts from previous years; or (2) any increase resulting from the allocation of quotas voluntarily released for one year.

Section 358 of the 1938 Act further provides that the farm poundage quota shall be considered produced on a farm if (1) the farm poundage quota was not produced on the farm because of drought, flood, or any other natural disaster, or any other condition beyond the control of the producer as determined by the Secretary; or (2) the farm poundage quota for the farm was released voluntarily for only one of the three marketing years immediately preceding the marketing year for which the determination is being made.

Proposed Regulations

Pursuant to the "fair and equitable" provision of the statute, the regulations provide that a farm poundage quota will be considered produced for purposes of the 1983–85 marketing years to the extent that the quota would have been protected from potential reduction under the regulations and implementing procedures which were applicable to those crop years. The regulations applicable to those crop years provided (among other instances in which a quota would be considered produced) that the quota could be considered produced in some situations where the quota had been transferred to another farm.

The proposed regulations provide that, with respect to production of the 1986–1990 crops, a quota will be considered produced, if not actually produced, only if the quota was not produced on the farm because of drought, flood, or other condition beyond the control of the producer or was voluntarily released for only one of the three marketing years preceding the marketing year for which the determination is being made.

C—Reallocation of Quotas Reduced for Nonproduction or Quotas That Have Been Permanently Released

Statutory Provisions

Section 358 of the 1938 Act, as amended, provides that the farm poundage quota established for a farm, or any part of such quota, may be permanently released by the owner of the farm, or the operator with the permission of the owner.

Section 358 provides further that the poundage quota for the farm for which such quota is released shall be adjusted downward to reflect the quota that is so released.

Section 358, as amended, also provides that the total amount of the farm poundage reduced for lack of production or permanently released shall be reallocated in such manner as the Secretary by regulation prescribes to other farms in the State on which peanuts were produced in at least two of the three crop years immediately preceding the year for which such allocation is being made, but that not less than 25 percent of such amount shall be allocated to farms for which no farm poundage quota was established for the immediately preceding crop year.

Proposed Regulations

The proposed regulations provide that such reallocated amounts be prorated among quota and nonquota farms which produced peanuts in two of the three preceding crop years based upon the average of the two highest year's total production pounds for such farms for the three years preceding the year for which the determination is being made unless such a reallocation would not result in the apportionment of 25 percent of the total reallocated quota to those farms for which no farm poundage quota was established for the immediately preceding crop year (i.e., "nonquota" farms) based upon their production history. In such cases, "nonquota" farms will receive a 25 percent share of the total with such share to be prorated among all eligible "nonquota" farms. The remainder in such cases will be prorated among the remaining eligible farms (i.e., "quota" farms) based upon production history. In no case may such a reallocation produce a quota for a farm which exceeds the amount of quota which could be produced on the farm's tillable cropland.

D—Allocation of Quotas Temporarily Released

Statutory Provisions

Section 358 of the 1938 Act, as amended, also provides that a farm poundage quota, or any portion thereof, may be temporarily released. Specifically, section 358 provides that the quota or any portion thereof may be voluntarily released to the Secretary to the extent that such quota or any part thereof will not be produced on the farm for the marketing year. Section 358

further provides that any farm poundage quota so released in a State shall be allocated to other farms in the State on such basis as the Secretary may by regulation prescribe.

Proposed Regulations

The proposed regulations provide that such quotas will be reallocated in such manner as determined by the State ASC committee in accordance with instructions issued by the Deputy Administrator, State and County Operations, Agricultural Stabilization and Conservation Service (ASCS). Those instructions will take into account peanut marketing patterns. This flexibility will permit reallocations to be made, if determined appropriate, to farms in the same locality as the farm from which the release has been made. Persons seeking a reallocation of temporarily released quotas must apply for such reallocations at a county ASCS office.

E—Undermarketings

Statutory Provisions

Section 358 of the 1938 Act, as amended, provides that the farm poundage quota for a farm for any marketing year shall be increased by the number of pounds by which the total marketings of quota peanuts from the farm during previous marketing years (excluding any marketing year before the marketing year for the 1984 crop) were less than the total amount of the applicable farm poundage quotas (disregarding adjustments for undermarketings from previous marketing years) for such marketing years. However, section 358 further provides that no increase for undermarketings in previous marketing years shall be made to the poundage quota for any farm to the extent that the poundage quota for such farm for the marketing year was reduced for a failure to produce.

Section 358 further provides that any increases in farm poundage quotas for undermarketings shall not be counted against the national poundage quota for the marketing year involved. That section provides, in addition, that if the total of all increases in individual farm poundage quotas for undermarketings exceeds 10 percent of the national poundage quota for the marketing year in which such increase is applicable, the Secretary shall adjust such increases so that the total of such increases does not exceed 10 percent of the national poundage quota.

Proposed Regulations

The proposed regulations implement those provisions. The regulations provide for adjusting undermarketings if a full allowance of all undermarketings would produce a nationwide allowance in excess of 10 percent of the national poundage quota.

F—Miscellaneous Provisions

The proposed regulations also set forth a number of other related program provisions. Those provisions include provisions relating to transfers of quota and the establishment of farm yields. The provisions of the regulations regarding the circumstances under which a transfer of a poundage quota will be permitted are generally the same as those that have applied in previous crop years except with respect to fall transfers.

"Fall transfers" are transfers of quotas made after the end of the normal planting season. Section 358a of the 1938 Act, as amended, provides that a lease of poundage quota may be entered into after the normal planting season only if the quota has been planted on the farm from which the quota is to be leased and under such terms and conditions as the Secretary may by regulation prescribe.

The proposed regulations provide that, in order for a fall transfer to be approved, the operator of the transferring farm must certify and the county committee determine, that the acreage of peanuts planted on the transferring farm was equal to, or in excess of, the acreage determined by dividing the effective farm poundage quota by the larger of the current farm yield or the highest actual yield for the farm in any one of the preceding three years. The operator of the transferring farm must also certify and the county committee determine that the production of peanuts on the transferring farm was limited to less than the effective farm poundage quota because of conditions beyond the control of the producer.

Additional regulations will be published covering related matters such as peanut marketing cards and producer penalties.

List of Subjects in 7 CFR Part 729

Poundage quotas, Peanuts.

Proposed Rule

Accordingly, it is proposed that 7 CFR Part 729 be amended by adding a new subpart as follows:

PART 729—PEANUTS

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Subpart—Poundage Quota and Marketing Regulations for the 1986 Through 1990 Crops of Peanuts

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Transfers of Farm Poundage Quota.

