

# HCFR LEGISLATIVE SUMMARY

April 12, 1989

## THE FAMILY SUPPORT ACT OF 1988

On October 13, 1988, the President signed into law H.R. 1720, the Family Support Act of 1988, P.L. 100-485. The new law, popularly known as "welfare reform," contains far-reaching changes to the AFDC and child support enforcement programs under Title IV of the Social Security Act. It also significantly expands the duration and scope of provisions for continuation of Medicaid coverage for families losing AFDC cash assistance, and includes technical corrections to the Medicare Catastrophic Coverage Act of 1988 and other miscellaneous provisions. Provisions with significant Medicaid or Medicare impact are included in the attached summary.



Nancy J. Dapper  
Acting Director  
Office of Legislation and Policy

**FAMILY SUPPORT ACT OF 1988**  
**(Public Law 100-485)**

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## FAMILY SUPPORT ACT OF 1988

### TITLE II -- JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAM

Establishment and Operation of Program (Sec. 201, subsec. (b), new 482(e)(6) - Mandatory medical assistance for States opting to operate work supplementation programs)

#### Current Law

- o A State that operates a work supplementation program (one of several optional activities for improving the employability of AFDC recipients) has the option to provide Medicaid for participants and family members.

#### Provision

- o Work supplementation is still optional, but if the State does have such a program it must provide Medicaid coverage to participants and family members.

#### Effective Date

- o October 1, 1990 or earlier at State option, but no earlier than the first day of any calendar quarter beginning on or after the date that Federal proposed regulations are published (or are required to be published) and after the State has made the necessary changes in its AFDC State plan and has formally notified the Secretary of its desire to be covered earlier.

### **TITLE III -- SUPPORTIVE SERVICES FOR FAMILIES**

Child Care During Participation in Employment, Education, and Training (Sec. 301, new 402(g)(1)(E) - Value of child care not to be treated as income for Medicaid)

#### Current Law

- o (No provision.)

#### Provision

- o Under the new Family Support Act, States must now guarantee the availability of and make payments for child care necessary for families to participate in employment, education, and training to assist them in making the transition from welfare to work. A new subsection (g) is added to section 402 of the Act. It contains a new paragraph (1), subparagraph (E), which provides that the value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for such care) under section 402 shall not be treated as income for purposes of Medicaid (or other means-tested Federally-assisted programs).

#### Effective Date

- o The provisions of section 301 are effective for a State on the same date that Title II of the Family Support Act becomes effective for that State (generally October 1, 1990, or earlier at State option, but no earlier than the first day of any calendar quarter beginning on or after the date that Federal proposed regulations are published (or are required to be published) and after the State has made the necessary changes in its AFDC State plan and has formally notified the Secretary of its desire to be covered earlier).

#### Extended Eligibility for Medical Assistance (Sec. 303)

##### Current Law

- o For AFDC families that received cash benefits in 3 of the preceding 6 months and that are losing cash benefits because of increased hours of or earnings from employment, States must continue to provide Medicaid coverage for an additional 4 months. (Section 1902(e)(1) of the Social Security Act)
- o For AFDC families that are losing cash benefits because of termination of the earned income disregard (first \$30 plus 1/3 of the remainder), States must continue to provide Medicaid coverage for an additional 9 months, and at State option may do so for another 6 months beyond that (total of 15 months). (Section 402(a)(37) of the Act)

- o For AFDC families that received cash benefits in 3 of the preceding 6 months and that are losing cash benefits as a result (wholly or in part) of collection or increased collection of child or spousal support, States were required to provide Medicaid coverage for an additional 4 months. (Section 406(h) of the Act, which expired on October 1, 1988)

### Provisions

- o Adds a new Section 1925 to the Act to provide transitional extended Medicaid eligibility for AFDC families that lose cash benefits under certain specified circumstances related to the employment of the caretaker relative. Payments by the State for premiums, deductibles, coinsurance, and similar expenses are eligible for Federal matching funds.

### Initial 6-Month Extension

#### Requirement

The State must provide an initial extension of medical assistance eligibility for 6 months to families that received AFDC cash benefits in 3 of the preceding 6 months and that are losing cash benefits because of the hours of or income from employment of the caretaker relative; or because of expiration of the time-limited earned income disregard.

#### Notice of Benefits

The State must notify the family of its rights to extended medical assistance; describe the reporting requirements and the circumstances under which the extension may be terminated; and include a card or other evidence of the family's entitlement to assistance during the extension period.

