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Presidential Documents

Title 3—

The President

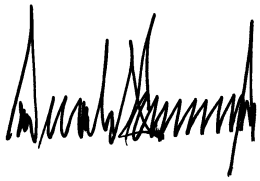
Notice of June 18, 2019

Continuation of the National Emergency With Respect to the Western Balkans

On June 26, 2001, by Executive Order 13219, the President declared a national emergency with respect to the Western Balkans, pursuant to the International Emergency Economic Powers Act (50 U.S.C. 1701–1706), to deal with the unusual and extraordinary threat to the national security and foreign policy of the United States constituted by the actions of persons engaged in, or assisting, sponsoring, or supporting (i) extremist violence in the former Republic of Macedonia (what is now the Republic of North Macedonia) and elsewhere in the Western Balkans region, or (ii) acts obstructing implementation of the Dayton Accords in Bosnia or United Nations Security Council Resolution 1244 of June 10, 1999, in Kosovo. The President subsequently amended that order in Executive Order 13304 of May 28, 2003, to take additional steps with respect to acts obstructing implementation of the Ohrid Framework Agreement of 2001 relating to Macedonia.

The actions of persons threatening the peace and international stabilization efforts in the Western Balkans, including acts of extremist violence and obstructionist activity, continue to pose an unusual and extraordinary threat to the national security and foreign policy of the United States. For this reason, the national emergency declared on June 26, 2001, and the measures adopted on that date and thereafter to deal with that emergency, must continue in effect beyond June 26, 2019. Therefore, in accordance with section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)), I am continuing for 1 year the national emergency with respect to the Western Balkans declared in Executive Order 13219.

This notice shall be published in the *Federal Register* and transmitted to the Congress.



THE WHITE HOUSE,
June 18, 2019.

[FR Doc. 2019–13258
Filed 6–19–19; 8:45 am]
Billing code 3295–F9–P

Rules and Regulations

Federal Register

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This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2019–0212; Product Identifier 2019–NE–05–AD; Amendment 39–19660; AD 2019–12–05]

RIN 2120–AA64

Airworthiness Directives; CFM International S.A. Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain CFM International S.A. (CFM) CFM56–5B, CFM56–5C, and CFM56–7B model turbofan engines with a certain rotating air high-pressure turbine (HPT) front seal. This AD requires replacement of the affected rotating air HPT front seal with a part eligible for installation. This AD was prompted by cracks found in the rotating air HPT front seal. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective July 5, 2019.

The FAA must receive comments on this AD by August 5, 2019.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this final rule, contact CFM International Inc., Aviation Operations Center, 1 Neumann Way, M/D Room 285, Cincinnati, OH 45125; phone: 877–432–3272; fax: 877–432–3329; email: *aviation.fleetsupport@ge.com.* You may view this service information at the FAA, Engine and Propeller Standards Branch, 1200 District Avenue, Burlington, MA 01803. For information on the availability of this material at the FAA, call 781–238–7759. It is also available on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2019–0212.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2019–0212; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations is listed above. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Christopher McGuire, Aerospace Engineer, ECO Branch, FAA, 1200 District Avenue, Burlington, MA 01803; phone: 781–238–7120; fax: 781–238–7199; email: *chris.mcguire@faa.gov.*

SUPPLEMENTARY INFORMATION:

Discussion

The FAA received reports that cracks were found in the rotating air HPT front seal on CFM56–5B model turbofan engines during a scheduled shop visit. After further analysis, CFM determined that when a single rotating air HPT front seal is mated to more than one HPT disk some seals develop microcracks. These cracks resulted from variations in the geometry of the parts being mated.

This AD pertains to the highest risk engines and therefore addresses certain CFM CFM56–5B, CFM56–5C, and CFM56–7B model turbofan engines with an affected rotating air HPT front seal that has a specified number of cycles since being reconfigured. The FAA expects to propose future rulemaking for additional CFM CFM56–5B, CFM56–5C, and CFM56–7B model turbofan engines with this same rotating air HPT front seal that have fewer cycles since being reconfigured. These engines have the same unsafe condition as the engines affected by this AD but represent a lower safety risk due to the lower number of cycles since being reconfigured on the affected rotating air HPT front seal.

This condition, if not addressed, could result in the uncontained release of the rotating air HPT front seal, damage to the engine, and damage to the airplane. The FAA is issuing this AD to address the unsafe condition on these products.

Related Service Information

The FAA reviewed CFM Service Bulletin (SB) CFM56–5B S/B 72–1074, Revision 01, dated December 5, 2018; CFM SB CFM56–5C S/B 72–0794, Revision 01, dated January 2, 2019; and CFM SB CFM56–7B S/B 72–1042, Revision 01, dated January 2, 2019. CFM SB CFM56–5B S/B 72–1074, Revision 01, describes procedures for replacement of the affected rotating air HPT front seal on CFM CFM56–5B turbofan engines. CFM SB CFM56–5C S/B 72–0794, Revision 01, describes procedures for replacement of the affected rotating air HPT front seal on CFM CFM56–5C turbofan engines. CFM SB CFM56–7B S/B 72–1042, Revision 01, describes procedures for replacement of the affected rotating air HPT front seal on CFM CFM56–7B turbofan engines.

FAA's Determination

The FAA is issuing this AD because it evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design.

AD Requirements

This AD requires replacement of the affected rotating air HPT front seal with a part eligible for installation.

FAA's Justification and Determination of the Effective Date

No domestic operators use the affected higher risk CFM CFM56–5B, CFM56–5C, and CFM56–7B model turbofan engines. Therefore, the FAA finds good cause that notice and opportunity for prior public comment

are impracticable. In addition, for the reason stated above, the FAA finds that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety and was not preceded by notice and an opportunity for public comment. However, the FAA invites you to send any written data, views, or arguments about this final rule. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number FAA–2019–0212 and Product Identifier 2019–NE–05–AD at the beginning of your comments. The FAA specifically invites comments on the overall regulatory, economic, environmental, and energy aspects of this final rule. The FAA will consider all comments received by the closing date and may amend this final rule because of those comments.

The FAA will post all comments received, without change, to *http://www.regulations.gov,* including any personal information you provide. The FAA will also post a report summarizing each substantive verbal contact received about this final rule.

Regulatory Flexibility Act

The requirements of the Regulatory Flexibility Act (RFA) do not apply when an agency finds good cause pursuant to 5 U.S.C. 553 to adopt a rule without prior notice and comment. Because the FAA has determined that it has good cause to adopt this rule without notice and comment, RFA analysis is not required.

Costs of Compliance

The FAA estimates that this AD affects no engines installed on airplanes of U.S. registry.

The FAA estimates the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Replace the rotating air HPT front seal	1 work-hour × $85 per hour = $85	$344,600	$344,685	$0

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs'' describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

This AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to engines, propellers, and associated appliances to the Manager, Engine and Propeller Standards Branch, Policy and Innovation Division.

Regulatory Findings

This AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866, and

(2) Will not affect intrastate aviation in Alaska.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2019–12–05 CFM International S.A.: Amendment 39–19660; Docket No. FAA–2019–0212; Product Identifier 2019–NE–05–AD.

(a) Effective Date

This AD is effective July 5, 2019.

(b) Affected ADs

None.

(c) Applicability

This AD applies to:

(1) CFM International S.A. (CFM) CFM56–5B1, –5B2, –5B4, –5B5, –5B6, –5B7, –5B1/P, –5B2/P, –5B3/P, –5B4/P, –5B5/P, –5B6/P, –5B7/P, –5B8/P, –5B9/P, –5B3/P1, –5B4/P1, –5B1/2P, –5B2/2P, –5B3/2P, –5B4/2P, –5B6/2P, –5B9/2P, –5B3/2P1, –5B4/2P1, –7B20, –7B22, –7B24, –7B26, –7B27, –7B22/B1, –7B24/B1, –7B26/B1, –7B26/B2, –7B27/B1, –7B27/B3, –7B20/2, –7B22/2, –7B24/2, –7B26/2, –7B27/2, –7B27A model turbofan engines with a:

(i) rotating air high-pressure turbine (HPT) front seal:

(A) with part number (P/N) 1795M36P01 or P/N 1795M36P02 and serial numbers (S/Ns) GWNDN949 through GWNSE969 or S/Ns GWN000CE through GWN0990L, not including S/Ns GWN08ND7, GWN0923A, GWN0971E, GWN098A1, GWN098W6, GWN098W8, GWN098WA, and GWN0990G, installed;

(B) that has been removed from the original HPT disk and re-assembled to a different HPT disk; and

(C) that has 6,001 or more cycles since being reconfigured.

(ii) [Reserved]

(2) CFM CFM56–5C2, –5C2/4, –5C2/F, –5C2/F4, –5C2/G, –5C2/G4, –5C2/P, –5C3/F, –5C3/F4, –5C3/G, –5C3/G4, –5C3/P, –5C4, –5C4/1, –5C4/P, –5C4/1P model turbofan engines with a:

(i) rotating air HPT front seal:

(A) with P/N 1795M36P01 or P/N 1795M36P02 and S/Ns GWNDN949 through GWNSE969 or S/Ns GWN000CE through GWN0990L, not including S/Ns GWN08ND7, GWN0923A, GWN0971E, GWN098A1, GWN098W6, GWN098W8, GWN098WA, and GWN0990G, installed;

(B) that has been removed from the original HPT disk and re-assembled to a different HPT disk; and

(C) that has 3,751 or more cycles since being reconfigured.

(ii) [Reserved]

(d) Subject

Joint Aircraft System Component (JASC) Code 7250, Turbine Section.

(e) Unsafe Condition

This AD was prompted by cracks found in the rotating air HPT front seal. The FAA is issuing this AD to prevent failure of the rotating air HPT front seal. The unsafe condition, if not addressed, could result in the uncontained release of the rotating air HPT front seal, damage to the engine, and damage to the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

(1) For all affected CFM CFM56–5B and CFM56–7B model turbofan engines:

(i) If, on the effective date of this AD, the rotating air HPT front seal has 7,000 cycles or greater since being reconfigured, remove the part from service within 50 cycles after the effective date of this AD and replace with a part eligible for installation.

(ii) If, on the effective date of this AD, the rotating air HPT front seal has between 6,001 and 6,999 cycles, inclusive, since being reconfigured, remove the part from service within 500 cycles after the effective date of this AD, but not to exceed 7,050 cycles since being reconfigured, and replace with a part eligible for installation.

(2) For all affected CFM CFM56–5C model turbofan engines:

(i) If, on the effective date of this AD, the rotating air HPT front seal has 4,250 cycles or greater since being reconfigured, remove the part from service within 25 cycles after the effective date of this AD, or within 1,500 cycles since the last fluorescent penetrant inspection (FPI) of the rotating air HPT front seal, whichever occurs later, and replace with a part eligible for installation.

(ii) If, on the effective date of this AD, the rotating air HPT front seal has between 3,751 and 4,249 cycles, inclusive, since being reconfigured, remove the part from service within 250 cycles after the effective date of this AD, before accumulating 4,275 cycles since being reconfigured, or within 1,500 cycles since the last FPI of the rotating air HPT front seal, whichever occurs later, and replace with a part eligible for installation.

(h) Definition

For the purpose of this AD, reconfigured is when a rotating air HPT front seal has been removed from the original HPT disk and re-assembled to a different HPT disk.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, ECO Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the certification office, send it to the attention of the person identified in paragraph (j) of this AD. You may email your request to: *ANE-AD-AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(j) Related Information

For more information about this AD, contact Christopher McGuire, Aerospace Engineer, ECO Branch, FAA, 1200 District Avenue, Burlington, MA 01803; phone: 781–238–7120; fax: 781–238–7199; email: *chris.mcguire@faa.gov.*

(k) Material Incorporated by Reference

None.

Issued in Burlington, Massachusetts, on June 14, 2019.

Karen M. Grant,

Acting Manager, Engine and Propeller Standards Branch, Aircraft Certification Service.

[FR Doc. 2019–13040 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–1068; Product Identifier 2018–NM–140–AD; Amendment 39–19655; AD 2019–11–09]

RIN 2120–AA64

Airworthiness Directives; Airbus SAS Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for all Airbus SAS Model A319–113 and –114 airplanes, and Model A320–211 and –212 airplanes. This AD was prompted by a report that a life-limit of 64,000 flight cycles has been established for certain titanium crossbeams of the forward engine mount. This AD requires repetitive replacements of all affected crossbeams of the forward engine mount, as specified in European Aviation Safety Agency (EASA) ADs, which are incorporated by reference. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective July 25, 2019.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in this AD as of July 25, 2019.

ADDRESSES: For the material incorporated by reference (IBR) in this final rule, contact the EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 89990 1000; email *ADs@easa.europa.eu;* internet *www.easa.europa.eu.* You may find this IBR material on the EASA website at *https://ad.easa.europa.eu.* You may view this IBR material at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. It is also available in the AD docket on the internet at *http://www.regulations.gov.*

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–1068; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, the regulatory evaluation, any comments received, and other information. The address for Docket Operations is U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Sanjay Ralhan, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3223.

SUPPLEMENTARY INFORMATION:

Discussion

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 by adding an AD that would apply to all Airbus SAS Model A319–113 and –114 airplanes, and Model A320–211 and –212 airplanes. The NPRM published in the **Federal Register** on February 7, 2019 (84 FR 2465). The NPRM was prompted by a report that a life-limit of 64,000 flight cycles has been established for certain titanium crossbeams of the forward engine mount. The NPRM proposed to require repetitive replacements of all affected crossbeams of the forward engine mount.

The FAA is issuing this AD to address failure of a crossbeam of the forward engine mount, which could result in detachment of the engine and

consequent reduced controllability of the airplane.

The EASA, which is the Technical Agent for the Member States of the European Union, has issued EASA AD 2018–0212R1, dated March 28, 2019 (''EASA AD 2018–0212R1'') (also referred to as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for all Airbus SAS Model A319–113 and –114 airplanes, and Model A320–211 and –212 airplanes. The MCAI states:

> The forward engine mount crossbeam of the CFM56–5A engine, [part number] P/N 238–0204–501, is made of titanium. A life limit of 64,000 FC [flight cycles] has been demonstrated. Due to potential transferability of a crossbeam from one aeroplane to another, it is necessary to track the life of this part and to remove it before exceeding the life limit.
>
> This condition, if not corrected, could lead to forward engine mount crossbeam failure, possibly resulting in engine detachment in flight and consequent reduced control of the aeroplane.
>
> To address this potential unsafe condition, Airbus published the SB [Service Bulletin A320–71–1073, dated June 8, 2018], providing instructions to identify the P/N of the crossbeam installed on an aeroplane and to remove affected crossbeam before exceeding the life limit. Airbus also issued SB A320–71–1076, providing modification instructions for installation of improved forward engine mount steel crossbeams P/N 642–2002–503. Consequently, EASA issued AD 2018–0212 [which was referred to as the appropriate source of service information for accomplishing the actions specified in the FAA NPRM], requiring the implementation of the new life limit for the affected crossbeams.
>
> Since that [EASA] AD was issued, following a re-assessment of comments received during the consultation period of [Proposed Airworthiness Directive] PAD 18–091 which preceded EASA AD 2018–0212, EASA agrees that an affected crossbeam having P/N 238–0204–501 can be (re)installed on any aeroplane, provided its accumulated life is less than the applicable life limit.
>
> For the reason described above, this [EASA] AD is revised accordingly.

You may examine the MCAI in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–1068.

Comments

The FAA gave the public the opportunity to participate in developing this final rule. The following presents the comments received on the NPRM and the FAA's response to each comment.

Support for the NPRM

Donovan Twiddle, Jr., agreed that the proposed AD should be implemented.

Request for Exception to EASA AD Requirement

Delta Air Lines (DAL) asked that the proposed AD include an exception to the language in paragraph (2) of EASA AD 2018–2012, which specifies ''Replacing on an aeroplane any affected crossbeam with crossbeam having P/N 642–2002–503 in accordance with instructions provided by Airbus is an acceptable alternative method to comply with the requirements of paragraph (1) of this [EASA] AD, provided that, following modification, no affected crossbeam is installed on that aeroplane.'' DAL stated that omitting the language ''provided that, following modification, no affected crossbeam is installed on that aeroplane'' would allow for the crossbeam having P/N 642–2002–503 to be managed like any other CFM56 life-limited engine component, while continuing to prohibit installing a crossbeam that has been modified to have P/N 642–2002–503.

DAL pointed out that, since the NPRM was published, the EASA has issued EASA AD 2018–0212R1, which addresses its original request (described previously) and, therefore, requested that the NPRM be revised to refer to EASA AD 2018–0212R1 as the appropriate source of information for complying with the proposed AD.

The FAA agrees that this final rule should refer to EASA AD 2018–0212R1 for accomplishing the required actions. As noted by the commenter, paragraph (2) of EASA AD 2018–0212R1 does not contain the language ''provided that, following modification, no affected crossbeam is installed on that aeroplane.'' The agency determined that no additional work is required for airplanes that have accomplished the actions as required by EASA AD 2018–0212, dated September 28, 2018 (''EASA AD 2018–0212''). Therefore, the agency has revised all applicable sections in this final rule to also specify EASA AD 2018–0212R1.

Request To Revise Crossbeam Accumulated Life Definition

DAL asked that the FAA revise the proposed AD to include a revised definition of crossbeam accumulated life. DAL stated that it received information from Airbus indicating that the data contained in the life estimation tables of EASA AD 2018–0212 and EASA AD 2018–0212R1, and in Airbus Service Bulletin A320–71–1073, dated June 8, 2018, and Revision 01, dated January 3, 2019, was generated using 2015 fleet utilization data. DAL noted that Airbus has received updated fleet utilization data from 2017 that better estimates the flight cycle count for operators, and substantiates a compliance window later than the January 31, 2019 date required by EASA AD 2018–0212 and EASA AD 2018–0212R1, and the referenced service information. DAL added that there are operators that have the ability to trace the actual accumulated mount assembly and crossbeam flight cycles from dates earlier than ''Life estimation done on'' date of the life estimation tables included in Appendix 01 of EASA AD 2018–0212 and EASA AD 2018–0212R1. DAL explained that Airbus has been able to provide operators with an accumulated life estimation that takes Airbus's updated fleet utilization Monte Carlo counting method and the operator's actual flight cycle data into account. DAL went on to explain that the updated Monte Carlo counting method also includes crossbeams where the date of manufacture was not explicitly known and was assumed to be before January 1, 1988. For crossbeams where the date of manufacture was not identified, DAL stated that it believes the use of Airbus data and maintenance records, while still assuming a date of manufacture before January 1, 1988, would not adversely affect the level of safety of the airplane. By still assuming the worst case scenario for the date of manufacture, DAL asserted that the most conservative estimate for crossbeam accumulated life is still being used. DAL provided a revised definition of crossbeam accumulated life, and stated that the proposed definition would allow operators to use the updated Monte Carlo counting method from Airbus and maintenance records for all crossbeams, as well as also taking into account the fact that the final rule should require the use of ''total flight cycles.''

The FAA does not agree with the commenter's request. The agency has not received any new life estimation data either from EASA or Airbus, other than that referenced in EASA AD 2018–0212R1. After the NPRM comment period closed, the FAA contacted EASA; EASA confirmed that the life estimation table in Appendix 1 of EASA AD 2018–0212R1 is based on the latest data received from Airbus. In addition, the agency does not have access to the latest data referenced by DAL. In order to calculate flight cycles based on new fleet utilization information received from Airbus, which would allow DAL to continue operation with the affected part later than EASA's estimation, DAL may request approval of an alternative method of compliance (AMOC) under

the provisions of paragraph (i)(1) of this AD. The FAA has not changed this AD regarding this issue.

Conclusion

The FAA reviewed the relevant data, considered the comments received, and determined that air safety and the public interest require adopting this final rule with the changes described previously and minor editorial changes. The FAA has determined that these minor changes:

- Are consistent with the intent that was proposed in the NPRM for addressing the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM.

The FAA has also determined that these changes will not increase the economic burden on any operator or increase the scope of this final rule.

Related IBR Material Under 1 CFR Part 51

EASA ADs 2018–0212 and 2018–0212R1 describe procedures for repetitive replacements of all affected crossbeams of the forward engine mount and an optional replacement as an acceptable method of compliance for the required replacement. These documents are distinct since AD 2018–0212R1 includes updated requirements and definitions, and references updated service information. This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Costs of Compliance

The FAA estimates that this AD affects 59 airplanes of U.S. registry. The FAA estimates the following costs to comply with this AD:

ESTIMATED COSTS FOR REQUIRED ACTIONS

Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Up to 134 work-hours × $85 per hour = Up to $11,390.	Up to $23,278	Up to $34,668	Up to $2,045,412.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

This AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to transport category airplanes and associated appliances to the Director of the System Oversight Division.

Regulatory Findings

This AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Will not affect intrastate aviation in Alaska, and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2019–11–09 Airbus SAS: Amendment 39–19655; Docket No. FAA–2018–1068; Product Identifier 2018–NM–140–AD.

(a) Effective Date

This AD is effective July 25, 2019.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all Airbus SAS Model A319–113 and –114 airplanes, and Model A320–211 and –212 airplanes, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 71, Powerplant.

(e) Reason

This AD was prompted by a report that a life-limit of 64,000 flight cycles has been established for certain titanium crossbeams of the forward engine mount. The FAA is issuing this AD to address failure of a crossbeam of the forward engine mount, which could result in detachment of the engine and consequent reduced controllability of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Requirements

Except as specified in paragraph (h) of this AD: Comply with all required actions and compliance times specified in, and in accordance with European Aviation Safety Agency (EASA) AD 2018–0212, dated September 28, 2018 (''EASA AD 2018–0212''), or EASA AD 2018–0212R1, dated March 28, 2019 (''EASA AD 2018–0212R1'').

(h) Exceptions to EASA ADs 2018–0212 and 2018–0212R1

(1) For purposes of determining compliance with the requirements of this AD: Where EASA ADs 2018–0212 and 2018–0212R1 refer to the effective date of EASA

AD 2018–0212 (October 12, 2018), this AD requires using the effective date of this AD.

(2) Where paragraph (2) of EASA ADs 2018–0212 and 2018–0212R1 specifies replacing ''with instructions provided by Airbus,'' for this AD, the replacement must be done using a method approved in accordance with the procedures specified in paragraph (i)(2) of this AD.

(3) Where paragraphs (1) and (3) of EASA ADs 2018–0212 and 2018–0212R1 specify flight cycles (FC), this AD requires using ''total flight cycles.''

(4) The ''Remarks'' sections of EASA ADs 2018–0212 and 2018–0212R1 do not apply.

(i) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Section, Transport Standards Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the International Section, send it to the attention of the person identified in paragraph (j) of this AD. Information may be emailed to: *9-ANM-116-AMOC-REQUESTS@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, International Section, Transport Standards Branch, FAA; or EASA; or Airbus SAS's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(3) *Required for Compliance (RC)*: For any service information referenced in EASA AD 2018–0212 or EASA AD 2018–0212R1 that contains RC procedures and tests: Except as required by paragraph (i)(2) of this AD, RC procedures and tests must be done to comply with this AD; any procedures or tests that are not identified as RC are recommended. Those procedures and tests that are not identified as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the procedures and tests identified as RC can be done and the airplane can be put back in an airworthy condition. Any substitutions or changes to procedures or tests identified as RC require approval of an AMOC.

(j) Related Information

For more information about this AD, contact Sanjay Ralhan, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3223.

(k) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(i) European Aviation Safety Agency (EASA) AD 2018–0212, dated September 28, 2018.

(ii) European Aviation Safety Agency (EASA) AD 2018–0212R1, dated March 28, 2019.

(3) For EASA AD 2018–0212 and EASA AD 2018–0212R1, contact the EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 89990 6017; email *ADs@easa.europa.eu;* internet *www.easa.europa.eu.* You may find these EASA ADs on the EASA website at *https://ad.easa.europa.eu.*

(4) You may view these EASA ADs at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. EASA AD 2018–0212 and EASA AD 2018–0212R1 may be found in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–1068.

(5) You may view this material that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Des Moines, Washington, on June 10, 2019.

Michael Kaszycki,

Acting Director, System Oversight Division, Aircraft Certification Service.

[FR Doc. 2019–13059 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2019–0407; Product Identifier 2019–NM–075–AD; Amendment 39–19648; AD 2019–11–02]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: The FAA is superseding Airworthiness Directive (AD) 2017–16–10, which applied to all The Boeing Company Model 777 airplanes. AD 2017–16–10 required repetitive inspections of the left and right side underwing longerons for any crack, and related investigative and corrective actions if necessary. This AD retains the requirements of AD 2017–16–10, reduces certain compliance times for certain airplanes, and removes airplanes from the applicability. This AD was prompted by reports of cracks on the underwing longerons. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective July 5, 2019.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of July 5, 2019.

The FAA must receive any comments on this AD by August 5, 2019.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this final rule, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; phone: 562–797–1717; internet: *https://www.myboeingfleet.com.* You may view this service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. It is also available on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2019–0407.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2019–0407; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, the regulatory evaluation, any comments received, and other information. The street address for Docket Operations is listed above. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Eric Lin, Aerospace Engineer, Airframe

Section, FAA, Seattle ACO Branch, 2200 South 216th St., Des Moines, WA 98198; phone and fax: 206–231–3523; email: *eric.lin@faa.gov.*

SUPPLEMENTARY INFORMATION:

Discussion

The FAA issued AD 2017–16–10, Amendment 39–18987 (82 FR 39513, August 21, 2017) (''AD 2017–16–10''), for all The Boeing Company Model 777 airplanes. AD 2017–16–10 required repetitive inspections of the left and right side underwing longerons for any crack, and related investigative and corrective actions if necessary. AD 2017–16–10 resulted from reports of cracks on the underwing longerons. The FAA issued AD 2017–16–10 to address cracks in the underwing longerons, which could result in fuel leakage into the forward cargo area and consequent increased risk of a fire or, in a more severe case, could adversely affect the structural integrity of the airplane.

Actions Since AD 2017–16–10 Was Issued

Since we issued AD 2017–16–10, the FAA has determined that it is necessary to reduce certain compliance times for certain airplanes to address the unsafe condition. The FAA has also determined that it is necessary to remove certain airplanes from the applicability because the unsafe condition has been addressed in production on line numbers 1523, and 1525 and subsequent. The FAA is issuing this AD to address cracks in the underwing longerons, which could result in fuel leakage into the forward cargo area and consequent increased risk of a fire or, in a more severe case, could adversely affect the structural integrity of the airplane.

Related Service Information Under 1 CFR Part 51

The FAA reviewed Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019. This service information describes procedures for repetitive detailed inspections, ultrasonic inspections, high frequency eddy current (HFEC) inspections of the left and right side underwing longerons, a surface HFEC inspection of the external surface of the fuselage skin, and applicable on-condition actions. On condition actions include replacement of the left or right underwing longeron, as applicable. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

The FAA is issuing this AD because we evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design.

AD Requirements

Although this AD does not explicitly restate the requirements of AD 2017–16–10, this AD retains all of the requirements of AD 2017–16–10. Those requirements are referenced in the service information identified previously, which, in turn, is referenced in paragraph (g) of this AD. This AD reduces certain compliance times for certain airplanes and removes airplanes from the applicability. This AD also requires accomplishment of the actions identified as ''RC'' (required for compliance) in the Accomplishment Instructions of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, described previously.

For information on the procedures and compliance times, see this service information at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2019–0407.

FAA's Justification and Determination of the Effective Date

There are currently no U.S. operators affected by the new reduced compliance times required by this AD. Therefore, we find good cause that notice and opportunity for prior public comment are unnecessary. In addition, for the reason(s) stated above, the FAA finds that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety and was not preceded by notice and an opportunity for public comment. However, the FAA invites you to send any written data, views, or arguments about this final rule. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number FAA–2019–0407 and Product Identifier 2019–NM–075–AD at the beginning of your comments. The agency specifically invites comments on the overall regulatory, economic, environmental, and energy aspects of this final rule. The agency will consider all comments received by the closing date and may amend this final rule because of those comments.

The FAA will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact the agency receives about this final rule.

Costs of Compliance

The FAA estimate that this AD affects 214 airplanes of U.S. registry. We estimate the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Option 1: Detailed Inspection (retained actions from AD 2017–16–10).	4 work-hours × $85 per hour = $340 per inspection cycle.	$0	$340 per inspection cycle	$72,760 per inspection cycle.
Option 2: Detailed and HFEC or Ultrasonic Inspection (retained actions from AD 2017–16–10).	12 work-hours × $85 per hour = $1,020 per inspection cycle.	$0	$1,020 per inspection cycle	$218,280 per inspection cycle.

The new requirements of this AD (reduced compliance times) do not currently affect U.S. operators and, therefore, add no additional economic burden.

The FAA estimates the following costs to do any necessary replacements that would be required based on the results of the inspections. The agency has no way of determining the number

of aircraft that might need these replacements:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Left side or right side underwing longeron replacement.	102 work-hours × $85 per hour = $8,670 per side.	$31,000 per side	$39,670 per side.

The FAA has received no definitive data that would enable us to provide cost estimates for the on-condition actions, other than the replacement, specified in this AD.

According to the manufacturer, some or all of the costs of this AD may be covered under warranty, thereby reducing the cost impact on affected individuals. The FAA does not control warranty coverage for affected individuals. As a result, the FAA has included all known costs in our cost estimate.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

This AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to transport category airplanes and associated appliances to the Director of the System Oversight Division.

Regulatory Findings

The FAA has determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Will not affect intrastate aviation in Alaska, and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Airworthiness Directive (AD) 2017–16–10, Amendment 39–18987 (82 FR 39513, August 21, 2017), and adding the following new AD:

2019–11–02 The Boeing Company: Amendment 39–19648; Docket No. FAA–2019–0407; Product Identifier 2019–NM–075–AD.

(a) Effective Date

This AD is effective July 5, 2019.

(b) Affected ADs

This AD replaces AD 2017–16–10, Amendment 39–18987 (82 FR 39513, August 21, 2017) (''AD 2017–16–10'').

(c) Applicability

This AD applies to The Boeing Company Model 777–200, –200LR, –300, –300ER, and 777F series airplanes, certificated in any category, as identified in Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by reports of cracks on the underwing longerons. The FAA is issuing this AD to address cracks in the underwing longerons, which could result in fuel leakage into the forward cargo area and consequent increased risk of a fire or, in a more severe case, could adversely affect the structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

Except as specified in paragraph (h) of this AD: At the applicable times specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, do all applicable actions identified as ''RC'' (required for compliance) in, and in accordance with, the Accomplishment Instructions of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019. Replacing an underwing longeron, including doing all applicable on-condition actions, in accordance with the Accomplishment Instructions of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, except as required by paragraph (h)(2) of this AD, terminates the repetitive inspections specified in tables 1 through 6 and table 15 of paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, for that longeron only.

(h) Exceptions to Service Information Specifications

(1) For purposes of determining compliance with the requirements of this AD: Where Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, uses the phrase ''the Revision 2 date of this service bulletin,'' this AD requires using ''the effective date of this AD.''

(2) Where Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, specifies contacting Boeing for repair instructions: This AD requires doing the repair using a method approved in accordance with the procedures specified in paragraph (j) of this AD.

(i) Credit for Previous Actions

This paragraph provides credit for the actions specified in paragraph (g) of this AD, if those actions were performed before the effective date of this AD using Boeing Alert Service Bulletin 777–53A0081, dated September 8, 2016, or Boeing Alert Service Bulletin 777–53A0081, Revision 1, dated May 1, 2017.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle ACO Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the certification office, send it to the attention of the person identified in paragraph (k)(1) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by The Boeing Company Organization Designation Authorization (ODA) that has been authorized by the Manager, Seattle ACO Branch, FAA, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(4) AMOCs approved previously for AD 2017–16–10 are approved as AMOCs for the corresponding provisions of Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019, that are required by paragraph (g) of this AD.

(5) Except as specified by paragraph (h)(2) of this AD: For service information that contains steps that are labeled as Required for Compliance (RC), the provisions of paragraphs (j)(5)(i) and (j)(5)(ii) of this AD apply.

(i) The steps labeled as RC, including substeps under an RC step and any figures identified in an RC step, must be done to comply with the AD. If a step or substep is labeled ''RC Exempt,'' then the RC requirement is removed from that step or substep. An AMOC is required for any deviations to RC steps, including substeps and identified figures.

(ii) Steps not labeled as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the RC steps, including substeps and identified figures, can still be done as specified, and the airplane can be put back in an airworthy condition.

(k) Related Information

(1) For more information about this AD, contact Eric Lin, Aerospace Engineer, Airframe Section, FAA, Seattle ACO Branch, 2200 South 216th St., Des Moines, WA 98198; phone and fax: 206–231–3523; email: *eric.lin@faa.gov.*

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; phone: 562–797–1717; internet: *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(l) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Boeing Alert Service Bulletin 777–53A0081, Revision 2, dated March 29, 2019.

(ii) [Reserved]

(3) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; phone: 562–797–1717; internet: *https://www.myboeingfleet.com.*

(4) You may view this service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Des Moines, Washington, on June 5, 2019.

Michael Kaszycki,

Acting Director, System Oversight Division, Aircraft Certification Service.

[FR Doc. 2019–13058 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–13–P

RAILROAD RETIREMENT BOARD

20 CFR Part 200

RIN 3220–AB67

General Administration: Designation of Central and Field Organization; Internal Organization

AGENCY: Railroad Retirement Board.

ACTION: Final rule.

SUMMARY: The Railroad Retirement Board (Board) amends its regulations to update the members of the Executive Committee, update the responsibilities of the Executive Committee members, and update office titles.

DATES: This rule becomes effective June 20, 2019.

ADDRESSES: Stephanie Hillyard, Secretary to the Board, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois 60611–1275.

FOR FURTHER INFORMATION CONTACT: Marguerite P. Dadabo, Assistant General Counsel, (312) 751–4945, TTD (312) 751–4701.

SUPPLEMENTARY INFORMATION: The Railroad Retirement Board (Board) amends its regulations in regard to the Board's policy on internal organization. The regulations amended are all contained in § 200.1(b). In § 200.1(b)(1) of the Board's regulations, the Board removes the language that states ''the General Counsel also serves as the Senior Executive Officer,'' and increases the number of members of the Executive Committee from six to seven members by adding as a member the Director of Field Service. A description of the Director of Field Service's responsibilities is added to § 200.1(b)(2). Finally, under § 200.1(b)(3), the office name of the Washington/Legislative Office is changed to the Office of Legislative Affairs. Section 200.1(b)(3) of the regulation also removes the Office of Planning, and renames the Bureau of Quality Assurance to the Program Evaluation and Management Services (PEMS).

This change was published as a proposed rule on April 27, 2017, and comments were invited to be submitted by June 26, 2017. See 82 FR 19330 (April 27, 2017). No comments were submitted, and the final rule is essentially the same as the proposed rule.

The Board, with the concurrence of the Office of Management and Budget, has determined that this is not a significant regulatory action under Executive Order 12866, as amended. Therefore, no regulatory impact analysis is required. There are no changes to the information collections associated with § 200.1(b).

List of Subjects in 20 CFR Part 200

Railroad employees, Railroad retirement, General administration.

For the reasons set out in the preamble, the Railroad Retirement Board amends title 20, chapter II, subchapter A, part 200 of the Code of Federal Regulations as follows:

PART 200—GENERAL ADMINISTRATION

■ 1. The authority citation for part 200 continues to read as follows:

Authority: 45 U.S.C. 231f (b)(5) and 45 U.S.C. 362; § 200.4 also issued under 5 U.S.C. 552; § 200.5 also issued under 5 U.S.C. 552a; § 200.6 also issued under 5 U.S.C. 552b; and § 200.7 also issued under 31 U.S.C. 3717.

■ 2. Section 200.1 is amended by revising paragraph (b) to read as follows:

§ 200.1 Designation of central and field organization.

* * * * *

(b) Internal organization. (1) Reporting directly to the Board Members is the seven member Executive Committee. The Executive Committee is comprised of the General Counsel, the Director of Administration, the Director of Programs, the Chief Financial Officer, the Chief Information Officer, and the Director of Field Service. The Chief Actuary is a non-voting member. The Board members will designate a member of the Executive Committee as Senior Executive Officer.

(2) The Executive Committee is responsible for the day to day operations of the agency. The Senior Executive Officer is responsible for the direction and oversight of the Executive Committee. The General Counsel is responsible for advising the Board Members on major issues, interpreting the Acts and regulations administered by the Board, drafting and analyzing legislation, representing the Board in litigation and administrative forums and planning, directing, and coordinating the work of the Office of General Counsel, the Office of Secretary to the Board, the Bureau of Hearings and Appeals, and the Office of Legislative Affairs through their respective directors. The Director of Programs is responsible for managing, coordinating, and controlling the program operations of the agency which carry out provisions of the Railroad Retirement and Railroad Unemployment Insurance Acts. The Director of Administration is responsible for managing, coordinating and controlling certain administrative operations of the Board including the Division of Acquisition Management, the Bureau of Human Resources, the Office of Public Affairs, and the Division of Real Property Management. The Chief Financial Officer is responsible for the financial management of the agency, and the Chief Information Officer is responsible for coordinating the agency's information resources management program.

The Chief Actuary is responsible for the actuarial program of the Board, and for maintaining statistical and financial information. The Director of Field Services is responsible for the oversight of the agency's nationwide field offices.

(3) The Office of Equal Employment Opportunity is responsible for equal employment opportunity and affirmative employment programs.

* * * * *

By Authority of the Board

Stephanie Hillyard,

Secretary to the Board.

[FR Doc. 2019–13050 Filed 6–19–19; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 101

[Docket No. FDA–2018–D–0075]

The Declaration of Added Sugars on Honey, Maple Syrup, Other Single-Ingredient Sugars and Syrups, and Certain Cranberry Products; Guidance for Industry; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notification of availability.

SUMMARY: The Food and Drug Administration (FDA or we) is announcing the availability of a final guidance for industry entitled ''The Declaration of Added Sugars on Honey, Maple Syrup, Other Single-Ingredient Sugars and Syrups, and Certain Cranberry Products.'' This guidance provides clarification on the labeling requirements for single-ingredient packages and/or containers of pure honey, pure maple syrup, and other pure sugars and syrups, which are not required to bear the words ''Includes Xg Added Sugars,'' but must still include the percent Daily Value for added sugars on their labels. This guidance is also intended to advise food manufacturers of our intent to exercise enforcement discretion related to the use of a ''†'' symbol immediately following the percent Daily Value for added sugars on single-ingredient packages and/or containers of pure honey, pure maple syrup, and other pure sugars and syrups; the ''†'' symbol would lead the consumer to a statement that is truthful and not misleading in a footnote at the bottom of the Nutrition Facts label. The guidance also advises food manufacturers of our intent to exercise enforcement discretion with respect to the use of a ''†'' symbol immediately after the added sugars percent Daily Value information that leads the consumer to a statement that is truthful and not misleading outside of the Nutrition Facts label on certain dried cranberry and cranberry beverage products that are made up of cranberry juice sweetened with added sugars and that contain total sugars at levels no greater than comparable products with endogenous (inherent) sugars, but no added sugars. Further, this guidance advises of our intent to exercise enforcement discretion regarding compliance with Nutrition Facts label final rule and Serving Size final rule requirements until July 1, 2021, for the single-ingredient sugars and syrups as well as the cranberry products discussed in the guidance document.

DATES: The announcement of the guidance is published in the **Federal Register** on June 20, 2019.

ADDRESSES: You may submit either electronic or written comments on FDA guidances at any time as follows:

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2018–D–0075 for ''The Declaration of Added Sugars on Honey, Maple Syrup, Other Single-Ingredient Sugars and Syrups, and Certain Cranberry Products: Guidance for Industry.'' Received comments will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday.

• Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' We will review this copy, including the claimed confidential information, in our consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.gpo.gov/fdsys/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

You may submit comments on any guidance at any time (see 21 CFR 10.115(g)(5)).

Submit written requests for single copies of the guidance to the Office of Nutrition and Food Labeling, Nutrition Programs Staff, Center for Food Safety and Applied Nutrition, Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740. Send two self-addressed adhesive labels to assist that office in processing your request. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance.

FOR FURTHER INFORMATION CONTACT: Blakeley Fitzpatrick, Center for Food Safety and Applied Nutrition, Office of Nutrition and Food Labeling, 5001 Campus Dr., College Park, MD 20740, 240–402–1450.

SUPPLEMENTARY INFORMATION:

I. Background

We are announcing the availability of a guidance for industry entitled ''The Declaration of Added Sugars on Honey, Maple Syrup, Other Single-Ingredient Sugars and Syrups, and Certain Cranberry Products.'' We are issuing this guidance consistent with our good guidance practices regulation (21 CFR 10.115). The guidance represents the current thinking of FDA on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. This guidance is not subject to Executive Order 12866.

This guidance provides clarification on the labeling requirements for single-ingredient packages and/or containers of pure honey, pure maple syrup, and other pure sugars and syrups, which are not required to bear the words ''Includes Xg Added Sugars'' but must still include the percent Daily Value for added sugars on their labels. This guidance is also intended to advise food manufacturers of our intent to exercise enforcement discretion related to use of a ''†'' symbol on single-ingredient packages and/or containers of pure honey, pure maple syrup, and other pure sugars and syrups immediately following the percent Daily Value for the contribution of added sugars to the diet obtained from these products. This would lead the consumer to a statement that is truthful and not misleading in a footnote at the bottom of the Nutrition Facts label. We also intend to exercise our enforcement discretion with respect to the use of a ''†'' symbol immediately after the added sugars percent Daily Value information that would lead the consumer to a statement outside of the Nutrition Facts label on certain dried cranberry and cranberry beverage products that are made up of cranberry juice sweetened with added sugars and that contain total sugars at levels no greater than comparable products with endogenous (inherent) sugars, but no added sugars.