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729.367 Temporary release and temporary reapportionment.
729.368 Temporary release of farm poundage quota.
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729.372 Signature requirements for temporary releases.
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729.374 Reapportionment of farm poundage quota temporarily released.
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729.376 Credit for voluntary temporary release of quota or for reapportioned poundage quota.
729.377 Withdrawal or minor revision of released quota.
729.378 Notification of State committees of permanent or temporary release of quotas.
729.379–729.384 [Reserved]

Subpart-Poundage Quota and Marketing Regulations for The 1986 Through 1990 Crops of Peanuts

Authority: Secs. 301, 357, 358, 358a, 359, 372, 373, 375, 52 Stat. 38, as amended, 55 Stat. 88, as amended, 81 Stat. 658, as amended, 55 Stat. 90, as amended, 52 Stat. 65, as amended, 66, as amended (7 U.S.C. 1301, 1357, 1358, 1358a, 1359, 1372, 1373, 1375, as amended); Section 108B of the Agricultural Act of 1949 as added by Section 705 of the Food Security Act of 1985 (Pub. L. No. 99–198).

General

§ 729.311 Basis and purpose.

The regulations contained in this subpart are issued in accordance with the Agricultural Adjustment Act of 1938, as amended, and the Agricultural Act of 1949, as amended, and are applicable to the 1986 through 1990 crops of peanuts. They govern the establishment of farm poundage quotas, the issuance of marketing cards, the identification of marketings of peanuts, the collection and refund of penalties, the keeping of records, and the making of reports incident thereto.

§ 729.312 Extent of calculations and rule of fractions.

Computations made pursuant to this subpart shall be rounded in accordance with the provisions of Part 793 of this chapter, provided further:

(a) Acreages shall be rounded to the nearest tenth;

(b) Penalties and damages shall be rounded to the nearest cent;

(c) Per pound penalties and liquidated damages shall be rounded to the nearest tenth of a cent.

(d) The following calculations shall be rounded to the nearest whole pound: (1) peanuts produced, considered produced and marketed; (2) preliminary farm poundage quotas; (3) farm poundage quotas; (4) initial basic farm poundage quotas; (5) basic farm poundage quotas; (6) effective farm poundage quotas; (7) farm yields; and (8) actual yields per acre; and

(e) All mathematical factors arising under this subpart shall be calculated to four decimal places unless the Deputy Administrator shall determine otherwise.

§ 729.313 Definitions

The definitions in, and provisions of, Parts 718, 719, 720, and 1446 of this chapter are hereby incorporated by reference in these regulations unless the context or subject matter or the provisions of these regulations require otherwise. References to other parts of this chapter or title or any other regulations, shall include any amendments to the referenced parts. Unless the context or subject matter require otherwise, the following words and phrases, as used in this subpart and in all related instructions and forms shall mean:

(a) *Additional peanuts.* Any peanuts which are marketed from a farm other than peanuts marketed or considered marketed as quota peanuts.

(b) *Areas*—(1) The southeastern area consisting of Puerto Rico, the U.S. Virgin Islands, and the States of Alabama, Georgia, Mississippi, Florida, and that part of South Carolina south and west of the Santee-Congaree-Board Rivers.

(2) The southwestern area consisting of the States of Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Kansas, Louisiana, Montana, Nebraska, New Mexico, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, and Wyoming and all territories and possessions of the United States not otherwise assigned.

(3) The Virginia-Carolina area consisting of the District of Columbia and the States of Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, and that part of South Carolina north and east of the Santee-Congaree-Board Rivers.

(c) *Base period.* The 3 calendar years immediately preceding the year for which a farm poundage quota is being established.

(d) *Basic farm poundage quota.*

(1) For the 1985 crop, the basic quota established pursuant to § 729.224 for a farm.

(2) For the 1986–90 crops, the quota determined for the 1986–1990 crops for a farm in accordance with § 729.325.

(e) *Buyer.* A person who:

(1) Buys or otherwise acquires peanuts in any form;

(2) Markets, as a commission merchant, broker, cooperative, agent, or in any other capacity, any peanuts for the account of a producer and is responsible to the producer for the amount received for the peanuts; or

(3) Receives peanuts as collateral for, or in settlement of, a price support loan.

(f) *Commingled peanuts.* Peanuts produced on different farms and placed into a single wagon, truck or any other vehicle so that the peanuts become, or can become, intermingled in whole or in part within the same vehicle, or such that it is not possible because of such placement of peanuts to identify the farm on which the individual peanuts were produced.

(g) *Considered produced peanuts.* To the extent permitted by this subpart, peanuts for which credit for production is given to a farm when the peanuts were not actually produced or grown on such farm in a current year or one of the base period years.

(h) *Deputy Administrator.* The Deputy Administrator, or acting Deputy Administrator, State and County Operations, Agricultural Stabilization and Conservation Service, U.S. Department of Agriculture.

(i) *Director.* The Director, or Acting Director, Tobacco and Peanuts Division, Agricultural Stabilization and Conservation Service, U.S. Department of Agriculture.

(j) *Effective farm poundage quota.* For the 1986-90 crops, the quota determined in accordance with § 729.326.

(k) *Excess peanuts.* The quantity of peanuts marketed or considered marketed as quota peanuts from the farm in the current marketing year in excess of the farm's effective farm poundage quota.

(l) *False identification.* The deliberate or inadvertent identification of peanuts at the time of marketing as being produced on a farm when the peanuts were not produced on such farm.

(m) *Farm yield.* The yield for a farm determined in accordance with § 729.334.

(n) *Farmers stock peanuts.* Dug peanuts produced in the United States which have not been shelled, crushed, cleaned, or otherwise changed (except for removal of foreign material, loose shelled kernels, and excess moisture) from the condition in which picked or threshed peanuts are customarily marketed by producers.

(o) *Final acreage.* The acreage on the farm on which peanuts are produced as determined and adjusted in accordance with Part 718 of this chapter.

(p) *Green peanuts.* Peanuts which, before drying or removal of moisture from the peanuts either by natural or artificial means, are marketed by the producer for consumption exclusively as boiled peanuts.

(q) *Initial basic farm poundage quota.* The quota determined in accordance with § 729.324.

(r) *Inspector.* A Federal or Federal-State inspector authorized or licensed by the Secretary, U.S. Department of Agriculture to grade peanuts.

(s) *Loan additional peanuts.* Peanuts which are not eligible for marketing as quota peanuts, are not subject to delivery to fulfill a contract for additional peanuts, and which are pledged as collateral for a price support loan at the additional loan rate.