#### Termination of Extension

A family's eligibility terminates at the close of the first month in which the family ceases to include a child who is (or would, if needy, be) a dependent child for AFDC purposes.

The termination shall not become effective until after the State has given the family notice of the grounds for termination, and until after the State has determined that the child is not otherwise eligible for Medicaid under another eligibility status for children.

### Scope of Coverage

The State must provide (either through Medicaid or through a combination of employer coverage and Medicaid supplementation described below under the wrap-around option) for continued medical assistance coverage for the family of the same amount, duration, and scope as if the family were still receiving cash benefits.

### State Medicaid "Wrap-Around" Option

At the State's option, it may pay a family's expenses for premiums, deductibles, coinsurance, and similar expenses for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of a dependent child.

The State may require the caretaker relative to apply for coverage offered by his or her employer, but only if the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise); and the State provides for payment of any expenses that the employee would otherwise be required to pay.

The State shall treat coverage under an employer plan as a third party liability.

### Additional 6-Month Extension

#### Requirement

The State must offer an additional extension of medical assistance eligibility for 6 months to families that had Medicaid coverage during the entire 6-month initial extension period, and that meet the reporting requirements described below.

#### Notice and Reporting Requirements

During the 3rd and 6th month of the initial extension period the State must notify families of the option for additional extended assistance.

The notice shall include a description of the reporting requirements during the initial and additional extension periods; whether any premiums will be required for the additional extension and, in the 6th month, the amount of such premium for the first 3 months of the additional extension; and a description of significant features of any alternative coverage to Medicaid which the State elects to offer.

During the 3rd month of the additional extension, the State must notify families of the reporting requirements during the additional extension period; and the amount of any premium required for the second 3 months of the additional extension.

In order to receive the additional extension of medical assistance eligibility, families are required to report to the State, not later than the 21st day of: the 4th month of the initial extension, the 1st month of the additional extension, and the 4th month of the additional extension, the following information: the family's gross monthly earnings in each of the 3 preceding months; and the family's costs for child care necessary for employment of the caretaker relative in each of the 3 preceding months.

#### Termination of Extension

A family's eligibility during the additional extension terminates:

- At the close of the first month in which the family ceases to include a child who is (or would, if needy, be) a dependent child for AFDC purposes; or
- If the State chooses to impose a premium during the additional extension and the family fails, without good cause, to pay the premium for a month by the 21st day of the following month, at the close of that following month; or
- At the close of the first or fourth month of the additional extension if: the family failed, without good cause, to timely report its earnings and child care expenses (instead of termination, the State may suspend eligibility until the month after the month in which the required reports are received, if the family has not been terminated for another reason); or the caretaker relative had no earnings in one or more of the previous 3 months, unless the State determines that such lack of earnings was due to involuntary loss of employment, illness or other good cause; or the State determines that the family's average gross monthly earnings (less the costs of child care necessary for employment of the caretaker relative) during the immediately preceding 3-month period exceeded 185% of the Federal poverty level for a family of that size.

The State must give the family notice prior to termination which includes the grounds for termination and, if termination was for no earnings, how the family may reestablish eligibility for medical assistance.

The termination of Medicaid eligibility because of failure to report income or to satisfy the income test shall not become effective until after the State has determined that the individual is not eligible for Medicaid as medically needy.

The termination from Medicaid eligibility of a child who ceases to be a member of a family in which dependency status exists, shall not take effect until after the State determines that the child is not otherwise eligible for Medicaid under another eligibility status for children.

#### Coverage

During the additional extension, the State must offer families medical assistance of the same amount, duration, and scope as if the family were still receiving AFDC cash assistance, with the following exceptions:

- The State may elect not to provide certain non-acute care benefits (nursing facility services; medical or other remedial care (as defined in Section 1905(a)(6) of the Social Security Act); home health care; private duty nursing services; physical therapy; other diagnostic, screening, preventive, and rehabilitative services; IMD services for individuals age 65 and over; inpatient psychiatric hospital services for individuals under age 21; hospice care; respiratory care services; and other medical or remedial care).
- The State may elect to require enrollment in an employer plan with a Medicaid wrap-around, as described above for the initial extension.

#### Alternative Coverage

The State may, at its option, also offer families enrollment of the caretaker relative and dependent children in one or more of the following alternative forms of coverage:

- A family option of employment-based group health coverage offered to the caretaker relative;
- A family option of a group health plan offered to State employees;
- A basic State health plan offered by the State to individuals in the State who are otherwise unable to obtain health insurance (risk pool);
- An HMO, less than 50% of whose prepaid membership consists of individuals eligible for Medicaid (those enrolled under this option do not count toward the 50%).