In the **Federal Register** of May 27, 2016, FDA issued a final rule entitled ''Food Labeling: Revision of the Nutrition and Supplement Facts Labels'' (81 FR 33742; the ''Nutrition Facts label final rule''). The Nutrition Facts label final rule amended the regulations for the nutrition labeling of conventional foods and dietary supplements to provide updated nutrition information and to improve how the nutrition information is presented to consumers. The Nutrition Facts label final rule also revised the Nutrition Facts label to replace ''sugars'' with ''total sugars'' and to include the declaration of added sugars. The Nutrition Facts label final rule defines ''added sugars,'' in part, to include sugars that are either added during the processing of foods or are packaged as such. The definition includes free sugars (free mono- and disaccharides), sugars from syrups and honey, and sugars from concentrated fruit or vegetable juices that are in excess of what would be expected from the same volume of 100 percent fruit or vegetable juice of the same type. The Nutrition Facts label final rule requires added sugars to be declared on the food label by stating ''Includes Xg Added Sugars'' indented directly below ''Total Sugars,'' where X represents the amount, in grams, of added sugars (see 21 CFR 101.9(c)(6)(ii)).

On December 20, 2018, the President signed into law the Agriculture Improvement Act of 2018 (Pub. L. 115–334) (''the Farm Bill''). Section 12516 of the Farm Bill states that the food labeling requirements under section 403(q) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)) shall not require that the Nutrition Facts label of any single-ingredient sugar, honey, agave, or syrup, including maple syrup, that is packaged and offered for sale as a single-ingredient food bear the declaration ''Includes Xg Added Sugars.'' Therefore, single-ingredient sugars, honey, agave, and syrups, including maple syrup, do not need to have the statement ''Includes Xg Added Sugars'' on their label. At the same time, the Farm Bill did not change the requirement under the final rule to include the percent Daily Value for the contribution of added sugars to the diet obtained from these products.

In the **Federal Register** of March 2, 2018 (83 FR 8953), we made available a draft guidance for industry entitled ''The Declaration of Added Sugars on Honey, Maple Syrup, and Certain Cranberry Products'' (hereafter referred to as ''the draft guidance'') and gave interested parties an opportunity to submit comments by May 1, 2018. In response to requests for more time to

comment on the draft guidance, we issued a notice in the **Federal Register** of April 25, 2018 (83 FR 17961) extending the comment period to June 15, 2018. We received over 3,600 comments to the draft guidance from industry, consumer advocacy groups, trade associations, members of Congress, State governments, and private citizens.

After consideration of the comments to the draft guidance, as well as Public Law 115–334, we have made changes in the final guidance to clarify the requirements for the labeling of added sugars on packages and/or containers of single ingredient honey, maple syrup, and other single ingredient sugars and syrups. The final guidance clarifies that the line representing added sugars on the Nutrition Facts label, as well as the percent Daily Value on that line, are retained for single-ingredient sugars and syrup, however these products do not need to have the statement ''Includes Xg Added sugars'' on that line. The final guidance also explains our intent to exercise enforcement discretion for all single ingredient sugars and syrups with respect to the inclusion of a ''†'' symbol after the percent Daily Value, which leads the reader to a truthful and not misleading statement within a footnote at the bottom of the Nutrition Facts label that includes a description of the gram amount of sugar added to the diet by one serving of the product and its contribution to the percent Daily Value for added sugars in the diet.

We are finalizing the guidance without any changes with respect to our intent to exercise enforcement discretion for the use of a ''†'' symbol that would direct consumers to truthful and not misleading statements on the package outside the Nutrition Facts label on certain cranberry products sweetened with added sugars that provide an amount of total sugars in a serving that does not exceed the level of total sugars in a serving of a comparable product with no added sugars.

At this time, we are not aware of products, other than the cranberry products discussed in the guidance document, for which the addition of sugars is intended to increase palatability, and for which the amount of total sugars per serving is at a level that does not exceed the amount of total sugars in a comparable product with no added sugars. Therefore, at this time we do not intend to exercise enforcement discretion with respect to the use of the ''†'' that would direct consumers to truthful and not misleading statements on the package outside the Nutrition Facts label on products, including dairy products and whole grain products, other than the cranberry products discussed in the guidance document. We specifically note that we do not intend to exercise enforcement discretion with respect to beverages made from açaí berries because it appears that açaí berry beverages are made, at least in part, from açaí berries combined with water. Therefore, we do not consider açaí berry beverages to be a comparable product to other naturally sweet juices. Furthermore, we do not have sufficient evidence to show that sugars are added to açaí berries to increase palatability like the naturally tart fruit described in the 2015–2020 Dietary Guidelines for Americans (available at *https://www.dietaryguidelines.gov/current-dietary-guidelines*). We note that we would consider whether the same type of enforcement discretion discussed with respect to certain cranberry products might be warranted for other products for which the addition of sugars is intended to increase palatability, such as naturally tart fruits, and for which the amount of total sugars per serving is at a level that does not exceed the amount of total sugars in a comparable product with no added sugars.

Further, the final guidance announces our intent to exercise enforcement discretion, until July 1, 2021, regarding the compliance with the Nutritional Facts Label final rule and Serving Size final rule (81 FR 33742 and 81 FR 34000 (May 27, 2016)) requirements for single-ingredient packages and/or containers of pure honey, pure maple syrup, and other pure sugars and syrups, as well as certain dried cranberry and cranberry beverage products. We recognize the importance of giving manufacturers of such products additional time to make appropriate label changes consistent with the Farm Bill and this final guidance. With respect to our enforcement discretion policy pertaining to compliance with updated Nutrition Facts label and serving size requirements, this part of the guidance is being implemented without prior public comment because we have determined that prior public participation is not feasible or appropriate (21 CFR 10.115(g)(2)).

II. Paperwork Reduction Act of 1995

This guidance refers to previously approved collections of information found in FDA regulations. These collections of information are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521). The collections of information in 21 CFR part 101 have been approved under OMB control number 0910–0813.

III. Electronic Access

Persons with access to the internet may obtain the guidance at either *https://www.fda.gov/FoodGuidances* or *https://www.regulations.gov.* Use the FDA website listed in the previous sentence to find the most current version of the guidance.

Dated: June 14, 2019.

Lowell J. Schiller,

Principal Associate Commissioner for Policy.

[FR Doc. 2019–12983 Filed 6–18–19; 11:15 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2012–1036]

Special Local Regulations: Recurring Marine Events in Captain of the Port Long Island Sound Zone

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce eight special local regulations for marine events in the Sector Long Island Sound area of responsibility on the dates and times listed in the table below. This action is necessary to provide for the safety of life on navigable waterways during the events. During the enforcement periods, no person or vessel may enter the safety zones without permission of the Captain of the Port (COTP) Sector Long Island Sound or designated representative.

DATES: The regulation in 33 CFR 100.100, Table 1 will be enforced during the dates and times listed in the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice of enforcement, call or email Chief Petty Officer Katherine Linnick, Waterways Management Division, U.S. Coast Guard Sector Long Island Sound; telephone 203–468–4565, email *Katherine.E.Linnick@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulations listed in 33 CFR 100.100 Table 1 on the specified dates and times:

5.2 Jones Beach Air Show	• Date: May 24, 2019—May 26, 2019. • Time: 09:30 a.m. to 3:30 p.m. • The ''Slow/No Wake Area'' and the ''No Southbound Traffic Area'' will be enforced each day for six hours after the air show concludes. • Location: ''No Entry Area'': Waters of the Atlantic Ocean off Jones Beach State Park, Wantagh, NY contained within the following described area; beginning at a point on land at position 40°34′54″ N, 073°33′21″ W; then east along the shoreline of Jones Beach State Park to a point on land at position 40°35′53″ N, 073°28′48″ W; then south to a point in the Atlantic Ocean off of Jones Beach at position 40°35′05″ N, 073°28′34″ W; then west to position 40°33′15″ N, 073°33′09″ W; then north to the point of origin (NAD 83). All positions are approximate. • Additional Stipulations: ''Slow/No Wake Area'': All navigable waters between Meadowbrook State Parkway and Wantagh State Parkway and contained within the following area. Beginning in position 40°35′49.01″ N, 73°32′33.63″ W; then north along the Meadowbrook State Parkway to its intersection with Merrick Road in position 40°39′14″ N, 73°34′0.76″ W; then east along Merrick Road to its intersection with Wantagh State Parkway in position 40°39′51.32″ N, 73°30′43.36″ W; then south along the Wantagh State Parkway to its intersection with Ocean Parkway in position 40°35′47.30″ N, 073°30′29.17″ W; then west along Ocean Parkway to its intersection with Meadowbrook State Parkway at the point of origin (NAD 83). All positions are approximate. ''No Southbound Traffic Area'': All navigable waters of Zach's Bay south of the line connecting a point near the western entrance to Zach's Bay at position 40°36′29.20″ N, 073°29′22.88″ W and a point near the eastern entrance of Zach's Bay at position 40°36′16.53″ N., 073°28′57.26″ W (NAD 83). All positions are approximate.
6.1 Swim Across America Greenwich	• Date: June 22, 2019. • Time: 5:30 a.m. to 12:30 a.m. • Location: All navigable waters of Stamford Harbor within an area starting at a point in position 41°01′32.03″ N, 073°33′8.93″ W, then southeast to a point in position 41°01′15.01″ N, 073°32′55.58″ W; then southwest to a point in position 41°0′49.25″ N, 073°33′20.36″ W; then northwest to a point in position 41°0′58″ N, 073°33′27″ W; then northeast to a point in position 41°1′15.8″ N, 073°33′9.85″ W, then heading north and ending at point of origin (NAD 83). All positions are approximate.
7.1 Connecticut River Raft Race, Middletown, CT	• Date: July 27, 2019. • Time: 10:00 a.m. to 2:00 p.m. • Location: All waters of the Connecticut River near Middletown, CT between Gildersleeve Island (Marker no. 99) at position 41°36′ 02.13″ N, 072°37′ 22.71″ W; and Portland Riverside Marina (Marker no. 88) at positon 41°33′ 38.3″ N, 072°37′ 36.53″ W (NAD 83). All positons are approximate. • Additional stipulations: Spectators or other vessels shall not anchor, block, loiter, or impede the transit of event participants or official patrol vessels in the regulated areas unless authorized by the COTP or designated representative.
7.3 Clam Shell Foundation Fireworks	• Date: July 13, 2019. • Rain Date: July 14, 2019. • Time: 8:30 p.m. to 10:30 p.m. • Location: ''No Entry Area'': All waters of Three Mile Harbor, East Hampton, NY within a 1000 foot radius of the launch platform in approximate position 41°01′15.49″ N, 072°11′27.5″ W (NAD 83). • Additional Stipulations: ''Northbound Traffic Only Area'': All waters of Three Mile Harbor, East Hampton, NY contained within the following area; beginning at a point in position at 41°02′5.05″ N, 072°11′19.52″ W; then southeast to a point on land in position at 41°02′2.67″ N, 072°11′17.97″ W; then south along shoreline to a point on land in position at 41°01′35.26″ N, 072°11′9.56″ W; then southeast across channel to a point on land in position at 41°01′30.28″ N, 072°10″52.77″ W; then north along the shoreline to a point on land in position at 41°01′41.35″ N, 072°10′52.57″ W; then north across channel to a point on land in position at 41°01′44.41″ N, 072°10′52.23″ W near the southern end of Sedge Island; then north along shoreline of Sedge Island to a point on land in position at 41°01′56.3″ N, 072°10′59.37″ W, near the northern end of Sedge Island; then northwest across the channel to a point on land in position 41°01′56.76″ N, 072°11′0.66″ W; then northwest along shoreline to a point on land in position 41°01′41.35″ N, 072°10′52.57″ W; then northwest to position at 41°02′5.92″ N, 072°11′16.73″ W; and then southwest to point of origin (NAD 83). All positions are approximate.

7.4 Jones Beach State Park Fireworks	• Date: July 4, 2019. • Time: 8:30 p.m. to 10:30 p.m. • Location: ''No Entry Area'': All waters off of Jones Beach State Park, Wantagh, NY within a 1000 foot radius of the launch platform in approximate position 40°34′56.68″ N, 073°30′31.19″ W (NAD 83). Additional stipulations: ''Slow/No Wake Area'': All navigable waters between Meadowbrook State Parkway and Wantagh State Parkway and contained within the following area. Beginning in position at 40°35′49.01″ N, 073°32′33.63″ W; then north along the Meadowbrook State Parkway to its intersection with Merrick Road in position at 40°39′14″ N, 073°34′0.76″ W; then east along Merrick Road to its intersection with Wantagh State Parkway in position at 40°39′51.32″ N, 073°30′43.36″ W; then south along the Wantagh State Parkway to its intersection with Ocean Parkway in position at 40°35′47.30″ N, 073°30′29.17″ W; then west along Ocean Parkway to its intersection with Meadowbrook State Parkway at the point of origin (NAD 83). All positions are approximate. ''No Southbound Traffic Area'': All navigable waters of Zach's Bay south of the line connecting a point near the western entrance to Zach's Bay in position at 40°36′29.20″ N, 073°29′22.88″ W and a point near the eastern entrance of Zach's Bay in position at 40°36′16.53″ N, 073°28′57.26″ W (NAD 83). All positions are approximate.
8.1 Riverfront Dragon Boat and Asian Festival	• Date: August 17, 2019. • Time: 8:00 a.m. to 5:00 p.m. • Location: All waters of the Connecticut River in Hartford, CT between the Bulkeley Bridge at 41°46′10.10″ N, 072°39′56.13″ W and the Wilbur Cross Bridge at 41°45′11.67″ N, 072°39′13.64″ W (NAD 83). All positions are approximate.
8.2 Swim Across the Sound	• Date: August 3, 2019. • Time: 6:30 a.m. to 7:30 p.m. • Location: Waters of Long Island Sound from Port Jefferson, NY in approximate position 40°58′11.71″ N, 073°05′51.12″ W; then northwest to Captain's Cove Seaport, Bridgeport, CT in approximate position 41°09′25.07″ N, 073°12′47.82″ W (NAD 83).
8.4 Island Beach Two Mile Swim	• Date: August 3, 2019. • Time: 8:00 a.m. to 11:00 a.m. • Location: All waters of Captain Harbor between Little Captain's Island and Bower's Island that are located within the box formed by connecting four points in the following positions. Beginning at 40°59′23.35″ N, 073°36′42.05″ W; then northwest to 40°59′51.04″ N, 073°37′57.32″ W; then southwest to 40°59′45.17″ N, 073°38′01.18″ W; then southeast to 40°59′17.38″ N, 073°36′45.9″ W; then northeast to the point of origin (NAD 83). All positions are approximate.

Under the provisions of 33 CFR 100.100, the events listed above are established as special local regulations. During the enforcement period, persons and vessels are prohibited from entering into, transiting through, mooring, or anchoring within these regulated areas unless they receive permission from the COTP or designated representative.

This notice of enforcement is issued under authority of 33 CFR 100 and 5 U.S.C. 552 (a). In addition to this notice of enforcement in the **Federal Register**, the Coast Guard will provide the maritime community with advance notification of this enforcement period via the Local Notice to Mariners or marine information broadcasts. If the COTP determines that these special local regulations need not be enforced for the full duration stated in this notice of enforcement, a Broadcast Notice to Mariners may be used to grant general permission to enter the regulated area.

Dated: May 15, 2019.

K.B. Reed,

Captain, U.S. Coast Guard, Captain of the Port Long Island Sound.

[FR Doc. 2019–12935 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2019–0404]

RIN 1625–AA09

Drawbridge Operation Regulation; Duwamish Waterway, Seattle, WA

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is modifying the operating schedule that governs the South Park highway bridge, across the Duwamish Waterway mile 3.8, at Seattle, WA. This rule removes the nighttime bridge operator, and will require a 12 hour advance notice for a late evening to early morning opening.

DATES: This rule is effective July 22, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov.* Type USCG–2019–0404 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rulemaking.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Steven M. Fischer, Bridge Administrator, Thirteenth Coast Guard District Bridge Program Office, telephone 206–220–7282; email *d13-pf-d13bridges@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register

NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

On March 29, 2019 we published a notice of proposed rulemaking entitled ''Drawbridge Operation Regulation; Duwamish Waterway, Seattle, WA'' in the **Federal Register** (84 FR 11912). This notice of proposed rulemaking was preceded by a six month test deviation published in the **Federal Register** (83 FR 10785) on March 13, 2018. The test deviation ran from March 22, 2018 to September 17, 2018. We received three comments on this rule during the deviation. Those comments and the response to the comments can be found in the NPRM, ''Drawbridge Operation Regulation; Duwamish Waterway, Seattle, WA'' in the **Federal Register** (84 FR 11912). We received no comments on the NPRM.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority 33 U.S.C. 499. The Duwamish Waterway provides no alternate route to pass around the South Park Bridge. The subject bridge provides 34 feet in the center of the span and 27 feet at the sides of the span above mean high water. King County, WA, owns the South Park Bridge, but the Seattle Department of Transportation (SDOT) operates the bridge per 33 CFR 117.1041(a)(2).

On behalf of SDOT, King County requested a permanent change to the existing operating regulation of the South Park Bridge. Due to infrequent bridge opening requests from 11 p.m. to 7 a.m., King County proposed to eliminate the nighttime bridge operator. This rule will remove SDOT's bridge operator from 11 p.m. to 7 a.m. unless a 12 hours' notice has been received prior to an opening request. If emergency responders require a bridge opening between 11 p.m. and 7 a.m., the South Park Bridge will open within 45 minutes from initial notification to the Fremont Bridge operator. Vessels engaged in sea-trials or dredging activities may request a standby drawtender to open the bridge, on demand, during sea-trials and/or dredging operations, if at least a 24 hour notice is given to the South Park Bridge drawtender. This rule reasonably accommodates waterway users while reducing SDOT's burden in operating the subject bridge. Vessels operating on the Duwamish Waterway range from small pleasure craft, small tribal fishing boats, large size pleasure motor vessels and large commercial vessels and barges.

IV. Discussion of Comments, Changes and the Final Rule

During the 30 day comment period ending April 30, 2019 no comments were received. The South Park Bridge will require a 12 hour notice given by telephone to the bridge operator (SDOT) between 7 a.m. and 11 p.m., and for emergencies between 11 p.m. to 7 a.m. call the Fremont Bridge operator. The phone numbers to use for a bridge opening is posted at the subject bridge, and the Coast Guard will publish the phone numbers and this rule in the Local Notice to Mariners (LNM) for six months after the approval date. In addition to the LNM, phone numbers for the two bridge operators will be added to the Coast Pilot. This rule adds 33 CFR 117.1041(a)(3) to provide specific requirements for the operation of the South Park Bridge.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive Orders related to rulemaking. Below we summarize our analysis based on these statutes and Executive Orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, it has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance, it is exempt from the requirements of Executive Order 13771. This regulatory action determination is based on the ability that vessels can still transit the bridge given advanced notice. This rule also applies to emergency openings.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit under the bridge may be small entities, for the reasons stated in section V.A. above, this rule will not have a significant economic impact on any vessel owners or operators.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT**, above.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520.).

D. Federalism and Indian Tribal Government

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would not have a substantial

direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. We have not received any comments for this rule change.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble. We have not received any comments for this rule change.

F. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have made a determination that this action is one of a category of actions which do not individually or cumulatively have a significant effect on the human environment. This rule simply promulgates the operating regulations or procedures for drawbridges. This action is categorically excluded from further review, under figure 2–1, paragraph (32) (e), of the Instruction. A Record of Environmental Consideration and a Memorandum for the Record are not required for this rule.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

■ 1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 33 CFR 1.05–1; and Department of Homeland Security Delegation No. 0170.1.

■ 2. Amend § 117.1041 by adding paragraph (a)(3) to read as follows:

§ 117.1041 Duwamish Waterway.

(a) * * *

(3) Between the hours of 11 p.m. and 7 a.m., Monday through Sunday, the South Park Bridge shall open if at least a 12 hour notice is given by telephone or VHF radio to the drawtender at the South Park Bridge. If emergency responders require a bridge opening between 11 p.m. and 7 a.m., the South Park Bridge shall open within 45 minutes from initial notification to the Fremont Bridge operator. Vessels engaged in sea-trials or dredging activities may request a standby drawtender to open the bridge, on demand, during sea-trials and/or dredging operations, if at least a 24 hour notice is given to the South Park Bridge drawtender.

* * * * *

David G. Throop,

Rear Admiral, U.S. Coast Guard, Commander, Thirteenth Coast Guard District.

[FR Doc. 2019–12958 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0451]

RIN 1625–AA00

Safety Zone; Ohio River, Miles 110.5 to 111.5, Moundsville, WV

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for all navigable waters of the Ohio River from mile 110.5 to mile 111.5. This safety zone is necessary to protect persons, vessels, and the marine environment from potential hazards associated with shoreside demolition activities. Entry of persons or vessels into this zone is prohibited unless authorized by the Captain of the Port Marine Safety Unit Pittsburgh or a designated representative.

DATES: This rule is effective from June 22, 2019 through June 30, 2019. The rule will be enforced from 6 a.m. through noon on one day between June 22, 2019 and June 30, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type USCG–2019–0451 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Petty Officer Jennifer Haggins, Marine Safety Unit Pittsburgh, U.S. Coast Guard; telephone 412–221–0807, email *Jennifer.L.Haggins@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port Marine Safety Unit Pittsburgh
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(3)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impracticable. This safety zone must be established by June 22, 2019 and we lack sufficient time to provide a reasonable comment period and then consider those comments before issuing this rule. The NPRM process would delay the establishment of the safety zone until after the date of the building demolition and compromise public safety.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying this rule would be contrary to the public interest because immediate action is necessary to respond to the potential safety hazards associated with the shoreside building demolition.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034. The Captain of the Port Marine Safety Unit Pittsburgh (COTP) has determined that potential hazards associated with shoreside demolition activities will be a safety hazard for anyone within a one-mile stretch of the Ohio River. The rule is needed to protect persons, vessels, and the marine environment on the navigable waters within the safety zone before, during, and after the building demolition.

IV. Discussion of the Rule

This rule establishes a temporary safety zone from 6 a.m. through noon on one day between June 22, 2019 and June 30, 2019. The rule will be enforced from 6 a.m. through noon on one day between June 22, 2019 and June 30, 2019. The safety zone will cover all navigable waters of the Ohio River, from mile 110.5 to mile 111.5. The duration of the zone is intended to protect persons, vessels, and the marine environment on these navigable waters before, during, and after the building demolition. No vessel or person will be permitted to enter the safety zone without obtaining permission from the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Marine Safety Unit Pittsburgh. Persons and vessels seeking entry into this safety zone must request permission from the COTP or a designated representative. They may be contacted on VHF–FM Channel 16 or by telephone at (412) 221–0807. Persons and vessels permitted to enter this safety zone must transit at their slowest safe speed and comply with all lawful instructions of the COTP or a designated representative. The COTP or a designated representative will inform the public of the enforcement period for the safety zone as well as any changes in the schedule through Broadcast Notices to Mariners (BNMs), Local Notices to Mariners (LNMs), and/or Marine Safety Information Bulletins (MSIBs) as appropriate.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the size, duration, and location of the safety zone. This rule will impact a one-mile stretch of the Ohio River for 6 hours. Moreover, the Coast Guard will issue Local Notices to Mariners (LNMs), Marine Safety Information Bulletins (MSIBs), and BNMs via VHF–FM marine channel 16 about the zones and the rule allows vessels to seek permission to enter the zones.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the temporary safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section above.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a temporary safety zone lasting one hour and prohibiting entry on a one-mile stretch of the Ohio River. It is categorically excluded from further review under paragraph L60(a) in Table 3–1 of U.S. Coast Guard Environmental Planning Implementing Procedures 5090.1. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T08–0451 to read as follows:

§ 165.T08–0451 Safety Zone; Ohio River, miles 110.5 to 111.5, Moundsville, WV.

(a) *Location.* The following area is a safety zone: all navigable waters of the Ohio River from mile 110.5 to mile 111.5.

(b) *Effective period.* This section is effective from June 22, 2019 through June 30, 2019.

(c) *Enforcement period.* This section will be enforced from 6 a.m. through noon on one day between June 22, 2019 and June 30, 2019.

(d) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry into this zone is prohibited unless authorized by the Captain of the Port Marine Safety Unit Pittsburgh (COTP) or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Marine Safety Unit Pittsburgh.

(2) Persons and vessels seeking entry into this safety zone must request permission from the COTP or a designated representative. They may be contacted on VHF–FM Channel 16 or by telephone at (412) 221–0807.

(3) Persons and vessels permitted to enter this safety zone must transit at their slowest safe speed and comply with all lawful instructions of the COTP or a designated representative.

(e) *Informational broadcasts.* The COTP or a designated representative will inform the public of the enforcement period for the safety zone as well as any changes in the schedule through Broadcast Notices to Mariners (BNMs), Local Notices to Mariners (LNMs), and/or Marine Safety Information Bulletins (MSIBs) as appropriate.

A.W. Demo,

Commander, U.S. Coast Guard, Captain of the Port Marine Safety Unit Pittsburgh.

[FR Doc. 2019–12957 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0509]

RIN 1625–AA87

Security Zone; Corpus Christi Ship Channel, Corpus Christi, TX

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing two security zones. One of the zones is a temporary fixed security zone for the receiving facility's mooring basin while the Liquefied Natural Gas Carrier (LNGC) CORCOVADO is moored at the facility. The other zone is a moving security zone encompassing all navigable waters within a 500-yard radius around the LNGC CORCOVADO while the vessel transits with cargo in the La Quinta Channel and Corpus Christi Ship Channel in Corpus Christi, TX. The security zones are needed to protect personnel, vessels, and the marine environment from potential hazards created by Liquified Natural Gas (LNG) cargo aboard the vessel. Entry of vessels or persons into these zones is prohibited unless specifically authorized by the Captain of the Port Sector Corpus Christi.

DATES: This rule is effective without actual notice on June 19, 2019. For the purposes of enforcement, actual notice will be used from June 15, 2019 until June 18, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *https://www.regulations.gov,* type USCG–2019–0509 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant Commander Margaret Brown, Sector Corpus Christi Waterways Management Division, U.S. Coast Guard; telephone 361–939–5130, email *Margaret.A.Brown@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impracticable. We must establish these security zones by June 15, 2019 and lack sufficient time to provide a reasonable comment period and then consider those comments before issuing the rule.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying the effective date of this rule would be contrary to the public

interest because immediate action is needed to provide for the security of the vessel.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034. The Captain of the Port Sector Corpus Christi (COTP) has determined that potential hazards associated with Liquefied Natural Gas Carrier (LNGC) CORCOVADO between June 15, 2019 and June 19, 2019 will be a security concern while the vessel is moored at the receiving facility and within a 500-yard radius of the vessel while the vessel is loaded with cargo.

IV. Discussion of the Rule

This rule establishes two security zones around LNGC CORCOVADO from June 15, 2019 through June 19, 2019. A fixed security zone will be in effect in the mooring basin bound by 27°52′53.38″ N, 097°16′20.66″ W on the northern shoreline; thence to 27°52′45.58″ N, 097°16′19.60″ W; thence to 27°52′38.55″ N, 097°15′45.56″ W; thence to 27°52′49.30″ N, 097°15′45.44″ W; thence west along the shoreline to 27°52′53.38″ N, 097°16′20.66″ W, while LNGC CORCOVADO is moored. A moving security zone will cover all navigable waters within a 500-yard radius of the LNGC CORCOVADO while the vessel transits outbound with cargo through the La Quinta Channel and Corpus Christi Ship Channel. No vessel or person will be permitted to enter the security zones without obtaining permission from the COTP or a designated representative.

Entry into these security zones is prohibited unless authorized by the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Sector Corpus Christi. Persons or vessels desiring to enter or pass through the zones must request permission from the COTP or a designated representative on VHF–FM channel 16 or by telephone at 361–939–0450. If permission is granted, all persons and vessels shall comply with the instructions of the COTP or designated representative. The COTP or a designated representative will inform the public through Broadcast Notices to Mariners (BNMs) of the enforcement times and dates for these security zones.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the size, duration, and location of the security zone. This rule will impact a small designated area of the Corpus Christi Ship Channel and La Quinta Channel while the vessel is moored at the receiving facility and during the vessel's transit while loaded with cargo. Moreover, the Coast Guard will issue BNMs via VHF–FM marine channel 16 about the zones and the rule allows vessels to seek permission to enter the zones.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the temporary moving security zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section above.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or

more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a temporary fixed security zone while LNGC CORCOVADO is moored at the receiving facility mooring basin bound by 27°52′53.38″ N, 097°16′20.66″ W on the northern shoreline; thence to 27°52′45.58″ N, 097°16′19.60″ W; thence to 27°52′38.55″ N, 097°15′45.56″ W; thence to 27°52′49.30″ N, 097°15′45.44″ W; thence west along the shoreline to 27°52′53.38″ N, 097°16′20.66″ W, and a temporary moving security zone while the vessel transits with cargo within the La Quinta Channel and Corpus Christi Ship Channel, that will prohibit entry within 500-yard radius of LNGC CORCOVADO. It is categorically excluded from further review under paragraph L[xxx] in Table 3–1 of U.S. Coast Guard Environmental Planning Implementing Procedures 5090.1. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and record keeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T08–0509 to read as follows:

§ 165.T08–0509 Security Zone; Corpus Christi Ship Channel, Corpus Christi, TX.

(a) *Location.* The following areas are security zones:

(1) The mooring basin bound by 27°52′53.38″ N, 097°16′20.66″ W on the northern shoreline; thence to 27°52′45.58″ N, 097°16′19.60″ W; thence to 27°52′38.55″ N, 097°15′45.56″ W; thence to 27°52′49.30″ N, 097°15′45.44″ W; thence west along the shoreline to 27°52′53.38″ N, 097°16′20.66″ W, while LNGC CORCOVADO is moored.

(2) All navigable waters encompassing a 500-yard radius around the Liquefied Natural Gas Carrier (LNGC) CORCOVADO while transiting outbound with cargo through the La Quinta Channel and Corpus Christi Ship Channel.

(b) *Effective period.* This rule is effective without actual notice on June 19, 2019. For the purposes of enforcement, actual notice will be used from June 15, 2019 until June 18, 2019.

(c) *Period of enforcement.* This section will be enforced from the time LNGC CORCOVADO moors and while the vessel is transiting outbound through the La Quinta Channel and Corpus Christi Ship Channel from June 15, 2019 through June 19, 2019.

(d) *Regulations.* (1) The general regulations in § 165.33 of this part apply. Entry into these zones is prohibited unless authorized by the Captain of the Port Sector Corpus Christi (COTP) or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Sector Corpus Christi.

(2) Persons or vessels desiring to enter or pass through the zones must request permission from the COTP or a designated representative on VHF–FM channel 16 or by telephone at 361–939–0450.

(3) If permission is granted, all persons and vessels shall comply with the instructions of the COTP or designated representative.

(e) *Information broadcasts.* The COTP or a designated representative will inform the public through Broadcast Notices to Mariners (BNMs) of the enforcement times and date for these security zones.

Dated: June 13, 2019.

E.J. Gaynor,

Captain, U.S. Coast Guard, Captain of the Port Sector Corpus Christi.

[FR Doc. 2019–13036 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0440]

RIN 1625–AA00

Safety Zone; Lower Mississippi River, Port Gibson, MS

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing an emergency temporary safety zone for all navigable waters of the Lower Mississippi River, extending the entire width of the river, from mile marker (MM) 405 to MM 408. This emergency safety zone is necessary to protect persons, property, and infrastructure from potential damage and safety hazards associated with vessels transiting this area during high water. This rule prohibits persons and vessels from entering the safety zone area unless specifically authorized by the Captain of the Port Sector Lower Mississippi River (COTP) or a designated representative.

DATES: This rule is effective without actual notice from June 20, 2019 through June 30, 2019, or until the high water event ceases, whichever occurs first. For the purposes of enforcement, actual notice will be used from June 7, 2019 through June 20, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type USCG–2019–0440 in the ''SEARCH'' box and click ''SEARCH.'' Click on ''Open Docket Folder'' on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Chief Petty Officer Todd Manow, Sector Lower Mississippi River Prevention Department, U.S. Coast Guard; telephone 901–521–4813, email *Todd.M.Manow@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port Sector Lower Mississippi River

DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impracticable. Increasing high water in this area requires immediate action to protect persons, property and power plant infrastructure from the potential safety hazards associated with vessels transiting this area during high water. This safety zone must be established immediately to protect people and vessels associated with and resulting from the high water and we lack sufficient time to provide a reasonable comment period and then consider those comments before issuing the rule.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making it effective less than 30 days after publication in the **Federal Register.** Delaying the effective date of this rule would be contrary to public interest because immediate action is needed to protect personnel, vessels, and the marine environment from potential hazards created by the increasing high water.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034. The Captain of the Port Sector Lower Mississippi River (COTP) has determined that there are potential hazards associated with increasing high water, including possible emergency operations to repair damage to power distribution infrastructure taking place on the left descending bank of the Lower Mississippi River between Mile Marker (MM) 405 and 408 in the vicinity of the Entergy Grand Gulf Nuclear Power Facility, in Port Gibson, MS. Loss of the power distribution lines system would be catastrophic to large areas of Louisiana and Mississippi. This rule is needed to protect persons, property, and infrastructure from potential damage and safety hazards associated with vessels transiting this safety zone during high water.

IV. Discussion of the Rule

The Coast Guard is establishing a temporary safety zone for all navigable waters of the Lower Mississippi River, extending the entire width of the river, from MM 405 to MM 408. Transit into and through this area is prohibited for all traffic beginning on June 7, 2019 to continue through June 30, 2019. The COTP will terminate the enforcement of this safety zone before June 30, 2019, if the high water event ceases. Entry into this safety zone is prohibited unless specifically authorized by the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Sector Lower Mississippi River.

Requests for entry will be considered and reviewed on a case-by-case basis. The COTP may be contacted by telephone at 1–866–777–2784 or can be reached by VHF–FM channel 16. Persons and vessels permitted to transit this safety zone shall not meet, pass, or overtake any vessel currently transiting, shall maintain slowest speed for safe navigation, and shall comply with all lawful directions issued by the COTP or the designated representative.

This safety zone may include closures and/or navigation restrictions and requirements that are vital to maintaining safe navigation on the Lower Mississippi River during the high water. Moreover, the Coast Guard will issue Broadcast Notice to Mariners via VHF–FM marine channel 16 about the zone.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the size, location, and duration of the safety zone. This emergency safety zone will restrict vessel traffic from entering or transiting through a three-mile section of the navigable waterways of the Lower Mississippi River from MM 405 to MM 408, in the vicinity of Port Gibson, MS, from May 31, 2019 through June 30, 2019.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the temporary safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section above.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves an emergency safety zone lasting approximately one month that will prohibit entry into a three-mile stretch of the Lower Mississippi River during a hazardous high-water event. It is categorically excluded from further review under paragraph L60(d) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 01. A Record of Environmental Consideration (REC) supporting this determination will be made available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places, or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034; 46 U.S.C. 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.35T08–0440 to read as follows:

§ 165.35T08–0440 Safety Zone; Lower Mississippi River; Port Gibson, MS.

(a) *Location.* The following area is a safety zone: All navigable waters of the Lower Mississippi River, extending the entire width of the river, from mile marker (MM) 405 to MM 408, in the vicinity of Port Gibson, MS.

(b) *Period of enforcement.* This section is effective without actual notice from June 20, 2019 through June 30, 2019, or until the high water event ceases, whichever occurs first. For the purposes of enforcement, actual notice will be used from June 7, 2019 through June 20, 2019.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry of vessels or persons into this zone is prohibited unless specifically authorized by the Captain of the Port Sector Lower Mississippi River (COTP) or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Sector Lower Mississippi River.

(2) Vessels requiring entry into this safety zone must request permission from the COTP or a designated representative. To seek entry into the safety zone, contact the COTP or the COTP's representative by telephone at 1–866–777–2784 or on VHF–FM channel 16.

(3) Persons and vessels permitted to enter this safety zone shall not meet, pass, or overtake any vessel currently transiting, shall maintain slowest speed for safe navigation, and shall comply with all lawful directions issued by the COTP or the designated representative.

(d) *Informational broadcasts.* This safety zone may include closures and/or navigation restrictions and requirements that are vital to maintaining safe navigation on this section of the Lower Mississippi River during the high water. The COTP or a designated representative will inform the public through broadcast notices to mariners of any changes in the enforcement period for the safety zone.

Dated: June 7, 2019.

R. Tamez,

Captain, U. S. Coast Guard, Captain of the Port Sector Lower Mississippi River.

[FR Doc. 2019–12954 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0334]

RIN 1625–AA00

Safety Zone; Upper Mississippi River, Miles 109.9 to 647.8, Chester, IL to Guttenberg, IA

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is extending a temporary safety zone on the navigable waters of the Upper Mississippi River from mile marker (MM) 109.9 to MM 647.8 between Chester, IL and Guttenberg, IA. This action is necessary to provide for the safety of persons, vessels, and the marine environment on these navigable waters as a result of increasing flood conditions on the river that threaten to overtop levees. Entry of vessels or persons into this zone is prohibited unless specifically authorized by the Captain of the Port Sector Upper

Mississippi River (COTP) or a designated representative.

DATES: This rule is effective without actual notice from June 20, 2019 through July 1, 2019. For the purposes of enforcement, actual notice will be used from June 1, 2019 through June 20, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *https://www.regulations.gov,* type USCG–2019–0334 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant Commander Christian Barger, Sector Upper Mississippi River Waterways Management Division, U.S. Coast Guard; telephone 314–269–2560, email *Christian.J.Barger@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port Sector Upper Mississippi River
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
USACE United States Army Corps of Engineers
U.S.C. United States Code
UMR Upper Mississippi River
WAP Waterways Action Plan

II. Background Information and Regulatory History

The Coast Guard is extending this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impracticable. It is impracticable because we must establish this safety zone immediately and lack sufficient time to provide a reasonable comment period and then consider those comments before issuing this rule. The NPRM process would delay the establishment of the safety zone and compromise public safety.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying this rule would be contrary to public interest because immediate action is necessary to respond to the potential safety hazards associated with floodwaters and high flow of the river.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034 (previously 33 U.S.C. 1231). The COTP has determined that potential hazards associated with flood waters threaten to overtop levees along the river due to reports that vessel traffic in the affected area is causing water to overtop levees resulting in increased damage to the levees and flooding impacts to local communities and residential areas. This rule is necessary to ensure the safety of persons, vessels, and the marine environment on these navigable waters due to the flood impacts to USACE levees.

IV. Discussion of the Rule

This rule extends a current temporary safety zone due to unanticipated longevity and geographic scope of flooding conditions and establishes a temporary safety zone from June 1, 2019 through July 1, 2019, or until cancelled by the COTP, whichever occurs first. The safety zone will cover all navigable waters of the Upper Mississippi River from MM 109.9 to MM 647.8 unless reduced in scope by the COTP as flood conditions warrant to prevent damage to residential areas and the overtopping of levees.

No vessel or person will be permitted to enter the safety zone without obtaining permission from the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard (USCG) assigned to units under the operational control of USCG Sector Upper Mississippi River. To seek permission to enter, contact the COTP or a designated representative via VHF–FM channel 16, or through USCG Sector Upper Mississippi River at 314–269–2332. Persons and vessels permitted to enter the safety zone must comply with all lawful orders or directions issued by the COTP or designated representative. The COTP or a designated representative will inform the public of the effective period for the safety zone as well as any changes in the dates and times of enforcement, as well as reductions in size of the safety zone as flood conditions improve, through Local Notice to Mariners (LNMs), Broadcast Notices to Mariners (BNMs), and/or Marine Safety Information Bulletins (MSIBs), as appropriate.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the emergency nature of the action and the increasing flow rates and river height. When the Upper Mississippi River gauge in St. Louis, MO reaches 38 feet above zero, increased flow rates and vertical clearances associated with bridges in the St. Louis area between MM 179 and MM 184 result in difficulty with making safe approaches to the bridges and increase the potential for bridge strikes. When the Upper Mississippi River gauge at St. Louis, MO reaches 45 feet above zero, increased flow rates and river heights coupled with passing vessels will threaten overtopping or failure of levees between MM 109.9 and MM 179. Additionally, above St. Louis, MO, between MM 184 to 647.8, increased flow rates and river heights coupled with passing vessels will threaten overtopping or failure of levees and as levees fail or are overtopped potentially cause destructive wake effects to residents and other structures in the inundated areas. Moreover, the Coast Guard will issue a BNM via VHF–FM marine channel 16 about the zones, and the rule allows vessels to seek permission to enter the zone on a case-by-case basis.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations

that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section above.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Commandant Instruction M16475.1D, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a temporary safety zone prohibiting entry on a 538 mile stretch of the Upper Mississippi River that is experiencing significant flooding. It is categorically excluded from further review under paragraph L60 (d) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 01. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Revise § 165.T08–0334 to read as follows:

§ 165.T08–0334 Safety Zone; Upper Mississippi River, Miles 109.9, Chester, IL to 647.8 Guttenberg, IA.

(a) *Location.* The following area is a safety zone: All navigable waters of the Upper Mississippi River from mile marker (MM) 109.9 to MM 647.8. This section will be enforced on all navigable waters of the Upper Mississippi River from MM 109.9 to MM 647.8, unless reduced in scope by the Captain of the Port Sector Upper Mississippi River (COTP) as flood conditions warrant.

(b) *Effective period.* This rule is effective without actual notice from June 20, 2019 until July 1, 2019, or until cancelled by the COTP, whichever occurs first. For the purposes of enforcement, actual notice will be provided on June 1, 2019 until June 20, 2019.

(c) *Regulations.* (1) In accordance with the general safety zone regulations in § 165.23, entry of persons or vessels into this safety zone described in paragraph (a) of this section is prohibited unless authorized by the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard (USCG) assigned to units under the operational control of USCG Sector Upper Mississippi River.

(2) To seek permission to enter, contact the COTP or a designated representative via VHF–FM channel 16, or through USCG Sector Upper Mississippi River at 314–269–2332. Persons and vessels permitted to enter the safety zone must comply with all lawful orders or directions issued by the COTP or designated representative.