(t) *Marketed.* To dispose of peanuts (including farmers stock peanuts, shelled peanuts, cleaned peanuts, or peanuts in processed form) by voluntary or involuntary sale, barter, or exchange, or by gift *inter vivos.* The terms "market", "marketing", and "for market" shall have corresponding meanings to the term "marketed" in the connection in which they are used. The terms "barter" and "exchange" shall include the use of any quantity of peanuts by the producer as payment to another for any reason including payment for the harvesting, picking, threshing, cleaning, crushing, or shelling of peanuts, or for any other service rendered to the producer. Any lot of farmers stock peanuts will be considered as marketed when delivered by the producer to the buyer. Peanuts which are delivered by the producer as collateral for, or in settlement of, a price support loan will be considered as marketed at the time of delivery. Delivery shall be deemed to have occurred when the peanuts are unloaded at the delivery point. Any peanuts produced on a farm which are retained on the farm after January 31, or such later date as may be established by the Executive Vice President, CCC, of the year following the year in which the peanuts were produced shall be considered as marketed for domestic edible use as of January 31 or such later date.

(u) *Marketing year.* For each crop of peanuts, the period beginning August 1 of the current year and ending July 31 of the following year.

(v) *National poundage quota.* The poundage quota announced by the Secretary for the relevant crop year.

(w) *Nonquota farm.* A farm that does not have an established farm poundage quota.

(x) *Peanuts.* All peanuts produced, excluding: (1) Any peanuts which were not dug or were not picked or threshed before or after marketing from the farm; and (2) green peanuts. If a lot of farmers stock peanuts has been inspected by the Federal-State Inspection Service at the time of marketing, the quantity in the lot shall be deemed to be the gross weight thereof less foreign material and excess moisture. Excess moisture shall be moisture in excess of 7 percent of the gross weight. For peanuts not inspected by the Federal-State Inspection Service, the quantity in the lot shall be deemed to be the gross weight. The quantity of the lot when shelled peanuts are marketed by a producer shall be deemed to be the poundage of the shelled peanuts multiplied by a factor of 1.5.

(y) *Planted acreage.* The final acreage of peanuts on a farm determined in accordance with the provisions of Part 718.

(z) *Preliminary farm poundage quota.* The quota quantity as determined for a farm in accordance with § 729.323.

(aa) *Produced.* Notwithstanding any other provision of this subpart, the total peanuts produced shall be the total pounds of peanuts dug.

(bb) *Quota farm.* A farm having a farm poundage quota.

(cc) *Quota peanuts.* Peanuts (except green peanuts) which are marketed or considered marketed from a farm for domestic edible use. Quota peanuts shall be considered to be all peanuts which are dug on a farm except the following: (1) green peanuts; (2) peanuts which are placed under loan at the additional support rate and not redeemed by the producer; (3) peanuts which are marketed under a contract, which had prior approval of the county committee, between a handler and a producer for exportation and/or crushing; (4) peanuts considered marketed but because of conditions beyond the control of the producer, as determined by the county committee in accordance with instructions issued by the Deputy Administrator, had no commercial value at the time the peanuts were marketed.

(dd) *Seed sheller.* A person who in the course of such person's usual business operations shells peanuts for producers for use as seed for the subsequent year's crop.

(ee) *Segregation 1 peanuts.* Peanuts of that segregation as identified and determined by the Federal-State Inspection Service.

(ff) *Tillable cropland.* Cropland (excluding orchards, vineyards, land devoted to trees, and land being prepared for nonagricultural uses) which the county committee determines can be planted to crops without unusual preparation or cultivation.

(gg) *Undermarketings.* The number of pounds determined to be undermarketed in accordance with the provisions of § 729.333.

(hh) *Yield per acre or actual yield.* The yield of peanuts for a farm for a crop year computed by dividing the total production of peanuts for the farm by the final acreage of peanuts for the farm.

§ 729.314 Types of peanuts.

Peanuts shall be classified by type into one of the following types as identified and determined by the Federal-State Inspection Service: (a) runner; (b) spanish; (3) valencia; or (4) virginia.

§ 729.315 Supervisory authority of State committee and Deputy Administrator.

(a) *State Committee.* The State committee shall take any action required to be taken by any county committee in the same State which the county committee fails to take. The State committee shall correct or require the county committee to correct any action taken by any such county committee which is not in accordance with this subpart. The State committee shall also require the county committee to withhold taking any action which is not in accordance with this subpart.

(b) *Deputy Administrator.* The Deputy Administrator shall take any action required to be taken by the State committee which the State committee fails to take. The Deputy Administrator shall correct or require the State committee to correct any action taken by the State committee which is not in accordance with this subpart. The Deputy Administrator shall also require the State committee to withhold taking any action which is not in accordance with this subpart.

§§ 729.316–729.319 [Reserved]

State Poundage Quotas, Farm Poundage Quotas, Notice to Farm Operator and Appeals

§ 729.320 Instructions and forms.

The Director shall cause to be prepared and issued such forms and instructions as are necessary for carrying out this subpart. The forms and instructions shall be approved by, and the instructions shall be issued by, the Deputy Administrator.

§ 729.321 Determination of State poundage quota.

The State poundage quota for a State for any crop year shall be the amount in pounds equal to the State's share of the current year's national poundage quota. That share, as a percentage of the national poundage quota for such year, shall equal the percentage of the 1985 national poundage quota allocated to farms in the State for 1985.

§ 729.322 Reserves for corrections.

(a) For purposes of correcting quota allocation errors, for each State with a share of the national peanut quota, the State committee shall establish a reserve which shall be, subject to the review and approval of the Deputy Administrator, as follows:

(1) *Increases in State's quota.* If a State's quota is higher for a crop than for the previous crop, the reserve established by a State committee for the State under this section shall be the sum of: (i) the unused reserve from the previous crop, plus (ii) an amount not to exceed 1 percent of the increase in the State's quota for the crop as compared with the previous crop.

(2) *Decrease or no increase in State quota.* If a State's quota for any of the 1986-90 crop years is equal to or less than that for the preceding year, the reserve established under this section for a State shall be the sum of: (i) The unused reserve for the previous year, plus (ii) 10 percent of the sum of (A) the quota reduced under§ 729.328 from farms for the State effective for the current crop year and (B) the quota permanently released pursuant to § 729.369 from farms in the State effective for the current crop year.

(b) Within the limits set by paragraph (a), in establishing the reserve, the State committee shall hold an amount that is estimated to be sufficient to satisfy the need to correct errors based on past history of appeals and other appropriate factors. If the amount of poundage quota necessary to correct errors is in excess of the reserve established by the State committee, such errors may nevertheless be corrected upon approval of the Deputy Administrator; however, the Deputy Administrator may require the State committee to recalculate the farm poundage quotas for all farms in the State if the Deputy Administrator determines that the amount of poundage quota necessary to correct errors is substantially in excess of the reserve. In such case, the State committee shall reissue corrected farm poundage quotas for all farms which shall constitute the actual quota for all farms for all purposes.

§ 729.323 Determination of preliminary farm poundage quota.

(a) *1986.* The preliminary farm poundage quota for a farm for the 1986 crop shall be the final quota established pursuant to $ 729.224 for the farm for the 1985 crop year.