If the State elects to offer an option to enroll a family in any of these alternative forms of coverage, the State must pay any premiums and other enrollment costs. In general, the State may choose whether or not to pay deductibles and coinsurance.

There must be no cost-sharing imposed upon recipients for maternity and for preventive pediatric care for children up to age 7 (or, at State option, up to age 8).

The State's payment of premiums for the enrollment of families (not including any premiums otherwise payable by the employer and less the amount of any premiums collected from the families) and payment of any deductibles and coinsurance shall be eligible for Federal matching funds.

### Premium

A State may choose to impose a premium for a premium payment period upon a family for coverage during the additional extension, but only if the family's average gross monthly earnings (less the average monthly costs of child care necessary for employment of the caretaker relative) exceed 100% of the Federal poverty level for a family that size during the relevant premium base period. These periods are as follows:

<u>Premium Base Period</u>	<u>Premium Payment Period</u>
Earnings, less child care expenses, during this period	trigger payment of premium during this period.
1st 3 mos. of initial ext.	1st 3 mos. of additional ext.
2nd 3 mos. of initial ext.	2nd 3 mos. of additional ext.

The State may vary the premium amount for the same family for each type of alternative coverage offered.

The premium for a family for a month in either premium payment period may not exceed 3% of the family's average gross monthly earnings (less the average monthly costs of child care necessary for employment of the caretaker relative [this parenthetical clarification was included in the subsequent Tax Technicals]) for the premium base period.

o Applicability in the States and Territories

The requirements of Section 1925 apply only to the 50 States (including Arizona which is operating its Medicaid program under a demonstration project under Section 1115 of the Social Security Act), and to the District of Columbia. Section 1925 does not apply to Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

o Disqualification for Fraud

Extended medical assistance requirements shall not apply to an individual who is a member of a family which has received AFDC if the State finds that, at any time during the last 6 months in which the family received AFDC before being provided extended eligibility under Section 1925, the individual was ineligible for such aid because of fraud.

o Definition of "Caretaker Relative"

The term "caretaker relative" is defined to have the same meaning as under the AFDC program in Title IV-A of the Act (under which the States are given flexibility to implement this definition).

o Reinstatement of Current Law Upon Sunset

The new section 1925 expires September 30, 1998. Current law will be automatically reinstated after that sunset date.

o Conforming amendments

The 4-month extension of medical assistance contained in Section 1902(e)(1) of current law is temporarily set aside while the new Section 1925 is in effect (i.e. for families losing eligibility for AFDC cash assistance, beginning April 1, 1990 and ending September 30, 1998, because of the employment of the caretaker relative). The 4-month extension would go back into effect when Section 1925 sunsets.

Effective April 1, 1990, the extension of medical assistance, contained in Section 402(a)(37) of current law (AFDC State plan requirements), for families losing AFDC cash benefits due to expiration of the earned income disregard, is temporarily replaced. The medical assistance extensions in the new Section 1925 will then apply to families that lose AFDC cash benefits because of hours of or income from employment of the caretaker relative or due to expiration of the earned income disregards. Like Section 1925 itself, Section 402(a)(37) reverts to its prior form after Section 1925 sunsets on September 30, 1998.

o Study by Secretary

Requires the Secretary of HHS to conduct a study of the impact of the Medicaid extensions in Section 1925, with particular focus on the costs of the provisions and the impact on welfare dependency. Several additional topics that the study must address are also specified. A report to Congress on the results of the study is due not later than April 1, 1993.

o Additional Conforming Amendment

Makes a conforming and clarifying amendment to Section 1902(e): Denial of cash assistance to households headed by minor parents shall not be grounds for denying medical assistance to an individual who is Medicaid eligible on a basis other than as an AFDC recipient. The State may not discontinue medical assistance until after it has determined that the individual is not otherwise eligible for Medicaid. Effective date is January 1, 1990.

o Extension of Sunset Date for Extended Medical Assistance Due to Collection of Child or Spousal Support

Effective October 1, 1988, the sunset date of the 4-month extension of medical assistance due to collection of child or spousal support contained in Section 406(h) of the Act is extended to October 1, 1989.

Effective Dates

- o Unless stated otherwise, regardless of whether or not implementing regulations have been promulgated, amendments establishing the new Section 1925 will apply to payments under Title XIX for calendar quarters beginning on or after April 1, 1990 (October 1, 1990 for Kentucky) with respect to families who cease to be eligible for AFDC cash assistance on or after such date.