(d) *Informational broadcasts.* The COTP or a designated representative will inform the public of the effective period for the safety zone as well as any changes in the dates and times of enforcement, as well as reductions in

size of the safety zone as flood conditions improve, through Local Notice to Mariners (LNMs), Broadcast Notices to Mariners (BNMs), and/or Marine Safety Information Bulletins (MSIBs) as appropriate.

Dated: June 1, 2019.

S.A. Stoermer,

Captain, U.S. Coast Guard, Captain of the Port Sector Upper Mississippi River.

[FR Doc. 2019–12944 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0364]

RIN 1625–AA00

Safety Zone; Ohio River, Miles 90.8 to 91.4, Wheeling, WV

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for navigable waters of the Ohio River from mile 90.8 to mile 91.4. The safety zone is needed to protect personnel, vessels, and the marine environment from potential hazards created by a land based fireworks display. Entry of vessels or persons into this zone is prohibited unless specifically authorized by Captain of the Port Marine Safety Unit Pittsburgh.

DATES: This rule is effective from 8:30 p.m. through 10:30 p.m. on July 27, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type USCG–2019–0364 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email MST1 Jennifer Haggins, Marine Safety Unit Pittsburgh, U.S. Coast Guard, at telephone 412–221–0807, email *Jennifer.L.Haggins@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impracticable. It would be impracticable to complete the full NPRM process for this safety zone because we need to establish it by July 27, 2019 and lack sufficient time to provide a reasonable comment period and then consider those comments before issuing the rule.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034 (previously 33 U.S.C. 1231). The Captain of the Port Marine Safety Unit Pittsburgh (COTP) has determined that a safety zone is needed to protect personnel, vessels, and the marine environment from potential hazards created from a land based firework display.

IV. Discussion of the Rule

This rule establishes a safety zone on July 27, 2019, from 8:30 p.m. through 10:30 p.m. The safety zone will cover all navigable waters on the Ohio River from mile 90.8 to mile 91.4. The duration of the safety zone is intended to protect personnel, vessels, and the marine environment from potential hazards created by a land based firework display.

No vessel or person is permitted to enter the safety zone without obtaining permission from the COTP or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard (USCG) assigned to units under the operational control of the COTP. To seek permission to enter, contact the COTP or a designated representative via VHF–FM channel 16, or through Marine Safety Unit Pittsburgh at 412–221–0807. Persons and vessels permitted to enter the safety zone must comply with all lawful orders or directions issued by the COTP or designated representative. The COTP or a designated representative will inform the public of the effective period for the safety zone as well as any changes in the dates and times of enforcement through Local Notice to Mariners (LNMs), Broadcast Notices to Mariners (BNMs), and/or Marine Safety Information Bulletins (MSIBs), as appropriate.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the size, location, and duration of the safety zone. This safety zone impacts a one half-mile stretch of the Ohio River for a limited duration of two hours. Vessel traffic will be informed about the safety zone through local notices to mariners. Moreover, the Coast Guard will issue LNMs, MSIBs, and BNMs via VHF–FM marine channel 16 about the zone and the rule allows vessels to seek permission to transit the zone.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the temporary safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a

significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section above.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone lasting less than two hours that will prohibit entry on the Ohio River from mile 90.8 to mile 91.4, during the land based firework event. It is categorically excluded from further review under paragraph L60(a) in Table 3–1 of U.S. Coast Guard Environmental Planning Implementing Procedures 5090.1. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T08–0364 to read as follows:

§ 165.T08–0364 Safety Zone; Ohio River, Miles 90.8 to mile 91.4, Wheeling, WV.

(a) *Location.* The following area is a safety zone: All navigable waters of the Ohio River from mile 90.8 to mile 91.4.

(b) *Effective period.* This section is effective from 8:30 p.m. through 10:30 p.m. on July 27, 2019.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry of persons and vessels into this zone is prohibited unless authorized by the Captain of the Port Marine Safety Unit Pittsburgh (COTP) or a designated representative.

(2) Persons or vessels requiring entry into or passage through the zone must request permission from the COTP or a designated representative. The COTP's representative may be contacted at 412–221–0807.

(3) All persons and vessels shall comply with the instructions of the COTP or a designated representative. Designated COTP representatives include United States Coast Guard commissioned, warrant, and petty officer.

(d) *Information broadcasts.* The COTP or a designated representative will inform the public through Local Notice to Mariners (LNMs), Broadcast Notices to Mariners (BNMs), and/or Marine Safety Information Bulletins (MSIBs), as appropriate.

A.W. Demo,

Commander, U.S. Coast Guard, Captain of the Port Marine Safety Unit Pittsburgh.

[FR Doc. 2019–12956 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2019–0493]

RIN 1625–AA00

Safety Zones; Tug Nancy Anne, Jack-Up Barge JUB–100, and M/V Highland Eagle Operating in the Straits of Mackinac, MI

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing two temporary safety zones in the Captain of the Port, Sault Sainte Marie zone. These temporary safety zones are necessary to protect the public, and contractors from potential hazards associated with geotechnical sampling by persons conducting bore hole drilling in the Straits of Mackinac. Vessels will not be able to operate in certain U.S. navigable waters in the Straits of Mackinac within 500 yards of the Tug Nancy Anne, Jack-Up Barge JUB–100, and the Motor Vessel (M/V) Highland Eagle without authorization from the Captain of the Port.

DATES: This rule is effective without actual notice from June 20, 2019 through 30 September 2019. For the purposes of enforcement, actual notice will be used from June 17, 2019, through June 20, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *https://www.regulations.gov,* type USCG–2019–0493 in the ''SEARCH'' box and click ''SEARCH.'' Click on ''Open Docket Folder'' on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions about this rule, call or email LT Sean V. Murphy, Sector Sault Sainte Marie Waterways Management Division, U.S. Coast Guard at telephone (906) 635–3223, and email *Sean.V.Murphy@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code
M/V Motor Vessel

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and an opportunity to comment, pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and an opportunity to comment when the agency, for good cause, finds that those procedures are impracticable, unnecessary, or contrary to the public interest. Pursuant to 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because doing so would be impracticable and contrary to the public interest. The final details of the specific dates, vessel names, and safety zone distances concerning the safety zones were not finalized within a sufficient time to allow for notice and a subsequent 30-day comment period before the commencement of geotechnical sampling operations. Delaying this rule to allow for a notice and comment period would be impracticable and contrary to the public interest because it would inhibit the Coast Guard's ability to protect the public from the potential hazards associated with geotechnical sampling.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. For the same reasons discussed in the preceding paragraph, delaying the effective date of this rule would be impracticable and contrary to public interest because immediate action is needed to respond to the potential safety hazards associated with geotechnical sampling.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034 (previously 33 U.S.C. 1231). The Captain of the Port Sault Sainte Marie (COTP) has determined that potential hazards associated with geotechnical sampling starting June 17, 2019, will be a safety concern for anyone within a 500-yard radius of all U.S. navigable waters of the Tug Nancy Anne, Jack-Up Barge JUB–100, and the Motor Vessel (M/V) Highland Eagle conducting bore hole drilling. This rule is needed to protect personnel and vessels in the navigable waters within the safety zones while geotechnical sampling is conducted.

IV. Discussion of the Rule

This rule establishes two safety zones from June 17, 2019 through September 30, 2019. The safety zones will cover all navigable waters within 500 yards of the Tug Nancy Anne, Jack-Up Barge JUB–100, and M/V Highland Eagle. The duration of the zone is intended to protect personnel and vessels in these navigable waters while vessels conduct geotechnical sampling. No vessel or person will be permitted to enter the safety zone without obtaining permission from the COTP or a designated representative.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive Orders related to rulemaking. Below, we summarize our analyses based on a number of these statutes and Executive Orders, and we also discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the size and location of the safety zones. Vessel traffic will be able to safely transit around this safety zone which would impact a small designated area of the Straits of Mackinac. Moreover, the Coast Guard would issue a Broadcast Notice to Mariners via VHF–FM marine channel 16 about the zone, and the rule would allow vessels to seek permission to enter the zone.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the safety zone may be small entities, for the reasons stated in section V.A above, this

rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments of the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small businesses. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Coast Guard Environmental Planning Policy, COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that does not individually or cumulatively have a significant effect on the human environment. This rule involves two safety zones that will prohibit entry within 500 yards of U.S. navigable waters of vessels, barges, and machinery being used by personnel to conduct geotechnical sampling. It is categorically excluded from further review under paragraph L60[a] in Table 3–1 of U.S. Coast Guard Environmental Planning Implementing Procedures 5090.1. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and record keeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T09–0493 to read as follows:

§ 165.T09–0493 Safety Zones; Tug Nancy Anne, Jack-Up Barge JUB–100, and M/V Highland Eagle operating in the Straits of Mackinac, MI.

(a) *Location.* The following areas are safety zones: All navigable waters within 500 yards of Tug Nancy Anne and Jack-Up Barge JUB–100 while conducting geotechnical sampling in the Straits of Mackinac, and all navigable waters within 500 yards of Motor Vessel (M/V) Highland Eagle while conducting geotechnical sampling in the Straits of Mackinac.

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Sault Sainte Marie (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry into, transiting, or anchoring within the safety zone described in paragraph (a) of this section is prohibited unless authorized by the Captain of the Port, Sault Sainte Marie or his on-scene representative.

(2) Before a vessel operator may enter or operate within the safety zones, they must obtain permission from the Captain of the Port, Sault Sainte Marie, or his on-scene representative via VHF Channel 16 or telephone at (906) 635–3233. Vessel operators given permission to enter or operate in the safety zone must comply with all orders given to them by the Captain of the Port, Sault Sainte Marie or his on-scene representative.

(d) *Enforcement period.* This section will be enforced from June 17, 2019 through September 30, 2019.

Dated: June 13, 2019.

P.S. Nelson,

Captain, U.S. Coast Guard, Captain of the Port Sault Sainte Marie.

[FR Doc. 2019–12955 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R05–OAR–2017–0583; FRL–9995–30–Region 5]

Air Plan Approval; Illinois; Infrastructure SIP Requirements for the 2012 $PM_{2.5}$ NAAQS; Interstate Transport

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving elements of the State Implementation Plan (SIP) submission from Illinois regarding the infrastructure requirements of section 110 of the Clean Air Act (CAA) for the 2012 annual fine particulate matter ($PM_{2.5}$) National Ambient Air Quality Standard (NAAQS or standard). The infrastructure requirements are designed to ensure that the structural components of each state's air quality management program are adequate to meet the state's responsibilities under the CAA. This action pertains specifically to infrastructure requirements in the Illinois SIP concerning interstate transport provisions.

DATES: This final rule is effective on July 22, 2019.

ADDRESSES: EPA has established a docket for this action under Docket ID No. EPA–R05–OAR–2017–0583. All documents in the docket are listed on the *www.regulations.gov* website. Although listed in the index, some information is not publicly available, *i.e.,* Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available either through *www.regulations.gov* or at the Environmental Protection Agency, Region 5, Air and Radiation Division, 77 West Jackson Boulevard, Chicago, Illinois 60604. This facility is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Samantha Panock, Environmental Scientist, Attainment Planning and Maintenance Section, Air Programs Branch (AR–18J), Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 353–8973, *panock.samantha@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document whenever ''we,'' ''us,'' or ''our'' is used, we mean EPA. This supplementary information section is arranged as follows:

I. What is being addressed by this document?
II. What comments did we receive on the proposed action?
III. What action is EPA taking?
IV. Statutory and Executive Order Reviews

I. What is being addressed by this document?

On September 29, 2017, the Illinois Environmental Protection Agency (IEPA) submitted a request to EPA for approval of its infrastructure SIP for the 2012 annual $PM_{2.5}$ NAAQS. On February 14, 2019, EPA proposed to approve the portion of the submission dealing with requirements one and two (otherwise known as ''prongs'' one and two) of the provision for interstate pollution transport under CAA section 110(a)(2)(D)(i), also known as the ''good neighbor'' provision.[1]

The September 29, 2017 IEPA submittal included a demonstration that Illinois' SIP contains sufficient major programs related to the interstate transport of pollution. Illinois' submittal also included a technical analysis of its interstate transport of pollution relative to the 2012 $PM_{2.5}$ NAAQS. This analysis demonstrated that current controls are adequate for Illinois to show that it meets prongs one and two of the ''good neighbor'' provision. After review, EPA proposed to approve Illinois' request relating to prongs one and two of the ''good neighbor'' provision.

II. What comments did we receive on the proposed action?

EPA's February 14, 2019 proposed rule provided a 30-day review and comment period (84 FR 4025). The comment period closed on March 18, 2019. EPA received one anonymous submission with supportive comments and one anonymous submission with adverse comments. The adverse comments and EPA's responses are addressed below.

Comment: The commenter asserts that EPA's approach to using only monitoring data to identify receptors for the purposes of evaluating interstate transport of $PM_{2.5}$ is ''long standing'' but is arbitrary and, thus, impermissible because EPA's approach ignores the fact that direct emissions of $PM_{2.5}$ can cause high local ambient concentrations in areas where there are no operating monitors.

Response: As described in the proposal, EPA has developed a consistent framework for addressing the prong one and two interstate transport requirements with respect to the $PM_{2.5}$ NAAQS in several previous Federal rulemakings. The four basic steps of that framework include: (1) Identifying downwind receptors that are expected to have problems attaining or maintaining the NAAQS; (2) identifying which upwind states contribute to these identified problems in amounts sufficient to warrant further review and analysis; (3) for states identified as contributing to downwind air quality problems, identifying upwind emissions reductions necessary to prevent an upwind state from significantly contributing to nonattainment or interfering with maintenance of the NAAQS downwind; and (4) for states that are found to have emissions that significantly contribute to nonattainment or interfere with maintenance of the NAAQS downwind, reducing the identified upwind emissions through adoption of permanent and enforceable measures. Regarding identifying potential nonattainment and/or maintenance receptors (*i.e.* step one of the framework), EPA relies primarily on existing monitoring sites and modeling to project $PM_{2.5}$ concentrations in future years. This approach to identifying potential receptors is consistent with how EPA determines whether an area is attaining or not attaining the $PM_{2.5}$ NAAQS. For the $PM_{2.5}$ NAAQS, determinations of attainment are based primarily on ambient data measured at ambient $PM_{2.5}$ Federal reference method (FRM) and Federal equivalent method (FEM) monitors. Although EPA sometimes considers other information for purposes of evaluating areas with sources that may contribute to monitored violations, the fundamental basis for evaluating attainment/nonattainment for a $PM_{2.5}$ NAAQS is the presence of one or more FRM or FEM monitors with data showing violations of the NAAQS. Similarly, for evaluating interstate $PM_{2.5}$ transport, the determination of whether there are downwind receptors that are expected to have problems attaining or maintaining the NAAQS is based on future year projections of ambient data

[1] There are four prongs to the Section 110(a)(2)(D)(i) ''good neighbor'' provision: (1) Prohibit any source or other type of emissions activity in one state from contributing significantly to nonattainment of the NAAQS in another state; (2) prohibit any source or other type of emissions activity in one state from interfering with maintenance of the NAAQS in another state; (3) prohibit any source or other type of emissions activity in one state from interfering with measures required to prevent significant deterioration (PSD) of air quality in another state; and (4) protect visibility in another state.

measured at the FRM and FEM monitors in the area in question. To develop data that may be useful for analyzing interstate transport with respect to the 2012 $PM_{2.5}$ NAAQS, EPA examined recent modeling analyses developed in support of other EPA rules to identify potential $PM_{2.5}$ nonattainment and maintenance receptors. The modeling was used to project design values for the 2012 annual $PM_{2.5}$ NAAQS to several future years for each ambient monitoring site. EPA believes this is a reasonable and consistent approach for addressing interstate transport for the 2012 $PM_{2.5}$ NAAQS, and the commenter has not provided any information that would cause EPA to change the approach in this action.

Comment: The commenter asserts that EPA guidance regarding interstate transport of $PM_{2.5}$ does not cite any AERMOD modeling of the impacts of direct emissions of $PM_{2.5,}$ and thus does not justify EPA's longstanding approach of ignoring this possibility. The commenter asserts that EPA should apply EPA's approach for evaluating interstate transport for the 1-hour SO_2 NAAQS, which the commenter states has in some cases examined the evidence regarding specific large, near-border sources of SO_2 emissions, to $PM_{2.5}$.

Response: The commenter asserts that EPA should apply EPA's approach for evaluating interstate transport for the 1-hour SO_2 NAAQS, which may include dispersion modeling using a model such as AERMOD. As described in the proposal, EPA has established a consistent framework for addressing the prong one and two interstate transport requirements with respect to the $PM_{2.5}$ NAAQS in several previous Federal rulemakings. As discussed in EPA's 2016 memorandum entitled ''Information on the Interstate Transport 'Good Neighbor' Provision for the 2012 Fine Particulate Matter National Ambient Air Quality Standards under Clean Air Act Section 110(a)(2)(D)(i)(I)'' (2016 memorandum), EPA and states have used a weight-of-evidence approach to assess $PM_{2.5}$ transport from a given state to a given downwind receptor location. A state's submission for this requirement should provide the technical information that the state deems appropriate to support its conclusions. Prior guidance and EPA SIP actions suggest that suitable information might include, but is not limited to, information concerning emissions in the state, meteorological conditions in the state and in potentially impacted states, monitored ambient pollutant concentrations in the state and in potentially impacted states, distances to the nearest areas not attaining the NAAQS in other states, and air quality modeling. In contrast, SO_2 is not a regional pollutant and does not commonly contribute to widespread nonattainment over a large (and often multi-state) area. Therefore, unlike for $PM_{2.5,}$ determinations of attainment or nonattainment for the SO_2 NAAQS may be based on monitoring data or dispersion modeling data (from air quality models such as AERMOD) or a combination of both. Therefore, EPA has adopted a different weight-of-evidence approach for SO_2 transport, which, when available, may include air dispersion modeling such as AERMOD in addition to other factors such as ambient monitoring data and source specific analyses. The fact that EPA has adopted an approach that has a different focus for purposes of evaluating SO_2 transport does not mean that approach is appropriate for evaluating interstate transport of a regional pollutant like $PM_{2.5}$. For these reasons, EPA believes its approach for addressing the good neighbor provision for the 2012 $PM_{2.5}$ NAAQS is reasonable and consistent with the nature of the interstate transport of $PM_{2.5}$ and its precursors. The commenter has not provided any information that would cause EPA to change its approach in this action.

Comment: The commenter asserts that EPA should disapprove Illinois' submission because the state has failed to provide any analysis to support the implicit assertion that no large sources of direct $PM_{2.5}$ emissions in Illinois and close to the border with another state are not causing or contributing to $PM_{2.5}$ NAAQS violations in the neighboring state. The commenter asserts that in the absence of any evidence there is transport problem due to direct emissions of $PM_{2.5,}$ EPA should not be applying a presumption of innocence. This is particularly true for Illinois, which has many sources that emit direct $PM_{2.5}$ (unlike some other states that mostly have sources that emit only $PM_{2.5}$ precursors).

Response: The EPA did not apply a presumption of innocence in evaluating Illinois' obligations under CAA section 110(a)(2)(D)(i)(I). Rather, EPA has used a weight-of-evidence approach to assess $PM_{2.5}$ transport from a given upwind state to a given downwind receptor location. The modeling discussed in the 2016 memorandum and referenced in the Illinois SIP considers both primary (directly emitted) $PM_{2.5}$ and precursor emissions, the different processes (*e.g.,* transport and deposition) that affect primary and secondary (*i.e.* formed by atmospheric processes) pollutants at scales and potential receptor locations that are consistent with determinations of attainment and nonattainment. Therefore, considering the weight of evidence, EPA has determined that the Illinois analysis is adequate for their transport SIP for the 2012 $PM_{2.5}$ NAAQS. The commenter does not provide any information that indicates inconsistency or inadequacy of EPA's approach in this action, nor of Illinois' submission, which EPA is approving through this action.

III. What action is EPA taking?

In this action, EPA is approving the portion of Illinois' September 29, 2017 submission certifying that the current Illinois SIP is sufficient to meet the required infrastructure requirements under CAA section 110(a)(2)(D)(i)(I), specifically prongs one and two, as set forth above.

IV. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the CAA and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- Is not an Executive Order 13771 (82 FR 9339, February 2, 2017) regulatory action because SIP approvals are exempted under Executive Order 12866;
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or

safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);

• Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);

• Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and

• Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications and will not impose substantial direct costs on tribal governments or preempt tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under CAA section 307(b)(1), petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by August 19, 2019. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See CAA section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Particulate matter, Reporting and recordkeeping requirements.

Dated: June 4, 2019.

Cheryl L Newton,

Acting Regional Administrator, Region 5.

40 CFR part 52 is amended as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

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

Authority: 42 U.S.C. 7401 *et seq.*

■ 2. In § 52.720, the table in paragraph (e) is amended under the heading ''Section 110(a)(2) Infrastructure Requirements'' by adding an entry at the end of the table for ''2012 $PM_{2.5}$ NAAQS Infrastructure Requirements'' to read as follows:

§ 52.720 Identification of plan.

* * * * *

(e) * * *

EPA-APPROVED ILLINOIS NONREGULATORY AND QUASI-REGULATORY PROVISIONS

Name of SIP provision	Applicable geographic or nonattainment area	State submittal date	EPA approval date	Comments
* *	*	*	* *	*
Section 110(a)(2) Infrastructure Requirements				
* *	*	*	* *	*
2012 $PM_{2.5}$ NAAQS Infrastructure Requirements.	Statewide	9/29/2017	6/20/2019, [Insert **Federal Register** citation].	Fully approving CAA transport requirements of (D)(i)(I).

[FR Doc. 2019–13033 Filed 6–19–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2018–0845; FRL–9994–34]

Melamine Formaldehyde Polycondensate Resin; Tolerance Exemption

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes an exemption from the requirement of a tolerance for residues of formaldehyde, reaction products with melamine; 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde; formaldehyde reaction products with melamine and methanol; and 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, methylated; collectively referred to as melamine formaldehyde polycondensate resin; when used as an inert ingredient in a pesticide chemical formulation. BASF Corporation submitted a petition to EPA under the Federal Food, Drug, and Cosmetic Act (FFDCA), requesting an exemption from the requirement of a tolerance. This regulation eliminates the need to establish a maximum permissible level for residues of formaldehyde, reaction products with melamine; 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde; formaldehyde reaction products with melamine and methanol; 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, methylated on food or feed commodities.

DATES: This regulation is effective June 20, 2019. Objections and requests for hearings must be received on or before August 19, 2019, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID) number EPA–HQ–OPP–2018–0845, is available at *http://www.regulations.gov*

or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW, Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OPP Docket is (703) 305–5805. Please review the visitor instructions and additional information about the docket available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT:

Michael Goodis, Registration Division (7505P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *RDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

B. How can I get electronic access to other related information?

You may access a frequently updated electronic version of 40 CFR part 180 through the Government Publishing Office's e-CFR site at *http://www.ecfr.gov/cgi-bin/text-idx?&c=ecfr&tpl=/ecfrbrowse/Title40/40tab_02.tpl.*

C. Can I file an objection or hearing request?

Under FFDCA section 408(g), 21 U.S.C. 346a, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. You must file your objection or request a hearing on this regulation in accordance with the instructions provided in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number EPA–HQ–OPP–2018–0845 in the subject line on the first page of your submission. All objections and requests for a hearing must be in writing, and must be received by the Hearing Clerk on or before August 19, 2019. Addresses for mail and hand delivery of objections and hearing requests are provided in 40 CFR 178.25(b).

In addition to filing an objection or hearing request with the Hearing Clerk as described in 40 CFR part 178, please submit a copy of the filing (excluding any Confidential Business Information (CBI)) for inclusion in the public docket. Information not marked confidential pursuant to 40 CFR part 2 may be disclosed publicly by EPA without prior notice. Submit the non-CBI copy of your objection or hearing request, identified by docket ID number EPA–HQ–OPP–2018–0845, by one of the following methods.

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be CBI or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets/contacts.html.* Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets.*

II. Background and Statutory Findings

In the **Federal Register** of March 18, 2019 (84 FR 9735) (FRL–9989–90), EPA issued a document pursuant to FFDCA section 408, 21 U.S.C. 346a, announcing the receipt of a pesticide petition (PP IN–11260) filed by BASF Corporation, 26 Davis Drive, Research Triangle Park, NC 27709. The petition requested that 40 CFR 180.960 be amended by establishing an exemption from the requirement of a tolerance for residues of formaldehyde, reaction products with melamine (CAS Reg. No. 94645–56–4); 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde (CAS Reg. No. 9003–08–1); formaldehyde reaction products with melamine and methanol (CAS Reg. No. 94645–53–1); 1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, methylated (CAS Reg. No. 68002–20–0). That document included a summary of the petition prepared by the petitioner and solicited comments on the petitioner's request. One comment was received on the notice of filing. EPA's response to these comments is discussed in Unit VIII.B.

Section 408(c)(2)(A)(i) of FFDCA allows EPA to establish an exemption from the requirement for a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the exemption is ''safe.'' Section 408(c)(2)(A)(ii) of FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and use in residential settings, but does not include occupational exposure. Section 408(b)(2)(C) of FFDCA requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing an exemption from the requirement of a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue . . .'' and specifies factors EPA is to consider in establishing an exemption.

III. Risk Assessment and Statutory Findings

EPA establishes exemptions from the requirement of a tolerance only in those cases where it can be shown that the risks from aggregate exposure to pesticide chemical residues under reasonably foreseeable circumstances will pose no appreciable risks to human health. In order to determine the risks from aggregate exposure to pesticide inert ingredients, the Agency considers the toxicity of the inert in conjunction with possible exposure to residues of the inert ingredient through food, drinking water, and through other exposures that occur as a result of pesticide use in residential settings. If EPA is able to determine that a finite tolerance is not necessary to ensure that there is a reasonable certainty that no harm will result from aggregate exposure to the inert ingredient, an exemption from the requirement of a tolerance may be established.

Consistent with FFDCA section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action and considered its validity, completeness and reliability and the relationship of this information to human risk. EPA has also considered available information concerning the

variability of the sensitivities of major identifiable subgroups of consumers, including infants and children. In the case of certain chemical substances that are defined as polymers, the Agency has established a set of criteria to identify categories of polymers expected to present minimal or no risk. The definition of a polymer is given in 40 CFR 723.250(b) and the exclusion criteria for identifying these low-risk polymers are described in 40 CFR 723.250(d). Melamine formaldehyde polycondensate resin conforms to the definition of a polymer given in 40 CFR 723.250(b) and meets the following criteria that are used to identify low-risk polymers.

1. The polymer is not a cationic polymer nor is it reasonably anticipated to become a cationic polymer in a natural aquatic environment.

2. The polymer does contain as an integral part of its composition at least two of the atomic elements carbon, hydrogen, nitrogen, oxygen, silicon, and sulfur.

3. The polymer does not contain as an integral part of its composition, except as impurities, any element other than those listed in 40 CFR 723.250(d)(2)(ii).

4. The polymer is neither designed nor can it be reasonably anticipated to substantially degrade, decompose, or depolymerize.

5. The polymer is manufactured or imported from monomers and/or reactants that are already included on the TSCA Chemical Substance Inventory or manufactured under an applicable TSCA section 5 exemption.

6. The polymer is not a water absorbing polymer with a number average molecular weight (MW) greater than or equal to 10,000 daltons.

7. The polymer does not contain certain perfluoroalkyl moieties consisting of a CF3- or longer chain length as listed in 40 CFR 723.250(d)(6).

Additionally, the polymer also meets as required the following exemption criteria specified in 40 CFR 723.250(e).

8. The polymer's number average MW of 10,000 is greater than or equal to 10,000 daltons. The polymer contains less than 2% oligomeric material below MW 500 and less than 5% oligomeric material below MW 1,000.

Thus, melamine formaldehyde polycondensate resin meet the criteria for a polymer to be considered low risk under 40 CFR 723.250. Based on its conformance to the criteria in this unit, no mammalian toxicity is anticipated from dietary, inhalation, or dermal exposure to melamine formaldehyde polycondensate resin.

IV. Aggregate Exposures

For the purposes of assessing potential exposure under this exemption, EPA considered that melamine formaldehyde polycondensate resin could be present in all raw and processed agricultural commodities and drinking water, and that non-occupational non-dietary exposure was possible. The number average MW of melamine formaldehyde polycondensate resin is 10,000 daltons. Generally, a polymer of this size would be poorly absorbed through the intact gastrointestinal tract or through intact human skin. Since melamine formaldehyde polycondensate resin conform to the criteria that identify a low-risk polymer, there are no concerns for risks associated with any potential exposure scenarios that are reasonably foreseeable. The Agency has determined that a tolerance is not necessary to protect the public health.

V. Cumulative Effects From Substances With a Common Mechanism of Toxicity

Section 408(b)(2)(D)(v) of FFDCA requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.''

EPA has not found melamine formaldehyde polycondensate resin to share a common mechanism of toxicity with any other substances, and melamine formaldehyde polycondensate resin does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has assumed that melamine formaldehyde polycondensate resin does not have a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see EPA's website at *http://www.epa.gov/pesticides/cumulative.*

VI. Additional Safety Factor for the Protection of Infants and Children

Section 408(b)(2)(C) of FFDCA provides that EPA shall apply an additional tenfold margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the data base unless EPA concludes that a different margin of safety will be safe for infants and children. Due to the expected low toxicity of melamine formaldehyde polycondensate resin, EPA has not used a safety factor analysis to assess the risk. For the same reasons the additional tenfold safety factor is unnecessary.

VII. Determination of Safety

Based on the conformance to the criteria used to identify a low-risk polymer, EPA concludes that there is a reasonable certainty of no harm to the U.S. population, including infants and children, from aggregate exposure to residues of melamine formaldehyde polycondensate resin.

VIII. Other Considerations

A. Analytical Enforcement Methodology

An analytical method is not required for enforcement purposes since the Agency is establishing an exemption from the requirement of a tolerance without any numerical limitation.

B. Response to Comments

One comment was received in response to the Notice of Filing, generally stating that exposure to pesticides needs to be decreased. The Agency recognizes that some individuals believe that pesticides should be limited or banned on agricultural crops. However, the existing legal framework provided by section 408 of the Federal Food, Drug and Cosmetic Act (FFDCA) states that tolerances may be set when persons seeking such tolerances or exemptions have demonstrated that the pesticide meets the safety standard imposed by that statute. This citizen's comment appears to be directed at the underlying statute and not EPA's implementation of it; the citizen has provided no information that would support a conclusion that these exemptions are not safe.

IX. Conclusion

Accordingly, EPA finds that exempting residues of melamine formaldehyde polycondensate resin from the requirement of a tolerance will be safe.

X. Statutory and Executive Order Reviews

This action establishes a tolerance under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled ''Regulatory Planning and Review'' (58 FR 51735, October 4, 1993). Because this action has been exempted from review under Executive Order 12866, this action is not subject to Executive Order 13211,

entitled ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) or Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997). This action does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), nor does it require any special considerations under Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), do not apply.

This action directly regulates growers, food processors, food handlers, and food retailers, not States or tribes, nor does this action alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4). As such, the Agency has determined that this action will not have a substantial direct effect on States or tribal governments, on the relationship between the national government and the States or tribal governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999) and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000) do not apply to this action. In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note).

XI. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: June 10, 2019.

Michael Goodis,

Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. In § 180.960, add alphabetically the polymers ''Formaldehyde, reaction products with melamine, minimum number average molecular weight (in amu), 10000''; ''Formaldehyde, reaction products with melamine and methanol, minimum number average molecular weight (in amu), 10000''; ''1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, minimum number average molecular weight (in amu), 10000''; and ''1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, methylated, minimum number average molecular weight (in amu), 10000'' to the table to read as follows:

§ 180.960 Polymers; exemptions from the requirement of a tolerance.

* * * * *

Polymer	CAS No.
* * * * * * *	
formaldehyde, reaction products with melamine, minimum number average molecular weight (in amu), 10000	94645–56–4
* * * * * * *	
formaldehyde, reaction products with melamine and methanol, minimum number average molecular weight (in amu), 10000	94645–53–1
* * * * * * *	
1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, minimum number average molecular weight (in amu), 10000	9003–08–1
* * * * * * *	
1,3,5-triazine-2,4,6-triamine, polymer with formaldehyde, methylated, minimum number average molecular weight (in amu), 10000	68002–20–0
* * * * * * *	

[FR Doc. 2019–12994 Filed 6–19–19; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1, 73, and 74

[AU Docket No. 17–329; DA 19–273]

Auction of Cross-Service FM Translator Construction Permits Scheduled for June 25, 2019; Notice and Filing Requirements, Minimum Opening Bids, Upfront Payments, and Other Procedures for Auction 100

AGENCY: Federal Communications Commission.

ACTION: Final action; requirements and procedures.

SUMMARY: This document summarizes procedures and announces upfront payment amounts and minimum opening bids for the auction of certain cross-service FM translator construction permits. The Public Notice summarized here is intended to familiarize applicants with the procedures and other requirements for participation in Auction 100.

DATES: Upfront payments are due on May 23, 2019. Bidding in Auction 100 is scheduled to start on June 25, 2019.

FOR FURTHER INFORMATION CONTACT: For auction legal questions, Lynne Milne in the Office of Economics and Analytics' Auctions Division at (202) 418–0660. For auction process and procedures, the FCC Auctions Hotline at (717) 338–2868. For FM translator service questions, James Bradshaw, Lisa Scanlan or Tom Nessinger in the Media Bureau's Audio Division at (202) 418–2700. To request materials in accessible formats (Braille, large print, electronic files, or audio format) for people with disabilities, send an email to *fcc504@fcc.gov* or call the Consumer and Governmental Affairs Bureau at (202) 418–0530 or (202) 418–0432 (TTY).

SUPPLEMENTARY INFORMATION: This is a summary of the *Auction 100 Procedures Public Notice,* released April 17, 2019. The complete text of the *Auction 100 Procedures Public Notice,* including attachments and any related document, is available for public inspection and copying from 8:00 a.m. to 4:30 p.m. Eastern Time (ET) Monday through Thursday or from 8:00 a.m. to 11:30 a.m. ET on Fridays in the FCC Reference Information Center, 445 12th Street SW, Room CY–A257, Washington, DC 20554. The *Auction 100 Procedures Public Notice* and related documents also are available on the internet at the Commission's website: *www.fcc.gov/auction/100,* or by using the search function for AU Docket No. 17–329 on the Commission's Electronic Comment Filing System (ECFS) web page at *https://www.fcc.gov/ecfs/*.

I. Background

1. Each applicant listed in Attachment A of the *Auction 100 Procedures Public Notice* previously filed a short-form application (FCC Form 175) during the initial filing window January 25–31, 2018, as an AM broadcaster seeking new cross-service FM translator construction permits. These applicants were previously given opportunities to eliminate their mutual exclusivity with other applicants' engineering proposals by settlement or technical modification to their proposals.

2. *Construction Permits and Entities Eligible to Participate in Auction 100.* Auction 100 will resolve by competitive bidding the remaining groups of mutually exclusive (MX) engineering proposals for FM translator construction permits. A list of the locations and channels of these proposed stations is included as Attachment A of the *Auction 100 Procedures Public Notice.* Attachment A also sets forth the names of applicants in each MX group, along with a minimum opening bid and an upfront payment amount for each construction permit in Auction 100.

3. Auction 100 is a closed auction; only those individual or entities listed in Attachment A of the *Auction 100 Procedures Public Notice* are eligible to complete the remaining steps to become qualified to bid in this auction. An applicant listed in Attachment A may become qualified to bid only if it conforms with the additional filing, qualification, and payment requirements, and otherwise complies with applicable rules, policies and procedures. Each listed applicant may become a qualified bidder only for those construction permits specified for that applicant in Attachment A of the *Auction 100 Procedures Public Notice.* Each of the engineering proposals within each MX group are directly mutually exclusive with one another; therefore, no more than one construction permit will be awarded for each MX group identified in Attachment A. Once mutually exclusive auction applications are accepted, and thus mutual exclusivity exists for auction purposes, an applicant cannot obtain a construction permit without placing a bid, even if no other applicant for that particular construction permit becomes qualified to bid or in fact places a bid.

4. Relevant Authority. Auction 100 applicants must familiarize themselves thoroughly with the Commission's general competitive bidding rules, including Commission decisions in proceedings regarding competitive bidding procedures (47 CFR part 1, subpart Q), application requirements, and obligations of Commission licensees. Broadcasters should also familiarize themselves with the Commission's FM translator service and competitive bidding requirements contained in 47 CFR parts 73 and 74, as well as Commission orders concerning competitive bidding for broadcast construction permits. Applicants must also be thoroughly familiar with the procedures, terms and conditions contained in the *Auction 100 Procedures Public Notice* and any future public notices that may be released in this proceeding.

5. The terms contained in the Commission's rules, relevant orders, and public notices are not negotiable. The Commission may amend or supplement the information contained in our public notices at any time and will issue public notices to convey any new or supplemental information to applicants. It is the responsibility of each applicant to remain current with all Commission rules and with all public notices pertaining to Auction 100.

6. *Prohibited Communications.* Starting at the deadline for filing a Form 175 on January 31, 2018, the rules prohibiting certain communications set forth in 47 CFR 1.2105(c) and 73.5002(d), (e) apply to each applicant that filed a Form 175 in Auction 100. Subject to specified exceptions, 47 CFR 1.2105(c)(1) provides that all applicants are prohibited from cooperating or collaborating with respect to, communicating with or disclosing, to each other in any manner the substance of their own, or each other's, or any other applicant's bids or bidding strategies (including post-auction market structure), or discussing or negotiating settlement agreements, until after the down payment deadline.

7. Thus, public disclosure of information relating to bids, bidding strategies, or to post-auction market structures may violate 47 CFR 1.2105(c). In accordance with 47 CFR 73.5002(e), the Wireless Telecommunications and Media Bureaus suspended for Auction 100 application of the prohibitions of 47 CFR 1.2105(c) and 73.5002(d) during specified periods for the limited purpose of allowing settlement discussions. Discussion of information covered by these rules outside of the settlement period would violate the rules.

8. *Entities Subject to Section 1.2105.* An applicant for purposes of this rule includes all officers and directors of the entity submitting the Form 175, all controlling interests in that entity, as

well as all holders of interests amounting to 10% or more of that entity. A party that submits an application becomes an applicant under the rule at the application deadline and that status does not change based on subsequent developments. Thus, an Auction 100 applicant that does not correct deficiencies in its application, fails to submit a timely and sufficient upfront payment, or does not otherwise become qualified to bid, remains an applicant for purposes of 47 CFR 1.2105(c) and remains subject to the prohibition on certain communications until the applicable down payment deadline.

9. *Scope of Prohibition on Communications; Prohibition on Joint Bidding Agreements.* The Commission in 2015 amended 47 CFR 1.2105(c) to extend the prohibition on communications to cover all applicants for an auction regardless of whether the applicants seek permits or licenses in the same geographic area or market. The Commission also now prohibits a joint bidding arrangement, including arrangements relating to the permits or licenses being auctioned that address or communicate, directly or indirectly, bids, bidding, or bidding strategies, including arrangements regarding price or the specific permits or licenses on which to bid, and any such arrangements relating to the post-auction market structure. The revised rule provides limited exceptions for a communication within the scope of any arrangement consistent with the exclusion from the Commission's rule prohibiting joint bidding, provided such arrangement is disclosed on the applicant's auction application. An applicant may continue to communicate pursuant to any pre-existing agreements, arrangements, or understandings that are solely operational or that provide for a transfer or assignment of license, provided that such agreements, arrangements or understandings do not involve the communication or coordination of bids (including amounts), bidding strategies, or the particular permits or licenses on which to bid and provided that such agreements, arrangements or understandings are disclosed on its application.

10. In recognition of the specific eligibility restrictions and filing procedures established by the Commission for the Auction 100 filing window, however, in the *Auction 100 Filing Instructions Public Notice,* the Bureaus waived for Auction 100 the provisions of section 1.2105(a)(3) to allow entities controlled by the same individual or set of individuals to file separate Forms 175. Some Auction 100 applicants under common control filed separate Forms 175 relying on the waiver of section 1.2105(a)(3).

11. In this public notice, Auction 100 applicants were reminded that the Commission presumes, due to the definition of an auction applicant contained in 47 CFR 1.2105(c), that bidding strategies are communicated between entities that share a common officer or director. Moreover, current rules bar most kinds of joint bidding agreements, including agreements for certain communication between commonly controlled entities or other auction applicants. Further, when there is a disclosable interest holder or holders for more than one Form 175 in the same auction, section 1.2105(a)(2)(x) requires that each such Form 175 include a certification that internal controls have been implemented that preclude any individual acting on behalf of an Auction 100 applicant from possessing information about the bids or bidding strategies, including post-auction market structure, of more than one Auction 100 applicant or communicating such information to anyone possessing such information regarding another Auction 100 applicant.

12. *Section 1.2105(c) Certification.* By electronically submitting its Form 175, each applicant in Auction 100 certified its compliance with 47 CFR 1.2105(c) and 73.5002(d). However, the mere filing of a certifying statement as part of an application will not outweigh specific evidence that a prohibited communication has occurred, nor will it preclude the initiation of an investigation when warranted. Any applicant found to have violated these communication prohibitions may be subject to sanctions.

13. *Reporting Requirements.* According to 47 CFR 1.2105(c)(4), any applicant that makes or receives a communication that appears to violate 47 CFR 1.2105(c) must report such communication in writing to the Commission immediately, and in no case later than five business days after the communication occurs. Each applicant's obligation under 47 CFR 1.2105(c)(4) to report any such communication continues beyond the five-day period after the communication is made, even if the report is not made within the five-day period.

14. *Procedures for Reporting Prohibited Communications.* Any report required by 47 CFR 1.2105(c) must be filed consistent with the instructions set forth in the *Auction 100 Procedures Public Notice*. For Auction 100, a party must file only a single report concerning a prohibited communication and the report must be filed with the Chief of the Auctions Division, Office of Economics and Analytics (OEA), by the most expeditious means available. Any such report should be submitted by email to Margaret W. Wiener at the following email address: *auction100@fcc.gov.* Any such report submitted in hard copy must be delivered only to: Margaret W. Wiener, Chief, Auctions Division, OEA, FCC, 445 12th Street SW, Washington, DC 20554.