(b) *1987–1990.* The preliminary farm poundage quota for a crop year for a farm for the 1987-90 crops shall be the basic farm poundage quota for the farm for the preceding year.

§ 729.324 Determination of initial basic farm poundage quota.

The initial basic farm poundage quota for a farm for any of the 1986–90 crop years shall equal the preliminary farm poundage quota for the farm for such crop year as adjusted for any increase or decrease in the State poundage quota.

§ 729.325 Determination of basic farm poundage quota.

The basic farm poundage quota for a farm for a crop year shall be the initial basic farm poundage quota for that year adjusted for: (a) Adjustments pursuant to § 729.328 for that crop year for a failure to produce the quota; (b) Reductions pursuant to § 729.369 for that year for permanent releases of quota from the farm; (c) permanent transfers of quota to or from the farm not already accounted for; (d) allocations to the farm for that year for error corrections from the State's reserve established under § 729.322; and (e) allocations to the farm pursuant to § 729.331 for the crop year from the State's distribution of quotas not produced or permanently released by other farms.

§ 729.326 Determination of effective farm poundage quota.

The effective farm poundage quota for a farm for a crop will be the basic farm poundage quota for the farm for that crop adjusted for: (a) Temporary transfers of quota to or from the farm applicable to that crop year; (b) temporary releases of quota for the farm applicable to that crop year; and (c) undermarketings.

§ 729.327 Considered produced credit.

(a) *General.* For purposes of this subpart, the considered produced credit which will be permitted for a farm for any crop year shall be the sum of the pounds (not to exceed the basic farm poundage quota for the farm for the crop year less the pounds of peanuts which were marketed from the farm from that crop) which with respect to the farm:

(1) Were not produced for the crop year because of drought, flood or any other natural disaster or any other condition beyond the control of the producer, as determined by the county committee in accordance with instructions issued by the Deputy Administrator;

(2) Were released temporarily by a voluntary release pursuant to § 729.368 for such year provided that there was no such release for either of the two years previous to the year of that release; or,

(3) Are considered produced under paragraph (b) of this section.

(b) *Additional allowance for 1983–1985 Crop years.* Subject to the provisions of paragraph (c) of this section, with respect to the 1983, 1984, and 1985 crop years only, considered produced credit will be allowed for purposes of this subpart for pounds temporarily transferred to another farm by owner, operator, or lease to a farm with the same operator, and all fall transfers made pursuant to § 729.244(b).

(c) *Limitation.* Considered produced credit will be permitted under paragraph (b) of this section only to the extent that the transferred quota was produced on the receiving farm.

§ 729.328 Reductions for nonproduction of a quota.

(a) *Determination.* For purposes of establishing a basic farm poundage quota for a farm for the 1986–90 marketing years, the initial basic farm poundage quota for the farm shall be reduced to the extent the county committee determines that the basic farm poundage quota for such farm was not produced or considered produced on the farm during any two years of the base period.

(b) *Calculation.* For purposes of paragraph (a) of this section, the quantity not produced or considered produced shall be considered to be: (1) The initial basic quota for the farm for the year for which the determination of whether to reduce the quota is being made (the "current year") multiplied by (2), the average of the two highest percentages of the farm's quota which was not produced or considered produced in the three years preceding the current year.

(c) *Reconstitutions and permanent transfers to the farm.*

(1) Determinations of whether a reduction shall be made in a farm's quota under this section shall be made separately for individual tracts within the farm if the farm's present constitution differs from the farm's constitution for any of the base period years.

(2) If a farm has been the beneficiary of a permanent transfer of a quota, the quota transferred to the farm shall be deemed produced or considered produced on the receiving farm only to the extent that it was produced or considered produced on the transferring farm.

§ 729.329 Allocation of increase in State poundage quota to farms.

(a) *Eligible farms.* After adjustments in a quota production history of farms resulting from permanent transfers of quota or permanent releases of a quota, if the poundage quota allocated to a State is greater than the poundage quota allocated to such State for the immediately preceding marketing year, the amount of the increase shall be allocated equally among: (1) All farms in the State which had a basic farm poundage quota greater than zero for the year immediately preceding the crop year for which the determination is being made, and (2) all other farms in the State on which peanuts were produced in at least two of the three years preceding the year for which the determination is being made provided that the total acres of peanuts dug exceeds 1.0 acre.

(b) *Method of allocation.* The amount of pounds so allocated to each group representing eligible quota and nonquota farms within a State shall be the result obtained by: (1) Dividing the amount by which such State's quota was increased from the preceding year by the total number of eligible quota and nonquota farms; (2) multiplying the result of paragraph (b)(1) of this section by (i) the number of eligible quota farms and (ii) the number of eligible nonquota farms; (3) prorating the pounds obtained as the result of applying the provisions of: (i) paragraph (b)(2)(i) of this section among quota farms based upon the larger of the basic quota established for the farm for the year preceding the year for which the determination is being made, or the average of the two highest year's total production pounds for the three years preceding the year for which the determination is being made; and (ii) paragraph (b)(2)(ii) of this section among nonquota farms based upon the average of the two highest year's total production pounds for the three years preceding the year for which the determination is being made. If there are no quota or nonquota farms in the State eligible to receive a quota increase in the State poundage quota under this section, the pounds shall be placed in the State reserve.

(c) *Quota reductions.* To the extent that quotas allocated under this section are subject to reduction pursuant to § 729.328 such quota shall be reallocated pursuant to § 729.331.

(d) *Farm Reconstitution.* Notwithstanding any other provisions of this subpart, for purposes of applying the provisions of paragraph (a) of this section, quotas shall be allocated on the basis on which farms were constituted for the preceding crop year.

§ 729.330 Allocation of decrease in State poundage quota to farms.

If a State's poundage quota for any crop year is less than the State's poundage quota for the immediately preceding crop year, the decrease shall be prorated by factor among all farms which are entitled to a preliminary farm poundage quota for the current year so as to reduce all such quotas by the same percentage.

§ 729.331 Allocation of permanently released quotas and nonproduced quotas.

(a) *Eligibility.* After adjustments in the quota or production history of farms to account for permanent releases or permanent transfers of quotas, quotas permanently released in accordance with § 729.369 or reduced for nonproduction pursuant to § 729.328 shall be allocated to farms that produced peanuts in at least two of the three crop years immediately preceding the year for which the allocation is being made.

(b) *Method of allocation.* Subject to the provisions of paragraph (c) of this section, the allocation of the total amount of quota available for allocation under this section shall be made by prorating that amount among all eligible quota and nonquota farms based upon the average of the two highest year's total production pounds for each farm for the three years preceding the year for which the determination is being made.