## **TITLE IV -- RELATED AFDC AMENDMENTS**

### **Benefits for Two-Parent Families (Sec. 401)**

#### **Expansion of Medicaid Coverage for Two-Parent Families (Subsec. (d))**

##### **Current Law**

- o States currently have the option (under Section 407 of the Act) to provide AFDC cash assistance to dependent children in two-parent families in which the parent who is the principal earner is unemployed (AFDC-UP program).
- o Pregnant women and children in two-parent families are eligible for Medicaid if they are eligible for AFDC-UP or if they would be if their State had such a program.

##### **Provisions**

- o AFDC-UP, the permanently authorized program of cash assistance to two-parent families, is made mandatory. States that had not previously opted to provide such assistance may limit cash payments to 6 months or more in a 12 month period. (Note: the AFDC-UP program is linked to Section 1905(n), which defines Medicaid eligibility for qualified pregnant women or children in 2-parent families. Section 1905(n) is also a permanent provision in the statute.)
- o A temporary provision is added which further expands Medicaid coverage (while it is in effect, from 1990-1998) to qualified family members in 2-parent families (other than a qualified pregnant woman or child as defined in 1905(n)). Such Medicaid coverage must be provided to all qualified family members in 2-parent families for the entire period during which they qualify under the UP program, even if a State elects to limit cash assistance to a portion of that period.

##### **Effective Dates**

- o The mandatory AFDC-UP provisions with time limit option are effective October 1, 1990, except for Puerto Rico, American Samoa, Guam, and the Virgin Islands, where they are effective October 1, 1992.
- o The expansion of Medicaid coverage for "qualified family members" begins October 1, 1990 and expires September 30, 1998.

**TITLE V -- DEMONSTRATION PROJECTS**

**Extension of Minnesota Prepaid Medicaid Demonstration Project  
(Sec. 507)**

**Current Law**

- o The State of Minnesota had a Section 1115(a) waiver to demonstrate the feasibility of HMOs for Medicaid beneficiaries in 3 locations in Minnesota. The waiver was due to expire on December 31, 1988.

**Provision**

- o The Secretary is directed to extend Minnesota's waiver, upon application by the State, until June 30, 1990.

**Effective Date**

- o Enactment (October 13, 1988).

## TITLE VI -- MISCELLANEOUS PROVISIONS

### Uniform Reporting Requirements (Sec. 606)

#### Current Law

- o (No provision.)

#### Provision

- o The Secretary is required to establish uniform reporting requirements under which each State will be required periodically to furnish information and data that the Secretary determines to be necessary to ensure that provisions of the Family Support Act are being effectively implemented.
  - Information must be furnished for the following provisions: 402(a)(37) (extension of medical assistance to families losing AFDC cash benefits due to hours of or income from employment of the caretaker relative, and to families losing AFDC cash benefits due to expiration of the earned income disregards); 402(a)(43) (households headed by minor parents); and 402(g)(1)(A) (guaranteed child care so that families can participate in Family Support Act activities).
  - The uniform reporting requirements must include, at a minimum: the average number of families assisted under each of the three provisions above, the types of such families, and the length of time that such families are assisted. In addition, for families assisted under Section 402(g), the reporting requirements must provide for separate reporting with respect to families that have income and those that do not and for families receiving aid under the AFDC State plan and those that do not.

#### Effective Date

- o Enactment (October 13, 1988).

Miscellaneous Technical Corrections to Medicare Catastrophic Coverage Act of 1988 (MCCA) and Other Statutory Changes (Sec. 608)

Inclusion of Provisions Repealing Authority for Administering Proficiency Examinations (Subsec. (b))

Current Law

- o The Secretary was required, under Section 1123 of the Social Security Act, to develop and conduct a program for testing the proficiency of practical nurses, therapists, laboratory technicians, cytotechnologists, X-ray technicians, psychiatric technicians or other health care technicians and technologists who had not met the formal educational, professional membership and other requirements established for determining their qualification to perform the duties of their respective health care specialty.

Provisions

- o A new Section 430 is inserted in MCCA, which repeals the proficiency testing requirement in Section 1123 of the Social Security Act.
- o The new Section clarifies that repeal of the proficiency testing requirement does not affect the individuals who were determined to be proficient and qualified to perform the duties of their respective health care specialty under that procedure.

Effective Date

- o As if included in the enactment of MCCA (July 1, 1988).