15. A party reporting any communication pursuant to 47 CFR 1.65, 1.2105(a)(2), or 1.2105(c)(4) must take care to ensure that any report of a prohibited communication does not itself give rise to a violation of 47 CFR 1.2105(c). For example, a party's report of a prohibited communication could violate the rule by communicating prohibited information to other applicants through the use of Commission filing procedures that would allow such materials to be made available for public inspection, such as, a submission to the Commission's Office of the Secretary or ECFS. A party seeking to report such a prohibited communication should consider submitting its report with a request that the report or portions of the submission be withheld from public inspection by following the procedures specified in 47 CFR 0.459. Such parties also are encouraged to coordinate with the Auctions Division staff about the procedures for submitting such reports.

16. *Winning Bidders Must Disclose Terms of Agreements.* Each applicant that is a winning bidder will be required to disclose in its long-form application the specific terms, conditions, and parties involved in any agreement it has entered into. This applies to any bidding consortia, joint venture, partnership, or agreement, understanding, or other arrangement entered into relating to the competitive bidding process, including any agreement relating to the post-auction market structure. Failure to comply with the Commission's rules can result in enforcement action.

17. Compliance with Antitrust Laws. Conduct that is permissible under the Commission's rules may be prohibited by antitrust laws. Regardless of compliance with the Commission's rules, applicants remain subject to the antitrust laws. Compliance with the disclosure requirements of 47 CFR 1.2105(c) will not insulate a party from enforcement of the antitrust laws. To the extent the Commission becomes aware of specific allegations that suggest that violations of the federal antitrust laws may have occurred, the Commission

may refer such allegations to the U.S. Department of Justice for investigation. If an applicant is found to have violated the antitrust laws or the Commission's rules in connection with its participation in the competitive bidding process, it may be subject to forfeiture of its upfront payment, down payment, or full bid amount and may be prohibited from participating in future auctions, among other sanctions.

18. *Due Diligence.* Each potential bidder is solely responsible for investigating and evaluating all technical and marketplace factors that may have a bearing on the value of the cross-service FM translator construction permits that it is seeking in Auction 100. The FCC makes no representations or warranties about the use of this spectrum or these construction permits for particular services. Applicants should be aware that an FCC auction represents an opportunity to become an FCC permittee in a broadcast service, subject to certain conditions and regulations. An FCC auction does not constitute an endorsement by the FCC of any particular service, technology, or product, nor does an FCC construction permit or license constitute a guarantee of business success.

19. An applicant should perform its due diligence research and analysis before proceeding, as it would with any new business venture. In particular, each potential bidder is strongly encouraged to perform technical analyses and/or refresh its previous analyses to assure itself that, should it become a winning bidder for any Auction 100 construction permit, it will be able to build and operate facilities that will fully comply with all applicable technical and legal requirements. Each applicant is strongly encouraged to inspect any prospective transmitter sites located in, or near, the service area for which it plans to bid, confirm the availability of such sites, and to familiarize itself with the Commission's rules regarding the National Environmental Policy Act, 47 CFR part 1, subpart I.

20. Each applicant is strongly encouraged to continue to conduct its own research throughout Auction 100 in order to determine the existence of pending or future administrative or judicial proceedings that might affect its decision on continued participation in Auction 100. Each Auction 100 applicant is responsible for assessing the likelihood of the various possible outcomes and for considering the potential impact on construction permits available in Auction 100. These due diligence considerations do not comprise an exhaustive list of steps that should be undertaken prior to participating in Auction 100. As always, the burden is on the potential bidder to determine how much research to undertake, depending upon specific facts and circumstances related to its interests.

21. Applicants are solely responsible for identifying associated risks and for investigating and evaluating the degree to which such matters may affect their ability to bid on, otherwise acquire, or make use of the construction permits available in Auction 100. Each potential bidder is responsible for undertaking research to ensure that any permits won in Auction 100 will be suitable for its business plans and needs. Each potential bidder must undertake its own assessment of the relevance and importance of information gathered as part of its due diligence efforts.

22. The Commission makes no representations or guarantees regarding the accuracy or completeness of information in its databases or any third party databases, including, for example, court docketing systems. Furthermore, the Commission makes no representations or guarantees regarding the accuracy or completeness of information that has been provided by incumbent licensees and incorporated into its databases. To the extent the Commission's databases may not include all information deemed necessary or desirable by an applicant, it must obtain or verify such information from independent sources or assume the risk of any incompleteness or inaccuracy in said databases.

23. *Use of Auction Systems.* The Commission makes no warranty whatsoever with respect to the FCC auction application system and the auction bidding system. In no event shall the Commission, or any of its officers, employees, or agents, be liable for any damages whatsoever (including, but not limited to, loss of business profits, business interruption, loss of business information, or any other loss) arising out of or relating to the existence, furnishing, functioning, or use of the FCC auction systems that are accessible to qualified bidders in connection with Auction 100. Moreover, no obligation or liability will arise out of the Commission's technical, programming, or other advice or service provided in connection with the FCC auction systems.

II. Short-Form Application Requirements

24. *Maintaining Current Information in Forms 175.* Each Auction 100 applicant has a duty pursuant to 47 CFR 1.65 and 1.2105(b) to continuously maintain the accuracy and completeness of all information furnished in its pending application and in competitive bidding proceedings to furnish additional or corrected information to the Commission within 5 days of a significant occurrence, or to amend a Form 175 no more than 5 days after the applicant becomes aware of the need for the amendment.

25. *Minor Modifications to Forms 175.* After the initial application filing deadline on January 31, 2018, an Auction 100 applicant is permitted to make only minor changes to its application consistent with the Commission's rules. Permissible minor changes include, among other things, deletion and addition of authorized bidders (to a maximum of three) and revision of addresses and telephone numbers of the applicant, its responsible party, or its contact person. Pursuant to 47 CFR 1.2105(b), minor amendments include any changes that are not major, such as correcting typographical errors or supplying and correcting information as requested to support certifications made in the application.

26. In this context, major amendments to a Form 175 include a change of technical proposal, change in control of the applicant (*e.g.,* certain changes in ownership or control that would constitute an assignment or transfer of control of the applicant), change in claimed bidding credit eligibility to a higher percentage of bidding credit, change in required certifications, change in the applicant's legal classification that results in a change of control, or change in the identification of the application's proposed facilities as noncommercial educational after the initial application filing deadline. If revised or updated information constitutes a major amendment as defined by section 1.2105, such changes will not be accepted and may result in dismissal of the application. Even if an applicant's Form 175 is dismissed, the applicant would remain subject to the prohibitions on certain communications of 47 CFR 1.2105(c) until the down payment deadline for Auction 100.

27. Submission of Updates to Forms 175. Updates to Forms 175 should be made electronically using the FCC auction application system whenever possible. For the change to be submitted and considered by the Commission, be sure to click on the SUBMIT button.

28. An applicant should not use the auction application system outside of the initial and resubmission filing windows to make changes to its Form 175 for other than administrative

changes (*e.g.,* changing contact information). After the filing window has closed, the system will not permit applicants to modify information in most of the application's data fields.

29. If changes need to be made outside of the initial and resubmission filing windows for other than the minor administrative changes as described, the applicant must submit a letter briefly summarizing the changes and subsequently update its Form 175 in the auction application system once it is available. Any letter describing changes to an applicant's Form 175 must be addressed to Margaret W. Wiener, Chief, Auctions Division, OEA, and submitted by email to *auction100@fcc.gov*. The email summarizing the changes must include a subject or caption referring to Auction 100 and the name of the applicant, for example, ''Re: Changes to Auction 100 Short-Form Application of ABC Corp.'' Parties should format any attachments to email as Adobe® Acrobat® (pdf) or Microsoft® Word documents. Questions about Form 175 amendments should be directed to the Auctions Division at (202) 418–0660.

30. Applicants must not submit application-specific material through the Commission's ECFS.

31. Submission of a Form 175 (and any amendments thereto) constitutes a representation by the person certifying the application that he or she is an authorized representative of the applicant with authority to bind the applicant, that he or she has read the form's instructions and certifications, and that the contents of the application, its certifications, and any attachments are true and correct. Submission of a false certification to the Commission is a serious matter that may result in severe penalties, including monetary forfeitures, license revocations, exclusion from participation in future auctions, and/or criminal prosecution.

32. *Provisions Regarding Former and Current Defaulters.* Current defaulters or delinquents are not eligible to participate in Auction 100, but former defaulters or delinquents can participate so long as they are otherwise qualified and make upfront payments that are 50% more than would otherwise be necessary. An applicant is considered a current defaulter or a current delinquent when it, any of its affiliates (as defined in 47 CFR 1.2110), any of its controlling interests (as defined in 47 CFR 1.2105(a)(4)(i)), or any of the affiliates of its controlling interests, is in default on any payment for any Commission construction permit or license (including a down payment) or is delinquent on any non-tax debt owed to any Federal agency as of the filing deadline for Forms 175 in that auction.

33. Thus, an auction applicant must certify under penalty of perjury on its Form 175 that it, its affiliates, its controlling interests, and the affiliates of its controlling interests, were not in default on any payment for a Commission construction permit or license (including down payments) and not delinquent on any non-tax debt owed to any Federal agency. Accordingly, if an applicant had an outstanding non-tax debt to the Commission or any other Federal agency, including any debt that resulted in a listing of the applicant on the Commission's Red Light Display System, the applicant would have been unable to make the required certification that it is not currently in default; if so, such applicant will not be eligible to participate in the bidding for Auction 100.

34. An applicant is considered a former defaulter or a former delinquent when the applicant or any of its controlling interests has defaulted on any Commission construction permit or license or has been delinquent on any non-tax debt owed to any Federal agency, but has since remedied all such defaults and cured all of the outstanding non-tax delinquencies prior to the Form 175 filing deadline in Auction 100. Each Auction 100 applicant must certify under penalty of perjury whether it, along with any of its controlling interests (as defined in 47 CFR 1.2105(a)(4)(i)), has ever been in default on any payment for a Commission construction permit or license (including a down payment) or has ever been delinquent on any non-tax debt owed to any Federal agency. If an applicant or any controlling interest is a former defaulter or former delinquent, the applicant may participate further in Auction 100 so long as it is otherwise qualified and that applicant makes an upfront payment that is 50% more than would otherwise be required.

35. In 2015, the Commission narrowed the scope of the individuals and entities to be considered a former defaulter or a former delinquent. For purposes of the certification under 47 CFR 1.2105(a)(2)(xii), the applicant may exclude from consideration any cured default on a Commission construction permit or license or any cured delinquency on a non-tax debt owed to a Federal agency for which any of the following criteria are met: (1) The notice of the final payment deadline or delinquency was received more than seven years before the Form 175 filing deadline; (2) the default or delinquency amounted to less than $100,000; (3) the default or delinquency was paid within six months after receiving the notice of the final payment deadline or delinquency; or (4) the default or delinquency was the subject of a legal or arbitration proceeding and was cured upon resolution of the proceeding.

36. Applicants are encouraged to review previous guidance on default and delinquency disclosure requirements in the context of the auction Form 175 process. For example, it has been determined that, to the extent that Commission rules permit late payment of regulatory or application fees accompanied by late fees, such debts will become delinquent for purposes of 47 CFR 1.2105(a) and 1.2106(a) only after the expiration of a final payment deadline. Therefore, with respect to regulatory or application fees, the provisions of 47 CFR 1.2105(a) and 1.2106(a) regarding default and delinquency in connection with competitive bidding are limited to circumstances in which the relevant party has not complied with a final payment deadline. Parties are encouraged to consult with the Auctions Division staff if they have any questions about default and delinquency disclosure requirements.

37. The FCC considers outstanding debts owed to the U.S. Government, in any amount, to be a serious matter. The FCC adopted rules that implement its obligations under the Debt Collection Improvement Act of 1996, including a provision referred to as the red light rule. The FCC's competitive bidding rules with regard to current and former defaults or delinquencies, including the provisions and certifications of 47 CFR 1.2105 and 1.2106, are not affected by the red light rule.

38. The FCC's Red Light Display System, which provides information regarding debts currently owed to the FCC, may not be determinative of an auction applicant's ability to comply with the default and delinquency disclosure requirements of 47 CFR 1.2105. Thus, while the red light rule ultimately may prevent the processing of long-form applications by auction winners, an auction applicant's lack of current red light status is not necessarily determinative of its eligibility to participate in an auction (or whether it will have an increased upfront payment obligation).

39. Moreover, applicants in Auction 100 should note that any long-form applications filed after the close of bidding will be reviewed for compliance with the Commission's red light rule, and such review may result in the dismissal of a winning bidder's long-form application. Each applicant is

strongly encouraged to carefully review all records and other available federal agency databases and information sources to determine whether the applicant, or any of its affiliates, or any of its controlling interests, or any of the affiliates of its controlling interests, currently owes or was ever delinquent in the payment of non-tax debt owed to any federal agency. An applicant that has its long-form application dismissed will be deemed to have defaulted and will be subject to default payments under 47 CFR 1.2104(g) and 1.2109(c).

III. Preparing for Bidding

40. *Tutorial.* A bidding procedures tutorial is available in the Education section of the Auction 100 website and will remain accessible for reference.

41. *Correction of Application Deficiencies.* An applicant whose application is found to contain deficiencies will be provided with a limited opportunity to bring its application into compliance with the Commission's competitive rules during a resubmission window, the dates for which will be announced in a future public notice. Commission staff will communicate only with an applicant's contact person or certifying official, as designated on the Form 175, unless the applicant's certifying official or contact person notifies the Commission in writing that applicant's counsel or other representative is authorized to speak on its behalf. Authorizations may be sent by email to *auction100@fcc.gov*.

42. *Deadline for Upfront Payments.* In order to become eligible to bid in Auction 100, a sufficient upfront payment must be submitted by wire transfer to the FCC's account for Auction 100 at the U.S. Treasury before 6:00 p.m. ET on May 23, 2019, following the instructions in Attachment B to the *Auction 100 Procedures Public Notice,* together with submission to the FCC of a complete and accurate FCC Remittance Advice Form (FCC Form 159). After completing its short-form application, an applicant will have access to an electronic version of the Form 159. This Form 159 can be printed, and the completed form must be sent by fax to the FCC at (202) 418–2843, or by email to *RROGWireFaxes@fcc.gov*.

43. *Upfront Payments and Bidding Eligibility.* Applicants must make upfront payments sufficient to obtain bidding eligibility on the construction permit(s) on which they will bid. The amount of the applicant's upfront payment will determine a bidder's initial bidding eligibility, the maximum number of bidding units on which a bidder may place bids in any single round. In order to bid on a particular construction permit, otherwise qualified bidders that are designated in Attachment A of the *Auction 100 Procedures Public Notice* for that construction permit, must have a current eligibility level that meets or exceeds the number of bidding units assigned to that construction permit. At a minimum, therefore, an applicant's total upfront payment must be enough to establish eligibility to bid on at least one of the construction permits designated for that applicant in Attachment A of the *Auction 100 Procedures Public Notice,* or else the applicant will not be eligible to participate in the auction. An applicant does not have to make an upfront payment to cover all construction permits designated for that applicant in Attachment A of the *Auction 100 Procedures Public Notice,* but only enough to cover the maximum number of bidding units that are associated with construction permits on which they wish to place bids and hold provisionally winning bids in any given round. The total upfront payment does not affect the total dollar amount the bidder may bid on any given construction permit.

44. In Auction 100, the upfront payment amount determines a bidder's initial bidding eligibility, The specific upfront payment amount and bidding units for each construction permit are set forth in Attachment A of the *Auction 100 Procedures Public Notice*. In calculating its upfront payment amount, an applicant should determine the maximum number of bidding units on which it may wish to be active (bid on or hold provisionally winning bids on) in any single round, and submit an upfront payment amount covering that number of bidding units. In order to make this calculation, an applicant should add together the bidding units for all construction permits on which it seeks to be active in any given round. Applicants should check their calculations carefully as there is no provision for increasing a bidder's eligibility after the upfront payment deadline.

45. Applicants that are former defaulters must pay upfront payments 50% greater than non-former defaulters. For this classification as a former defaulter or a former delinquent, defaults and delinquencies of the applicant itself and its controlling interests are included. For this purpose, the term controlling interest is defined in 47 CFR 1.2105(a)(4)(i). As required by 47 CFR 1.2106(a), if an applicant is a former defaulter, it must calculate its upfront payment for all of its construction permits by multiplying the number of bidding units on which it wishes to be active by 1.5. In order to calculate the number of bidding units to assign to former defaulters, the Commission will divide the upfront payment received by 1.5 and round the result up to the nearest bidding unit. If a former defaulter fails to submit a sufficient upfront payment to establish eligibility to bid on at least one of the construction permits designated for that applicant in Attachment A of the *Auction 100 Procedures Public Notice,* the applicant will not be eligible to participate further in the auction. This applicant will retain its status as an applicant in Auction 100 and will remain subject to 47 CFR 1.2105(c) and 73.5002(d).

46. *Qualified Bidder Classification.* Only qualified bidders are permitted to bid. A qualified bidder is an applicant identified in Attachment A of the *Auction 100 Procedures Public Notice,* with a submitted Form 175 that is found to be timely filed, accurate, and substantially complete (*i.e.* substantially complies with the Commission's competitive bidding rules and other applicable Commission rules, as well as the procedures and deadlines set forth in the *Auction 100 Procedures Public Notice,* provided that such applicant has timely submitted an upfront payment following the procedures and instructions set forth in Attachment B to the *Auction 100 Procedures Public Notice* and that is sufficient for at least one of the construction permits for which it is designated as an applicant in Attachment A.

47. *Auction Registration.* All qualified bidders are automatically registered for the auction. Registration materials will be distributed prior to the auction by overnight mail. For security purposes, the mailing will be sent only to the contact person at the contact address listed in the Form 175 and will include the SecurID® tokens that will be required to place bids, an FCC assigned username (User ID) for each authorized bidder, the bidding system web address and instructions for accessing and logging in to the auction bidding system, and the telephonic bidding telephone number.

48. Qualified bidders that do not receive this registration mailing will not be able to submit bids. Therefore, if this mailing is not received by noon on June 19, 2019, the contact listed on that applicant's Form 175 must call the Auctions Hotline at (717) 338–2868. Receipt of the registration mailing is critical to participating in the auction, and each applicant is responsible for

ensuring it has received all of the registration materials.

49. In the event that SecurID® tokens are lost or damaged, only a person who has been designated as an authorized bidder, contact, or certifying official on the applicant's Form 175 may request replacements. To request replacement of these items, call the Auction Bidder Line at the telephone number provided in the registration materials or the Auction Hotline at (717) 338–2868.

50. Each authorized bidder must have its own SecurID® token, which the Commission will provide at no charge. Each applicant with one authorized bidder will be issued two SecurID® tokens, while applicants with two or three authorized bidders will be issued three tokens. Each SecurID® token is tailored to a specific auction.

51. *Mock Auction.* All qualified bidders will be eligible to participate in a mock auction on Friday, June 21, 2019. The mock auction will enable bidders to become familiar with the FCC auction bidding system and to practice submitting bids prior to the auction. All qualified bidders, including all authorized bidders, are strongly encouraged to participate in the mock auction.

IV. Auction Structure

52. *Simultaneous Multiple Round Auction.* The Commission's standard simultaneous multiple-round auction format will be used for Auction 100. This type of auction offers every construction permit for bid at the same time and consists of successive bidding rounds in which qualified bidders may place bids on individual construction permits. Unless otherwise announced, bids will be accepted on all construction permits in each round of the auction until bidding stops on every construction permit.

53. *Eligibility and Activity Rules.* For Auction 100, the amount of the upfront payment submitted by a bidder determines initial bidding eligibility, the maximum number of bidding units on which a bidder may be active. Each construction permit is assigned a specific number of bidding units as listed in Attachment A of the *Auction 100 Procedures Public Notice*. Bidding units assigned to each construction permit do not change as prices rise during the auction. Upfront payments are not attributed to specific construction permits. Rather, a bidder may place bids on any of the construction permits for which it is designated an applicant in Attachment A of the *Auction 100 Procedures Public Notice* as long as the total number of bidding units associated with those construction permits does not exceed its current eligibility. Eligibility cannot be increased during the auction; it can only remain the same or decrease. Thus, in calculating its upfront payment amount and therefore its initial bidding eligibility, an applicant must determine the maximum number of bidding units on which it may wish to bid or hold provisionally winning bids in any single round, and submit an upfront payment amount covering that total number of bidding units. At a minimum, an applicant's upfront payment must cover the bidding units for at least one of the construction permits for which it is designated an applicant in Attachment A in the *Auction 100 Procedures Public Notice*. The total upfront payment does not affect the total dollar amount a bidder may bid on any given construction permit.

54. To ensure that an auction closes within a reasonable period of time, an activity rule requires bidders to bid actively throughout the auction, rather than wait until late in the auction before participating. Bidders are required to be active on a specific percentage of their current bidding eligibility during each round of the auction.

55. A bidder's activity level in a round is the sum of the bidding units associated with construction permits covered by the bidder's new bids in the current round and provisionally winning bids from the previous round. A provisionally winning bid is a bid that would become a final winning bid if the auction were to close after the given round.

56. In Auction 100, a bidder is required to be active on 100% of its current eligibility during each round of the auction. That is, a bidder must either place a bid or be a provisionally winning bidder during each round of the auction. Failure to maintain the requisite activity level will result in the use of an activity rule waiver, if any remain, or a reduction in the bidder's eligibility, possibly curtailing or eliminating the bidder's ability to place additional bids in the auction.

57. *Activity Rule Waivers.* In Auction 100, each bidder is provided with three activity rule waivers. Bidders may use an activity rule waiver in any round during the course of the auction. Use of an activity rule waiver preserves the bidder's eligibility despite its activity in the current round being below the required minimum activity level. An activity rule waiver applies to an entire round of bidding, not to a particular construction permit. Activity rule waivers can be either proactive or automatic. Activity rule waivers are principally a mechanism for a bidder to avoid the loss of bidding eligibility in the event that exigent circumstances prevent it from bidding in a particular round.

58. The FCC auction bidding system will assume that a bidder that does not meet the activity requirement would prefer to use an activity rule waiver (if available) rather than lose bidding eligibility. Therefore, the system will automatically apply a waiver at the end of any bidding round in which a bidder's activity level is below the minimum required unless (1) the bidder has no activity rule waivers remaining or (2) the bidder overrides the automatic application of a waiver by reducing eligibility, thereby meeting the activity requirement. If a bidder has no waivers remaining and does not satisfy the required activity level, the bidder's current eligibility will be permanently reduced, possibly curtailing or eliminating the ability to place additional bids in the auction.

59. A bidder with insufficient activity may wish to reduce its bidding eligibility rather than use an activity rule waiver. If so, the bidder must affirmatively override the automatic waiver mechanism during the bidding round by using the reduce eligibility function in the FCC auction bidding system. In this case, the bidder's eligibility would be permanently reduced to bring it into compliance with the Auction 100 activity rule. Reducing eligibility is an irreversible action; once eligibility has been reduced, a bidder cannot regain its lost bidding eligibility.

60. Also, a bidder may apply an activity rule waiver proactively as a means to keep the auction open without placing a bid. If a bidder proactively were to apply an activity rule waiver (using the proactive waiver function in the FCC auction bidding system) during a bidding round in which no bid is placed, the auction will remain open and the bidder's eligibility will be preserved. An automatic waiver applied by the FCC auction bidding system in a round in which there is no new bid or a proactive waiver will not keep the auction open.

61. *Auction Stopping Rule.* For Auction 100, a simultaneous stopping rule approach will be employed, which means all construction permits remain available for bidding until bidding stops on every construction permit. Specifically, bidding will close on all construction permits after the first round in which no bidder submits any new bid or applies a proactive waiver.

62. Alternative versions of the simultaneous stopping procedure also may be employed for Auction 100. (1) The auction would close for all

construction permits after the first round in which no bidder applies a waiver or places any new bid on a construction permit for which it is not the provisionally winning bidder. Thus, absent any other bidding activity, a bidder placing a new bid on a construction permit for which it is the provisionally winning bidder would not keep the auction open under this modified stopping rule. (2) The auction would close for all construction permits after the first round in which no bidder applies a proactive waiver or places any new bid on a construction permit that already has a provisionally winning bid. Thus, absent any other bidding activity, a bidder placing a new bid on an FCC-held construction permit (a construction permit that does not have a provisionally winning bid) would not keep the auction open under this modified stopping rule. (3) The auction would close using a modified version of the simultaneous stopping rule that combines options (1) and (2). (4) The auction would close after announcement of a specified number of additional rounds (special stopping rule). If this special stopping rule is invoked, bids in the specified final round(s) will be accepted, after which the auction will close. (5) The auction would remain open even if no bidder places any new bids or applies a waiver. In this event, the effect will be the same as if a bidder had applied a waiver. The activity rule will apply as usual, and a bidder with insufficient activity will either lose bidding eligibility or use a waiver.

63. These options will be exercised only in certain circumstances. For example, where the auction is proceeding unusually slowly or quickly, there is minimal overall bidding activity, or it appears likely that the auction will not close within a reasonable period of time or will close prematurely. Before exercising these options, it is likely that there will be an attempt to change the pace of the auction, such as, changing the number of bidding rounds per day and/or the minimum acceptable bids. The Media Bureau (MB) and OEA retain the discretion to exercise any of these options with or without prior announcement during the auction.

64. *Auction Delay, Suspension or Cancellation.* By public notice and/or by announcement through the FCC auction bidding system, bidding in Auction 100 may be delayed, suspended, or cancelled in the event of natural disaster, technical obstacle, administrative or weather necessity, evidence of an auction security breach or unlawful bidding activity, or for any other reason that affects the fair and efficient conduct of competitive bidding. In such cases, MB and OEA, in their sole discretion, may elect to resume the auction starting from the beginning of the current round or from some previous round, or cancel the auction in its entirety. Network interruption may cause delay or suspension of the auction. MB and OEA will exercise this authority solely at their discretion, and not as a substitute for situations in which bidders may wish to apply their activity rule waivers.

V. Bidding Procedures

65. *Round Structure.* The initial schedule of bidding rounds will be announced in the public notice listing the qualified bidders, which is released at least one week before the start of bidding in the auction. Each bidding round is followed by the release of round results. Multiple bidding rounds may be conducted each day. Moreover, unless otherwise announced, bidding on all construction permits will be conducted on each business day until bidding has stopped on all construction permits. MB and OEA retain the discretion to change the bidding schedule, and may change the amount of time for the bidding rounds, the amount of time between rounds, or the number of rounds per day, depending upon bidding activity and other factors.

66. *Reserve Price and Minimum Opening Bids.* Normally, a reserve price is an absolute minimum price below which a construction permit or license will not be sold in a specific auction. There are no reserve prices for construction permits in Auction 100.

67. A minimum opening bid is the minimum bid price set at the beginning of the auction below which no bids are accepted. The specific minimum opening amount adopted for each construction permit is listed in Attachment A to the *Auction 100 Procedures Public Notice.*

68. *Bid Amounts.* If the qualified bidder has sufficient eligibility to place a bid on a particular construction permit, a bidder will be able to place a bid on a given construction permit in any of up to 9 different amounts. The FCC auction bidding system interface will list the 9 acceptable bid amounts for each construction permit. For calculation of the 9 acceptable bid amounts for each construction permit, Auction 100 will begin with a minimum acceptable bid increment percentage of 10% and an additional bid increment percentage of 5%.

69. In Auction 100, the minimum acceptable bid amount for a construction permit will be equal to its minimum opening bid amount until there is a provisionally winning bid for the construction permit. After there is a provisionally winning bid for a construction permit, the minimum acceptable bid amount will be calculated by multiplying the provisionally winning bid amount by one plus the minimum acceptable bid percentage—*i.e.,* provisionally winning bid amount * 1.10, rounded using the Commission's standard rounding procedures for auctions as described in the *Auction 100 Procedures Public Notice*.

70. In Auction 100, the FCC auction bidding system will calculate the 8 additional bid amounts by multiplying the minimum acceptable bid amount by the additional bid increment percentage of 5%, and that result (rounded) is the additional increment amount. The first additional acceptable bid amount equals the minimum acceptable bid amount plus the additional increment amount. The second additional acceptable bid amount equals the minimum acceptable bid amount plus two times the additional increment amount; the third additional acceptable bid amount is the minimum acceptable bid amount plus three times the additional increment amount; etc. Because the additional bid increment percentage is 5%, the calculation of the additional increment amount is (minimum acceptable bid amount) * (0.05), rounded. The first additional acceptable bid amount equals (minimum acceptable bid amount) + (additional increment amount); the second additional acceptable bid amount equals (minimum acceptable bid amount) + (2 * (additional increment amount)); the third additional acceptable bid amount equals (minimum acceptable bid amount) + (3 * (additional increment amount)); etc.

71. MB and OEA retain the discretion to change bid amounts, including the minimum acceptable bid amounts, the minimum acceptable bid percentage, the additional bid increment percentage, and the number of acceptable bid amounts if MB and OEA determine that circumstances so dictate. Further, MB and OEA retain the discretion to do so on a construction permit-by-construction permit basis. MB and OEA also retain the discretion to limit (a) the amount by which a minimum acceptable bid for a construction permit may increase compared with the corresponding provisionally winning bid, and (b) the amount by which an additional bid amount may increase compared with the immediately preceding acceptable bid amount. For example, MB and OEA could set a $1,000 limit on increases in minimum

acceptable bid amounts over provisionally winning bids. Thus, if calculating a minimum acceptable bid using the minimum acceptable bid percentage results in a minimum acceptable bid amount that is $1,200 higher than the provisionally winning bid on a construction permit, the minimum acceptable bid amount would instead be capped at $1,000 above the provisionally winning bid. If MB and OEA exercise this discretion to change bid amounts, they will alert bidders by announcement in the FCC auction bidding system during the auction.

72. *Provisionally Winning Bids.* The FCC auction bidding system at the end of each bidding round will determine a provisionally winning bid for each construction permit based on the highest bid amount received for that permit. A provisionally winning bid will remain the provisionally winning bid until there is a higher bid on the same construction permit at the close of a subsequent round. Provisionally winning bids at the end of the auction become the winning bids. Provisionally winning bids count toward activity for purposes of the activity rule.

73. The FCC auction bidding system, using a pseudo-random number generator, will assign a pseudo-random number to each bid upon submission. In the event of identical high bid amounts being submitted on a construction permit in a given round (*i.e.,* tied bids), the tied bid with the highest random number wins the tiebreaker, and becomes the provisionally winning bid. The remaining bidders, as well as the provisionally winning bidder, can submit higher bids in subsequent rounds. However, if the auction were to close with no other bids being placed, the winning bidder would be the one that placed the provisionally winning bid. If the construction permit receives any bids in a subsequent round, the provisionally winning bid again will be determined by the highest bid amount received for the construction permit.

74. *Remote Electronic Bidding.* The Commission will conduct Auction 100 remotely over the internet using the FCC auction bidding system, and telephonic bidding will be available as well. There will be no on-site bidding during Auction 100. Telephonic bid assistants are required to use a script when entering bids placed by telephone. Telephonic bidders are reminded to allow sufficient time to bid by placing their calls well in advance of the close of a round. The length of a call to place a telephonic bid may vary; please allow a minimum of 10 minutes. All telephone calls are recorded.

75. An Auction 100 bidder's ability to bid on specific construction permits is determined by two factors: (1) The construction permits designated for that applicant in Attachment A of the *Auction 100 Procedures Public Notice* and (2) the bidder's eligibility in that a bidder must have sufficient eligibility to place a bid on a particular construction permit. The bid submission screens will allow bidders to submit bids on only those construction permits designated for that applicant in Attachment A.

76. In order to access the bidding function of the FCC auction bidding system, bidders must be logged in during the bidding round using the passcode generated by the SecurID® token and a personal identification number (PIN) created by the bidder. Bidders are strongly encouraged to print a round summary for each round after they have completed all of their activity for that round.

77. In each round, if a qualified bidder has sufficient eligibility for a particular construction permit, that bidder will be able to place bids on a given construction permit in any of up to 9 pre-defined bid amounts. For each construction permit, the FCC auction bidding system will list the acceptable bid amounts in a drop-down box. Bidders use the drop-down box to select from among the acceptable bid amounts. The FCC auction bidding system also includes an upload function that allows text files containing bid information to be uploaded.

78. Until a bid has been placed on a construction permit, the minimum acceptable bid amount for that permit will be equal to its minimum opening bid amount. Once there are bids on a permit, minimum acceptable bids for the following round will be determined as described in the *Auction 100 Procedures Public Notice.*

79. During a round, an eligible bidder may submit bids for as many construction permits as it wishes (providing that it is eligible to bid on the specific permits), remove bids placed in the current bidding round, or permanently reduce eligibility. If multiple bids are submitted for the same construction permit in the same round, the system takes the last bid entered as that bidder's bid for the round. Bidding units associated with construction permits for which the bidder has removed bids do not count towards current activity.

80. *Bid Removal and Bid Withdrawal.* In the FCC auction bidding system, each qualified bidder has the option of removing any bids placed in a round provided that such bids are removed before the close of that bidding round. By removing a bid within a round, a bidder effectively unsubmits the bid. A bidder removing a bid placed in the same round is not subject to withdrawal payments. Removing a bid will affect a bidder's activity because a removed bid no longer counts toward bidding activity for the round. Once a round closes, a bidder may no longer remove a bid.

81. In Auction 100, bidders are prohibited from withdrawing any bid after close of the round in which that bid was placed. Bidders are cautioned to select bid amounts carefully because no bid withdrawals will be allowed, even if a bid was mistakenly or erroneously made.

82. *Round Results.* Reports reflecting bidders' identities for Auction 100 will be available before and during the auction. Thus, bidders will know in advance of Auction 100 the identities of the bidders against which they are bidding.

83. Bids placed during a round will not be made public until the conclusion of that round. After a round closes, reports will be compiled of all bids placed, current provisionally winning bids, new minimum acceptable bid amounts for the following round, whether the construction permit is FCC-held, and bidder eligibility status (bidding eligibility and activity rule waivers). These reports will be posted for public access.

84. *Auction Announcements.* The Commission will use auction announcements to report necessary information such as schedule changes. All auction announcements will be available by clicking a link in the FCC auction bidding system.

VI. Post-Auction Procedures

85. Shortly after bidding has ended, the Commission will issue a public notice declaring the auction closed, identifying the winning bidders, and establishing the deadlines for submitting down payments, final payments, and long-form applications.

86. *Down Payments.* As required by 47 CFR 1.2107(b), within 10 business days after release of the auction closing public notice, each winning bidder must submit sufficient funds (in addition to its upfront payment) to bring its total amount of money on deposit with the Commission for Auction 100 to 20% of the net amount of its winning bids (gross bids less any applicable new entrant bidding credit).

87. *Final Payments.* As required by 1.2109(a), each winning bidder will be required to submit the balance of the net amount for each of its winning bids within ten business days after the

applicable deadline for submitting down payments.

88. *Long-Form Applications.* Section 73.5005(a) provides that within 30 days following the close of bidding and notification to winning bidders, unless a longer period is specified by public notice, winning bidders must electronically submit a properly completed long-form application (FCC Form 349, Application for Authority to Construct or Make Changes in an FM Translator or FM Booster Station) and required exhibits for each construction permit won through Auction 100.

89. As required by 47 CFR 1.1104, a winning bidder in a commercial broadcast spectrum auction must submit an application filing fee with its post-auction long-form application. When an application filing fee is due by Auction 100 winning bidders, the amount may be higher or lower than the $835 currently specified at 47 CFR 1.1104. See also 47 CFR 1.2107(c).

90. Further instructions on these and other filing requirements will be provided to winning bidders in the auction closing public notice. An Auction 100 applicant that has its long-form application dismissed will be deemed to have defaulted and will be subject to default payments under 47 CFR 1.2104(g) and 1.2107(c).

91. *Default and Disqualification.* Any winning bidder that defaults or is disqualified after the close of the auction (*i.e.,* fails to remit the required down payment by the specified deadline, fails to submit a timely long-form application, fails to make a full and timely final payment, or is otherwise disqualified) is liable for default payments as described in 47 CFR 1.2104(g)(2). This payment consists of a deficiency payment, equal to the difference between the amount of the Auction 100 bidder's winning bid and the amount of the winning bid the next time a construction permit covering the same spectrum is won in an auction, plus an additional payment equal to a percentage of the defaulter's bid or of the subsequent winning bid, whichever is less. The percentage of the applicable bid to be assessed as an additional payment for a default in Auction 100 is 20% of the applicable bid.

92. In the event of a default, the Commission has the discretion to re-auction the construction permit or offer it to the next highest bidder (in descending order) at its final bid amount. In addition, if a default or disqualification involves gross misconduct, misrepresentation, or bad faith by an applicant, the Commission may declare the applicant and its principals ineligible to bid in future auctions, and may take any other action that it deems necessary, including institution of proceedings to revoke any existing authorizations held by the applicant.

93. *Refund of Remaining Upfront Balance.* All refunds of upfront payment balances will be returned to the payer of record as identified on the Form 159 unless the payer submits written authorization instructing otherwise. This written authorization must comply with the refund instructions in the *Auction 100 Procedures Public Notice*.

VII. Procedural Matters

94. *Paperwork Reduction Act.* This document does not contain new or modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13, nor does it contain any new or modified information burden for small business concerns with fewer than 25 employees pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198. See 44 U.S.C. 3506(c)(4).

95. *Congressional Review Act.* The Commission will send a copy of this *Auction 100 Procedures Public Notice* to Congress and the Government Accountability Office pursuant to the Congressional Review Act. See 5 U.S.C. 801(a)(1)(A).

96. *Supplemental Final Regulatory Flexibility Act Analysis.* As required by the Regulatory Flexibility Act of 1980, as amended (RFA), 5 U.S.C. 601–612, the FCC prepared Initial Regulatory Flexibility Analyses (IRFAs) in connection with the Broadcast Competitive Bidding Notice of Proposed Rulemaking (NPRM) and other FCC NPRMs (collectively Competitive Bidding NPRMs) pursuant to which Auction 100 will be conducted. Final Regulatory Flexibility Analyses (FRFAs) likewise were prepared in the Broadcast Competitive Bidding Order and other FCC orders (collectively Broadcast Competitive Bidding Orders) pursuant to which Auction 100 will be conducted. In this proceeding, a Supplemental Initial Regulatory Flexibility Analysis (Supplemental IRFA) was incorporated in the *Auction 100 Comment Public Notice,* 83 FR 56031, Nov 9, 2018. The FCC sought written public comment on the proposals in the *Auction 100 Comment Public Notice,* including comments on the Supplemental IRFA. This Supplemental FRFA supplements the FRFAs in the Broadcast Competitive Bidding Orders to reflect the actions taken in the *Auction 100 Procedures Public Notice* and conforms to the RFA.

97. *Need for, and Objectives of, the Public Notice.* The procedures for the conduct of Auction 100 as described in the *Auction 100 Procedures Public Notice* implement the Commission's competitive bidding rules which have been adopted by the FCC in multiple notice-and-comment rulemaking proceedings. More specifically, the *Auction 100 Procedures Public Notice* provides an overview of the procedures, terms and conditions governing Auction 100 and the post-auction application and payment processes, as well as setting the minimum opening bid amount for each of the cross-service FM translator construction permits that are subject to being assigned by competitive bidding.

98. To promote the efficient and fair administration of the competitive bidding process for all Auction 100 participants, including small businesses, the Office of Economics and Analytics (OEA), in conjunction with the Media Bureau (MB), in the *Auction 100 Procedures Public Notice* announce the following procedures: (1) Use of a simultaneous multiple-round auction format, consisting of sequential bidding rounds with a simultaneous stopping procedure (with discretion by MB and OEA to exercise alternative stopping rules under certain circumstances); (2) a specific minimum opening bid amount for each construction permit available in Auction 100; (3) a specific number of bidding units for each construction permit; (4) establishment of a bidder's initial bidding eligibility in bidding units based on that bidder's upfront payment through assignment of a specific number of bidding units for each construction permit; (5) so that bidders must bid actively during the auction rather than waiting until late in the auction before participating, Auction 100 is a single stage auction in which a bidder is required to be active on 100% of its bidding eligibility in each round of the auction; (6) provision of three activity waivers for each qualified bidder to allow it to preserve bidding eligibility during the course of the auction; (7) use of minimum acceptable bid amounts and additional acceptable increments, along with a proposed methodology for calculating such amounts, with MB and OEA retaining discretion to change their methodology if circumstances dictate; (8) a procedure for breaking ties if identical high bid amounts are submitted on one permit in a given round; (9) a prohibition on bid withdrawals in Auction 100; and (10) establishment of an additional default payment of 20% under 47 CFR

1.2104(g)(2) in the event that a winning bidder defaults or is disqualified after the auction.

99. *Summary of Significant Issues Raised by Public Comments in Response to the IRFA.* There were no comments filed that specifically addressed the procedures and policies proposed in the Supplemental IFRA. In fact, no comments were filed in this proceeding after release of the *Auction 100 Comment Public Notice.*

100. *Response to Comments by the Chief Counsel for Advocacy of the Small Business Administration.* Pursuant to the Small Business Jobs Act of 2010, which amended the RFA, the FCC is required to respond to any comment filed by the Chief Counsel for Advocacy of the Small Business Administration (SBA), and to provide a detailed statement of any change made to the proposed procedures as a result of those comments, 5 U.S.C. 604(a)(3). The Chief Counsel did not file any comments in response to the procedures that were proposed in the *Auction 100 Comment Public Notice.* The FCC will send a copy of this *Auction 100 Procedures Public Notice,* including this Supplemental FRFA, to the Chief Counsel for Advocacy of the SBA pursuant to 5 U.S.C. 604(b).