(c) *Exception to basic allocation method.* If the method of allocation provided for in paragraph (b) of this section would not allocate at least 25 percent of the quota to farms that were nonquota farms for the preceding crop year, the State committee shall prorate 25 percent of the quota to such farms and prorate the remainder to each other eligible farm on the same production history basis as is provided for in paragraph (a) of this section.

(d) *Farm reconstitution.* Notwithstanding any other provisions of this subpart, for purposes of applying the provisions of paragraph (a) of this section, quotas shall be allocated on the basis on which farms were constituted for the preceding year.

§ 729.332 Lack of adequate tillable cropland.

A farm may only receive an allocation pursuant to § 729.329 and § 729.331 to the extent that adequate tillable cropland is available for the production of the quota as so increased based upon the farm's yield. If adequate tillable cropland is not available, the excess quota may be allocated to other eligible quota and nonquota farms in such manner as the Deputy Administrator shall determine appropriate.

§ 729.333 Determination of undermarketings.

(a) *Actual undermarketings.* Actual undermarketings for a farm for a crop year are the number of pounds by which the total marketings of quota peanuts from the farm during previous marketing years for previous crops (excluding any marketing year before the marketing year for the 1984 crop) were less than the total amount of the applicable effective farm poundage quotas (disregarding adjustments for undermarketings from prior marketing years) for such marketing years, except that no increase for undermarketings in any marketing years shall be made to the poundage quota for any farm to the extent that the quota on such farm for any subsequent year was or is subject to reduction pursuant to § 729.328.

(b) *Total marketings of quota peanuts.* For purposes of the paragraph (a) of this section, "total marketings of quota peanuts" for any marketing year shall: (1) Not exceed the effective farm poundage quota for the marketing year disregarding adjustments for undermarketings for prior marketing years, and (2) shall, within the limitation specified in paragraph (b)(1) of this section, be the larger of: (i) The total production of segregation 1 peanuts on the farm during such year, and (ii) the total amount of quota peanuts which were marketed or considered marketed from the farm for the relevant marketing year.

(c) *Determining effective quota.* For purposes of determining a farm's effective farm poundage quota for a crop year under § 729.326, the farm's basic farm poundage quota shall be increased by the amount of the farm's effective

undermarketings for the relevant crop year.

(d) *Effective undermarketings.* (1) If 10 percent of the national poundage quota for the crop year is equal to or greater than the actual undermarketings for all farms as determined under subsection (a), the effective undermarketings for that crop year for all farms for that year shall be equal to the actual undermarketings for each such farm for that year.

(2) If the provisions of paragraph (d)(1) of this section are not applicable: (i) The effective undermarketings for a farm shall not be less than the smaller, for that crop year, of the farm's actual undermarketings or 10 percent of the farm's basic farm poundage quota; and (ii) the total effective undermarketings on all farms for the crop year shall, to the extent practicable, equal 10 percent of the national poundage quota for the relevant crop year.

§ 729.334 Determination of farm yield.

The farm yield established for a farm for which a farm poundage quota is established for the current year shall be the farm yield established for the farm for the immediately preceding year. Except as provided in § 729.335, if a farm yield was not established for a farm for the previous year, the county committee shall establish a farm yield taking into account: (a) Farm yields and actual yields on other farms in the locality on which the soil and other physical factors affecting production are similar, and (b) the normal yields for the county.

§ 729.335 Determination of farm yield for reconstituted farms.

For reconstituted farms, the farm yield for such farm shall be established in accordance with the following rules to the extent applicable:

(a) *Combinations*—(1) *Combination of Quota farms.* The farm yield for combined quota tracts shall be the weighted average of the farm yields for the tracts being combined.

(2) *Combinations of Quota and nonquota farm.* A combined farm shall be assigned the farm yield of the tract with an established quota if placed in combination with a nonquota tract even though a farm yield had been previously established for such nonquota tract.

(3) *Combination of Nonquota farms.* The farm yield for combined nonquota tracts shall be established by the county committee in accordance with § 729.334 even though a farm yield had been previously established for the individual tracts.

(b) *Divisions*—(1) *No identifiable tracts having tract yield established.* If a farm is divided and none of the tracts have an identifiable tract yield, the farm yield shall be the same for each tract as the farm yield for the parent farm.

(2) *Identifiable tracts with tract yield established.* If a farm is divided and the individual tracts have established yields, the farm yield for each tract will be that previously established for the tract.

(3) *Division of an identifiable tract having a tract yield established.* If a tract with an identifiable yield is divided, the farm yield, for the divided tracts shall be the same as the farm yield which has been previously established for the parent tract.

§ 729.336 Approval of farm poundage quota and notice to farm operator.

(a) *Approval.* Each farm yield, preliminary farm poundage quota, farm poundage quota, and effective farm poundage quota shall be determined under the supervision of, and approved by, the county committee of the county in which the farm is administratively located, subject to the concurrence of the State committee or a representative of the State committee. The initial notice of farm poundage quota shall not be mailed to a farm operator until the farm poundage quota has been so approved. A revised notice may be mailed without the approval of the county committee in any case resulting from: (1) A farm reconstitution; (2) a transfer of poundage quota by lease, sale, owner or operator; or (3) quotas apportioned pursuant to § 729.368 as a result of a temporary releases of quota by other farms.

(b) *Notice to farm operator.* (1) As soon as practicable after the farm poundage quota or the effective farm poundage quota is approved, an official notice of such quota shall be mailed to the farm operator.

(2) If a farm poundage quota is reduced to zero for the current year, the county committee shall mail to the farm operator a notice of such determination.

(3) A revised notice of farm poundage quota or effective farm poundage quota shall be mailed to the farm operator as soon as possible after the county committee determines that an incorrect notice has been mailed, or the county committee takes an action which requires a revision of the previously determined quota.

(4) The notice to the operator shall constitute notice to all persons, including, but not limited to, any person who as operator, landlord, tenant, or sharecropper has an interest in the farm for which the quota is established.

§ 729.337 Erroneous notice of effective farm poundage quota.

(a) *Marketing penalty computations where an erroneous notice has been issued.* If the official notice of effective farm poundage quota issued for a farm erroneously stated a quota larger than the correct effective farm poundage quota, the quota shown on the erroneous notice shall serve as the basis for marketing penalty computations for the farm for the current marketing year only if the county committee determines and the State Executive Director concurs that:

(1) The error was not so substantial as to place the operator on notice thereof; and

(2) The operator, relying upon such notice and acting in good faith (i) materially changes the operator's position in order to produce the quota set forth on the erroneous notice (by, for example, obligating expenditures for land preparation, additional equipment and labor) and (ii) has planted the acreage of peanuts needed to produce the erroneous farm poundage quota.

