Sunshine Act Meetings

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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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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.

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