101. *Description and Estimate of the Number of Small Entities to Which the Proposed Procedures Will Apply.* The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the rules adopted herein. The RFA generally defines the term small entity as having the same meaning as the terms small business, small organization, and small governmental jurisdiction. In addition, the term small business has the same meaning as the term small business concern under the Small Business Act. A small business concern is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA, 15 U.S.C. 632.

102. Auction 100 is a closed auction; therefore, the specific competitive bidding procedures and minimum opening bid amounts described in the *Auction 100 Procedures Public Notice* will affect at a maximum only the 23 individuals or entities listed in Attachment A of the *Auction 100 Procedures Public Notice* and who are the only parties eligible to complete the remaining steps to become qualified to bid in Auction 100. These specific 23 individuals or entities listed in Attachment A include firms of all sizes.

103. *Radio Stations.* This Economic Census category comprises establishments primarily engaged in broadcasting aural programs by radio to the public. Programming may originate in their own studio, from an affiliated network, or from external sources. The SBA has established a small business size standard for this category as firms having $38.5 million or less in annual receipts. Economic Census data for 2012 shows that 2,849 radio station firms operated during that year. Of that number, 2,806 firms operated with annual receipts of less than $25 million per year, 17 with annual receipts between $25 million and $49,999,999 and 26 with annual receipts of $50 million or more. Therefore, based on the SBA's size standard the majority of such entities are small entities.

104. According to Commission staff review of the BIA/Kelsey, LLC's Media Access Pro Radio Database as of September 6, 2018, about 11,024 (or about 99.92%) of 11,033 commercial radio stations had revenues of $38.5 million or less and thus qualify as small entities under the SBA definition. The SBA size standard data does not enable MB and OEA to make a meaningful estimate of the number of small entities who may participate in Auction 100. There are a maximum of 23 individuals or entities that may become qualified bidders in Auction 100, in which applicant eligibility is closed. The specific procedures and minimum opening bid amounts announced in the *Auction 100 Procedures Public Notice* will affect directly all applicants participating in Auction 100.

105. MB and OEA are unable to accurately develop an estimate of how many of these 23 individuals or entities are small businesses based on the number of small entities that applied to participate in prior broadcast auctions, because that information is not collected from applicants for broadcast auctions in which bidding credits are not based on an applicant's size (as is the case in auctions for wireless service licenses). Due to the eligibility criteria established by the FCC, potential bidders in Auction 100 may include only existing holders of broadcast station construction permits or licenses. In 2013, the FCC estimated that 97% of radio broadcasters met the SBA's prior definition of small business concern, based on annual revenues of $7 million. The SBA has since increased that revenue threshold to $38.5 million, which suggests that an even greater percentage of radio broadcasters would fall within the SBA's definition. Based on FCC staff review of the BIA/Kelsey, LLC's Media Access Pro Radio Database, 4,626 (99.94%) of 4,629 a.m. radio stations have revenue of $38.5 million or less. Accordingly, based on this data, MB and OEA conclude that the majority of Auction 100 bidders will likely meet the SBA's definition of a small business concern.

106. In assessing whether a business entity qualifies as small under the SBA definition, business control affiliations must be included. This estimate therefore likely overstates the number of small entities that might be affected by Auction 100 because the revenue figure on which it is based does not include or aggregate revenues from affiliated companies. Moreover, the definition of small business also requires that an entity not be dominant in its field of operation and that the entity be independently owned and operated. The estimate of small businesses to which Auction 100 competitive bidding requirements may apply does not exclude any radio station from the definition of a small business on these bases and is therefore over-inclusive to that extent. Furthermore, it is not possible at this time to define or quantify the criteria that would establish whether a specific radio station is dominant in its field of operation. In addition, given the difficulty in assessing these criteria in the context of media entities, these estimates of small businesses to which they apply may be over-inclusive.

107. *Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities.* As articulated in a 1994 rulemaking order, the FCC designed the auction application process itself to minimize reporting and compliance requirements for applicants, including small business applicants. For all spectrum auctions, in the first part of the Commission's two-phased auction application process, parties desiring to participate in an auction file streamlined short-form applications in which they certify under penalty of perjury as to their qualifications. Eligibility to participate in bidding is based on an applicant's short-form application and certifications, as well as its upfront payment.

108. To become qualified to bid in Auction 100, applicants, including small entities, must submit a Form 175 that is timely and is found to be substantially complete and submit an upfront payment that is timely and sufficient for at least one of the construction permits for which it is designated as an applicant on the Public Notice's Attachment A. The submission of the upfront payment must comply with the instructions provided in the

public notice. As established by the Commission in a 1994 rulemaking order and in accordance with the terms of 47 CFR 1.2105(b)(2), an applicant whose application is found to contain deficiencies will have a limited opportunity to bring its application into compliance with the Commission's competitive bidding rules during a resubmission window. As required by 47 CFR 1.65 and 1.2105(b), each Auction 100 applicant must maintain the accuracy of its previously filed Form 175. As required by 47 CFR 1.1111, each upfront payment must be accompanied by a Form 159.

109. In the second phase of the process, there are additional compliance requirements only applicable to winning bidders. As with other winning bidders, any small entity that is a winning bidder will be required to comply with the terms of: (1) 47 CFR 1.2107(b) by submitting as a down payment within 10 business days after release of the auction closing public notice sufficient funds (in addition to its upfront payment) to bring its total amount of money on deposit with the FCC for Auction 100 to 20% of the net amount of its winning bid(s), a requirement adopted by the FCC in a 1994 rulemaking order; (2) 47 CFR 1.2109(a) by submitting within 10 business days after the down payment deadline the balance of the net amount for each of its winning bids, a requirement adopted by the FCC in a 1994 rulemaking order; and (3) 47 CFR 73.5005(a) by filing electronically within 30 days following release of the closing public notice, unless a longer period is specified by public notice, a properly completed long-form application and required exhibits for each construction permit won through Auction 100, a requirement adopted by the FCC for broadcast auction winning bidders in a 1998 rulemaking order.

110. As required by 47 CFR 1.2105(c), reports concerning a prohibited communication must be filed with the Chief of the Auctions Division, as detailed in the *Auction 100 Procedures Public Notice.*

111. *Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered.* The RFA requires an agency to describe any significant, specifically small business, alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): (1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance and reporting requirements under the rule for such small entities; (3) the use of performance rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for such small entities. See 5 U.S.C. 603(c)(1)–(4).

112. MB and OEA anticipate that the steps taken to make numerous resources available to small entities and other auction participants at no cost should minimize any economic impact of the auction processes and procedures on small entities and should result in both operational and administrative cost savings for small entities and other auction participants. For example, prior to the beginning of bidding in Auction 100, the FCC will hold a mock auction to allow eligible bidders the opportunity to familiarize themselves with both the processes and systems that will be utilized in Auction 100. During the auction, participants will be able to access and participate in bidding via the internet using a web-based system, or telephonically, providing two cost effective methods of participation and avoiding the cost of travel for in-person participation. Further, small entities as well as other auction participants will be able to avail themselves of a telephonic hotline for assistance with auction processes and procedures as well as a technical support hotline to assist with issues such as access to or navigation within the electronic Form 175 and use of the FCC's auction bidding system. In addition, all auction participants, including small business entities, will have access to various other sources of information and databases through the Commission that will aid in both their understanding and participation in the process. These resources, coupled with the description and communication of the bidding procedures before bidding begins in Auction 100, should ensure that the auction will be administered predictably, efficiently and fairly, thus providing certainty for small entities as well as other auction participants.

Federal Communications Commission.

Gary Michaels,

Deputy Chief, Auctions Division, Office of Economics and Analytics.

[FR Doc. 2019–13100 Filed 6–19–19; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 76

[MB Docket Nos. 07–42 and 17–105; FCC 19–52]

Leased Commercial Access; Modernization of Media Regulation Initiative

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Commission updates its leased access rules as part of its Modernization of Media Regulation Initiative. First, the Commission vacates its *2008 Leased Access Order,* which never went into effect due to a stay by the U.S. Court of Appeals for the Sixth Circuit and the Office of Management and Budget issuance of a notice of disapproval of the associated information collection requirements. Second, the Commission adopts certain updates and improvements to its existing leased access rules.

DATES: Effective July 22, 2019, except for §§ 76.970(h) and 76.975(e), which are delayed. The Commission will publish a document in the **Federal Register** announcing the effective date.

FOR FURTHER INFORMATION CONTACT: For additional information on this proceeding, contact Diana Sokolow, *Diana.Sokolow@fcc.gov,* of the Policy Division, Media Bureau, (202) 418–2120.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, FCC 19–52, adopted on June 6, 2019 and released on June 7, 2019. The full text is available for public inspection and copying during regular business hours in the FCC Reference Center, Federal Communications Commission, 445 12th Street SW, Room CY–A257, Washington, DC 20554. This document will also be available via ECFS at *http://fjallfoss.fcc.gov/ecfs/.* Documents will be available electronically in ASCII, Microsoft Word, and/or Adobe Acrobat. Alternative formats are available for people with disabilities (Braille, large print, electronic files, audio format), by sending an email to *fcc504@fcc.gov* or calling the Commission's Consumer and Governmental Affairs Bureau at (202) 418–0530 (voice), (202) 418–0432 (TTY).

Synopsis

1. In the Report and Order, we update our leased access rules as part of the

Commission's Modernization of Media Regulation Initiative. The leased access rules, which implement the statutory leased access requirements, direct cable operators to set aside channel capacity for commercial use by unaffiliated video programmers.[1] In 2018, the Commission adopted a Further Notice of Proposed Rulemaking (FNPRM) addressing leased access proposals filed in response to the *Media Modernization Public Notice.* With this proceeding, we continue our efforts to modernize media regulations and remove unnecessary requirements that can impede competition and innovation in the media marketplace.

2. The video marketplace has changed significantly since the Commission initially adopted its leased access rules. Specifically, today a wide variety of media platforms are available to programmers, including in particular online platforms that creators can use to distribute their content for free. This change has reduced the importance of leased access and, thus, the justification for burdensome leased access requirements.

3. Below, first we adopt the FNPRM's tentative conclusion that we should vacate the Commission's *2008 Leased Access Order.*[2] That order never went into effect due to a stay by the U.S. Court of Appeals for the Sixth Circuit (Sixth Circuit) and the Office of Management and Budget (OMB) issuance of a notice of disapproval of the associated information collection requirements. Second, we adopt certain updates and improvements to our existing leased access rules.

4. *Vacating the 2008 Leased Access Order.* We adopt the FNPRM's tentative conclusion that we should vacate the *2008 Leased Access Order,* including the Further Notice of Proposed Rulemaking issued in conjunction with that order. We conclude that this approach, which cable operators support, is consistent with our public interest objectives and is the most practical and legally tenable option available to us. Specifically, vacating the prior order will clarify the status of our leased access regime, further the Commission's media modernization efforts, and obviate the need to address the significant legal concerns raised in the related Sixth Circuit proceeding and OMB Notice.[3]

5. By vacating the *2008 Leased Access Order,* we are resolving the longstanding challenges to the order that have been pending for more than a decade due to the stay of this order.[4] Vacating the *2008 Leased Access Order* will not have any impact on any party's compliance with or expectations concerning the leased access requirements, because the rule changes contained in that order never went into effect.[5] Accordingly, as a result of our decision today, except for the rule changes set forth below, parties simply will remain subject to the same leased access rules they were operating under prior to 2008.

6. Vacating the *2008 Leased Access Order* is consistent with the Commission's media modernization efforts, pursuant to which we seek to remove rules that are outdated or no longer justified by market realities. As commenters point out, implementing the *2008 Leased Access Order* would have made leased access significantly more burdensome for cable operators, which would be contrary to the highly competitive marketplace in existence today. For example, NCTA explains that implementing the 2008 order ''would have changed the formula for establishing the maximum permissible rate for leased access in a manner that would have resulted in rates approaching zero.'' We agree with commenters that in today's marketplace the appropriate course is to ease, rather than increase, regulatory burdens associated with leased access and that the Commission should not have leased access regulations where the maximum allowable rates approach zero. Indeed, as discussed below, today we find that certain rule changes are needed to provide cable operators with relief from their existing leased access burdens because the burdens are no longer justified in today's marketplace, given the increased distribution alternatives for leased access programmers. While we recognize that some leased access programmers have expressed a preference for leased access via cable as compared to alternatives such as online programming distribution, we are persuaded that these alternatives have developed into a viable substitute for leased access today. In addition, we note that easing the regulatory burdens associated with leased access will effectuate the statutory requirement to implement rules ''in a manner consistent with the growth and development of cable systems.''

7. We disagree with commenters claiming that the Commission should ''adopt the parts [of the *2008 Leased Access Order*] that are not subject to OMB or Sixth Circuit . . . scrutiny and either staff review or issue a FNPRM to address the issues of concern to the OMB and the Appeals Court.''[6] The FNPRM sought comment on whether there is ''any policy justification for retaining any particular rules adopted'' in the *2008 Leased Access Order.* Commenters advocating the retention of all portions of the *2008 Leased Access Order* ''that are not subject to OMB or Sixth Circuit . . . scrutiny'' do not explain with sufficient specificity which rules from the *2008 Leased Access Order* should go into effect and why they are justified today. We believe that vacating the entire order and proceeding anew is preferable to commenters' suggested piecemeal approach.

8. *Modifying the Leased Access Rules.* We next adopt certain updates and improvements to our existing leased access rules. It is our goal to modernize our leased access regulations given the significant changes in the video marketplace, including specifically the availability of online media platforms. We stated in the FNPRM that this proceeding would ''advance our efforts to modernize our media regulations and remove unnecessary requirements that can impede competition and innovation

[1] The leased access rules are in subpart N of part 76, which was listed in the *Media Modernization Public Notice* as one of the principal rule parts that pertains to media entities and that is the subject of the media modernization review.

[2] Federal Communications Commission, Leased Commercial Access, 73 FR 10675 (final rule), 10732 (proposed rule) (Feb. 28, 2008).

[3] Because we vacate the *2008 Leased Access Order,* we also dismiss as moot the related NCTA FCC Stay Request, which asked the Commission to stay the *2008 Leased Access Order,* and the TVC Recon Petition, which sought reconsideration of the *2008 Leased Access Order.*

[4] Vacating the *2008 Leased Access Order* eliminates the need to move forward with the judicial proceedings currently pending in the Sixth Circuit. The Sixth Circuit Stay Order, which has been in effect for over a decade, recognized ''that NCTA has raised some substantial appellate issues'' pertaining to the rules adopted in the *2008 Leased Access Order.* Similarly, vacating the *2008 Leased Access Order* eliminates the need to overcome OMB's denial of the information collection requirements associated with major portions of the *2008 Leased Access Order.* OMB detailed the ways in which certain requirements adopted in the *2008 Leased Access Order* were inconsistent with the PRA, including the Commission's failure to demonstrate the need for the more burdensome requirements adopted, its failure to demonstrate that it had taken reasonable steps to minimize the burdens, and its failure to provide reasonable protection for proprietary and confidential information.

[5] We need not make any modifications to our rules to reflect our vacating of the *2008 Leased Access Order* because the leased access rules that are currently in effect, and that currently appear in the Code of Federal Regulations, are those that were in existence prior to the *2008 Leased Access Order.*

[6] We also reject LAPA's request that the Commission adopt customer service standards akin to those in the *2008 Leased Access Order,* finding instead that the contact information requirement we adopt below is sufficient at this time and appropriately balances the burdens on cable operators with the needs of leased access programmers.

in the media marketplace.'' We find that the benefits of updating our leased access rules to reflect the current video marketplace outweigh the anticipated costs.

9. *Part-Time Leased Access.* We eliminate the requirement that cable operators make leased access available on a part-time basis. Instead, our leased access rules will apply only to leased access programmers that purchase channel capacity on a full-time basis [7] for at least a one-year contract term. The Commission's rules currently direct ''[c]able operators that have not satisfied their statutory leased access requirements [to] accommodate part-time leased access requests,'' but there is no statutory requirement for part-time leased access. And, contrary to SBN's suggestion ''that part-time access is the 'genuine outlet' Congress sought to promote with the leased access statute,'' the legislative history does not mention part-time leased access. Further, we are persuaded by comments that because part-time leased access is regulatory, and not statutory, we should seek to avoid unnecessary burdens in light of possible First Amendment concerns.[8] In response to the FNPRM's request for further comment on this topic,[9] cable operators support elimination of the part-time leased access requirement.

10. We find that eliminating part-time leased access is consistent with marketplace changes. Since the Commission adopted the rule governing part-time leased access in 1993, the available platforms to distribute programming have multiplied, including in particular internet options. At the same time, the part-time leased access requirement has continued to apply to cable operators, and the record indicates that those operators do not usually generate enough revenue from part-time leased access programming to cover the administrative costs of providing such programming.[10] Even in the *1997 Leased Access Order,* the Commission ''recognize[d] that part-time leasing is not expressly required by the statute, that it may impose additional administrative and other costs on cable operators, and that it may pose the risk of capacity being under-used.'' Unlike in 1997, when the Commission affirmed its rule requiring cable operators to lease time in 30-minute increments, however, our decision today reflects the fact that the internet has developed into a flourishing means of distribution for short-form programming. SBN claims that the focus of leased access should be providing diverse information sources to cable subscribers. Eliminating part-time leased access, however, will not prevent leased access programmers from reaching all households with internet access, including the households of cable subscribers. We find that the costs of mandating part-time leased access to provide programming to the small portion of the population without internet access but with cable television outweighs the benefits. While we recognize the interest of leased access programmers in maintaining part-time leased access,[11] we are persuaded that the costs to cable providers associated with accommodating part-time leased access outweigh any countervailing benefits, especially given the plethora of alternative distribution options for such programming and the applicable First Amendment concerns.[12] To the extent that any cable operator wishes to carry programming on a part-time basis, it may negotiate such carriage as a private contractual matter, outside the scope of the leased access statute.

11. Because leased access will only occur on a full-time basis going forward, we delete section 76.970(h) of our rules, which currently addresses the maximum commercial leased access rate for part-time channel placement. Current § 76.970(i) and (j) will be redesignated as § 76.970(h) and (i). We also delete the reference to part-time leased access rates in current section 76.970(i)(1)(ii) (redesignated section 76.970(h)(1)(ii)), and we delete section 76.971(a)(4), which sets forth the current requirements for accommodating part-time leased access.[13]

12. *Bona Fide Requests.* We adopt the proposal set out in the FNPRM to ease burdens on cable operators by revising

[7] Leasing of a channel on a full-time basis will require that the channel is under the exclusive use of the programmer for the term of the contract.

[8] SBN argues that there is no speech-related distinction between part-time access and full-time access, and thus the First Amendment concerns cannot be used to ban the former but not the latter. As an initial matter, as described above, our elimination of part-time leased access is sufficiently supported by policy justifications that are independent of our First Amendment concerns. In addition, we proceed here incrementally by eliminating the part-time leased access rules that impose speech burdens that are not required by statute. In the related Second FNPRM, we seek further comment on whether the statutory leased access requirements continue to withstand First Amendment scrutiny.

[9] SBN is incorrect when it claims that the FNPRM did not provide sufficient notice of the elimination of part-time leased access. First, the FNPRM specifically sought comment on new rules governing part-time leased access. In response, commenters urged the Commission to adopt new rules that would no longer require cable operators to make leased access available on a part-time basis. We adopt such rules today, but permit existing part-time commercial leased access agreements to remain in place under their current terms. Cable operators have the discretion to negotiate future part-time agreements as a private contractual matter. Second, our new rules regarding part-time leased access are a logical outgrowth of the Commission's request for comment on ''whether our rules implicate First Amendment interests.'' Finally, any argument regarding lack of notice is refuted by the fact that leased access programmers themselves opposed the elimination of part-time leased access in their initial comments.

[10] These administrative costs include such matters as negotiating contracts and sending invoices, which cost the same for part-time leased access as for full-time leased access. SBN asserts that rather than eliminating part-time leased access, we should ''revise the pricing rules in accordance with Section 612(c)(1) to cover the[] costs'' that part-time leased access imposes on cable operators. We disagree that this is the appropriate course. We find that in light of the other platforms now available to distribute part-time programming, there is no longer a sufficient policy justification for part-time leased access. We also are mindful that simply adjusting the price that cable operators may charge for part-time leased access would not address the First Amendment concerns that it presents.

[11] SBN states that the ''Report and Order does not address the effect of the abandonment of the part-time leasing regime on part-time programmers, most of whom (like SBN) are small businesses.'' In the Final Regulatory Flexibility Analysis, we analyze the potential impact of the rule changes adopted herein on small entities. We recognize that the changes in the Report and Order that ease burdens on cable operators, such as the elimination of part-time leased access, may also impact leased access programmers, including small programmers. This outcome, however, is justified by marketplace changes, including in particular the availability of online platforms for these small programmers to distribute their content. SBN also claims that we have not examined the effect of the elimination of part-time leased access on barriers to market entry and the promotion of a diversity of media voices, which SBN contends is required by section 257 of the Act. In fact, we find, based on evidence in the record, that any entry barriers that existed for part-time programmers have been largely overtaken by the plethora of alternative distribution options for such programmers. Furthermore, in light of these alternative distribution options, elimination of part-time leased access should have at most a minimal adverse effect on the promotion of a diversity of media voices, and that effect is outweighed by the costs to cable operators of part-time leased access.

[12] Cable commenters provide that if we decline to eliminate part-time leased access entirely, we could adopt an alternative approach pursuant to which we could require a cable system to carry a leased access programmer only if the programmer provides a set minimum amount of leased access programming. Based on the record before us, we conclude that eliminating part-time leased access entirely is a preferable approach, given the alternative means of distribution available to programmers today and the costs that part-time leased access imposes on cable operators.

[13] Section 76.970(i)(1)(i) of our rules requires a cable operator's response to a leased access request to include ''[h]ow much of the operator's leased access set-aside capacity is available.'' ACA proposed that cable operators should be required to inform a potential leased access programmer only whether the specific time slot it requests is available, ''rather than indicating the total amount of available leased access set-aside capacity.'' Because we eliminate the part-time leased access requirement, ACA's time slot proposal is no longer relevant. We clarify that going forward, we will permit cable operators to comply with section 76.970(i)(1)(i) by confirming whether there is a channel available for the prospective leased access programmer.

section 76.970(i) of our rules to provide that all cable operators, and not just those that qualify as ''small systems'' [14] under that rule, are required to respond to a request for leased access information only if the request is bona fide. Larger cable systems currently must respond to all written leased access requests, which can be inefficient, difficult, and costly. We also make one change to our existing definition of a ''bona fide request'' for information, which currently is defined as a request from a potential leased access programmer that includes: ''(i) The desired length of a contract term; (ii) The time slot desired; (iii) The anticipated commencement date for carriage; and (iv) The nature of the programming.'' Specifically, we delete the second criteria (the time slot desired), because as explained above we eliminate part-time leased access and time slot thus will be irrelevant for programming that occupies a channel on a full-time basis. As proposed in the FNPRM, the criteria for a bona fide request must be met before a cable system will be required to provide the information specified in section 76.970(i)(1).

13. Adoption of this bona fide request provision will expand relief afforded small systems to all cable operators.[15] Section 76.970(i)(1) currently directs cable operators to provide prospective leased access programmers with the following information: ''(i) How much of the operator's leased access set-aside capacity is available; (ii) A complete schedule of the operator's full-time and part-time leased access rates; (iii) Rates associated with technical and studio costs; and (iv) If specifically requested, a sample leased access contract.'' Even with the other modifications to section 76.970(i) that we adopt below, we are persuaded that, absent this change to our rules, some operators of systems that do not qualify as ''small'' would continue to spend a significant amount of time responding to non-bona fide leased access inquiries.

14. We recognize that this is a change from the Commission's previous decision to limit the flexibility to respond only to bona fide requests to small cable operators. However, based on the record evidence that both small and large cable operators face significant burdens in responding to leased access requests, we find that there is no longer a reason to limit this flexibility to small cable operators. We further conclude that it does not serve the public interest to require cable operators to continue responding to requests that are not considered bona fide under our rules. We see no evidence that cable operators will use the bona fide request requirement to discourage leasing access, whereas there is clear evidence that cable operators currently are required to undertake the expense of responding to all requests for leased access information even though most such requests do not result in a leased access programming contract.[16] We recognize that some commenters claim that it is difficult for potential leased access programmers to provide the information required for a bona fide leased access request. We find, however, that providing this very basic information is necessary to demonstrate that a leased access programmer is serious about its inquiry. We believe it is reasonable to expect basic information such as the desired contract term, anticipated start date, and nature of programing to be developed prior to submitting a leased access request. To the extent that the responsive information from the cable operator presents a concern for the programmer, for example regarding the rate schedule, nothing in this change would prevent the programmer from further modifying its request and continuing to negotiate with the cable operator on the terms of an agreement.

15. Contrary to the suggestion of NCTA, we will not permit cable operators to seek further information from potential leased access programmers before responding to a leased access request, such as: (1) How the potential leased access programmer would deliver its programming to the cable system; and (2) an affidavit identifying all of the programmer's owners and declaring that all are in compliance with applicable trade sanctions. We must balance between the competing interests of potential leased access programmers who should be able to obtain basic information that will enable them to determine whether they wish to proceed with a leased access programming contract, and cable operators who should not be required to incur costs in providing information to a programmer that is not seriously committed to securing a leased access contract. We find that the approach we adopt herein strikes an appropriate balance, but we will continue monitoring the marketplace to determine whether any further modifications are needed in the future.[17]

16. *Timeframe for Responding to Requests.* To ease burdens on cable operators, we extend the timeframe within which they must provide prospective leased access programmers with the information specified in section 76.970(i)(1) of our rules, from 15 calendar days to 30 calendar days for cable operators generally, and from 30 calendar days to 45 calendar days for operators of systems subject to small system relief. These timeframes apply only to bona fide requests for information pursuant to section 76.970(i), and not to simple requests for contact information.

17. The record demonstrates that cable operators, especially those with multiple systems, would benefit from having additional time to gather the information specified in section 76.970(i)(1), as is required in response to a request for leased access information. First, section 76.970(i)(1)(i) currently requires the provision of ''[h]ow much of the operator's leased access set-aside capacity is available.'' Although as explained above we clarify that cable operators may comply with that requirement by confirming whether there is sufficient capacity for the prospective leased access programmer, operators still will need to analyze current system capacity to make that determination, given that as ACA states capacity is constantly changing ''as cable operators add and drop channels, and repurpose system bandwidth from video to broadband services.''

18. Second, section 76.970(i)(1)(ii) requires the provision of ''[a] complete schedule of the operator's full-time and part-time leased access rates.'' ACA explains that, because the rate formula utilizes data points that are constantly changing, a cable operator must complete this calculation anew in response to every leased access request for information. ACA further claims the cost of determining the rates can be one thousand dollars or more per request. Third, section 76.970(i)(1)(iii) requires the provision of ''[r]ates associated with technical and studio costs.'' ACA

[14] The leased access rules define a small system as either (i) a system that qualifies as small under section 76.901(c) of the Commission's rules and is owned by a small cable company as defined in section 76.901(e); or (ii) a system that has been granted special relief.

[15] Current rules require operators of small cable systems to provide the information only in response to a bona fide request from a prospective leased access programmer, whereas other cable system operators must provide the information in response to any request for leased access information.

[16] We thus are not persuaded by one commenter's assertion that there is no evidence that cable companies are overwhelmed by the volume of requests by leased access programmers.

[17] In addition, we note that section 76.970(i)(2) currently references ''paragraph (h)(1) of this section,'' which does not exist. Instead the rule should have cited current paragraph (i)(1), but given that herein we redesignate paragraph (i) as paragraph (h), no corrective action is needed.

explains that cable operators may not have standardized technical and studio costs, because these costs must be calculated based on the specific types of services the programmer seeks. Finally, section 76.970(i)(1)(iv) requires, if specifically requested, the provision of ''a sample leased access contract.'' While some cable operators may have a contract readily available, the record indicates that others may only have an out-of-date contract in their files. For all of these reasons, we find that the current deadlines for providing the information required in response to leased access requests for information are insufficient.[18] Our new requirement that all cable operators need only provide the listed information in response to a bona fide request does not alter this analysis, because it may not make it any easier to provide the required information; rather, it could lead to less frequent provision of the information since cable operators will not need to provide it if a request is not bona fide.[19] We see no indication in the record that increasing the timeframe within which cable operators must provide the required information will prejudice programmers seeking to lease access. Rather, programmers seeking to lease access can simply take the longer timeframe into account in deciding when to submit a bona fide request.

19. We extend each deadline by 15 calendar days, such that the general deadline will be 30 days, and the small system deadline will be 45 days. Although NCTA seeks a 45-day response period for all cable operators, we think that tripling the current deadline is excessive. Rather, we find it appropriate to extend each deadline by 15 calendar days, thus maintaining the longer deadline for small cable systems that may lack the resources to gather information as quickly as larger systems. Although one commenter posits that lengthening the deadline could deter potential leased access programmers from seeking access, particularly if their programming is time-sensitive, we see no evidence supporting this concern.

20. *Application Fees and Deposits.* As proposed by NCTA and supported by others, we permit cable operators to impose a maximum leased access application fee of $100 per system-specific bona fide request,[20] and we deem as reasonable under the Commission's rules a security deposit or prepayment requirement equivalent to up to 60 days of the applicable lease fee.[21] We agree with commenters that application fees and deposits are justified to help reimburse cable operators for their leased access costs,[22] to discourage frivolous leased access requests, and to reimburse cable operators for situations in which a leased access programmer only leases access for a brief time before the arrangement is terminated due to non-payment.[23] We acknowledge leased access programmers' concerns that any application fee or deposit could dissuade potential leased access programmers, particularly small entities, from seeking to lease access. Accordingly, rather than permitting ''nominal'' application fees and deposits as proposed in the FNPRM, we establish maximum application fees and deposits at levels that we do not expect will be unduly burdensome for leased access programmers.[24] Cable operators may require leased access programmers to pay any application fee before the cable operator provides the information set forth in section 76.970(i)(1) in response to a leased access request,[25] whereas a deposit may be assessed as part of the execution of a leased access agreement.

21. We revise section 76.970(i)(1) of our rules to provide that cable operators are required to provide leased access programmers with the information set forth in that section only if the programmer has remitted any application fee that the cable system operator requires up to a maximum of $100 per system-specific bona fide leased access request for information. The maximum leased access application fee applies to an entire system-specific bona fide request, as defined above. If a programmer amends such a request, the cable operator cannot use the amendment as an opportunity to assess a second application fee. We recognize that permitting a leased access application fee is a departure from past Commission practice. That past practice was based on an expectation that cable operators would be sufficiently protected by the ''bona fide'' request requirement that then applied only to small cable operators, but as NCTA states, ''experience has shown that even bona fide applicants may opt to walk away without signing [an] agreement'' which ''can leave cable operators with unreimbursed costs''[26] which we do not believe Congress intended cable operators to absorb.

22. Section 76.971(d) of our rules already permits cable operators to ''require reasonable security deposits or other assurances from users who are unable to prepay in full for access to leased commercial channels.'' We hereby deem as reasonable under the Commission's rules a security deposit or prepayment equivalent to up to 60 days of the applicable lease fee, and we agree with NCTA that 60 days is a reasonable timeframe to enable cable operators to protect themselves against lessees that

[18] Some commenters claim that the current deadlines are sufficient, and that cable operators should have the required information readily available. We are not persuaded by these comments; instead we recognize the specific difficulties flagged by cable operators including, in particular, ACA.

[19] Given that many of the difficulties discussed in this paragraph apply to operators of single cable systems as well as to operators of multiple cable systems, we will not distinguish between those categories of operators.

[20] We will consider one ''system-specific bona fide request'' to be a request covering a system that is served by a primary headend. If a leased access programmer wishes to provide its leased access programming on the cable operator's system that is served by a different primary headend, then it would be subject to another $100 application fee.

[21] A cable operator may assess both an application fee and a deposit or prepayment. By ''application fee,'' we mean a processing fee that the cable operator collects and retains regardless of whether the leased access request ultimately results in carriage. By ''deposit'' or ''prepayment,'' we mean a fee that the cable operator collects as part of the execution of a leased access agreement and then applies to offset future payments due under the agreement. The FNPRM applied a different definition of ''deposit,'' which would have made a deposit part of the leased access request process. We have determined that this approach is not logical, given that the Commission's rules currently refer to leased access security deposits in the context of section 76.971 (addressing leased access terms and conditions) rather than section 76.970 (addressing leased access requests for information).

[22] A cable operator's leased access costs include, as ACA states, ''processing the application, negotiating terms, and making arrangements for the delivery of programming to the cable headend. Negotiating a leased access agreement can be time consuming, and for small operators often requires the assistance of outside counsel.''

[23] While the FNPRM sought comment on whether the Commission should permit only small cable operators to require an application fee or deposit, commenters did not address that issue. We conclude that the rationale for permitting an application fee or deposit discussed herein applies to cable operators of all sizes.

[24] Establishing a maximum for application fees and deposits also addresses SBN's concerns that an approach of permitting ''nominal'' fees and deposits would ''engender deal-killing controversies over what fees and deposits are 'nominal.' ''

[25] Leased access programmers assert that they should not be treated any differently than potential commercial advertisers, to which cable system operators provide information such as rates without requiring any payment. We disagree because, as Charter states, ''most leased access programmers lack the performance record and financial resources of commercial programmers with whom the operator would customarily engage.'' Cable operators thus are justified in assessing fees before the cable operator undertakes the expense of providing the information set forth in section 76.970(i)(1). In addition, cable operators have a different relationship with leased access programmers than with commercial programmers insofar as cable operators are required by statute to engage with leased access programmers, whereas cable operators make a voluntary business decision to engage with commercial programmers.

[26] We thus conclude that, even given the adoption of the proposal to require all cable operators to respond only to bona fide leased access requests, permitting application fees remains reasonable and justified.

fail to pay after launching. This approach will address concerns that the current case-by-case determination of what constitutes a ''reasonable'' deposit leads to marketplace uncertainty. A cable operator may choose to assess either a security deposit or prepayment that exceeds 60 days of the applicable lease fee, but such an assessment would remain subject to the current case-by-case review process if the programmer asserts that it is not reasonable. While one leased access programmer advocates a maximum deposit equivalent to the cost of a single day of airtime, we find that such an amount would be insufficient to protect cable operators from a leased access programmer that ceases paying for access prior to the completion of its agreement's term, which will now be a minimum of one year. Because a deposit is assessed as part of the execution of a leased access agreement, it will either be applied to payments due under the agreement, or it will be retained by the cable operator to compensate it for the leased access programmer's failure to remit payments required by the agreement. We see no reason to modify the existing requirement of section 76.971(d) that reasonable security deposits are permitted only if the leased access user does not prepay in full because if the leased access user prepays in full, the cable operator does not need protection against nonpayment.

23. We reject requests by cable operators to impose additional new financial requirements on leased access programmers aside from application fees and deposits. Specifically, ACA proposes that the Commission permit cable operators to assess a ''closing fee'' upon finalization of a leased access agreement. We find that giving cable operators this flexibility is not necessary because it is intended to address the same cable operator concerns as the application fee and security deposit. NCTA proposes that cable operators ''should be permitted to require an acknowledgement in the application that certain ordinary commercial protections will apply, including that a lessee must provide proof of insurance . . . and pass a credit check prior to entering into a lease.'' In addition, NCTA requests that the rules ''provide that if a leased access user has previously been dropped for non-payment, an operator can refuse to enter into a leasing agreement with that entity or its principals in the future.'' We note that our rules already permit cable operators to ''impose reasonable insurance requirements on leased access programmers,'' and we decline to adopt further protections for cable operators against non-payment by leased access programmers given the expected sufficiency of the application fees and deposits that we authorize today.

24. *Contact Information.* We adopt a requirement that cable operators provide potential leased access programmers with contact information for the person responsible for leased access matters. Multiple commenters support a leased access contact information requirement, and none oppose it. We provide flexibility for cable operators in complying with this requirement by permitting them to disclose on their own websites, or through alternate means if they do not have their own websites,[27] basic contact information including the name or title, telephone number, and email address for the person responsible for responding to requests for information about leased access channels. This information is necessary for potential leased access programmers to initiate productive contact with cable systems, which is vital to the leased access process, and our approach is consistent with the contact information requirements the Commission has adopted in other contexts. We provide further flexibility by requiring cable operators to provide either a contact person's name or title.[28] This approach eliminates the need to update the website due to personnel changes, and it is permissible so long as the provided telephone number and email address reach the appropriate person. However, a cable operator provides the required contact information, it should be reasonably identifiable, though it need not appear on a cable operator's main web page.[29]

25. *Dispute Procedures.* As proposed in the FNPRM, we adopt common-sense modifications to the procedures for leased access disputes, which no commenter opposed. These modifications resolve inconsistencies between the leased access dispute resolution rule (section 76.975) and the Commission's more general rule governing complaints (section 76.7). First, we adopt the proposal to revise the terminology in section 76.975 by referencing an answer to a petition, rather than a response to a petition. Second, we adopt the proposal to modify section 76.975 by calculating the 30-day timeframe for filing an answer to a leased access petition from the date of service of the petition, rather than from the date on which the petition was filed. Third, whereas section 76.975 currently does not include any allowance for replies, we adopt the proposal to add a provision stating that replies to answers must be filed within 15 days after submission of the answer.[30] Fourth, we adopt the proposal to add to section 76.975 a statement that section 76.7 applies to petitions for relief filed under section 76.975, unless otherwise provided in section 76.975. We expect that these modifications will make dispute procedures clearer both for the parties to a leased access dispute and for the Commission.[31]

26. *Other Issues.* Commenters put forth several additional proposals in response to the FNPRM, and we reject the proposals at this time as follows.

27. HD leased access. We will not require cable systems to carry leased access programming in high definition (HD).[32] Rather, HD carriage is at the discretion of the cable operator. This approach is consistent with the Act, which does not require cable systems to carry leased access programming in HD. Carrying leased access programming in HD expands the use of spectrum without increasing the volume of leased access programming distributed. Further, we note that cable operators negotiate to carry even some

[27] For example, a cable operator that does not have its own website could post its contact information on a third-party website, such as the website of a cable or programmer trade association, and it could train employees to provide that website to callers inquiring about leased access matters.

[28] For example, rather than specifying the contact person's name, Cox has opted to provide that communications should be directed to the ''Leased Access Coordinator'' and it lists an email address for this person.

[29] Although the Commission adopted a comparable requirement in the *2008 Leased Access Order,* that requirement never went into effect because OMB disapproved of the information collection requirements contained in that order. The reasons for the disapproval, however, were not specifically related to the contact information requirement, and as explained above we have minimized burdens of the new contact information requirement by providing cable operators with flexibility in complying.

[30] The FNPRM sought comment on whether 15 days is the appropriate timeframe for submitting a reply to an answer to a leased access petition. Commenters did not address this issue, with the exception of Jones's support of the Commission's 15-day proposal. To be consistent with the answer filing deadline, which is 20 days under the general complaint-filing rule but 30 days under the leased access rule, we find that it is appropriate for the reply filing deadline to be 10 days under the general complaint-filing rule but 15 days under the leased access rule.

[31] Although some commenters argue that we should make additional changes to make the dispute resolution process faster and more efficient, we find insufficient justification for such changes at this time. We will revisit these issues in the future if we determine that further modifications to the leased access dispute resolution procedures are needed.

[32] While some leased access programmers support a requirement that cable systems carry leased access programming in HD, cable operators object to such a requirement.

commercial programming in standard definition (SD).

28. Insurance requirements. We decline to adopt new limits on the insurance requirements that cable operators may impose on leased access programmers. We find that this proposal is inconsistent with the Cable Services Bureau's prior conclusion that a cable operator has the ''right to require reasonable liability insurance coverage for leased access programming.'' We are not persuaded that this conclusion was in error, and leased access programmers have provided no compelling evidence that the Commission should adopt limits on the reasonable insurance requirements that cable operators may impose on leased access programmers, including limits on naming cable affiliates as additional insureds.[33]

29. Limited carriage areas. We will not prohibit cable operators from refusing to carry leased access programmers on only a portion of the operator's system, even if the programmer is willing to pay the reasonable cost of a modulator or other piece of equipment that would be needed to limit the carriage area.[34] Rather, consistent with past practice, we will continue evaluating any programmer complaints regarding cable operator denials of leased access carriage on a case-by-case basis. We agree with Charter that the Act ''does not require that leased access be accommodated in this piece-meal fashion.'' Customers depend on a consistent channel lineup in a given geographic area, and cable operators should not be required to reconfigure their systems to make leased access programming available only on a portion of the system. Indeed, if the Commission permitted every leased access programmer to provide a modulator and request a custom service area, the ensuing technical and operational burdens on cable operators easily could become unmanageable.

30. Disclosure requirements. We decline to modify the information that cable system operators must provide prospective leased access programmers, as set forth in section 76.970(i)(1) of our rules, except for the elimination of the reference to part-time rates discussed above. ACA proposes that we could ease burdens on cable operators by: (1) Permitting them to provide ACA's proposed safe harbor rates, or a rate estimate, rather than a complete rate schedule; (2) eliminating the requirement that they provide rates associated with technical and studio costs; and (3) eliminating the requirement that they provide sample contracts, or permitting them to provide term sheets instead of sample contracts. We find that a leased access programmer may need to review the rate schedule, technical and studio costs, and a sample contract before deciding whether to proceed in leasing access under our current rules. We therefore decline to adopt ACA's proposals at this time.[35]

31. Other proposals. We note that commenters responding to the FNPRM raised several additional proposals on a variety of topics, which are not fully developed in the record or are outside the scope of this proceeding.[36] We decline to address any of these proposals at this time because we find that it is preferable to monitor the impact of the rule changes we adopt today before deciding if any of these modifications are needed.

32. The First Amendment. The changes in the video marketplace described above call into question whether our leased access rules are consistent with the First Amendment. Specifically, while the leased access rules were originally justified as safeguarding competition and diversity in the face of cable operators' monopoly power, the growth in available platforms to distribute programming seems to have eroded this justification. We sought comment on this issue in the FNPRM. Some commenters argue that changes in the marketplace mean that strict scrutiny may be the appropriate standard of review for the leased access statute today. Some commenters further claim that even under intermediate scrutiny, which is the standard the D.C. Circuit applied when it upheld the leased access statute in 1996, marketplace changes would dictate a finding that the leased access regime is no longer consistent with the First Amendment. Because changes in the marketplace have dramatically increased diversity and competition in the video programming market, these commenters argue, the leased access rules are no longer necessary to further the government's interest in promoting these goals.