(b) *Determination of undermarketings where an erroneous notice has been issued.* Notwithstanding the provisions of subsection (a), undermarketings for farms which receive an erroneous notice of effective farm poundage quota shall be determined on the basis of the correct effective farm poundage quota for the farm.

§ 729.338 Request for reconsideration or appeal.

Any producer dissatisfied with the determination of a farm poundage quota or effective farm poundage quota may file a request for reconsideration with the county committee in accordance with Part 780 of this Chapter. Such request must be filed no later than 15 days after date of mailing the notice of the farm poundage quota or effective farm poundage quota. Following such reconsideration, the producer may appeal such determination to the State committee in accordance with Part 780 of this Chapter. Determinations rendered by the State committee with respect to individual farm poundage quotas and individual effective farm poundage quotas shall be final and there shall be no further administrative appeal, unless it is determined by the Deputy Administrator that such action is needed in the interests of the program.

(Approved by the Office of Management and Budget Under Control No. 0560-0006)

§ 729.339 Farms with one acre or less of peanuts.

Peanuts produced on a farm on which the acreage of peanuts dug is one acre or less are eligible to be marketed for domestic edible use provided that no producer who shares in the peanuts produced on any such farm shares in the peanuts produced on any other farm. Notwithstanding any other provision of this subpart, farms to which this section applies shall not be considered eligible farms for the purpose of allocating farm poundage quota under this subpart.

§§ 729.340-729.342 [Reserved]

Transfers of Farm Poundage Quota

§ 729.343 Transfer by sale or lease.

Subject to the provisions of this subpart, the owner and operator of any farm having a farm poundage quota in the current year may have approved by the county committee a record of transfer for sale or lease of all or any part of the farm poundage quota to any other owner or operator of a farm in the same county. The receiving farm need not have a farm poundage quota. If the owner(s) and operator of the farm from which the transfer by sale or lease is to be made are different persons, each shall execute the record of transfer. However, only the owner(s) or operator of the receiving farm is required to execute the record of transfer.

§ 729.344 Transfer by owner or operator.

The owner or operator of any farm having a farm poundage quota in the current year may have approved by the county committee a record of transfer to transfer the farm poundage quota from such farm to another farm owned or controlled by the same person: (a) in the same county: or (b) in a county that is contiguous to the transferring county in the same State if the receiving farm had a farm poundage quota established for the preceding year's crop.

§ 729.345 Transfer by sale or permanent transfer by owner from or to separately owned tracts within a farm combination.

The owner of a separately owned tract within a farm may, with the approval of the farm operator, permanently transfer by sale, or by owner, the farm poundage quota attributable to the tract to another tract within the same farm combination if the owner of the receiving tract agrees to the transfer. The quota for such tract may also be transferred by sale or owner to a different farm to the extent that such a transfer could be permitted if the tract were a separate farm.

§ 729.346 Transfers within certain States.

Notwithstanding any other provisions of this subpart, a transfer of a farm poundage quota by sale, lease or by the owner or operator, for farms in the States of Arizona, Arkansas, California, Louisiana, Mississippi, Missouri, New Mexico and Tennessee may be made to any other farm in the same State, pursuant to instructions issued by the Deputy Administrator.

§ 729.347 Witness of signatures.

A county committee number or employee must witness the signature of either the owner or operator of the transferring farm and the owner or operator of the receiving farm. If such signatures cannot be witnessed in the county office where the farm is administratively located, they may be witnessed in any county office.

§ 729.348 Filing record of transfer and time for filing.

No transfer of any quota under this section shall become effective until a record of transfer, determined by the county committee to be in compliance with the provisions of this subpart, has been executed on Form ASCS–375, or such other form approved for general use for that purpose by the Deputy Administrator, and filed within the time periods set forth in this section with the county committee in the county where the farms are administratively located.

(a) *Record of transfer filed during the normal planting period ("spring transfers").* In order to be effective during the normal planting period, a record of transfer shall be filed by the date established for that purpose by the State committee for the relevant State, which date shall not be later than June 15. A record of transfer filed after the date established by the State committee for purposes of the preceding sentence but prior to July 1 may nonetheless be considered to be timely filed for a spring transfer, if the county committee finds that: (1) The transfer was agreed upon no later than the date established by the State committee, and (2) the record of transfer was not timely filed with the county committee because of conditions beyond the control of the parties to the transfer.

(b) *Record of transfer filed after the normal planting period ("fall transfers").* A record of transfer which is filed after the date established by the State committee for "spring transfers" pursuant to § 729.348(a) shall not become effective unless filed not later than December 31 of the current year. A record of transfer filed after December 31 but prior to the following January 31 may be considered timely filed by December 31 if the county committee with approval of the State committee finds that: (1) The transfer was agreed upon no later than December 31, and (2) the record of transfer was not timely filed with the county committee because of conditions beyond the control of the parties to the transfer.

(Approved by the Office of Management and Budget under Control No. 0560–0006)

§ 729.349 Maximum period of transfer.

(a) *Owner transfer.* (1) An owner transfer may be approved to a farm owned by such person for a temporary period (but not to exceed two successive years during the 1986–1990 crop years) or permanently.

(2) An owner transfer to a farm controlled by such person may be approved for only one year.

(b) *All other transfers.* Transfers by lease and by operator may only be approved for one year. Multiyear leases and permanent operator transfers shall not be permitted.

§ 729.350 Transfers not to be approved.

The county committee shall not approve:

(a) A transfer of poundage quota by sale if poundage quota was transferred to the transferring farm by sale within the 3 preceding crop years.

(b) Temporary transfers by an operator for more than one year.

(c) Permanent transfers by an operator.

(d) Transfers for more than one marketing year filed after the date established by the State committee for "spring transfers" pursuant to § 729.348(a).

(e) Transfers of actual or effective undermarketings, or of quotas received as a result of a reapportionment of temporarily released quota or temporarily transferred quotas.

(f) Transfers of poundage quotas to farms with inadequate tillable cropland to produce the poundage quota.

§ 729.351 Consent of lienholders.

A transfer of poundage quota from a farm which the county committee has been informed is subject to mortgage or other lien shall not be approved unless the transfer is agreed to in writing by the lienholder. Any transfer approved by the county committee where there was a lien on the transferring farm shall be cancelled by the county committee effective as of the date of approval if it is determined that the lienholder(s) did not approve the transfer.

§ 729.352 Transfer to and from the same farm (subleasing).

(a) *Record of transfer filed during the normal planting period.* The county committee shall not approve a record of transfer which is filed (or considered filed) on or before the date established by the State committee for "spring transfers" pursuant to § 729.348(a) if the approval would result in a transfer both to and from either the transferring or receiving farm during the period ending on such date for the same crop year, except that in such instance a record of transfer may be approved if: (1) A poundage quota has been transferred temporarily from a farm for one or more years; (2) the transfer remains in effect; and, (3) the farm is combined subsequent to such temporary transfer with another farm that is otherwise eligible to receive a poundage quota by transfer.