Continuation of Cost Pass-Through for Certified Registered Nurse Anesthetists (CRNAs) (Subsec. (c))

Current Law

- o Section 9320 of OBRA 1986 provided for direct Medicare reimbursement for anesthesia services and related care furnished by CRNAs, subject to State licensure requirements, effective for cost-reporting periods beginning on or after January 1, 1989 and until December 31, 1990 or one year after the report to Congress on the relative value scale, whichever is later.

- o The Secretary was also required to establish a fee schedule for CRNA services, using a system of time units, base and time units, or any other appropriate methodology. The initial fee schedule base would be adjusted annually by the percentage increase in the Medicare Economic Index. The fee schedule could be national or adjusted for geographical areas.

#### Provision

- o Rural hospitals are exempt in 1989 from paying CRNAs according to a fee schedule if they establish before April 1, 1989 that:
  - as of January 1, 1988, the hospital employed or contracted with no more than one, full-time equivalent CRNA,
  - in 1987, the hospital performed no more than 250 surgical procedures requiring anesthesia services (or a higher number determined by the Secretary to be appropriate), and
  - each CRNA employed or under contract with the hospital agrees not to bill under Part B of title XVIII for direct Medicare reimbursement for services provided to the hospital.
- o Rural hospitals are exempt in 1990 and 1991 from paying CRNAs according to a fee schedule if they establish before the beginning of each respective year that the hospital performed no more than 250 surgical procedures requiring anesthesia services (or a higher number determined by the Secretary to be appropriate).
- o The implementation of this provision is to be budget neutral.

#### Effective Date

- o Upon enactment of the Family Support Act (October 13, 1988).

Miscellaneous Technical Corrections to Various Provisions in MCCA  
(Subsec. (d)) (Note: only significant, substantive changes are summarized.)

(14) Medicare Buy-In (Sec. 301 of MCCA)

Current Law

- o MCCA made the optional Medicaid buy-in for Qualified Medicare Beneficiaries (QMBs) mandatory.

Provision

- o The MCCA provision is clarified to ensure that QMBs are eligible to have Medicaid pay the Medicare cost sharing for the full range of Medicare covered services, even when those services are not covered by the Medicaid State plan for a State's Medicaid beneficiaries.

Effective Date

- o As if included in the enactment of MCCA on July 1, 1988.

(16) Spousal Impoverishment/Transfer of Assets (Sec. 303 of MCCA)

Current Law

- o MCCA added to Medicaid new protections for the income and assets of a spouse of an institutionalized Medicaid beneficiary who remains in the community. The existing transfer of assets provisions were also modified to apply only in the case of institutionalization.

Provisions

- o Clarifies that an application by either spouse for a fair hearing concerning the protection of the income and assets of, or for, the community spouse is to be made when the institutionalized spouse applies for Medicaid.
- o Clarifies that the transfer of assets penalty applies to assets transferred at any time during or after the 30-month period immediately before either: (1) the date the individual becomes institutionalized - if he or she is Medicaid eligible on that date; or (2) if not Medicaid eligible when institutionalized - the date of application for Medicaid (not just in the first situation).
- o The penalty for unallowable or excess transfers of assets is limited to denial of Medicaid payment for nursing home services, not all Medicaid services.

- o The transfer of asset rules amendment made by MCCA does not apply to inter-spousal transfers occurring before October 1, 1989.

Effective Date

- o As if included in the enactment of MCCA on July 1, 1988.

Extension of Pilot Program (Subsec. (e))

Current Law

- o (No provision in statute. The Department had undertaken a pilot project to test the use of annual rather than quarterly cash awards to States for the Medicaid, AFDC, Title XX Social Services Block Grant, and Low Income Home Energy Assistance Programs. The pilot was being conducted in seven States (Virginia, Louisiana, Indiana, Tennessee, Wisconsin, Nebraska, and Washington state). It was scheduled to continue until the end of FY 88, but whether it would continue beyond that date and, if so, under what circumstances and conditions, had not been decided.)

Provision

- o The Secretary is required to continue the pilot project through December 31, 1989 on the same terms and conditions that existed as of September 30, 1988.

Effective Date

- o Enactment (October 13, 1988).

Quality Control Transition (Subsec. (h))

Current Law

- o Under section 1903(u), if a State's erroneous payments for Medicaid exceed 3% of total Medicaid expenditures, the Secretary must disallow payments in excess of the 3% tolerance level for purposes of Federal matching funds.

Provision

- o The Secretary may not disallow any expenditures related to cost-sharing (including "buy-in") for QMBs during a 6-month transition period.

Effective Date

- o Effective for expenditures on or after January 1, 1989 and before July 1, 1989.