33. We agree that dramatic changes in technology and the marketplace for the distribution of programming cast substantial doubt on the constitutional foundation for our leased access rules. We recognize that we rejected similar constitutional arguments in the *2008 Leased Access Order,* which we vacate today. Our analysis has changed because the facts have changed: as explained above, the growth in alternative outlets for programmers—particularly on the internet—has exploded in the decade since the adoption of the *2008 Leased Access Order.* Given this proliferation of new distribution platforms, we now find that the First Amendment concerns raised by commenters provide additional reason to interpret the statutory obligations of section 612 in a manner that reduces burdens on the speech of cable operators. We do so here by, among other things, eliminating the Commission rule requiring that cable operators make leased access available on a part-time basis. While our rule changes are independently and sufficiently supported by the policy justifications above, we note that constitutional concerns rely on the same premise: that changes in the video marketplace have substantially weakened the justifications for leased access.[37]

34. *Procedural Matters.* As required by the Regulatory Flexibility Act of 1980, as amended (RFA), the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) relating to the Report and Order. In summary, the Report and Order updates the Commission's leased access rules as part of its Modernization of Media Regulation Initiative. First, we adopt the FNPRM's tentative conclusion that we should vacate the Commission's *2008 Leased Access Order.* Second, we adopt certain updates and improvements to our existing leased access rules. The

[33] Note that last year the Media Bureau dismissed in part and otherwise denied a petition alleging that a cable operator failed to demonstrate that its insurance requirement was reasonable. The Bureau concluded that ''[t]he threshold issue of whether a cable operator may require insurance coverage for leased access programming is settled,'' and the cable operator ''was reasonable to require insurance coverage in this instance.''

[34] LAPA proposed that we impose such a prohibition.

[35] Similarly, we find that the costs to cable operators of providing potential leased access programmers with extensive additional information would outweigh the potential benefits of providing that additional information to prospective leased access programmers. Accordingly, we decline to adopt such requirements. We note, however, that we do adopt leased access contact information requirements. In addition, current rules require disclosure of ''[a] complete schedule of the operator's full-time and part-time leased access rates.''

[36] In addition, SBN asks the Commission to ''clarify that independent programmers have the same right of access to multichannel video systems owned by telephone companies as they have to other cable systems.'' To the extent there is any doubt, we clarify that a telephone company that is acting as a ''cable operator'' is subject to the leased access requirements in the same manner as any other cable operator.

[37] In the related Section Further Notice of Proposed Rulemaking, we seek further comment on the constitutionality of the Commission's overall leased access regime, which the Commission adopted pursuant to express Congressional authorization.

action is authorized pursuant to sections 4(i), 303, and 612 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i), 303, and 532. The types of small entities that may be affected by the proposals contained in the FNPRM fall within the following categories: Cable Television Distribution Services, Cable Companies and Systems (Rate Regulation), Cable System Operators (Telecom Act Standard), Cable and Other Subscription Programming, Motion Picture and Video Production, and Motion Picture and Video Distribution. The projected reporting, recordkeeping, and other compliance requirements are: (1) Vacating the *2008 Leased Access Order,* including the Further Notice of Proposed Rulemaking issued in conjunction with that order; (2) Eliminating the requirement that cable operators make leased access available on a part-time basis; (3) Adopting the proposal set out in the FNPRM to ease burdens on cable operators by revising § 76.970(i) of our rules to provide that all cable operators, and not just those that qualify as ''small systems'' under that rule, are required to respond to a request for leased access information only if the request is bona fide; (4) Easing burdens on cable operators by extending the timeframe within which they must provide prospective leased access programmers with the information specified in § 76.970(i)(1) of our rules, from 15 calendar days to 30 calendar days for cable operators generally, and from 30 calendar days to 45 calendar days for operators of systems subject to small system relief; (5) Permitting cable operators to impose a maximum leased access application fee of $100 per system-specific bona fide request, and deeming as reasonable under the Commission's rules a security deposit or prepayment requirement equivalent to up to 60 days of the applicable lease fee; (6) Adopting a requirement that cable operators provide potential leased access programmers with contact information for the person responsible for leased access matters; and (7) Adopting common-sense modifications to the procedures for leased access disputes, which no commenter opposed. Finally, commenters put forth several additional proposals in response to the FNPRM, and we reject the proposals at this time. The SBA did not file comments. Many of the actions taken in the Report and Order will ease burdens, including economic burdens, on cable operators of all sizes. The changes in the Report and Order that ease burdens on cable operators, such as the elimination of part-time leased access, may also impact leased access programmers, including small programmers. We find that the marketplace changes discussed above, including in particular the availability of online platforms for these small programmers to distribute their content, justify this approach. The Report and Order considered alternatives to take into account the impact on small entities as follows: (1) The Report and Order concludes that eliminating part-time leased access entirely is a preferable approach to the alternative of establishing a set minimum amount of leased access programming, given the alternative means of distribution available to programmers today and the costs that part-time leased access imposes on cable operators. (2) While we consider one commenter's alternative proposal of a 45-day response period for all cable operators, we conclude that tripling the current deadline is excessive.

35. The Report and Order contains new or revised information collection requirements, as reflected in the Final Rules, §§ 76.970(h) and 76.975(e). The Commission, as part of its continuing effort to reduce paperwork burdens, will invite the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3501–3520). In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4), the Commission previously sought specific comment on how it might ''further reduce the information collection burden for small business concerns with fewer than 25 employees.''

36. The Commission will send a copy of the Report and Order in a report to be sent to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

37. *Ordering Clauses.* Accordingly, *it is ordered* that, pursuant to the authority found in sections 4(i), 303, and 612 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i), 303, and 532, this Report and Order *is hereby adopted.*

38. *It is further ordered* that part 76 of the Commission's rules, 47 CFR part 76, *is amended* as set forth below, and such rule amendments shall be effective thirty (30) days after the date of publication in the **Federal Register**, except for §§ 76.970(h) and 76.975(e) that contain new or modified information collection requirements, which shall become effective after the Commission publishes a notice in the **Federal Register** announcing OMB approval and the relevant effective date.

39. *It is further ordered* that the Commission's Report and Order and Further Notice of Proposed Rulemaking in the *Leased Commercial Access* proceeding, MB Docket No. 07–42, FCC 07–208, *is hereby vacated.*

40. *It is further ordered* that the March 28, 2008 Request of National Cable & Telecommunications Association for a Stay, MB Docket No. 07–42, *is dismissed as moot.*

41. *It is further ordered* that the March 31, 2008 TVC Broadcasting LLC Petition for Reconsideration, MB Docket No. 07–42, *is dismissed as moot.*

42. *It is further ordered* that the Commission *shall send* a copy of this Report and Order and Second Further Notice of Proposed Rulemaking in a report to be sent to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

List of Subjects in 47 CFR Part 76

Administrative practice and procedure, Cable television, Reporting and recordkeeping requirements.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR part 76 as follows:

PART 76—MULTICHANNEL VIDEO AND CABLE TELEVISION SERVICE

■ 1. The authority citation for part 76 continues to read as follows:

Authority: 47 U.S.C. 151, 152, 153, 154, 301, 302, 302a, 303, 303a, 307, 308, 309, 312, 315, 317, 325, 338, 339, 340, 341, 503, 521, 522, 531, 532, 534, 535, 536, 537, 543, 544, 544a, 545, 548, 549, 552, 554, 556, 558, 560, 561, 571, 572, 573.

■ 2. In § 76.970:

■ A. Revise paragraph (a);

■ B. Remove paragraph (h);

■ C. Redesignate paragraphs (i) and (j) as paragraphs (h) and (i);

■ D. Revise newly redesignated paragraph (h).

The revisions read as follows:

§ 76.970 Commercial leased access rates.

(a) Cable operators shall designate channel capacity for commercial use by persons unaffiliated with the operator, and that seek to lease a programming channel on a full-time basis, in accordance with the requirement of 47

U.S.C. 532. For purposes of 47 U.S.C. 532(b)(1)(A) and (B), only those channels that must be carried pursuant to 47 U.S.C. 534 and 535 qualify as channels that are required for use by Federal law or regulation. For cable systems with 100 or fewer channels, channels that cannot be used due to technical and safety regulations of the Federal Government (*e.g.,* aeronautical channels) shall be excluded when calculating the set-aside requirement.

* * * * *

(h)(1) Cable system operators shall provide prospective leased access programmers with the following information within 30 calendar days of the date on which a bona fide request for leased access information is made, provided that the programmer has remitted any application fee that the cable system operator requires up to a maximum of $100 per system-specific bona fide request:

(i) How much of the operator's leased access set-aside capacity is available;

(ii) A complete schedule of the operator's full-time leased access rates;

(iii) Rates associated with technical and studio costs; and

(iv) If specifically requested, a sample leased access contract.

(2) Operators of systems subject to small system relief shall provide the information required in paragraph (h)(1) of this section within 45 calendar days of a bona fide request from a prospective leased access programmer. For these purposes, systems subject to small system relief are systems that either:

(i) Qualify as small systems under § 76.901(c) and are owned by a small cable company as defined under § 76.901(e); or

(ii) Have been granted special relief.

(3) Bona fide requests, as used in this section, are defined as requests from potential leased access programmers that have provided the following information:

(i) The desired length of a contract term;

(ii) The anticipated commencement date for carriage; and

(iii) The nature of the programming,

(4) All requests for leased access must be made in writing and must specify the date on which the request was sent to the operator.

(5) Operators shall maintain, for Commission inspection, sufficient supporting documentation to justify the scheduled rates, including supporting contracts, calculations of the implicit fees, and justifications for all adjustments.

(6) Cable system operators shall disclose on their own websites, or through alternate means if they do not have their own websites, a contact name or title, telephone number, and email address for the person responsible for responding to requests for information about leased access channels.

(i) Cable operators are permitted to negotiate rates below the maximum rates permitted in paragraphs (c) through (g) of this section.

§ 76.971 [Amended]

■ 3. Amend § 76.971, by removing paragraph (a)(4).

■ 4. Amend § 76.975 by revising paragraph (e) and adding paragraph (i) to read as follows:

§ 76.975 Commercial leased access dispute resolution.

* * * * *

(e) The cable operator or other respondent will have 30 days from service of the petition to file an answer. If a leased access rate is disputed, the answer must show that the rate charged is not higher than the maximum permitted rate for such leased access, and must be supported by the affidavit of a responsible company official. If, after an answer is submitted, the staff finds a prima facie violation of our rules, the staff may require a respondent to produce additional information, or specify other procedures necessary for resolution of the proceeding. Replies to answers must be filed within fifteen (15) days after submission of the answer.

* * * * *

(i) Section 76.7 applies to petitions for relief filed under this section, except as otherwise provided in this section.

[FR Doc. 2019–13134 Filed 6–19–19; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Parts 20 and 21

[Docket No. FWS–HQ–MB–2018–0012; FF09M21200–178–FXMB1232099BPP0L2]

RIN 1018–BC72

Migratory Bird Permits; Regulations for Managing Resident Canada Goose Populations

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: In 2005, the U.S. Fish and Wildlife Service (Service or ''we'') published a final environmental impact statement on management of resident Canada geese (*Branta canadensis*) that documented resident Canada goose population levels ''that are increasingly coming into conflict with people and causing personal and public property damage.'' Subsequently, the Service implemented several actions intended to reduce, manage, and control resident Canada goose populations in the continental United States and to reduce related damages; those actions included depredation and control orders that allow destruction of Canada goose nests and eggs by authorized personnel between March 1 and June 30. However, some resident Canada geese currently initiate nests in February, particularly in the southern United States, and it seems likely that in the future nest initiation dates will begin earlier and hatching of eggs will perhaps end later than dates currently experienced. This final rule amends the depredation and control orders to allow destruction of resident Canada goose nests and eggs at any time of year.

DATES: This rule is effective July 22, 2019.

ADDRESSES: Comments we received on the proposed rule, as well as the proposed rule itself, the related environmental assessment, and this final rule, are available at *http://www.regulations.gov* in Docket No. FWS–HQ–MB–2018–0012.

FOR FURTHER INFORMATION CONTACT: Paul I. Padding, Atlantic Flyway Representative, Division of Migratory Bird Management, U.S. Fish and Wildlife Service, 11510 American Holly Drive, Laurel, MD 20708; (301) 497–5851; *paul_padding@fws.gov*.

SUPPLEMENTARY INFORMATION:

Authority and Responsibility

Migratory birds are protected under four bilateral migratory bird treaties the United States entered into with Great Britain (for Canada in 1916, as amended in 1999), the United Mexican States (1936, as amended in 1972 and 1999), Japan (1972, as amended in 1974), and the Soviet Union (1978). Regulations allowing the take of migratory birds are authorized by the Migratory Bird Treaty Act (Act; 16 U.S.C. 703–712), which implements the above-mentioned treaties. The Act provides that, subject to and to carry out the purposes of the treaties, the Secretary of the Interior is authorized and directed to determine when, to what extent, and by what means allowing hunting, killing, and other forms of taking of migratory birds, their nests, and eggs is compatible with the conventions. The Act requires the Secretary to implement a determination by adopting regulations permitting and governing those activities.

Canada geese are federally protected by the Act because they are listed as migratory birds in all four treaties. Because Canada geese are covered by all four treaties, regulations must meet the requirements of the most restrictive of the four. For Canada geese, this is the treaty with Canada. All regulations concerning resident Canada geese are compatible with its terms, with particular reference to Articles II, V, and VII.

Each treaty not only permits sport hunting, but permits the take of migratory birds for other reasons, including scientific, educational, propagative, or other specific purposes consistent with the conservation principles of the various Conventions. More specifically, Article VII, Article II (paragraph 3), and Article V of ''The Protocol Between the Government of the United States of America and the Government of Canada Amending the 1916 Convention between the United Kingdom and the United States of America for the Protection of Migratory Birds in Canada and the United States'' provides specific limitations on allowing the take of migratory birds for reasons other than sport hunting. Article VII authorizes permitting the take, kill, etc., of migratory birds that, under extraordinary conditions, become seriously injurious to agricultural or other interests. Article V relates to the taking of nests and eggs, and Article II, paragraph 3, states that, in order to ensure the long-term conservation of migratory birds, migratory bird populations shall be managed in accord with listed conservation principles.

The other treaties are less restrictive. The treaties with both Japan (Article III, paragraph 1, subparagraph (b)) and the Soviet Union (Article II, paragraph 1, subparagraph (d)) provide specific exceptions to migratory bird take prohibitions for the purpose of protecting persons and property. The treaty with Mexico requires, with regard to migratory game birds, only that there be a ''closed season'' on hunting and that hunting be limited to 4 months in each year. Regulations governing the issuance of permits to take, capture, kill, possess, and transport migratory birds are promulgated at title 50 of the Code of Federal Regulations (CFR), parts 13, 21 and 22, and are issued by the Service. The Service annually promulgates regulations governing the take, possession, and transportation of migratory game birds under sport hunting seasons at 50 CFR part 20. Regulations regarding all other take of migratory birds (except for eagles) are published at 50 CFR part 21, and typically are not changed annually.

Background

In November 2005, the Service published a final environmental impact statement (FEIS) on management of resident Canada geese that documented resident Canada goose population levels ''that are increasingly coming into conflict with people and causing personal and public property damage'' (see the FEIS' notice of availability at 70 FR 69985; November 18, 2005).

On August 10, 2006, we published in the **Federal Register** (71 FR 45964) a final rule establishing regulations at 50 CFR parts 20 and 21 authorizing State wildlife agencies, private landowners, and airports to conduct (or allow) indirect and/or direct population control management activities to reduce, manage, and control resident Canada goose populations in the continental United States and to reduce related damages. Those activities include depredation and control orders that allow destruction of resident Canada goose nests and eggs by authorized personnel between March 1 and June 30, because that timeframe encompassed the period when resident Canada geese typically nested. However, in recent years, some resident Canada geese have initiated nests in February, particularly in the southern United States, and it seems likely that in the future nest initiation dates will begin earlier and hatching of eggs will perhaps end later than dates currently experienced.

On April 25, 2018, we published in the **Federal Register** (83 FR 17987) a proposed rule to amend the special permit and depredation and control orders to allow destruction of resident Canada goose nests and eggs at any time of year, thereby affording State agencies, private landowners, and airports greater flexibility to use these methods of controlling local abundances of resident Canada geese. This final rule adopts the changes set forth in that proposed rule.

Definition of Resident Canada Geese

The current definition of resident Canada geese set forth at 50 CFR 20.11 and 21.3 states that ''Canada geese that nest within the lower 48 States and the District of Columbia in the months of March, April, May, or June, or reside within the lower 48 States and the District of Columbia in the months of April, May, June, July, or August'' are considered resident Canada geese. We are amending this definition by deleting the phrase, ''in the months of March, April, May, or June,'' following the first appearance of the word ''Columbia,'' to clarify that any Canada geese that nest within lower 48 States and the District of Columbia are resident Canada geese.

Removal of Date Restrictions on Nest and Egg Destruction

In title 50 of the CFR, destruction of resident Canada goose nests and eggs is currently authorized under special Canada goose permits (§ 21.26), a control order for airports and military airfields (§ 21.49), a depredation order specific to nests and eggs (§ 21.50), a depredation order for agricultural facilities (§ 21.51), and a public health control order (§ 21.52). Each of these regulations prescribes the dates during which nests and eggs of resident Canada goose may be destroyed. This rule removes those date restrictions and allows destruction of Canada goose nests and eggs, as otherwise authorized under these regulations, at any time of year.

This adjustment is based on several factors. First, nest and egg destruction has been an effective tool in reducing local conflicts and damages caused by resident Canada geese. Second, resident Canada geese are identified as such based on where, not when, they nest. Lastly, some Canada geese are already nesting in February in southern States, and it seems likely that nest initiation dates will also advance into February in mid-latitude and perhaps northern States in the future and hatching of nests may occur later than June 30.

Eliminating Date Restrictions for Lethal Control Activities in California, Oregon, and Washington

On June 17, 1999, we published in the **Federal Register** (64 FR 32766) a final rule establishing 50 CFR 21.26, the special Canada goose permit. Special Canada goose permits may be issued to State wildlife agencies authorizing them to conduct certain resident Canada goose management and control activities that are normally prohibited. At that time, we indicated that States may conduct those control activities between March 11 and August 31, but that they should make a concerted effort to limit the take of adult birds to June, July, and August in order to minimize the potential impact on migrant populations. We imposed a date restriction of May 1 through August 31 in some areas in California, Oregon, and Washington inhabited by the threatened Aleutian Canada goose (*Branta canadensis leucopareia*) pursuant to the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*). The Aleutian Canada goose was listed as endangered in 1967 (32 FR 4001; March 11, 1967) and reclassified to threatened status in 1990 (55 FR 51106; December

12, 1990). Aleutian geese occur in a small numbers within these States, primarily San Joaquin Valley and Sacramento River Delta areas in central California, Humboldt Bay and Crescent City areas on the northern California coast, and Langlois and Pacific City areas on the Oregon coast. We indicated that if this subspecies is delisted, we would review this provision.

On March 20, 2001, we published in the **Federal Register** (66 FR 15643) a final rule to remove the Aleutian Canada goose from the Federal List of Endangered and Threatened Wildlife, due to recovery. Abundance of this population increased from 790 birds in 1975, to an estimated 156,030 in the winter of 2016. The Pacific Flyway Council's objective for this population is 60,000 geese. Currently, there is no special habitat or other threat that may reduce this population back to levels that may need protection under the ESA. Considering the current status of the Aleutian Canada goose, we are removing the May 1 restriction so that management and control activities may be conducted during the same period (March 11 through August 31) throughout all States.

Environmental Assessment

We prepared an environmental assessment (EA) that analyzed two alternative courses of action to address these earlier nesting and later hatching dates and decrease local abundances of Canada geese that nest in the lower 48 States and the District of Columbia:

(1) Maintain the current date restrictions specified in regulations at 50 CFR 21.26, 21.49, 21.50, 21.51, and 21.52 on destruction of resident Canada goose nests and eggs, and make no change to the definition of resident Canada geese at 50 CFR 20.11 and 21.3 (No action); and

(2) Revise the definition of resident Canada geese at 50 CFR 20.11 and 21.3, and allow destruction of resident Canada goose nests and eggs at any time of year under 50 CFR 21.26, 21.49, 21.50, 21.51, and 21.52 (Proposed action).

The full EA can be found on our website at *http://www.fws.gov/birds* or at *http://www.regulations.gov* at Docket No. FWS–HQ–MB–2018–0012. We note that the amendment to § 21.26 in regard to accounting for the current status of the Aleutian Canada goose was not addressed in the EA, but is a categorically excluded action (43 CFR 46.210) addressed in an environmental action statement (EAS). The EAS can be found on our website at *http://www.fws.gov/birds* or at *http://www.regulations.gov* at Docket No. FWS–HQ–MB–2018–0012.

Review of Public Comments

We accepted comments on our April 25, 2018, proposed rule (83 FR 17987) for 30 days, ending May 25, 2018. During the public comment period on the proposed rule, we received public comments from seven private individuals (two of which were not relevant to this rule) and one organization.

Summary of Relevant Comments

The National Wildlife Control Operators Association supported the proposed changes, but each of the private individuals opposed some aspect(s) of the rule. One individual stated that we should allow larger bag limits and more access to hunting locations instead of conducting direct control operations, while another commenter expressed opposition to capturing resident Canada geese on National Wildlife Refuges and then euthanizing them, because this reduces hunting opportunity. One commenter objected to the lethal control of a native species and urged the Service to expend its resources on invasive species and recovering endangered species instead, and two individuals expressed opposition to the killing of any animals.

Service Response to Relevant Comments

Hunting harvest alone has not reduced resident Canada goose numbers enough to alleviate conflicts in some areas, despite long hunting seasons and large bag limits; also, the hunting season does not coincide with the time when many conflicts with geese, such as crop depredation, need to be addressed. Furthermore, many locales frequented by Canada geese are either closed to hunting for safety purposes (*e.g.,* airports, urban areas) or are privately owned, where access to hunters can only be granted by the property owner. Direct control measures such as nest and egg destruction and lethal removal are usually employed to alleviate local conflicts; thus, whether to conduct such measures is a local decision. The Service has a responsibility to reduce risks to public safety (*e.g.,* at airports) and prevent serious injuries to agricultural crops that are caused by resident Canada geese. We favor nonlethal control methods, but if those fail to resolve an identified conflict, we do allow lethal take. Therefore, this final rule does not make any changes in response to these comments to the actions we proposed on April 25, 2018 (83 FR 17987).

Required Determinations

Regulatory Planning and Review (Executive Orders 12866 and 13563)

Executive Order (E.O.) 12866 provides that the Office of Information and Regulatory Affairs (OIRA) in the Office of Management and Budget (OMB) will review all significant rules. OIRA has determined that this rule is not significant.

Executive Order 13563 reaffirms the principles of E.O. 12866 while calling for improvements in the nation's regulatory system to promote predictability, to reduce uncertainty, and to use the best, most innovative, and least burdensome tools for achieving regulatory ends. The executive order directs agencies to consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public where these approaches are relevant, feasible, and consistent with regulatory objectives. E.O. 13563 emphasizes further that regulations must be based on the best available science and that the rulemaking process must allow for public participation and an open exchange of ideas. We developed this rule in a manner consistent with these requirements.

Regulatory Flexibility Act

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.,* as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 (Pub. L. 104–121)), whenever an agency is required to publish a notice of rulemaking for any proposed or final rule, it must prepare and make available for public comment a regulatory flexibility analysis that describes the effects of the rule on small businesses, small organizations, and small government jurisdictions. However, no regulatory flexibility analysis is required if the head of an agency certifies the rule will not have a significant economic impact on a substantial number of small entities.

SBREFA amended the Regulatory Flexibility Act to require Federal agencies to provide a statement of the factual basis for certifying that a rule will not have a significant economic impact on a substantial number of small entities. Thus, for a regulatory flexibility analysis to be required, impacts must exceed a threshold for ''significant impact'' and a threshold for a ''substantial number of small entities.'' See 5 U.S.C. 605(b).

The economic impacts of this rule will primarily affect State and local governments and the U.S. Department of Agriculture's Wildlife Services because

of the structure of wildlife damage management. Data are not available to estimate the exact number of local governments that will be affected, but it is unlikely to be a substantial number nationally. Therefore, we certify that this rule will not have a significant economic impact on a substantial number of small entities.

Small Business Regulatory Enforcement Fairness Act

This rule is not a major rule under SBREFA (5 U.S.C. 804(2)). It will not have a significant impact on a substantial number of small entities.

This rule will not have an annual effect on the economy of $100 million or more. This rule will not cause a major increase in costs or prices for consumers; individual industries; Federal, State, or local government agencies; or geographic regions. Finally, this rule will not have significant adverse effects on competition, employment, investment, productivity, innovation, or the abilities of U.S.-based enterprises to compete with foreign-based enterprises.

Executive Order 13771—Reducing Regulation and Controlling Regulatory Costs

This final rule is an Executive Order (E.O.) 13771 (82 FR 9339, February 3, 2017) deregulatory action because it relieves a restriction in 50 CFR parts 20 and 21.

Unfunded Mandates Reform Act

In accordance with the Unfunded Mandates Reform Act (2 U.S.C. 1501 *et seq.*), we have determined the following:

a. This rule will not ''significantly or uniquely'' affect small government activities. A small government agency plan is not required.

b. This rule will not produce a Federal mandate on local or State government or private entities. Therefore, this action is not a ''significant regulatory action'' under the Unfunded Mandates Reform Act.

Takings

In accordance with E.O. 12630, this rule does not contain a provision for taking of private property, and will not have significant takings implications. A takings implication assessment is not required.

Federalism

This rule does not interfere with the States' abilities to manage themselves or their funds.

We do not expect any economic impacts to result from this regulations change. This rule will not have sufficient Federalism effects to warrant preparation of a federalism summary impact statement under E.O. 13132.

Civil Justice Reform

In accordance with E.O. 12988, the Office of the Solicitor has determined that the rule will not unduly burden the judicial system and meets the requirements of sections 3(a) and 3(b)(2) of the Order.

Paperwork Reduction Act

This rule does not contain new collections of information that require approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). OMB has approved the information collection requirements associated with the control and management of resident Canada geese at 50 CFR part 20 and 50 CFR part 21, and assigned assigned OMB Control Number 1018–0133 (expires May 31, 2019, and in accordance with 5 CFR 1320.10, an agency may continue to conduct or sponsor this collection of information while the submission is pending at OMB). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

National Environmental Policy Act

We have analyzed this rule in accordance with the National Environmental Policy Act (NEPA; 42 U.S.C. 4321 *et seq.*) and U.S. Department of the Interior regulations at 43 CFR part 46. We have completed an environmental assessment of the amendment of the depredation and control orders that allows destruction of resident Canada goose nests and eggs at any time of year; that environmental assessment is included in the docket for this rule (available at *http://www.regulations.gov*; Docket No. FWS–HQ–MB–2018–0012). We conclude that our action will have the impacts listed below under ''Environmental Consequences of the Action.'' The amendment to § 21.26 in regard to accounting for the current status of the Aleutian Canada goose was not addressed in the EA, but is a NEPA categorically excluded action (43 CFR 46.210) addressed in an environmental action statement (EAS), which is also included in the docket for this rule (available at *http://www.regulations.gov*; Docket No. FWS–HQ–MB–2018–0012).

Environmental Consequences of the Action

Migrant Canada geese do not nest in the lower 48 States or the District of Columbia; thus, this action (amendments related only to depredation and control orders) is not expected to have any significant impacts on migrant Canada geese. All resident Canada goose population abundances are well above population objectives. Assuming that the number of resident Canada geese that initiate nests in January or February does not exceed the current number that initiate nests in March, we expect that this action will result in destruction of a maximum of 2,749 additional nests in January and February. We expect it is more likely that the action will shift some portion of the current resident Canada goose nest and egg destruction activities occurring in March to either January or February. All populations of resident Canada geese are expected to remain at or above population objective levels.

Socioeconomic. This action is expected to have positive impacts on the socioeconomic environment in localized urban and suburban areas where resident Canada geese are subjected to continued (annual) nest and egg destruction actions that gradually reduce goose numbers and resulting conflicts. It is also expected to reduce crop depredation at some localized agricultural sites where nest destruction can encourage geese to leave the site.

Endangered and threatened species. The rule will not affect endangered or threatened species or critical habitats.

Compliance With Endangered Species Act Requirements

Section 7 of the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*), requires that ''The Secretary [of the Interior] shall review other programs administered by him and utilize such programs in furtherance of the purposes of this Act'' (16 U.S.C. 1536(a)(1)). It further states that ''[e]ach Federal agency shall, in consultation with and with the assistance of the Secretary, insure that any action authorized, funded, or carried out by such agency * * * is not likely to jeopardize the continued existence of any endangered species or threatened species or result in the destruction or adverse modification of [critical] habitat'' (16 U.S.C. 1536(a)(2)). This rule will not affect endangered or threatened species or critical habitats.

Government-to-Government Relationship With Tribes

In accordance with the President's memorandum of April 29, 1994, ''Government-to-Government Relations with Native American Tribal Governments'' (59 FR 22951), E.O.

13175, and 512 DM 2, we have evaluated potential effects on federally recognized Indian tribes and have determined that there are no potential effects. This rule will not interfere with the tribes' abilities to manage themselves or their funds or to regulate migratory bird activities on tribal lands.

Energy Supply, Distribution, or Use (E.O. 13211)

E.O. 13211 requires agencies to prepare Statements of Energy Effects when undertaking certain actions. This rule is not a significant regulatory action under E.O. 13211, and will not significantly affect energy supplies, distribution, or use. Therefore, this action is not a significant energy action. No Statement of Energy Effects is required.

List of Subjects in 50 CFR Parts 20 and 21

Exports, Hunting, Imports, Reporting and recordkeeping requirements, Transportation, Wildlife.

Regulation Promulgation

For the reasons stated in the preamble, we hereby amend parts 20 and 21, of subchapter B, chapter I, title 50 of the Code of Federal Regulations, as set forth below:

PART 20—MIGRATORY BIRD HUNTING

■ 1. The authority citation for part 20 continues to read as follows:

Authority: 16 U.S.C. 703 *et seq.,* and 16 U.S.C. 742a–j.

■ 2. Amend § 20.11 by revising paragraph (n) to read as follows:

§ 20.11 What terms do I need to understand?

* * * * *

(n) *Resident Canada geese* means Canada geese that nest within the lower 48 States and the District of Columbia or that reside within the lower 48 States and the District of Columbia in the months of April, May, June, July, or August.

PART 21—MIGRATORY BIRD PERMITS

■ 3. The authority citation for part 21 continues to read as follows:

Authority: 16 U.S.C. 703–712.

■ 4. Amend § 21.3 by revising the definition for ''*Resident Canada geese*'' to read as follows:

§ 21.3 Definitions.

* * * * *

Resident Canada geese means Canada geese that nest within the lower 48 States and the District of Columbia or that reside within the lower 48 States and the District of Columbia in the months of April, May, June, July, or August.

* * * * *

■ 5. Amend § 21.26 by revising paragraph (d)(2) to read as follows:

§ 21.26 Special Canada goose permit.

* * * * *

(d) * * *

(2) *When may a State conduct management and control activities?* States and their employees and agents may conduct egg and nest manipulation activities at any time of year. Other management and control activities, including the take of resident Canada geese, under this section may only be conducted between March 11 and August 31.

* * * * *

■ 6. Amend § 21.49 by revising paragraph (d)(3) to read as follows:

§ 21.49 Control order for resident Canada geese at airports and military airfields.

* * * * *

(d) * * *

(3) Airports and military airfields may conduct management and control activities, involving the take of resident Canada geese, under this section between April 1 and September 15. The destruction of resident Canada goose nests and eggs may take place at any time of year.

* * * * *

■ 7. Amend § 21.50 by revising paragraph (d)(4) to read as follows:

§ 21.50 Depredation order for resident Canada geese nests and eggs.

* * * * *

(d) * * *

(4) Registrants may conduct resident Canada goose nest and egg destruction activities at any time of year. Homeowners' associations and local governments or their agents must obtain landowner consent prior to destroying nests and eggs on private property within the homeowners' association or local government's jurisdiction and be in compliance with all State and local laws and regulations.

* * * * *

■ 8. Amend § 21.51 by revising paragraph (d)(4) to read as follows:

§ 21.51 Depredation order for resident Canada geese at agricultural facilities.

* * * * *

(d) * * *

(4) Authorized agricultural producers and their employees and agents may conduct management and control activities, involving the take of resident Canada geese, under this section between May 1 and August 31. The destruction of resident Canada goose nests and eggs may take place at any time of year.

* * * * *

■ 9. Amend § 21.52 by revising paragraph (e)(3) to read as follows:

§ 21.52 Public health control order for resident Canada geese.

* * * * *

(e) * * *

(3) Authorized State and Tribal wildlife agencies and their employees and agents may conduct management and control activities, involving the take of resident Canada geese, under this section between April 1 and August 31. The destruction of resident Canada goose nests and eggs may take place at any time of year.

* * * * *

Dated: June 13, 2019.

Karen Budd-Falen,

Deputy Solicitor for Parks and Wildlife, Exercising the Authority of the Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 2019–13097 Filed 6–19–19; 8:45 am]

BILLING CODE 4333–15–P

Proposed Rules

Federal Register

Vol. 84, No. 119

Thursday, June 20, 2019

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 166

[Docket No. APHIS–2018–0067]

RIN 0579–AE50

Swine Health Protection Act; Amendments to Garbage Feeding Regulations

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Proposed rule.

SUMMARY: We are proposing to amend the Swine Health Protection Act regulations by removing the State status lists from the regulations in order to maintain these lists on the Agency's website. These changes would allow us to use a notice-based, streamlined approach to update the lists while continuing to protect swine health in the United States.

DATES: We will consider all comments that we receive on or before August 19, 2019.

ADDRESSES: You may submit comments by either of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov/#!docketDetail;D=APHIS-2018-0067.*
- *Postal Mail/Commercial Delivery:* Send your comment to Docket No. APHIS–2018–0067, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road, Unit 118, Riverdale, MD 20737–1238.

Supporting documents and any comments we receive on this docket may be viewed at *http://www.regulations.gov/#!docketDetail;D=APHIS-2018-0067* or in our reading room, which is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799–7039 before coming.

FOR FURTHER INFORMATION CONTACT: Dr. John Korslund, DVM, Staff Officer, Veterinary Services, Surveillance, Preparedness, and Response Services, APHIS, 4700 River Road Unit 46, Riverdale, MD 20737–1236; email: *John.A.Korslund@usda.gov;* phone: (301) 851–3468.

SUPPLEMENTARY INFORMATION:

Background

The Swine Health Protection Act (7 U.S.C. 3801 *et seq.,* referred to below as the Act) is intended to protect the commerce, health, and welfare of the people of the United States by ensuring that food waste fed to swine does not contain active disease organisms that pose a risk to domestic swine. The regulations in 9 CFR part 166 regarding swine health protection (referred to below as the regulations) were promulgated in accordance with the Act.

The regulations contain provisions that regulate food waste containing any meat products fed to swine. Compliance with these regulations ensures that all food waste fed to swine is properly treated to kill disease organisms. Raw or undercooked meat may transmit numerous infectious or communicable diseases to swine, including exotic viral diseases such as foot-and-mouth disease, African swine fever, classical swine fever, and swine vesicular disease. Under the regulations, food waste containing meat may be fed to swine only if it has been treated to kill disease organisms.

Section 166.15 of the regulations contains provisions regarding garbage feeding and enforcement responsibility, with lists of States that are subject to each provision. Paragraph (a) lists States prohibiting feeding garbage to swine, paragraph (b) lists States permitting the feeding of treated garbage to swine, paragraph (c) lists States with primary enforcement responsibility under the Act, and paragraph (d) lists States without primary enforcement responsibility under the Act issuing licenses under a cooperative agreement with the Animal and Plant Health Inspection Service (APHIS). Paragraph (e) provides contact information for persons with questions about the feeding of garbage to swine.

The last change to a State's status in § 166.15 was made in 2004. Historically, changes to State statuses have been announced through a final rule published in the **Federal Register**. These final rules, published without an initial proposed rule or comment period, affirmed changes already made by a State to its laws governing the feeding of garbage to swine. We determined that, because these rules reflected already completed State actions to their garbage feeding laws, soliciting public comments would not yield additional relevant information.

We are proposing to revise § 166.15 by moving the State status lists in § 166.15(a) through (d) from the regulations to the APHIS website. As a result of this move, any subsequent changes to a State's status would be communicated through a notice, *i.e.,* we would publish a notice in the **Federal Register** announcing the change to the State's status in conjunction with updating the lists maintained on the APHIS website. This action would allow us to provide more timely and up-to-date information about State and territory statuses to our stakeholders and the public.

As revised, proposed § 166.15 would list the categories of States currently described in paragraphs (a) through (d) while referencing the location of the State lists in a website address. We would also retain the contact information found in paragraph (e).

These changes would allow us to use a notice-based, streamlined approach to update the lists while continuing to protect swine health in the United States.

Executive Orders 12866 and 13771 and Regulatory Flexibility Act

This proposed rule has been determined to be not significant for the purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget. This proposed rule is not expected to be an Executive Order 13771 regulatory action because this proposed rule is not significant under Executive Order 12866.

In accordance with the Regulatory Flexibility Act, we have analyzed the potential economic effects of this action on small entities. The analysis is summarized below. Copies of the full analysis are available by contacting the person listed under **FOR FURTHER**

INFORMATION CONTACT or on the *Regulations.gov* website (see **ADDRESSES** above for instructions for accessing *Regulations.gov*).

In accordance with the Swine Health Protection Act (7 U.S.C. 3801 *et seq.*), APHIS regulates food waste containing any meat products fed to swine. Raw or undercooked meat may transmit numerous infectious or communicable diseases. Compliance with these regulations ensures that all food waste fed to swine is properly treated to kill disease organisms.

We are proposing to revise the regulations by moving the State status lists in § 166.15(a) through (d) from the regulations to the APHIS website. As a result of this proposed move, any subsequent additions, deletions, and other changes to a State's status would be made using a notice-based process.

The proposed rule, while facilitating changes to the State status lists, is not expected to have an economic impact on hog and pig farms.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action would not have a significant economic impact on a substantial number of small entities.

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 2 CFR chapter IV.)

Executive Order 12988

This proposed rule has been reviewed under Executive Order 12988, Civil Justice Reform. If this proposed rule is adopted: (1) All State and local laws and regulations that are in conflict with this rule will be preempted; (2) no retroactive effect will be given to this rule; and (3) administrative proceedings will not be required before parties may file suit in court challenging this rule.

Paperwork Reduction Act

In accordance with section 3507(d) of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the information collection requirements included in this proposed rule have already been approved by the Office of Management and Budget (OMB) under OMB control number 0579–0065.

E-Government Act Compliance

The Animal and Plant Health Inspection Service is committed to compliance with the E-Government Act to promote the use of the internet and other information technologies, to provide increased opportunities for citizen access to Government information and services, and for other purposes. For information pertinent to E-Government Act compliance related to this proposed rule, please contact Ms. Kimberly Hardy, APHIS' Information Collection Coordinator, at (301) 851–2483.

List of Subjects in 9 CFR Part 166

Animal diseases, Reporting and recordkeeping requirements, Swine.

Accordingly, we propose to amend 9 CFR part 166 as follows:

PART 166—SWINE HEALTH PROTECTION

■ 1. The authority citation for part 166 continues to read as follows:

Authority: 7 U.S.C. 3801–3813; 7 CFR 2.22, 2.80, and 371.4.

■ 2. Section 166.12 is amended by:
■ a. Removing the phrase ''listed in § 166.15(d) of this part'' each time it appears and adding the phrase ''referenced in § 166.15(a)'' in its place;
■ b. Revising footnote 1; and
■ c. Removing the words ''of this part'' in paragraph (c).

The revision reads as follows:

§ 166.12 Cancellation of licenses.

* * * * *

[1] To find the name and address of the Area Veterinarian in Charge, go to *https://www.aphis.usda.gov/animal_health/contacts/field-operations-districts.pdf.*

■ 3. Section 166.15 is revised to read as follows:

§ 166.15 State status.

(a) The Animal and Plant Health Inspection Service (APHIS) will maintain on its website [2] the following lists of States:

(1) States that prohibit the feeding of garbage to swine;

(2) States that allow the feeding of treated garbage to swine;

(3) States that have primary enforcement responsibility under the Act; and

(4) States that issue licenses under cooperative agreements with APHIS, but do not have primary responsibility under the Act.

(b) For information concerning the feeding of garbage to swine, the public may contact the APHIS Area Veterinarian in Charge, the State animal health official, or Veterinary Services, 4700 River Road Unit 37, Riverdale, MD 20737–1231.

[2] *https://www.aphis.usda.gov/aphis/ourfocus/animalhealth/animal-disease-information/swine-disease-information.*

Done in Washington, DC, this 14th day of June 2019.

Kevin Shea,

Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2019–13154 Filed 6–19–19; 8:45 am]

BILLING CODE 3410–34–P

NUCLEAR REGULATORY COMMISSION

10 CFR Chapter I

[NRC–2015–0167]

Withdrawal of Regulatory Issue Summary 2005–29 and its Draft Revision 1 Anticipated Transients That Could Develop Into More Serious Events

AGENCY: Nuclear Regulatory Commission.

ACTION: Regulatory issue summary; withdrawal.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is withdrawing the Regulatory Issue Summary (RIS) 2005–29 and its draft Revision 1, ''Anticipated Transients that Could Develop into More Serious Events.'' These documents are being withdrawn because the NRC staff identified several regulatory and technical positions within the RIS and draft Revision 1 that either required clarification, were no longer supported, or were identified as a new agency position.