(b) *Record of transfer filed after the normal planting period.* The county committee shall not approve a temporary transfer of poundage quota which is filed (or considered filed) after the date established by the State committee for "spring transfers" pursuant to § 729.348(a) if it would result in a temporary transfer both to and from either the receiving farm or transferring farm during the period beginning on the last date for "spring transfers", and ending on December 31.

§ 729.353 Fall transfers.

In order for any transfer filed after the last date for "spring transfers" established by the State committee to be approved by the county committee, the following conditions must be met, as applicable:

(a) *Receiving farm.* The operator of the receiving farm must certify and the county committee must determine that the poundage quota being transferred is not more than will be required to market the entire production of peanuts from the receiving farm as quota peanuts in the current year. The amount so determined shall be limited to the quantity equal to the estimated ungraded pounds yet to be marketed subtracted from the quota pounds yet to be marketed as quota peanuts as shown on the marketing card for the receiving farm.

(b) *Transferring farm.* The operator of the transferring farm must certify and the county committee determine that: (1) The acreage of peanuts planted on the transferring farm was equal to or in excess of the acreage determined by dividing the effective farm poundage quota by the larger of the current farm yield or the highest actual yield for the farm in any one of the preceding three years; and (2) the production of peanuts on the transferring farm was limited to less than the effective farm poundage quota because of conditions beyond the control of the producer.

§ 729.354 Effect of permanent transfer on quota and/or production history and on determination of farm poundage quota.

In the event of a permanent transfer of a quota, the quota and/or production history of the transferring farm shall be transferred to the receiving farm in proportion to the quantity of quota which has been so transferred.

§ 729.355 County committee action.

(a) *Approval of transfer.* The county committee shall approve the transfer of poundage quota only if it determines that a timely filed record of transfer has been received and that the transfer complies with the requirements of this subpart. A transfer shall not be effective until approved by the county committee. The county committee may delegate authority to the county executive director and to other county office employees to approve transfers of poundage quotas.

(b) *Notice of revised quotas.* A revised notice of farm poundage quota shall be issued for each farm affected by the transfer of farm poundage quota.

(c) *Cancellation of transfer.* (1) A transfer approved on the basis of incorrect information furnished by the parties to the transfer agreement, or approved due to error by the county committee, shall be void and canceled effective as of the date of approval. The cancellation shall not be effective for the current marketing year if:

(i) The transfer approval was made on the basis of incorrect information unknowingly furnished in good faith by the parties to the transfer agreement or the transfer approval was made in error by the county committee, and (ii) the parties to the transfer agreement were not notified of the cancellation prior to the marketing of quota peanuts in excess of the revised effective farm poundage quota.

(2) Where cancellation of a transfer is required, the county committee shall issue revised notices of poundage quota showing the reasons for, and effect of, the cancellation.

§ 729.356 Withdrawal or minor revision.

Where the county committee determines that: (a) It is clearly in the best interest of all the producers, and (b) that effective operation of the peanut program will not be impaired, the county committee may permit withdrawal or minor revisions of a transfer upon written request by all parties to the transfer. A temporary transfer may be withdrawn or revised before peanuts are harvested during any year of the agreement.

§§ 729.357–729.366 [Reserved].

Temporary and Permanent Release and Temporary Reapportionment

§ 729.367 Temporary release and temporary reapportionment.

Temporary release and temporary reapportionment shall result from any voluntary temporary release and temporary reapportionment of farm poundage quotas as provided for in this subpart.

§ 729.368 Temporary release of farm poundage quota.

Except as provided in § 729.372, the farm operator may temporarily release part or all of the basic farm poundage quota to the State committee by filing a written release with the county committee.

§ 729.369 Permanent release of farm poundage quota; effect on quota and/or production history and on future quota determinations.

The farm poundage quota, except for undermarketings and quota temporarily transferred to the farm, may be permanently released by the owner and operator to the extent that the quota will not be produced on the farm. The farm poundage quota for the farm from which quota is permanently released shall be adjusted downward by the amount of the quota permanently released and the farm shall lose any production history which preceded any release to which this section applies.

§ 729.370 Permanent release from farm containing separate ownership tracts.

Where the farm consists of separately identifiable owned tracts, the owner of an individual tract may permanently release the quota contributed to the farm by the tract.

§ 729.371 Closing date for temporary or permanent releases of quotas and for requesting reapportionment of temporary released quotas.

The State committee shall establish and publicize the closing date(s) for temporary and permanent releases of farm poundage quota for the State or for areas consisting of one or more counties in the State taking into consideration the normal planting date(s) for the State. The closing date for such release and for requesting reapportionment of temporarily released poundage quota shall be the date established by the State committee in accordance with

instructions issued by the Deputy Administrator.

§ 729.372 Signature requirements for temporary releases.

If a farm's quota was temporarily released in one or more of the crop years preceding the current year, the document setting forth the release of the farm poundage quota for the current year shall be signed by both the owner and the operator of the farm. The farm poundage quota may not be temporarily released for the current year if the owner of the farm files an objection with the county committee in writing before the released quota is transmitted to the State committee for reapportionment.

§ 729.373 Signature requirements for permanent releases.

The signature of both the owner and operator are required for a permanent release of quota.

§ 729.374 Reapportionment of farm poundage quota temporarily released.

Poundage quotas which have been temporarily released may be reapportioned by the State committee to other farms in the State, upon application by the operator of such other farms in such manner as determined by the State committee in accordance with instructions issued by the Deputy Administrator.

§ 729.375 Closing date for reapportionment of temporarily released quota.

The final date for requesting a reapportionment pursuant to § 729.374 shall be the date established by the State committee in accordance with instructions issued by the Deputy Administrator. Such date shall be in advance of the final date for spring transfers for the relevant State.

§ 729.376 Credit for a voluntary temporary release of quota or for reapportioned poundage quota.

If a farm's quota has been temporarily released, the farm poundage quota shall be considered produced only to the extent permitted by this subpart. Any increase in a farm poundage quota resulting from reapportionment of quotas which have been temporarily released shall not be a basis for a grant of a quota for the receiving farm for any subsequent year.

§ 729.377 Withdrawal or minor revision of released quota.

A withdrawal or downward revision in the pounds temporarily or permanently released may be made upon a written request filed with the county committee, and such withdrawal or minor revision may be approved by the county committee provided that the notification of the release of quota has not at the time of the filing been transmitted to the State committee for reallocation.

§ 729.378 Notification of State Committees of permanent or temporary release of quotas.

Notification of the permanent or temporary release of quotas shall be transmitted to the State committee by the relevant county committee. The final date for such transmission shall be established by the State committee, subject to review by the Deputy Administrator.