DATES: The effective date of the withdrawal of the RIS 2005–29 and its draft Revision 1, ''Anticipated Transients that Could Develop into More Serious Events,'' is June 20, 2019.

ADDRESSES: Please refer to Docket ID NRC–2015–0167 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

• *Federal Rulemaking website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2015–0167. Address questions about NRC dockets IDs in *Regulations.gov* to Jennifer Borges; telephone: 301–287–9127; email: *Jennifer.Borges@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.

• *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select

''Begin Web-based ADAMS Search.'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if it is available in ADAMS) is provided the first time that it is mentioned in this document.

• *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: Tekia V. Govan, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–6197; email: *Tekia.Govan@nrc.gov.*

SUPPLEMENTARY INFORMATION:

The NRC issued RIS 2005–29, ''Anticipated Transients that Could Develop into More Serious Events,'' (ADAMS Accession No. ML051890212) to notify licensees of the concern identified during reviews of power uprate license amendment requests related to licensing bases of certain licensees failing to demonstrate that anticipated transients will not progress to more serious events. The draft Revision 1 of RIS 2005–29 expanded on this concern and offered staff positions that provided technical guidance for the implementation of NRC regulation (ADAMS Accession No. ML15014A469). The NRC is withdrawing RIS 2005–29, and its draft Revision 1, because the staff identified several regulatory and technical positions within the documents that either required clarification, were no longer supported, or were identified as a new agency position. By memorandum, dated May 15, 2019, the NRC staff provides a summary of the basis for withdrawing RIS 2005–29, and its draft Revision 1 (ADAMS Accession No. ML19121A534).

The NRC's generic communication website (*https://www.nrc.gov/reading-rm/doc-collections/gen-comm/reg-issues/2005/*) will be updated to reflect RIS 2005–29 as withdrawn.

Dated at Rockville, Maryland, this 12th day of June 2019.

For the Nuclear Regulatory Commission.

Tekia V. Govan,

Project Manager, ROP Support and Generic Communication Branch, Division of Inspection and Regional Support, Office of Nuclear Reactor Regulation.

[FR Doc. 2019–12725 Filed 6–19–19; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R08–OAR–2019–0180; FRL–9995–10–Region 8]

Approval and Promulgation of Air Quality State Implementation Plans; Utah; Interstate Transport Requirements for Nitrogen Dioxide, Sulfur Dioxide, and Fine Particulate Matter

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The Environmental Protection Agency (EPA) is proposing to approve State Implementation Plan (SIP) submissions from the State of Utah regarding certain interstate transport requirements of the Clean Air Act (CAA or ''Act''). These submissions respond to the EPA's promulgation of the 2010 nitrogen dioxide (NO_2) national ambient air quality standards (NAAQS), the 2010 sulfur dioxide (SO_2) NAAQS, and the 2012 fine particulate matter ($PM_{2.5}$) NAAQS. The submissions address the requirement that each SIP contain adequate provisions prohibiting air emissions that will significantly contribute to nonattainment or interfere with maintenance of these NAAQS in any other state.

DATES: Written comments must be received on or before July 22, 2019.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R08–OAR–2019–0180, to the Federal Rulemaking Portal: *https://www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *www.regulations.gov.* The EPA may publish any comment received to its public docket. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. The EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.,* on the web, cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on making effective comments, please visit *http://www2.epa.gov/dockets/commenting-epa-dockets.*

Docket: All documents in the docket are listed in the *www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *www.regulations.gov* or in hard copy at the Air and Radiation Division, Environmental Protection Agency (EPA), Region 8, 1595 Wynkoop Street, Denver, Colorado 80202–1129. The EPA requests that if at all possible, you contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section to view the hard copy of the docket. You may view the hard copy of the docket Monday through Friday, 8:00 a.m. to 4:00 p.m., excluding federal holidays.

FOR FURTHER INFORMATION CONTACT: Adam Clark, Air Quality Planning Branch, EPA, Region 8, Mailcode 8ARD–QP, 1595 Wynkoop Street, Denver, Colorado 80202–1129, (303) 312–7104, *clark.adam@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us'' or ''our'' is used, we mean the EPA.

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I. Background

Section 110(a)(1) of the CAA requires states to submit SIPs meeting the applicable requirements of section 110(a)(2) within 3 years after promulgation of a new or revised NAAQS or within such shorter period as the EPA may prescribe. Section 110(a)(2) requires states to address

structural SIP elements such as requirements for monitoring, basic program requirements, and legal authority that are designed to provide for implementation, maintenance, and enforcement of the NAAQS. The EPA refers to the SIP submissions required by these provisions as ''infrastructure SIPs.'' Section 110(a) imposes the obligation upon states to make an infrastructure SIP submission to the EPA for a new or revised NAAQS, but the contents of individual state submissions may vary depending upon the facts and circumstances. This proposed rule pertains to the infrastructure SIP requirements for interstate transport of air pollution.

A. Interstate Transport

Section 110(a)(2)(D)(i) of the CAA requires SIPs to include provisions prohibiting any source or other type of emissions activity in one state from emitting any air pollutant in amounts that will contribute significantly to nonattainment, or interfere with maintenance, of the NAAQS, or interfere with measures required to prevent significant deterioration of air quality or to protect visibility in any other state. This proposed rule addresses the two requirements under section 110(a)(2)(D)(i)(I), which we refer to as prong 1 (significant contribution to nonattainment of the NAAQS in any other state) and prong 2 (interference with maintenance of the NAAQS in any other state).[1] The EPA often refers to SIP revisions addressing the requirements of section 110(a)(2)(D)(i)(I) as ''interstate transport SIPs.''

The EPA evaluates each state's interstate transport SIP to see how the state evaluates the transport of air pollution to other states for a given air pollutant; what types of information the state used in its analysis; how that analysis compares with prior EPA rulemakings, modeling, monitoring, and guidance; and what conclusions were drawn by the state. If the EPA concludes that the SIP contains adequate provisions to prohibit sources from emitting air pollutants that significantly contribute to nonattainment, or interfere with maintenance, of a given NAAQS in any other state, we will approve the state's submission with regard to prongs 1 and 2 of CAA section 110(a)(2)(D)(i)(I).

Each of the following NAAQS revisions triggered the requirement for states to submit infrastructure SIPs, including provisions to address interstate transport prongs 1 and 2. On January 22, 2010, the EPA promulgated a new 1-hour primary NAAQS for NO_2 at a level of 100 parts per billion (ppb) while retaining the annual standard of 53 ppb.[2] On June 2, 2010, the EPA promulgated a new primary 1-hour SO_2 standard of 75 ppb and retained the secondary 3-hour standard of 0.5 parts per million (ppm).[3] Finally, on December 14, 2012, the EPA revised the primary annual $PM_{2.5}$ standard by lowering the level to 12.0 micrograms per cubic meter (μg/m^3) and retained the secondary annual $PM_{2.5}$ standard of 15.0 μg/m^3 and the primary and secondary 24-hour $PM_{2.5}$ standards of 35 μg/m^3.[4]

As discussed further in this notice, the EPA proposes to determine that Utah's SIP contains adequate provisions to prohibit sources from emitting air pollutants in amounts that significantly contribute to nonattainment or interfere with maintenance of the 2010 NO_2, 2010 SO_2 and 2012 $PM_{2.5}$ NAAQS.

B. Utah's Submissions

The State of Utah submitted infrastructure SIPs for the 2010 NO_2 NAAQS on January 31, 2013, and for the 2010 SO_2 NAAQS on June 2, 2013. In both of these submissions, the State addressed interstate transport prongs 1 and 2 by referencing the EPA's November 19, 2012 Memorandum[5] which outlined the EPA's intention to abide by the August 21, 2012 decision of the U.S. Court of Appeals for the D.C. Circuit, holding that a SIP cannot be deemed deficient for failing to meet the prong 1 and 2 requirements in Section 110(a)(2)(D)(i) before the EPA quantifies the state's obligation. *EME Homer City Generation, L.P.* v. *EPA,* 696 F.3d 7 (D.C. Cir. 2012). Utah stated that the EPA had not yet quantified Utah's interstate transport obligation under the 2010 NO_2 or 2010 SO_2 NAAQS and therefore Utah's infrastructure SIPs were adequate for section 110(a)(2)(D)(i)(I).[6]

On April 29, 2014, the U.S. Supreme Court reversed and remanded the D.C. Circuit's EME Homer City ruling and upheld the EPA's approach in the Cross-State Air Pollution Rule. *EPA* v. *EME Homer City Generation, L.P.,* 572 U.S. 489 (2014). As a result of the Supreme Court reversal, each state was again required to address the interstate transport requirements of 110(a)(2)(D)(i) regardless of whether the EPA had quantified the state's obligation. In accordance with the Supreme Court's decision, on May 8, 2018 Utah submitted to the EPA 2010 NO_2 and 2010 SO_2 infrastructure SIPs, both of which contained new analyses addressing interstate transport prongs 1 and 2 of Section 110(a)(2)(D)(i) for the respective NAAQS. These submissions supplement the State's prior 2013 interstate transport SIP submissions for both NAAQS. Utah submitted an infrastructure SIP for the 2012 $PM_{2.5}$ NAAQS, including an interstate transport SIP, on December 22, 2015. The EPA will discuss these submissions in further detail later in this proposed action.

II. Interstate Transport Evaluation

A. Evaluation for the 2010 1-Hour NO_2 NAAQS

1. EPA's General Approach To Evaluating the 2010 NO_2 NAAQS

Unlike certain other NAAQS like ozone and $PM_{2.5}$, the EPA has not developed a recommended approach for states to use when addressing prongs 1 and 2 for the 2010 NO_2 NAAQS. Following promulgation of the 2010 NO_2 NAAQS, the EPA designated all areas of the United States as ''unclassifiable/attainment'' for this NAAQS because monitors throughout the country had indicated no violations of the NAAQS from 2008–2010.[7] 77 FR 9532, February 17, 2012. Additionally, no violations occurred at any monitor in the country in the most recent available design value period of 2015–2017.[8] For these reasons, 110(a)(2)(D)(i)(I) demonstrations for states have been relatively straightforward because the EPA has not identified areas in any state to which emissions from another state would likely contribute significantly to nonattainment or interfere with maintenance.

[1] The remaining interstate transport requirements of CAA section 110(a)(2)(D)(i) for the 2010 NO_2, 2010 SO_2 and 2012 $PM_{2.5}$ NAAQS for Utah have been addressed in prior State submissions and EPA rulemakings. 81 FR 71991 (October 19, 2016); 81 FR 50626 (August 2, 2016). Specifically, this includes the section 110(a)(2)(D)(i)(II) requirements relating to interference with measures required to be included in the applicable implementation plan for any other state under part C to prevent significant deterioration of air quality (prong 3) or to protect visibility (prong 4).

[2] 75 FR 6474 (February 9, 2010).

[3] 75 FR 35520 (June 22, 2010).

[4] 78 FR 3086 (January 15, 2013).

[5] See ''Next Steps for Pending Redesignation Requests and State Implementation Plan Actions Affected by the Recent Court Decision Vacating the 2011 Cross-State Air Pollution Rule,'' signed by EPA Assistant Administrator Gina McCarthy November 19, 2012. This memorandum is in the docket for this action.

[6] These submissions are available in the docket for this action.

[7] For comparison with the 2010 NO_2 1-hour NAAQS, a three-year design value is used. 40 CFR 50.11(f).

[8] See *https://www.epa.gov/air-trends/air-quality-design-values#report.* As this report indicates, no regulatory monitor in the U.S. recorded a design value above 78 ppb for the 2015–2017 design value period.

2. State's Submission

Utah conducted a weight of evidence analysis to examine whether NO_2 emissions from Utah adversely affect attainment or maintenance of the 2010 NO_2 NAAQS in downwind states. In this analysis, the State reviewed ambient monitoring data in Utah and neighboring states, which all indicated that no monitor values in Utah or neighboring states approach the level of the 2010 NO_2 NAAQS. Based on this monitoring data, Utah concluded that the emissions from the State will not contribute significantly to nonattainment or interfere with maintenance of the 2010 NO_2 NAAQS in any other state, and therefore the SIP meets the requirements of section 110(a)(2)(D)(i)(I) prongs 1 and 2 for this NAAQS.

3. EPA's Analysis

In addition to the information provided in the SIP, the EPA notes that the highest monitored valid NO_2 design values in each state bordering Utah are well below the NAAQS (see Table 1, below), as are the maximum single year 98th percentile values from each neighboring state between 2015–2017 (see Table 2, below). These facts further support the State's assertion that significant contribution to nonattainment or interference with maintenance of the NO_2 NAAQS from Utah is very unlikely. With respect to prong 2 (interference with maintenance), specifically, in addition to the lack of areas violating the NO_2 NAAQS, there are also no areas in neighboring states approaching a violation of the 2010 NO_2 NAAQS (*i.e.,* 100 ppb) which might therefore be expected to have difficulty maintaining the standard. With respect to both prongs, we also note that there are no areas elsewhere in the United States approaching a violation of the 2010 NO_2 NAAQS.[9]

TABLE 1—1-HOUR NO_2 DESIGN VALUES IN UTAH AND NEIGHBORING STATES

State	2015–2017 1-hr NO_2 design value (ppb)
Utah	42
Arizona	60
Colorado	71
Nevada	55
New Mexico	45
Wyoming	40

[9] *Id.*

TABLE 2—MAX 98TH PERCENTILE NO_2 CONCENTRATION IN UTAH AND NEIGHBORING STATES

State	Year	Highest single year 98th percentile value from 2015–2017 (ppb)
Utah	2016	61
Arizona	2017	67
Colorado	2016	75
Idaho	2017	50
Nevada	2017	61
New Mexico	2016	46
Wyoming	2017	60

Based on all of these factors, the EPA proposes to concur with the State's conclusion in its January 31, 2013 and supplemental May 8, 2018 submissions that emissions from Utah will not contribute significantly to nonattainment or interfere with maintenance of the 2010 NO_2 NAAQS in other states. The EPA is therefore proposing to approve Utah's January 31, 2013 and supplemental May 8, 2018 NO_2 submissions.

B. Evaluation for the 2010 1-Hour SO_2 NAAQS

1. EPA's General Approach To Evaluating the 2010 SO_2 NAAQS

Although SO_2 is emitted from a similar universe of point and nonpoint sources as is directly emitted $PM_{2.5}$ and the precursors to ozone and $PM_{2.5}$, interstate transport of SO_2 is unlike the transport of $PM_{2.5}$ or ozone because SO_2 emissions sources usually do not have long range SO_2 impacts. The transport of SO_2 relative to the 1-hour NAAQS is more analogous to the transport of Pb relative to the Pb NAAQS in that emissions of SO_2 typically result in 1-hour pollutant impacts of possible concern only near the emissions source. However, ambient 1-hour concentrations of SO_2 do not decrease as quickly with distance from the source as do 3-month average concentrations of Pb, because SO_2 gas is not removed by deposition as rapidly as are Pb particles and because SO_2 typically has a higher emissions release height than Pb. Moreover, while emitted SO_2 has wider ranging impacts than emitted Pb, it does not have such wide-ranging impacts that treatment in a manner similar to ozone or $PM_{2.5}$ would be appropriate. The approaches that the EPA has adopted for ozone or $PM_{2.5}$ transport are too regionally focused and the approach for Pb transport is too tightly circumscribed to the source. SO_2 transport is therefore a unique case and requires a different approach.

In SO_2 transport analyses, we focus on a 50 km-wide zone because the physical properties of SO_2 result in relatively localized pollutant impacts near an emissions source that drop off with distance. Given the physical properties of SO_2, the EPA selected the ''urban scale''—a spatial scale with dimensions from 4 to 50 kilometers (km) from point sources—as that scale has been an appropriate range both for monitoring SO_2 concentrations and for modeling SO_2 impacts from such sources.[10] As such, the EPA utilized an assessment up to 50 km from point sources in order to assess trends in area-wide air quality that might impact downwind states.

2. State's Submission

Utah conducted a weight of evidence analysis to examine whether SO_2 emissions from Utah contribute significantly to nonattainment or interfere with maintenance of the 2010 SO_2 NAAQS in downwind states. Utah's analysis first reviewed monitoring data in neighboring states to determine whether there were cross-state areas to which Utah could potentially contribute significantly to nonattainment. Utah concluded that the only monitors in neighboring states near or above the NAAQS were violating monitors located in the Miami, Arizona and Hayden, Arizona SO_2 nonattainment areas.[11] Utah then analyzed the SO_2 source within the State with the closest proximity to the Arizona nonattainment areas. The State determined the distance (531 km) between this source (Cci Paradox Midstream, Llc: Lisbon Natural Gas Processing Plant) and the nearest nonattainment area (Miami, Arizona) showed that Utah will not contribute significantly to nonattainment in Arizona. For its analysis of interference with maintenance, Utah reviewed the sources with over 100 ton per year (tpy) SO_2 emissions in the State within 50 km of a state border, the distance from the nearest cross-state SO_2 monitors to Utah sources, and its proximity to the nearest former 2010 SO_2 nonattainment area in Billings, Montana. Utah also pointed to the significant decrease in SO_2 emissions from sources in the State over time, and its current low levels of monitored SO_2, as further evidence that Utah will not significantly contribute to

[10] For the definition of spatial scales for SO_2, please see 40 CFR part 58, Appendix D, section 4.4 (''Sulfur Dioxide (SO_2) Design Criteria''). For further discussion on how the EPA is applying these definitions with respect to interstate transport of SO_2, *see* 82 FR 21351, 21352, 21354 (May 8, 2017) (proposed approval of Connecticut's SO_2 transport SIP); 82 FR 37013 (Aug. 8, 2017) (final approval).

[11] *https://www3.epa.gov/airquality/greenbook/tbtc.html.*

nonattainment of the 2010 SO_2 NAAQS in any other state.

3. EPA's Analysis

Prong 1: Significant Contribution to Nonattainment

The EPA proposes to approve Utah's June 2, 2013 and supplemental May 8, 2018 submittals with respect to the interstate transport requirements of CAA section 110(a)(2)(D)(i)(I), prong 1 for the 2010 SO_2 NAAQS, as discussed below. We have analyzed the air quality, emission sources and emission trends in Utah and neighboring states, *i.e.,* Arizona, Colorado, Idaho, New Mexico, Nevada and Wyoming. Based on that analysis, we propose to find that Utah will not significantly contribute to nonattainment of the 2010 SO_2 NAAQS in any other state.

We first reviewed 2015–2017 1-hour SO_2 design value concentrations for Utah and neighboring states.[12] In Table 3, below, we have included monitoring data from four scenarios: (1) All of the monitor data from Utah; [13] (2) the monitor with the highest SO_2 level in each neighboring state; (3) the monitor in each neighboring state located closest to the Utah border; and (4) all monitors in each neighboring state within 50 km of the Utah border.[14] For monitors without a valid 2015–2017 design value, we have instead elected to present the highest annual 99th percentile daily maximum 1-hour SO_2 concentration between 2015 and 2017. These values are shown in the far-right column of Table 3, below. As the table indicates, all of these concentrations are below the level of the 2010 SO_2 NAAQS.

TABLE 3—SO_2 MONITOR VALUES IN UTAH AND NEIGHBORING STATES

State/area	Scenario	Site ID	Approx. distance to Utah border (km)	2015–2017 design value (ppb)	Annual 99th percentile 1-hour daily maximum SO_2 Concentration, 2015–2017 [15]
Arizona/Phoenix	3	040139997	388	6	
Arizona/Hayden	2	040071001	443	295	
Colorado/Denver	3	080310026	346	15	
Colorado/Colorado Springs	2	080410015	366	40	
Idaho/Pocatello	2	160050004	102	38	
Idaho/Soda Springs	3	160290031	76	30	
Nevada/Las Vegas	2, 3	320030540	134	6	
New Mexico/Farmington	2, 3	350451005	57	NA *	16 (2017)
Utah/Salt Lake City	1	490353006	76	NA *	13 (2016)
Wyoming/Rock Springs	3	560370300	105	21	
Wyoming/Riverton	2	560130003	315	NA *	65 (2017)

* The DV for this site is invalid due to incomplete data and/or quality assurance issues for this period and is not for use in comparison to the NAAQS.

The EPA reviewed these data to see whether there were any regulatory monitoring sites, particularly near the Utah border, with elevated SO_2 concentrations that might warrant further investigation with respect to interstate transport of SO_2 from emission sources near any given monitor. As shown, at the monitors with valid design values, there are no violating design values in Utah or neighboring states apart from Arizona, and the nearest monitor with the violating design value in Arizona is 443 km from the Utah border.

The data presented in Table 3, above, show that Utah's network of SO_2 monitors, while limited, indicates that monitored 1-hour SO_2 levels in Utah were 9% of the 75 ppb level of the NAAQS. As shown, there are no Utah monitors located within 50 km of a neighboring state's border, nor are there any monitors in neighboring states located within 50 km of the Utah border. Thus, these air quality data do not, by themselves, indicate any particular location that would warrant further investigation with respect to SO_2 emission sources that might significantly contribute to nonattainment in the neighboring states. However, because the monitoring network is not necessarily designed to find all locations of high SO_2 concentrations, we have also conducted a source-oriented analysis.

As noted, the EPA finds that it is appropriate to examine the impacts of emissions from stationary sources in Utah in distances ranging from 0 km to 50 km from the facility. Utah assessed point sources up to 50 km from state borders to evaluate SO_2 transport. The list of sources emitting 100 tpy [16] or more of SO_2 in 2017 within 50 km from Utah state borders is shown in Table 4 below.

[12] Data retrieved from EPA's *https://www.epa.gov/air-trends/air-quality-design-values#report.*

[13] There are currently three SO_2 monitors operating in Utah. However, two of these (AQS Site IDs 490352005 and 490353010) began operation in 2018, and therefore do not have data sufficient to assist the EPA in this technical analysis. We note that the highest 1-hr SO_2 concentration from either of the monitors in 2018 was 7 ppb, or roughly 9% of the NAAQS.

[14] There are no states within 50 km of the Utah border that are not also neighboring states.

[15] These values are only presented for monitors without a valid 2015–2017 design value.

[16] Utah limited its analysis to Utah sources of SO_2 emitting at least 100 tpy. We agree with Utah's choice to limit its analysis in this way, because in the absence of special factors, for example the presence of a nearby larger source or unusual physical factors, Utah sources emitting less than 100 tpy can appropriately be presumed to not be adversely impacting SO_2 concentrations in downwind states.

TABLE 4—UTAH SO_2 SOURCES NEAR NEIGHBORING STATES [17]

Utah source	2017 SO_2 emissions (tons) *	Distance to Utah border (km)	Approx. distance to nearest neighboring state SO_2 source (km)	Neighboring state source 2017 SO_2 emissions (tons)
CCI Paradox Midstream LLC: Lisbon Natural Gas Processing Plant—San Juan County, Utah.	499 (2016)	20	68 (Nucla Generating Station—Montrose County, Colorado).	153
Holcim Inc.: Devils Slide Plant—Morgan County, Utah.	196	41	109 (Naughton Power Plant—Lincoln County, Wyoming).	4,047

* Emissions data throughout this document were obtained using EPA's Emissions Inventory System (EIS) Gateway.

Table 4 also shows the distance from Utah sources located near a neighboring state to the nearest out-of-state SO_2 source emitting above 100 tpy of SO_2, because elevated levels of SO_2, to which SO_2 emitted in Utah may have a downwind impact, are most likely to be found near such sources. As shown, both Utah sources within 50 km of a neighboring state are beyond 50 km from the nearest major out-of-state source, with the shortest distance between such cross-state SO_2 sources at 68 km.[18] Given the localized range of potential 1-hour SO_2 impacts and the distance between sources, Table 4 suggests that emissions from these Utah sources are unlikely to contribute significantly to nonattainment of the 2010 SO_2 NAAQS in neighboring states. Additionally, the largest neighboring-state source in Table 4, Naughton Power Plant, was modeled and showed attainment with the 2010 SO_2 NAAQS.[19] Based on this modeling, the EPA designated Lincoln County, Wyoming as attainment/unclassifiable for this NAAQS. *See* 83 FR 1170, January 9, 2018. This provides additional support for our proposed conclusion that emissions from the Utah sources in Table 4 do not significantly contribute to nonattainment of the 2010 SO_2 NAAQS in neighboring states.[20]

The EPA also reviewed the location of sources in neighboring states emitting more than 100 tpy of SO_2 and located within 50 km of the Utah border (see Table 5) that were not already addressed in Table 4. As shown in Table 5, there is only one such source, and the shortest distance between it and any Utah source that emits 100 tpy or more of SO_2 is 233 km. The distance shown in Table 5 indicates that there are no locations in neighboring states that would warrant further investigation with respect to Utah SO_2 emission sources that might contribute significantly to nonattainment of the 2010 SO_2 NAAQS. The Hayden and Miami, Arizona 2010 SO_2 nonattainment areas, which Utah reviewed as part of its analysis, are over 380 km from the nearest Utah border and so were not included in Table 5. Utah asserted that the significant distance between its border and these nonattainment areas indicates that it is highly unlikely that SO_2 emissions generated in Utah are contributing significantly to either nonattainment area in Arizona, and the EPA proposes to agree with this conclusion.

TABLE 5—NEIGHBORING STATE SO_2 SOURCES NEAR UTAH *

Source	2016 SO_2 emissions (tons)	Distance to Utah border (km)	Approx. distance to nearest Utah SO_2 source (km)	Utah source 2016 emissions (tons)
Navajo Generating Station—Navajo Nation ...	3,585	11	233 (Lisbon Natural Gas Processing Plant) ..	499

* We have not included sources that are duplicative of those in Table 3.

In conclusion, for interstate transport prong 1, we reviewed ambient SO_2 monitoring data and SO_2 emission sources both within Utah and in neighboring states. Based on this analysis, we propose to determine that emissions from Utah will not significantly contribute to nonattainment of the 2010 SO_2 NAAQS in any other state and therefore propose to approve the June 2, 2013 and supplemental May 8, 2018 SO_2 submissions with respect to this requirement.

Prong 2: Interference With Maintenance

The EPA also proposes to approve the June 2, 2013 and supplemental May 8, 2018 submissions with respect to the prong 2 requirement. In its prong 2 analysis, Utah reviewed ambient SO_2 monitoring data, emissions trends within Utah, and potential SO_2 impacts on the Billings, Montana area, which is currently in ''maintenance'' status for the 2010 SO_2 NAAQS, noting the large distance between the nearest Utah border and the Billings area (457 km). However, in previous actions the EPA has analyzed prong 2 by evaluating the

[17] The EPA did not include information about sources located on tribal lands within the outer boundary of the state of Utah, as the State is not the regulatory authority for these sources.

[18] The EPA notes that the Nucla Generating Station is required by the Colorado regional haze SIP to shut down before December 31, 2022. *See* 83 FR 31332 (July 5, 2018).

[19] See ''Chapter 45: Intended Round 3 Area Designations for the 2010 1-Hour SO_2 Primary National Ambient Air Quality Standard for Wyoming,'' in the docket for this action and in the docket for the EPA's Round 3 2010 SO_2 Designations at EPA–HQ–OAR–2017–0003–0608.

[20] While designations may provide useful information for purposes of analyzing transport, particularly for a more source-specific pollutant such as SO_2, EPA notes that designations themselves are not dispositive of whether or not upwind emissions are impacting areas in downwind states. EPA has consistently taken the position that as to impacts, CAA section 110(a)(2)(D) refers only to prevention of 'nonattainment' in other states, not to prevention of nonattainment in designated nonattainment areas or any similar formulation requiring that designations for downwind nonattainment areas must first have occurred. *See e.g.,* Clean Air Interstate Rule, 70 FR 25162, 25265 (May 12, 2005); Cross-State Air Pollution Rule, 76 FR 48208, 48211 (Aug. 8, 2011); Final Response to Petition from New Jersey Regarding SO_2 Emissions From the Portland Generating Station, 76 FR 69052 (Nov. 7, 2011) (finding facility in violation of the prohibitions of CAA section 110(a)(2)(D)(i)(I) with respect to the 2010 1-hour SO_2 NAAQS prior to issuance of designations for that standard).

potential impact of a state's emissions on areas that are currently measuring data below the NAAQS, but that may have issues maintaining that air quality, rather than only former nonattainment areas which are in maintenance status.[21] Therefore, we focused our review on SO_2 monitoring data and emission trends to evaluate the State's conclusion that Utah will not interfere with maintenance of the 2010 SO_2 NAAQS in downwind states. This evaluation builds on the analysis regarding significant contribution to nonattainment (prong 1). Specifically, the low monitored ambient concentrations of SO_2 in Utah and neighboring states shown in Table 3, and the large distances between cross-state SO_2 sources shown in Tables 4 and 5, do not indicate any potential inability to maintain the SO_2 NAAQS that could be attributed in part to sources in Utah.

Table 6, below, shows emission trends for Utah and neighboring states.[22]

TABLE 6—SO_2 EMISSION TRENDS

State	2000	2005	2010	2016	SO_2 reduction, 2000–2016 (percent)
Arizona	118,528	90,577	73,075	38,089	68
Colorado	115,122	80,468	60,459	20,626	82
Idaho	34,525	35,451	14,774	10,051	70
Nevada	58,849	68,790	17,043	8,028	86
New Mexico	164,631	47,671	23,651	15,529	90
Utah	58,040	52,998	29,776	15,226	73
Wyoming	141,439	122,453	91,022	57,313	59

As shown in Table 6, the statewide SO_2 emissions from Utah and neighboring states have decreased substantially over time, per our review of the EPA's emissions trends data. This trend of decreasing SO_2 emissions does not by itself demonstrate that areas in Utah and neighboring states will maintain the 2010 SO_2 NAAQS. However, as a piece of this weight of evidence analysis for prong 2, it provides further indication (when considered alongside low monitor values in neighboring states and large distances between SO_2 emissions sources) that maintenance issues are unlikely. The geographic scope and large relative size of these reductions strongly suggest that they are not transient effects from reversible causes, and thus there is low likelihood that a strong upward trend in emissions will occur that might cause areas presently in attainment to violate the NAAQS in the future.

In conclusion, for interstate transport prong 2, we reviewed additional information about emission trends, as well as the technical information considered for interstate transport prong 1. We propose to find that the combination of low ambient concentrations of SO_2 in Utah and neighboring states, the large distances between cross-state SO_2 sources, and the downward trend in SO_2 emissions from Utah and neighboring states, show no interference with maintenance of the 2010 SO_2 NAAQS from Utah. Accordingly, we propose to approve Utah's June 2, 2013 and supplemental May 8, 2018 SO_2 submissions with respect to the prong 2 requirement.

C. Evaluation for the 2012 Annual $PM_{2.5}$ NAAQS

1. EPA's General Approach To Evaluating the 2012 $PM_{2.5}$ NAAQS

The EPA has developed a consistent framework for addressing interstate transport with respect to the $PM_{2.5}$ NAAQS. This framework includes the following four steps: (1) Identify downwind areas that are expected to have problems attaining or maintaining the NAAQS; (2) Identify which upwind states contribute to these air quality problems in amounts sufficient to warrant further review and analysis; (3) Identify any emissions reductions necessary to prevent an identified upwind state from significantly contributing to downwind nonattainment or interfering with downwind maintenance of the NAAQS; and (4) Adopt permanent and enforceable measures needed to achieve those emissions reductions.

To help states identify the receptors expected to have problems attaining or maintaining the 2012 annual $PM_{2.5}$ NAAQS, the EPA released a memorandum titled, ''Information on the Interstate Transport 'Good Neighbor' Provision for the 2012 Fine Particulate Matter National Ambient Air Quality Standards under Clean Air Act Section 110(a)(2)(D)(i)(I)'' on March 17, 2016 (hereon ''2016 Memo'').[23] The 2016 Memo provides projected future year annual $PM_{2.5}$ design values for monitors throughout the country based on quality-assured and certified ambient monitoring data and recent air quality modeling and explains the methodology used to develop these projected design values. The 2016 Memo also provides recommendations on how states can use the projected values to determine which monitors should be further evaluated as potential receptors under step 1 of the interstate transport framework described above, so that states can determine whether their emissions significantly contribute to nonattainment or interfere with maintenance of the 2012 annual $PM_{2.5}$ NAAQS at these monitoring sites.

To develop the projected values presented in the 2016 Memo, the EPA used the results of nationwide photochemical air quality modeling that it recently performed to support two ozone NAAQS-related rulemakings. We performed base year modeling for 2011 and future year modeling for 2017 to support the Cross-State Air Pollution Rule (CSAPR) Update for the 2008 Ozone NAAQS. *See* 81 FR 74504 (October 26, 2016). We also performed future year modeling for 2025 to support the Regulatory Impact Assessment of the final 2015 Ozone NAAQS.[24] The outputs from these model runs included hourly concentrations of $PM_{2.5}$ that the EPA used in conjunction with measured data to project annual average $PM_{2.5}$ design values for 2017 and 2025.

[21] The maintenance plan requirements for areas redesignated from nonattainment to attainment for a NAAQS can be found in CAA section 175A.

[22] This emissions trends information was derived from the EPA's web page *https://www.epa.gov/air-emissions-inventories/air-pollutant-emissions-trends-data.*

[23] This memorandum is available in the docket for this action and at *https://www.epa.gov/sites/production/files/2016–08/documents/good-neighbor-memo_implementation.pdf.*

[24] *See* 2015 ozone NAAQS RIA at: *http://www3.epa.gov/ozonepollution/pdfs/20151001ria.pdf.*

Areas that were designated as Moderate $PM_{2.5}$ nonattainment areas for the 2012 annual $PM_{2.5}$ NAAQS in 2014 must attain the NAAQS by December 31, 2021, or as expeditiously as practicable. Since modeling results are only available for 2017 and 2025, the 2016 Memo explains that one way to assess potential receptors for 2021 [25] is to assume that receptors projected to have average and/or maximum design values above the NAAQS in both 2017 and 2025 are also likely to be either nonattainment or maintenance receptors in 2021. Similarly, the EPA stated that it may be reasonable to assume that receptors that are projected to attain the NAAQS in both 2017 and 2025 are also likely to be attainment receptors in 2021. Where a potential receptor is projected to be nonattainment or maintenance in 2017, but projected to be attainment in 2025, further analysis of the emissions and modeling may be needed to make a further judgement regarding the receptor status in 2021.[26]

Based on this approach, the EPA identified nineteen potential nonattainment and/or maintenance receptors.[27] Seventeen of these are located in California. One of the potential maintenance-only receptors is located in Shoshone County, Idaho, and the other potential maintenance-only receptor is located in Allegheny County, Pennsylvania.

After identifying potential receptors, the next step is to identify whether upwind states contribute to air pollution at each of the identified receptors in other states. In the 2016 Memo, the EPA did not calculate the portion of any downwind state's predicted $PM_{2.5}$ concentrations that would result from emissions from individual states. Accordingly, the EPA will evaluate Utah's prong 1 and 2 submissions using a weight of evidence analysis. This analysis is based on a review of the State's submission and other available information, including air quality trends; topographical, geographical, and meteorological information; local emissions in downwind states and emissions from the upwind state; and contribution modeling from prior interstate transport analyses. While none of these factors is by itself dispositive, together they may be used in weight of evidence analyses to determine whether the emissions from Utah will significantly contribute to nonattainment or interfere with maintenance of the 2012 annual $PM_{2.5}$ NAAQS at the 19 potential nonattainment and/or maintenance receptors identified in the 2016 Memo.

2. State's Submission

Utah conducted a weight of evidence analysis to examine whether $PM_{2.5}$ emissions from Utah adversely affect attainment or maintenance of the 2012 $PM_{2.5}$ NAAQS in downwind states. The State's analysis primarily focused on potential contribution to the West Silver Valley, Idaho 2012 $PM_{2.5}$ nonattainment area,[28] which is also the location of the Shoshone County, Idaho potential maintenance-only receptor identified in the 2016 Memo and the only area in a state bordering Utah that contained a nonattainment or maintenance receptor. Utah considered the distance from the State to West Silver Valley, as well as meteorological information and $PM_{2.5}$ speciation data, and on this basis concluded that the State will not contribute significantly to nonattainment or interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS in Idaho or any other state.

The EPA notes that, because Utah's analysis focused on designated nonattainment areas, it does not independently address whether the SIP contains adequate provisions prohibiting emissions that will interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS in any other state. In remanding the Clean Air Interstate Rule (CAIR) to the EPA in *North Carolina* v. *EPA,* the D.C. Circuit explained that the regulating authority must give the ''interfere with maintenance'' clause of section 110(a)(2)(D)(i)(I) ''independent significance'' by evaluating the impact of upwind state emissions on downwind areas that, while currently in attainment, are at risk of future nonattainment, considering historic variability.[29] While Utah's submittal pre-dates the 2016 Memo, which provided the states with information about potential maintenance-only receptors, Utah was still required to evaluate the potential impact of its emissions on areas that are currently measuring data below the NAAQS, but that may have issues maintaining that air quality, and the State did not do so. The EPA also notes that while Utah elected to address areas in neighboring states designated as nonattainment for the 2012 $PM_{2.5}$ NAAQS, the State did not also address such areas in non-neighboring states, such as California, and should have done so because directly emitted $PM_{2.5}$ and $PM_{2.5}$ precursors can have long-ranging impacts.

When, as here, the EPA determines that a state's SIP has not addressed all of the statutory requirements or provided a technical analysis to justify its conclusion regarding the state's impact on downwind air quality problems, the EPA identifies those deficiencies in acting upon the state's SIP submission. However, if the EPA has supplemental analysis available that nonetheless supported a state's conclusion despite these deficiencies in the state's SIP submission, the EPA can nonetheless propose to approve the state's SIP submission. See 82 FR 9142, 9149 (Feb. 3, 2017).

3. EPA's Analysis

The EPA reviewed the information in Utah's submittal, as well as the 2016 Memo and additional information for our evaluation, and we propose to come to the same conclusion as the State, including (based on our supplemental information) Utah's conclusion that emissions from the State will not interfere with maintenance in downwind states. The EPA therefore proposes to approve the December 22, 2015 submission with respect to both the prong 1 and 2 requirements for the 2012 $PM_{2.5}$ NAAQS. In our evaluation, we identified potential downwind nonattainment and maintenance receptors using the modeling results presented in the 2016 Memo. We then

[25] Assessing downwind $PM_{2.5}$ air quality problems based on estimates of air quality concentrations in a future year aligned with the relevant attainment deadline is consistent with the instructions from the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) in *North Carolina* v. *EPA,* 531 F.3d 896, 911–12 (D.C. Cir. 2008), that upwind emission reductions should be harmonized, to the extent possible, with the attainment deadlines for downwind areas.

[26] The EPA notes that the modeling used to inform the 2016 Memo did not project any potential nonattainment or maintenance receptors in 2025 that were not also projected as potential nonattainment or maintenance receptors in 2017.

[27] As the EPA explained in the proposed action, titled ''Air Plan Approval; AL, FL, GA, KY, MS, NC, SC, TN; Interstate Transport for the 2012 $PM_{2.5}$ NAAQS,'' 83 FR 39387 (Aug. 9, 2018), the 2016 Memo noted that because of data quality problems, nonattainment and maintenance projections were not conducted for monitors in all or portions of Florida, Illinois, Idaho (outside of Shoshone County), Tennessee and Kentucky. The EPA noted, however, that data quality problems have subsequently been resolved for all of the aforementioned areas. These areas have current design values below the 2012 $PM_{2.5}$ NAAQS and are expected to continue to maintain the NAAQS (See EPA Region 4 Annual $PM_{2.5}$ Trends Analysis TSD, in the docket for this action) due to downward emission trends for nitrogen oxides (NOx) and SO_2 and therefore were not considered potential receptors for the purpose of interstate transport for the 2012 $PM_{2.5}$ NAAQS. The EPA finalized approved of the action on September 25, 2018 (83 FR 48387).

[28] *https://www3.epa.gov/airquality/greenbook/kbca.html#PM-2.5.2012.West_Silver_Valley.*

[29] 531 F.3d 896, 910–11 (D.C. Cir. 2008) (holding that the EPA must give ''independent significance'' to each prong of CAA section 110(a)(2)(D)(i)(I)).

evaluated these receptors to determine whether Utah emissions could significantly contribute to nonattainment or interfere with maintenance at them. Below, we provide an overview of our analysis. A more detailed evaluation of how the SIP revision meets the requirements of CAA section 110(a)(2)(D)(i)(I) may be found in our 2012 $PM_{2.5}$ technical support document (TSD) in the docket for this action.

Our prong 1 analysis focused on the 17 California receptors, which include the only nonattainment receptors modeled in the 2016 Memo. As shown in Table 1 of the 2016 Memo, 12 of the 17 California receptors are projected as nonattainment in both 2017 and 2025, while the remaining 5 receptors are projected as maintenance in either 2017 or 2025. Because all of the 17 California receptors are located in either the San Joaquin Valley or South Coast 2012 $PM_{2.5}$ nonattainment area, we have elected to analyze all of the California receptors together rather than separate the California nonattainment and maintenance receptor analyses. Our analysis of these receptors showed that elevated $PM_{2.5}$ levels in California are driven primarily by local emissions.[30] Additionally, Utah's southwestern border is more than 290 miles to the east and downwind of the California receptors, with intervening mountainous topography which tends to impede interstate pollution transport. Finally, as shown in Table 7, below, monitoring data from Interagency Monitoring of Protected Visual Environment (IMPROVE) monitors tend to show that the air in remote areas between Utah and the California nonattainment and maintenance receptors is well below the level of the 2012 $PM_{2.5}$ NAAQS.[31] All of these factors indicate that emissions from Utah are not likely to reach California in amounts that could impact the air quality at the California nonattainment and maintenance receptors. Thus, the EPA is proposing to find that Utah emissions will not significantly contribute to nonattainment or interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS at any California projected receptor.