§ 729.379–729.384 [Reserved]

Signed at Washington, DC on March 28, 1986.

Milton J. Hertz,

Acting Administrator, Agricultural Stabilization and Conservation Service.

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FEDERAL REGISTER PAGES AND DATES, APRIL

11007-11284 1

LIST OF PUBLIC LAWS

Last List March 28, 1986.

This is a continuing list of public bills from the current session of Congress which have become Federal laws. The text of laws is not published in the **Federal Register** but may be ordered in individual pamphlet form (referred to as "slip laws") from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone 202-275-3030).

H.R. 4399/Pub. L. 99-266

To designate the Federal building located in Jamaica, Queens, New York, as the "Joseph P. Addabbo Federal Building." (Mar. 27, 1986; 100 Stat. 72; 1 page) Price: $1.00

H.J. Res 563/Pub. L. 99-267

To provide for the temporary extension of certain programs relating to housing and community development, and for other purposes. (Mar. 27, 1986; 100 Stat. 73; 3 pages) Price: $1.00

S.J. Res 226/Pub. L. 99-268

To designate the week of April 6, 1986, through April 12, 1986, as "World Health Week", and to designate April 7, 1986, as "World Health Day." (Mar. 27, 1986; 100 Stat. 76; 2 pages) Price: $1.00

TABLE OF EFFECTIVE DATES AND TIME PERIODS—APRIL 1986

This table is for determining dates in documents which give advance notice of compliance, impose time limits on public response, or announce meetings.

Agencies using this table in planning publication of their documents must allow sufficient time for printing production.

In computing these dates, the day after publication is counted as the first day.

When a date falls on a weekend or a holiday, the next Federal business day is used. (See 1 CFR 18.17)

A new table will be published in the first issue of each month.

Dates of FR publication	15 days after publication	30 days after publication	45 days after publication	60 days after publication	90 days after publication
April 1	April 16	May 1	May 16	June 2	June 30
April 2	April 17	May 2	May 19	June 2	July 1
April 3	April 18	May 5	May 19	June 2	July 2
April 4	April 21	May 5	May 19	June 3	July 3
April 7	April 22	May 7	May 22	June 6	July 7
April 8	April 23	May 8	May 23	June 9	July 7
April 9	April 24	May 9	May 27	June 9	July 8
April 10	April 25	May 12	May 27	June 9	July 9
April 11	April 28	May 12	May 27	June 10	July 10
April 14	April 29	May 14	May 29	June 13	July 14
April 15	April 30	May 15	May 30	June 16	July 14
April 16	May 1	May 16	June 2	June 16	July 15
April 17	May 2	May 19	June 2	June 16	July 16
April 18	May 5	May 19	June 2	June 17	July 17
April 21	May 6	May 21	June 5	June 20	July 21
April 22	May 7	May 22	June 6	June 23	July 21
April 23	May 8	May 23	June 9	June 23	July 22
April 24	May 9	May 27	June 9	June 23	July 23
April 25	May 12	May 27	June 9	June 24	July 24
April 28	May 13	May 28	June 12	June 27	July 28
April 29	May 14	May 29	June 13	June 30	July 28
April 30	May 15	May 30	June 16	June 30	July 29

CFR ISSUANCES 1986
January 1986 Editions and Projected April, 1986 Editions

This list sets out the CFR issuances for the January 1986 editions and projects the publication plans for the **April, 1986** quarter. A projected schedule that will include the **July, 1986** quarter will appear in the first **Federal Register** issue of July.

For pricing information on available 1985-1986 volumes consult the CFR checklist which appears every Monday in the Federal Register.

Pricing information is not available on projected issuances. Individual announcements of the actual release of volumes will continue to be printed in the **Federal Register** and will provide the price and ordering information. The weekly CFR checklist or the monthly List of CFR Sections Affected will continue to provide a cumulative list of CFR volumes actually printed.

Normally, CFR volumes are revised according to the following schedule:

Titles 1-16—January 1
Titles 17-27—April 1
Titles 28-41—July 1
Titles 42-50—October 1

All volumes listed below will adhere to these scheduled revision dates unless a notation in the listing indicates a different revision date for a particular volume.

*Indicates volume is still in production.

Titles revised as of January 1, 1986:

Title

CFR Index
1-2

3 (Compilation)

4

5 Parts:
1-1199
1200-End

6 [Reserved]

7 Parts:
0-45*
46-51
52
53-209
210-299
300-399
400-699*
700-899
900-999
1000-1059
1060-1119
1120-1199
1200-1499
1500-1899
1900-1944*
1945-End*

8

9 Parts:
1-199
200-End

10 Parts:
0-199
200-399*
400-499*
500-End*

11

12 Parts:
1-199
200-299
300-499
500-End

13*

14 Parts:
1-59*
60-139*
140-199
200-1199
1200-End

15 Parts:
0-299
300-399*
400-End

16 Parts:
0-149
150-999
1000-End

Projected April 1, 1986 editions:

Title

17 Parts:
1-239
240-End

18 Parts:
1-149
150-399
400-End

19

20 Parts:
1-399
400-499
500-End

21 Parts:
1-99
100-169
170-199
200-299
300-499
500-599
600-799
800-1299
1300-End

22

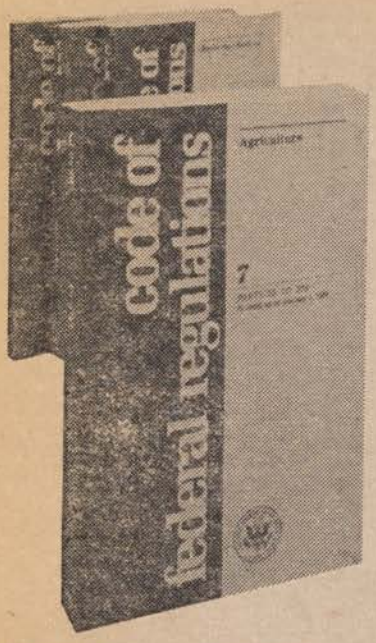
23

24 Parts:
0-199
200-499
500-699
700-1699
1700-End

25

26 Parts:
1 (§§ 1.0-1-1.169)
1 (§§ 1.170-1.300)
1 (§§ 1.301-1.400)
1 (§§ 1.401-1.500)
1 (§§ 1.501-1.640)
1 (§§ 1.641-1.850)
1 (§§ 1.851-1.1200)
1 (§§ 1.1201-End)
2-29
30-39
40-299
300-499
500-599
600-End

27 Parts:
1-199
200-End



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A cumulative checklist of CFR issuances appears every Monday in the Federal Register in the Reader Aids section. In addition, a checklist of current CFR volumes, comprising a complete CFR set, appears each month in the LSA (List of CFR Sections Affected).

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