TABLE 7—$PM_{2.5}$ AVERAGE ANNUAL CONCENTRATIONS AT REMOTE IMPROVE MONITORS [32]

Site No.	State	2015–2017 $PM_{2.5}$ average annual concentrations (μg/m³)
040159000	Arizona	2.75
060270002	California	3.63
060199000	California	4.06
060519000	California	2.82
060719002	California	3.63
160230101	Idaho	3.23
160370002	Idaho	3.99
320079000	Nevada	2.98
320330101	Nevada	2.25
490530130	Utah	2.74

For the EPA's prong 2 analysis, we reviewed potential impacts from Utah emissions at the two projected maintenance-only receptors outside of California identified in the 2016 Memo. With regard to the Shoshone County, Idaho receptor, our analysis showed that elevated $PM_{2.5}$ levels in the area are driven primarily by local emissions from wood burning in the wintertime, specifically when the West Silver Valley experiences the combination of cold surface temperatures, low wind speeds, and constrained vertical mixing.[33] The deep, narrow mountain valley magnifies this effect relative to other nearby areas. The combination of these meteorological effects and the mountainous terrain confine the geographical area that could contribute emissions to elevated wintertime $PM_{2.5}$ concentrations at the Shoshone County receptor.[34] Utah's prong 1 analysis noted that speciation data in the Utah 2006 $PM_{2.5}$ nonattainment areas [35] indicate that ammonium nitrate drives high $PM_{2.5}$ levels in north-central Utah, which contrasts with carbon-driven speciation data at the Shoshone County receptor during the winter and indicates emissions originating in Utah are not contributing to elevated $PM_{2.5}$ at the Shoshone County receptor. Additionally, Utah's nearest border is approximately 400 miles to the southeast and generally downwind of this receptor. Finally, the IMPROVE monitoring data in Table 7 tend to show that the air in remote areas in Idaho between Utah and the Shoshone County receptor is well below the level of the 2012 $PM_{2.5}$ NAAQS. This provides further indication that elevated $PM_{2.5}$ at the Shoshone County receptor is primarily driven by local emissions. All of these factors indicate that emissions from Utah will not interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS at the projected Shoshone County maintenance receptor.

With regard to the Allegheny County, Pennsylvania potential maintenance receptor, our analysis included review of previous modeling data conducted for the EPA's 2011 CSAPR, which addressed the 1997 and 2006 $PM_{2.5}$ NAAQS.[36] For the 2011 CSAPR, the EPA modeled contribution from states in the eastern U.S. to air quality monitors also located in the eastern

[30] See ''California: Imperial County, Los Angeles-South Coast Air Basin, Plumas County, San Joaquin Valley Area Designations for the 2012 Primary Annual $PM_{2.5}$ National Ambient Air Quality Standard Technical Support Document'' in the docket for this action.

[31] The IMPROVE program includes a long-term monitoring program to establish the current visibility conditions, track changes in visibility and determine causal mechanism for the visibility impairment in the National Parks and Wilderness Areas (*http://vista.cira.colostate.edu/improve/*). These monitors are not required to meet the same standards as regulatory monitors used by the EPA and states to determine compliance with the NAAQS.

[32] Id.

[33] See ''Idaho: West Silver Valley Nonattainment Area—2012 Primary Annual $PM_{2.5}$ National Ambient Air Quality Standard Technical Support Document'' in the docket for this action.

[34] *Id.*at 39.

[35] *https://www3.epa.gov/airquality/greenbook/rbtc.html.*

[36] See Table V.D–1 in the EPA's CSAPR (August 8, 2011), at 76 FR 48240.

U.S.[37] Therefore, the 2011 CSAPR modeling did not project downwind contribution of emissions from Utah, but projected contributions from states east of Utah, including Kansas and Nebraska. The CSAPR modeling indicated that Kansas and Nebraska, states located much closer to the Allegheny County receptor and with higher $PM_{2.5}$ precursor emissions than Utah,[38] were modeled to be below 1% (the contribution level at which eastern states were considered ''linked'' to downwind receptors in the CSAPR and CSAPR Update rulemakings) of the 1997 annual and 2006 24-hr $PM_{2.5}$ NAAQS at the Allegheny County receptor. These factors, in addition to the very large distance (1,525 miles) from the Allegheny County receptor to the Utah border, indicate that emissions from Utah will not interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS at the projected Allegheny County receptor.

Based on these analyses, the EPA is proposing to determine that Utah emissions will not contribute significantly to nonattainment or interfere with maintenance of the 2012 $PM_{2.5}$ NAAQS in any other state, and we therefore propose to approve the December 22, 2015 submittal.

III. Proposed Action

Based on our review of Utah's January 31, 2013, June 2, 2013, December 22, 2015 and May 8, 2018 infrastructure submissions, and our analysis of additional relevant information, we propose to determine that emissions from Utah will not significantly contribute to nonattainment, or interfere with maintenance, of the 2010 NO_2, 2010 SO_2, and 2012 $PM_{2.5}$ NAAQS in any other state. Accordingly, we propose to approve the January 31, 2013, June 2, 2013, December 22, 2015 and May 8, 2018 Utah SIP submissions as satisfying the requirements of CAA section 110(a)(2)(D)(i)(I) for these NAAQS. The EPA is soliciting public comments on this proposed action and will consider public comments received during the comment period.

IV. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, the EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this action merely proposes to approve state law as meeting federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- Is not an Executive Order 13771 (82 FR 9339, February 2, 2017) regulatory action because SIP approvals are exempted under Executive Order 12866;
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- Does not provide the EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where the EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the proposed rule does not have tribal implications and will not impose substantial direct costs on tribal governments or preempt tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: June 10, 2019.

Debra Thomas,

Acting Regional Administrator, EPA Region 8.

[FR Doc. 2019–12948 Filed 6–19–19; 8:45 am]

BILLING CODE 6560–50–P

[37] In these rules, ''Eastern'' states refer to all contiguous states east of the Rocky Mountains, specifically not including: Montana, Wyoming, Colorado and New Mexico.

[38] See Tables 7–1 and 7–2 in ''Emissions Inventory Final Rule Technical Support Document (TSD)'' for CSAPR, June 28, 2011, Document number EPA–HQ–OAR–2009–0491–4522 in *www.regulations.gov.*

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 76

[MB Docket Nos. 07–42 and 17–105; FCC 19–52]

Leased Commercial Access; Modernization of Media Regulation Initiative

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, which is part of the Commission's Modernization of Media Regulation Initiative, the Commission proposes to modify the leased access rate formula so that rates will be specific to the tier on which the programming is carried. The Commission also seeks comment on whether it should make additional adjustments to the formula. Finally, it also seeks comment on whether leased access requirements can withstand First Amendment scrutiny in light of video programming market changes.

DATES: Comments are due on or before July 22, 2019; reply comments are due on or before August 5, 2019.

ADDRESSES: You may submit comments, identified by MB Docket Nos. 07–42 and 17–105, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission's Web site: http://fjallfoss.fcc.gov/ecfs2/.* Follow the instructions for submitting comments.
- *Mail:* Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the

Commission's Secretary, Office of the Secretary, Federal Communications Commission.

• *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by email: *FCC504@fcc.gov* or phone: (202) 418–0530 or TTY: (202) 418–0432.

FOR FURTHER INFORMATION CONTACT: For additional information on this proceeding, contact Diana Sokolow, *Diana.Sokolow@fcc.gov,* of the Policy Division, Media Bureau, (202) 418–2120.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Second Further Notice of Proposed Rulemaking, FCC 19–52, adopted on June 6, 2019 and released on June 7, 2019. The full text is available for public inspection and copying during regular business hours in the FCC Reference Center, Federal Communications Commission, 445 12th Street, SW, Room CY–A257, Washington, DC 20554. This document will also be available via ECFS at *http://fjallfoss.fcc.gov/ecfs/.* Documents will be available electronically in ASCII, Microsoft Word, and/or Adobe Acrobat. Alternative formats are available for people with disabilities (Braille, large print, electronic files, audio format), by sending an email to *fcc504@fcc.gov* or calling the Commission's Consumer and Governmental Affairs Bureau at (202) 418–0530 (voice), (202) 418–0432 (TTY).

Synopsis

1. In the Second Further Notice of Proposed Rulemaking, we update our leased access rules as part of the Commission's Modernization of Media Regulation Initiative and propose to modify the leased access rate formula. The leased access rules, which implement the statutory leased access requirements, direct cable operators to set aside channel capacity for commercial use by unaffiliated video programmers.[1] In 2018, the Commission adopted a Further Notice of Proposed Rulemaking (FNPRM)[2] addressing leased access proposals filed in response to the *Media Modernization Public Notice.* With this proceeding, we continue our efforts to modernize media regulations and remove unnecessary requirements that can impede competition and innovation in the media marketplace.

2. The video marketplace has changed significantly since the Commission initially adopted its leased access rules. Specifically, today a wide variety of media platforms are available to programmers, including in particular online platforms that creators can use to distribute their content for free. This change has reduced the importance of leased access and, thus, the justification for burdensome leased access requirements.

3. In the Second Further Notice of Proposed Rulemaking (Second FNPRM), we address the leased access rate formula. Specifically, as discussed below, we propose one modification to the formula that would permit cable operators to calculate the ''average implicit fee'' for leased access based on the tier on which the leased access programming actually will be carried. In addition, we seek comment on whether to make other modifications to the existing rate formula. Finally, we seek comment on whether leased access requirements can withstand First Amendment scrutiny in light of video programming market changes.

4. Congress authorized the Commission to adopt maximum reasonable rates for commercial leased access as part of the Cable Television Consumer Protection and Competition Act of 1992 and also provided that the price, terms, and conditions for leased access must be ''sufficient to assure that such use will not adversely affect the operation, financial condition, or market development of the cable system.'' The Commission adopted leased access rate regulations in 1993, and the Commission subsequently modified its leased access regulations in 1996 and 1997. The Commission's implementing rules, which the D.C. Circuit upheld in 1998, included a formula for calculating maximum carriage rates that cable operators could charge leased access programmers.

5. Specifically, in order to permit cable operators to recover their costs and earn a profit, the Commission adopted a maximum reasonable rate formula for full-time leased access carriage based on the ''average implicit fee'' that other programmers implicitly charge for carriage.[3] The Commission then prorated that formula for part-time programming. Thus, these rate rules require that an operator calculate the average implicit fee for all eligible tiers rather than just the individual tier where the channel will be placed. The Commission reasoned that ''because the Communications Act requires cable operators to transmit must-carry and PEG access channels on the basic service tier, the average programming cost on that tier will tend to be lower.''

6. Although the Commission revised its commercial leased access rate rules in its *2008 Leased Access Order,* these rules never went into effect. Thus, the leased access rate rules adopted in the *1993 Rate Regulation Order,* as subsequently amended, remain in effect.

7. As suggested by commenters, we propose to make leased access fee calculations specific to the tier on which the programming will be carried. In this regard, we propose to permit cable operators that carry leased access programming on the basic service tier[4] ''to calculate the average implicit fee based on a basic tier-specific calculation, rather than based on the blended calculation required under the existing formula,'' as proposed by NCTA.[5] NCTA avers that it would ''be much simpler to calculate the leased access rate for basic tier placement on a tier-specific basis, rather than on a blended tier basis.'' We similarly propose that the rate formula should be a tier-specific calculation even if the leased access programming is carried on a tier other than the basic service tier. We seek comment on these proposals. Are there other advantages or disadvantages to this approach that we should consider?

8. We also seek comment on whether there are other changes we should make to our rate formula. In response to the FNPRM's request for information on whether the Commission should adopt any new rules governing leased access rates, commenters put forth a wide range of proposals to address their concerns. The record indicates that the current rate formula may be insufficient to compensate cable operators for their leased access administrative costs, particularly for small cable systems, and

[1] The leased access rules are in subpart N of part 76, which was listed in the *Media Modernization Public Notice* as one of the principal rule parts that pertains to media entities and that is the subject of the media modernization review.

[2] Federal Communications Commission, Leased Commercial Access; Modernization of Media Regulation Initiative, 83 FR 30639 (June 29, 2018).

[3] To illustrate, as the Commission stated in the *1997 Leased Access Order,* ''if subscribers pay an average of $0.50 per channel for a particular tier, and the average programming or license fee on the tier is $0.10, then, on average, programmers on the tier are implicitly 'paying' the operator $0.40 for carriage.''

[4] The Commission stated in the *1993 Rate Regulation Order* that the basic service tier ''includes, at a minimum, the broadcast signals distributed by the cable operator (except for superstations), along with any public, educational, and government (PEG) access channels that the local franchise authority requires the system operator to carry on the basic tier.''

[5] The ''average implicit fee'' is the maximum commercial leased access rate that a cable operator may charge. The current fee calculation is ''blended'' insofar as it utilizes a ''weighting scheme that accounts for differences in the number of subscribers and channels'' on multiple tiers, and not just on the basic service tier.

that the current method for calculating rates is unduly complex. On the other hand, AIM indicates that current rates are ''a de facto barrier to entry for a significant number of independent programmers.'' We seek comment on the pros and cons of the varying rate proposals in the record, and on any other rate proposals we should consider. Should we adopt any of these suggestions if we adopt our proposal to make the rate formula tier-specific? Even with this change, would the rate formula yield rates that are unduly low? For example, is there basis for concern that the current rate formula yields rates that are so low that it encourages a programmer with limited content to lease a channel and then air its programming on repeat? Alternatively, we seek comment on whether we should retain our existing rate formula. We seek input on the potential costs and benefits of the various proposals in the record.

9. We also seek comment today on whether the First Amendment concerns identified in paragraphs 39 and 40 of the Report and Order, FCC 19–52, apply to the Commission's rules and statutory provisions concerning full-time leased access requirements. In this regard, one commenter opines that ''[t]hese matters have already been addressed by the courts and they have upheld the leased access provisions enacted by Congress. Only the courts and Congress can change these provisions. In the meantime, the Commission is obligated to carry out the directions given to them by Congress.'' On the other hand, we note that the D.C. Circuit decision upholding the constitutionality of the statutory leased-access provisions largely antedates the market developments described in this order and arguably turned on the facts that existed at that time. We seek comment on this analysis. Can the statutory leased access requirements or the Commission's other leased-access rules continue to withstand First Amendment scrutiny in light of the market changes discussed in the Report and Order? If not, what discretion does the Commission have to reduce the burdens that those provisions impose on protected speech?

10. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), the Commission has prepared an Initial Regulatory Flexibility Analysis (IRFA) concerning the possible significant economic impact on small entities by the policies and rules proposed in the Second Further Notice of Proposed Rulemaking (Second FNPRM). Written public comments are requested on the IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments provided on the first page of the FNPRM. The Commission will send a copy of the Second FNPRM, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA). In summary, the Second FNPRM:'' (1) Proposes to modify the leased access rate formula so that rates will be specific to the tier on which the programming is carried; (2) seeks comment on whether we should make additional adjustments to the formula; and (3) seeks comment on whether leased access requirements can withstand First Amendment scrutiny in light of video programming market changes. The proposed action is authorized pursuant to sections 4(i), 303, and 612 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i), 303, and 532. The types of small entities that may be affected by the proposals contained in the FNPRM fall within the following categories: Cable Television Distribution Services, Cable Companies and Systems (Rate Regulation), Cable System Operators (Telecom Act Standard), Cable and Other Subscription Programming, Motion Picture and Video Production, and Motion Picture and Video Distribution. The projected reporting, recordkeeping, and other compliance requirements are: (1) Proposing one modification to the leased access rate formula that would permit cable operators to calculate the ''average implicit fee'' for leased access to be based on the tier on which the leased access programming actually will be carried; and (2) seeking comment on whether to make other modifications to the existing rate formula. There is no overlap with other regulations or laws. The record indicates that the current rate formula may be insufficient to compensate cable operators (including small operators) for their leased access administrative costs, and that the current method for calculating rates is unduly complex. Modifying the rate formula could address these concerns, thus easing the burdens of leased access on cable operators, including small entities. The Commission seeks comment on the pros and cons of the varying rate proposals in the record, and on alternative rate proposals it should consider.

11. The Second FNPRM may result in new or revised information collection requirements. If the Commission adopts any new or revised information collection requirement, the Commission will publish a notice in the **Federal Register** inviting the public to comment on the requirement, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3501–3520). In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4), the Commission seeks specific comment on how it might ''further reduce the information collection burden for small business concerns with fewer than 25 employees.''

12. *Permit-But-Disclose.* This proceeding shall be treated as a ''permit-but-disclose'' proceeding in accordance with the Commission's *ex parte* rules.[6] Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (*e.g.,* .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's *ex parte* rules.

13. The proposed action is authorized pursuant to sections 4(i), 303, and 612 of the Communications Act of 1934, as

[6] 47 CFR 1.1200 *et seq.*

amended, 47 U.S.C. 154(i), 303, and 532.

List of Subjects in 47 CFR Part 76

Administrative practice and procedure, Cable television, Reporting and recordkeeping requirements.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

[FR Doc. 2019–13135 Filed 6–19–19; 8:45 am]

BILLING CODE 6712–01–P

Notices

Federal Register

Vol. 84, No. 119

Thursday, June 20, 2019

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forest Service

Newspapers Used for Publication of Legal Notices by the Alaska Region

AGENCY: Forest Service, USDA.

ACTION: Notice.

SUMMARY: This notice lists the newspapers that will be used by the Ranger Districts, Forests, and Regional Office of the Alaska Region to publish legal notices required under Agency regulations. The intended effect of this action is to inform interested members of the public which newspapers the Forest Service will use to publish notices of proposed actions and notices of decision. This will provide the public with constructive notice of Forest Service proposals and decisions, provide information on the procedures to comment, object, or appeal, and establish the date that the Forest Service will use to determine if comments, appeals, or objection were timely.

DATES: Publication of legal notices in the listed newspapers begin will begin on the date of this publication and continue until further notice.

ADDRESSES: Lauren McChesney, Regional Environmental Coordinator; Forest Service, Alaska Region; P.O. Box 21628; Juneau, Alaska 99802–1628.

FOR FURTHER INFORMATION CONTACT: Lauren McChesney, Regional Environmental Coordinator, (907) 586–8796.

SUPPLEMENTARY INFORMATION: The administrative procedures at 36 CFR 218, and 219 require the Forest Service to publish notices in a newspaper of general circulation. The content of the notices is specified in 36 CFR 218 and 219. In general, the notices will identify: The decision or project by title or subject matter; the name and title of the official making the decision; how to obtain additional information; and where and how to file comments or appeals/objection. The date the notice is published will be used to establish the official date for the beginning of the comment, appeal, or objection period. The newspapers to be used are as follows:

Alaska Regional Office

Decisions of the Alaska Regional Forester: Juneau Empire, published daily except Saturday and official holidays in Juneau, Alaska; and the *Anchorage Daily News,* published daily in Anchorage, Alaska.

Chugach National Forest

Decisions of the Forest Supervisor and the Glacier and Seward District Rangers: Anchorage Daily News, published daily in Anchorage, Alaska.

Decisions of the Cordova District Ranger: Cordova Times, published weekly in Cordova, Alaska.

Tongass National Forest

Decisions of the Forest Supervisor and the Craig, Ketchikan/Misty, and Thorne Bay District Rangers: Ketchikan Daily News, published daily except Sundays and official holidays in Ketchikan, Alaska.

Decisions of the Admiralty Island National Monument Ranger, the Juneau District Ranger, the Hoonah District Ranger, and the Yakutat District Ranger: Juneau Empire, published daily except Saturday and official holidays in Juneau, Alaska.

Decisions of the Petersburg District Ranger: Petersburg Pilot, published weekly in Petersburg, Alaska.

Decisions of the Sitka District Ranger: Daily Sitka Sentinel, published daily except Saturday, Sunday, and official holidays in Sitka, Alaska.

Decisions of the Wrangell District Ranger: Wrangell Sentinel, published weekly in Wrangell, Alaska.

Supplemental notices may be published in any newspaper, but the timeframes for filing objections will be calculated based upon the date that legal notices are published in the newspapers of record listed in this notice.

Dated: June 6, 2019.

Frank R. Beum,

Acting Associate Deputy Chief, National Forest System.

[FR Doc. 2019–13046 Filed 6–19–19; 8:45 am]

BILLING CODE 3411–15–P

CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD

Sunshine Act Meeting

TIME AND DATE: June 25, 2019, 10:00 a.m. EDT.

PLACE: U.S. Chemical Safety Board, 1750 Pennsylvania Ave. NW, Suite 910, Washington, DC 20006.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED: The Chemical Safety and Hazard Investigation Board (CSB) will convene a public meeting on Tuesday, June 25, 2019, at 10:00 a.m. EDT in Washington, DC, at the CSB offices located at 1750 Pennsylvania Avenue NW, Suite 910. The Board will discuss open investigations, the status of audits from the Office of the Inspector General, financial and organizational updates. There will also be a presentation on the 2014 Dupont incident that occurred in LaPorte, TX.

Additional Information

The meeting is free and open to the public. If you require a translator or interpreter, please notify the individual listed below as the **CONTACT PERSON FOR FURTHER INFORMATION**, at least three business days prior to the meeting.

A conference call line will be provided for those who cannot attend in person. Please use the following dial-in number to join the conference:

Dial-In: 1 (888) 517–2470 Audience US Toll Free, 1 (630) 827–6818 Audience US Toll

Confirmation Number: 6466864 #

The CSB is an independent federal agency charged with investigating incidents and hazards that result, or may result, in the catastrophic release of extremely hazardous substances. The agency's Board Members are appointed by the President and confirmed by the Senate. CSB investigations look into all aspects of chemical accidents and hazards, including physical causes such as equipment failure as well as inadequacies in regulations, industry standards, and safety management systems.

Public Comment

The time provided for public statements will depend upon the number of people who wish to speak. Speakers should assume that their presentations will be limited to three

minutes or less, but commenters may submit written statements for the record.

Contact Person for Further Information

Hillary Cohen, Communications Manager, at *public@csb.gov* or (202) 446–8094. Further information about this public meeting can be found on the CSB website at: *www.csb.gov.*

Authority: 5 U.S.C. 552b; 40 CFR part 1603.

Dated: June 17, 2019.

Ray Porfiri,

Deputy General Counsel, Chemical Safety and Hazard Investigation Board.

[FR Doc. 2019–13144 Filed 6–18–19; 11:15 am]

BILLING CODE 6350–01–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Order No. 2083]

Reorganization and Expansion of Foreign-Trade Zone 142 under Alternative Site Framework Salem/ Millville, New Jersey

Pursuant to its authority under the Foreign-Trade Zones Act of June 18, 1934, as amended (19 U.S.C. 81a-81u), the Foreign-Trade Zones Board (the Board) adopts the following Order:

Whereas, the Foreign-Trade Zones (FTZ) Act provides for ''. . . the establishment . . . of foreign-trade zones in ports of entry of the United States, to expedite and encourage foreign commerce, and for other purposes,'' and authorizes the Board to grant to qualified corporations the privilege of establishing foreign-trade zones in or adjacent to U.S. Customs and Border Protection ports of entry;

Whereas, the Board adopted the alternative site framework (ASF) (15 CFR Sec. 400.2(c)) as an option for the establishment or reorganization of zones;

Whereas, the South Jersey Port Corporation, grantee of Foreign-Trade Zone 142, submitted an application to the Board (FTZ Docket B–63–2018, docketed October 11, 2018) for authority to reorganize and expand under the ASF with a service area of Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer and Salem Counties, New Jersey, within and adjacent to the Philadelphia U.S. Customs and Border Protection port of entry, and FTZ 142's existing Sites 1, 2 and 3 and proposed Site 4 would be categorized as magnet sites;

Whereas, notice inviting public comment was given in the **Federal Register** (83 FR 52382, October 17, 2018) and the application has been processed pursuant to the FTZ Act and the Board's regulations; and,

Whereas, the Board adopts the findings and recommendations of the examiner's report, and finds that the requirements of the FTZ Act and the Board's regulations are satisfied;

Now, Therefore, the Board hereby orders:

The application to reorganize and expand FTZ 142 under the ASF is approved, subject to the FTZ Act and the Board's regulations, including Section 400.13, to the Board's standard 2,000-acre activation limit for the zone, and to an ASF sunset provision for magnet sites that would terminate authority for Sites 1, 2, 3 and 4 if not activated within five years from the month of approval.

Dated: June 11, 2019.

Jeffrey I. Kessler,

Assistant Secretary for Enforcement and Compliance Alternate Chairman, Foreign-Trade Zones Board.

[FR Doc. 2019–13125 Filed 6–19–19; 8:45 am]

BILLING CODE 3510–DS–P

COMMODITY FUTURES TRADING COMMISSION

Agency Information Collection Activities Under OMB Review

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (PRA), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collection and its expected costs and burden.

DATES: Comments must be submitted on or before July 22, 2019.

ADDRESSES: Comments regarding the burden estimated or any other aspect of the information collection, including suggestions for reducing the burden, may be submitted directly to the Office of Information and Regulatory Affairs (OIRA) in OMB, within 30 days of the notice's publication, by either of the following methods. Please identify the comments by OMB Control No. 3038–0080.

- *By email addressed to: OIRAsubmissions@omb.eop.gov* or
- *By mail addressed to:* the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention Desk Officer for the Commodity Futures Trading Commission, 725 17th Street NW, Washington DC 20503.

A copy of all comments submitted to OIRA should be sent to the Commodity Futures Trading Commission (the ''Commission'') by either of the following methods. The copies should refer to ''OMB Control No. 3038–0080.''

- Through the Commission's website at *http://comments.cftc.gov/.* Follow the instructions for submitting comments through the website.
- *By mail addressed to:* Christopher Kirkpatrick, Secretary of the Commission, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street NW, Washington, DC 20581; or
- By Hand Delivery/Courier to the same address.

Please submit your comments using only one method. All comments must be submitted in English, or if not, accompanied by an English translation. Comments will be posted as received to *http://www.cftc.gov.* You should submit only information that you wish to make available publicly. If you wish the Commission to consider information that you believe is exempt from disclosure under the Freedom of Information Act, a petition for confidential treatment of the exempt information may be submitted according to the procedures established in § 145.9 of the Commission's regulations.[1] The Commission reserves the right, but shall have no obligation, to review, pre-screen, filter, redact, refuse or remove any or all of your submission from *http://www.cftc.gov* that it may deem to be inappropriate for publication, such as obscene language. All submissions that have been redacted or removed that contain comments on the merits of the ICR will be retained in the public comment file and will be considered as required under the Administrative Procedure Act and other applicable laws, and may be accessible under the Freedom of Information Act.

A copy of the supporting statements for the collection of information discussed herein may be obtained by visiting *http://RegInfo.gov.*

FOR FURTHER INFORMATION CONTACT: Pamela M. Geraghty, Special Counsel, Division of Swap Dealer and Intermediary Oversight, Commodity Futures Trading Commission, (202) 418–5634, email: *pgeraghty@cftc.gov,* and refer to OMB Control No. 3038–0080.

[1] 17 CFR 145.9.

SUPPLEMENTARY INFORMATION:

Title: Annual Report for Chief Compliance Officer of Registrants (OMB Control No. 3038–0080). This is a request for an extension of a currently approved information collection.

Abstract: On April 3, 2012, the Commission adopted Commission regulation 3.3 (Chief Compliance Officer) [2] under sections 4d(d) and 4s(k) [3] of the Commodity Exchange Act (''CEA''). Commission regulation 3.3 requires each futures commission merchant (''FCM''),[4] swap dealer (''SD''),[5] and major swap participant (''MSP'') [6] to designate, by filing a form 8–R, a chief compliance officer who is responsible for developing and administering policies and procedures that fulfill certain duties of the FCM, SD, or MSP and that are reasonably designed to ensure the registrant's compliance with the CEA and Commission regulations; establishing procedures for the remediation of noncompliance issues identified by the chief compliance officer; establishing procedures for the handling, management response, remediation, retesting, and closing of noncompliance issues; preparing, signing, certifying and filing with the Commission an annual compliance report that contains the information specified in the regulations; amending the annual report if material errors or omissions are identified; and maintaining records of the registrant's compliance policies and procedures and records related to the annual report. The information collection obligations imposed by Commission regulation 3.3 are essential to ensuring that FCMs, SDs, and MSPs maintain comprehensive policies and procedures that promote compliance with the CEA and Commission regulations. In particular, the Commission believes that, among other things, these obligations (i) promote compliance behavior through periodic self-evaluation, (ii) inform the Commission of possible compliance weaknesses, (iii) assist the Commission in determining whether the registrant remains in compliance with the CEA and Commission regulations, and (iv) help the Commission to assess whether the registrant has mechanisms in place to adequately address compliance problems that could lead to a failure of the registrant.

Burden Statement: In light of the current number of Commission-registered FCMs, SDs, and MSPs, the Commission revised its estimate of the burden for this collection. Accordingly, the respondent burden for this collection is estimated to be as follows:

Number of Registrants: 171.

Estimated Average Burden Hours per Registrant: 1,006.

Estimated Aggregate Burden Hours: 172,026.

Frequency of Recordkeeping/Third-party Disclosure: Annually or on occasion.

There are no capital or operating and maintenance costs associated with this collection.

(Authority: 44 U.S.C. 3501 *et seq.*)

Dated: June 14, 2019.

Robert Sidman,

Deputy Secretary of the Commission.

[FR Doc. 2019–13083 Filed 6–19–19; 8:45 am]

BILLING CODE 6351–01–P

[2] 17 CFR 3.3.

[3] 7 U.S.C. 6d(d) and 6s(k).

[4] For the definition of FCM, *see* section 1a(28) of the CEA and Commission regulation 1.3(p). 7 U.S.C. 1a(28) and 17 CFR 1.3(p).

[5] For the definition of SD, *see* section 1a(49) of the CEA and Commission regulation 1.3(ggg). 7 U.S.C. 1a(49) and 17 CFR 1.3(ggg).

[6] For the definitions of MSP, *see* section 1a(33) of the CEA and Commission regulation 1.3(hhh). 7 U.S.C. 1a(33) and 17 CFR 1.3(hhh).

COMMODITY FUTURES TRADING COMMISSION

Agency Information Collection Activities Under OMB Review

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (PRA), this notice announces that the Information Collection Request (''ICR'') abstracted below has been forwarded to the Office of Management and Budget (''OMB'') for review and comment. The ICR describes the nature of the information collection and its expected costs and burdens.

DATES: Comments must be submitted on or before July 22, 2019.

ADDRESSES: Comments regarding the burden estimate or any other aspect of the information collection, including suggestions for reducing the burden, may be submitted directly to the Office of Information and Regulatory Affairs (''OIRA'') in OMB within 30 days of publication of this notice by either of the methods specified below. Please identify the comments by ''OMB Control Numbers 3038–0023 and 3038–0072; Adoption of Revised Registration Form 7–R.''

- *By email addressed to: OIRAsubmissions@omb.eop.gov*; or
- *By mail addressed to:* Office of Information and Regulatory Affairs, Office of Management and Budget, Attention Desk Officer for the Commodity Futures Trading Commission, 725 17th Street NW, Washington, DC 20503.

A copy of all comments submitted to OIRA should be sent to the Commodity Futures Trading Commission (''Commission'') by any of the following methods. The copies should refer to ''OMB Control Numbers 3038–0023 and 3038–0072.''

- *By mail addressed to:* Christopher Kirkpatrick, Secretary of the Commission, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street NW, Washington, DC 20581;
- By Hand Delivery/Courier to the same address; or
- Through the Commission's website at *http://comments.cftc.gov.* Please follow the instructions for submitting comments through the website.

Please submit your comments using only one method. All comments must be submitted in English, or if not, accompanied by an English translation. Comments will be posted as received to *http://www.cftc.gov.* You should submit only information that you wish to make available publicly. If you wish the Commission to consider information that you believe is exempt from disclosure under the Freedom of Information Act, a petition for confidential treatment of the exempt information may be submitted according to the procedures established in § 145.9 of the Commission's regulations.[1] The Commission reserves the right, but shall have no obligation, to review, pre-screen, filter, redact, refuse or remove any or all of your submission from *http://www.cftc.gov* that it may deem to be inappropriate for publication, such as obscene language. All submissions that have been redacted or removed that contain comments on the merits of the ICR will be retained in the public comment file and will be considered as required under the Administrative Procedure Act and other applicable laws, and may be accessible under the Freedom of Information Act.

A copy of the supporting statements for the collections of information discussed herein may be obtained by visiting *http://RegInfo.gov.*

FOR FURTHER INFORMATION CONTACT: Matthew Kulkin, Director, (202) 418–5213, *mkulkin@cftc.gov;* or Christopher W. Cummings, Special Counsel, (202) 418–5445, *ccummings@cftc.gov,* Division of Swap Dealer and Intermediary Oversight, Commodity Futures Trading Commission, 1155 21st Street NW, Washington, DC 20581, and

[1] 17 CFR 145.9.

refer to OMB Control Numbers 3038–0023 and 3038–0072.

SUPPLEMENTARY INFORMATION:

Titles: Registration Under the Commodity Exchange Act (OMB control number 3038–0023); Registration of Swap Dealers and Major Swap Participants (OMB control number 3038–0072). This is a request for extension and revision of these currently approved information collections.

Abstract: In *Revised Registration Form 7–R,* 84 FR 8671 (Mar. 11, 2019), the Commission published a revised version of Commission Form 7–R. The Form 7–R is the application form that entities must use to register with the Commission as a futures commission merchant, retail foreign exchange dealer, introducing broker, commodity trading advisor, commodity pool operator, leverage transaction merchant, swap dealer, major swap participant, or floor trader firm. Separately, in *Agency Information Collection Activities: Notice of Intent to Extend and Revise Collections 3038–0023 and 3038–0072; Adoption of Revised Registration Form 7–R,* 84 FR 8696 (Mar. 11, 2019) (''60-Day Notice''), the Commission addressed the PRA implications of the revisions to Form 7–R. As indicated above, Form 7–R is covered by two OMB control numbers. OMB control number 3038–0023 applies to Form 7–R in connection with registering as a futures commission merchant, retail foreign exchange dealer, introducing broker, commodity trading advisor, commodity pool operator, floor trader firm or leverage transaction merchant.[2] OMB control number 3038–0072 applies to Form 7–R in connection with for registration as a swap dealer or major swap participant.[3] The revisions to Form 7–R, when considered together in the aggregate, result in no net change to the existing information collection burden associated with Form 7–R.

Revision of Commission Form 7–R. The revised Form 7–R contains several changes that, when considered together in aggregate, result in no net change to the existing information collection burden associated with Form 7–R. That burden varies by registration category and is currently 0.5 hour for futures commission merchants, 0.4 hour for introducing brokers, 0.4 hour for commodity pool operators, 0.4 hour for commodity trading advisors, 0.5 hour for floor trader firms, 0.5 hour for retail foreign exchange dealers, 1 hour for swap dealers, and 1 hour for major swap participants. Discussion of the noteworthy changes follows.

In the section titled ''Location of Business Records,'' Form 7–R no longer separately requests that non-U.S. applicants identify the non-U.S. address where their business records are located. Instead, both U.S. and non-U.S. applicants are required to comply only with the existing requirements of Form 7–R to identify the location of their business records, which remain unchanged, and, for non-U.S. applicants, to indicate that such records will be produced for inspection at NFA's offices, or at another physical location (not a post office box) within the U.S that the applicant identifies.

In the section titled ''Holding Company Information,'' the revised Form 7–R requests additional information about any entity that is a principal (as defined in Form 7–R) of the applicant. Form 7–R previously required applicants to identify by name any entity that was a principal of the applicant. The revised Form 7–R requires, for each entity that is identified as a principal of the applicant, then the applicant also must provide the entity's Federal EIN and the location where the entity is incorporated, organized, or established. This additional information is intended to ensure accurate identification of the entity, given that firms sometimes can have the same or similar names.

In the section titled ''Disciplinary Information—Regulatory Disclosures,'' a new question was added to existing Question E. The new question directs the applicant to disclose whether it has ever been found to have ''failed to supervise another person's activities under any investment-related statute or regulation.'' The new question is intended to ensure complete disclosure of conduct that may result in a refusal or limitation on registration.

Items that pertain only to NFA membership have been removed from the form. In the past, Form 7–R functioned as a registration form for the Commission and NFA, and as an application for NFA membership. To the extent that questions ask for information that is necessary for NFA membership but is not necessary for registration, those questions have been removed from the form and will appear in a separate application for NFA membership. Specifically, revised Form 7–R no longer contains: A series of questions that inquire whether the applicant will transact in retail off-exchange foreign currency, swap, futures, or options; a question that is directed to applicants that are registering in multiple capacities that asks them to select the capacity in which they intend to vote on NFA membership matters; a question that asks applicants that are applying to register as a futures commission merchant to indicate whether the applicant has ''applied for membership at any United States commodity exchange;'' a question that asks an applicant that is applying for registration as a swap dealer or major swap participant to indicate whether the applicant is currently regulated by other U.S. regulators and to identify those regulators; and lastly, contact information for the applicant's Membership Contact, Accounting Contact, Assessment Fee Contact, Arbitration Contact, Compliance Contact, or Chief Compliance Officer Contact.

Additionally, NFA is simplifying the process by which it requests supplemental information and documentation regarding the applicant's criminal, regulatory or financial disclosures. The prior version of Form 7–R requested that applicants provide a written explanation of the facts and circumstances regarding any such disclosures. Applicants were also separately requested to provide NFA with copies of pertinent documents associated with each disclosure. To consolidate and modernize this process, the revised Form 7–R allows applicants to complete electronically a separate ''Disclosure Matter Page'' for each matter, instance or event requiring disclosure and to simultaneously upload all pertinent documents associated with each disclosure. The Disclosure Matter Page provides applicants with an efficient and effective method of supplying the supplemental information and documentation that NFA requests in the normal course whenever an applicant responds affirmatively to any of the questions regarding criminal, regulatory or financial disclosures.

Lastly, revised Form 7–R contains several changes that do not alter the information collection burdens associated with Form 7–R. The revised Form 7–R incorporates new functionality throughout the form,

[2] OMB control number 3038–0023 also covers Commission Forms 8–R, 7–W and 8–T in connection with various registration activities involving floor brokers, floor traders, futures commission merchants, retail foreign exchange dealers, introducing brokers, commodity trading advisors, commodity pool operators, floor trader firms or leverage transaction merchants, and their principals and associated persons, as applicable. Forms 8–R, 7–W and 8–T were not amended in connection with the revision of Form 7–R.

[3] OMB control number 3038–0072 also covers Commission Forms 8–R, 7–W and 8–T in connection with various registration activities involving swap dealers and major swap participants, and principals thereof. Forms 8–R, 7–W and 8–T were not amended in connection with the revision of Form 7–R.

consisting of hyperlinks to the text of the applicable provisions of the Commodity Exchange Act, Commission Regulations, and NFA Rules, whenever those authorities are referenced in the form. Additionally, revised Form 7–R incorporates certain clarifying language where appropriate. For example, the term ''futures'' has been replaced with the term ''derivatives'' in several locations to more accurately reflect the full scope of the Commission's jurisdiction. Similarly, the reference to a failure ''to pay an award issued in a futures-related arbitration'' was replaced with the phrase ''failure to pay an award related to a CFTC-related product.'' The revised Form 7–R contains other changes to the language, formatting and organization of Form 7–R, all of which—individually and collectively—do not alter the information collection burdens associated with Form 7–R. The only changes to Form 7–R that could affect the information collection burdens associated with the form are those discussed above.

Comments. In the 60-Day Notice, the Commission provided 60 days for public comment on the extension and revision of the currently approved information collections under OMB control numbers 3038–0023 and 3038–0072 including, among other things, its estimates regarding the modified information collection burdens associated with the amendments to Form 7–R. The Commission received one relevant comment letter that: (1) Contended that a new question that was added to Question E of Form 7–R directing the applicant to disclose whether it has ever been found to have ''failed to supervise another person's activities under any investment-related statute or regulation'' is redundant because Question E already requires an applicant to disclose whether it has ''violated any provision of any investment-related statute or regulation thereunder''; and (2) suggested broadening Question G of Form 7–R by deleting the portion of that question that only requires disclosure of self-regulatory organizations actions ''that prevented or restricted the firm's ability to engage in any business in the financial services industry.'' [4] The letter did not address or offer alternatives to the Commission's estimates of the burden associated with revised Form 7–R. The Commission has determined that no further changes to Form 7–R or the information collection burdens associated therewith are warranted in response to this comment because: (1) The new required disclosure item in Question E asks for different information than the existing item that was claimed to be redundant, and is intended to ensure complete disclosure of conduct that may result in a refusal or limitation on registration; [5] and (2) the Commission believes that the suggested broadening of Question G would require disclosure of matters that are outside the jurisdiction of the Commission.[6]

Burden Statement: As explained above, the Commission believes that the revisions to Form 7–R will result in no net change to the information collection burdens associated with that Form under OMB control numbers 3038–0023 and 3038–0072.[7]

The Commission estimates the burden of this collection of information under OMB control number 3038–0023 to be:

Respondents/Affected Entities: Users of Form 7–R that are futures commission merchants, retail foreign exchange dealers, introducing brokers, commodity trading advisors, commodity pool operators, floor trader firms, and leverage transaction merchants.

Estimated number of respondents: 78,055.[8]

Estimated total annual burden on respondents: 7,735 hours.

Frequency of collection: Periodically.

There are no capital costs or operating and maintenance costs associated with this collection.

The Commission estimates the burden of this collection of information under OMB control number 3038–0072 to be:

Respondents/Affected Entities: Users of Form 7–R that are swap dealers and major swap participants. The following estimates are based on the average annual number of swap dealer and major swap participant Form 7–R filers for the past three years.

Estimated number of respondents: 772.

Estimated total annual burden on respondents: 672 hours.

Frequency of collection: Periodically.

There are no capital costs or operating and maintenance costs associated with this collection.

Dated: June 14, 2019.

Robert Sidman,

Deputy Secretary of the Commission.

[FR Doc. 2019–13082 Filed 6–19–19; 8:45 am]

BILLING CODE 6351–01–P

[4] *See* Letter from James L. Simon dated May 6, 2019, available at *https://comments.cftc.gov/PublicComments/ViewComment.aspx?id=62116&SearchText=.*

[5] *See* Adoption of Revised Registration Form 7–R, 84 FR 8671, 8672 (Mar. 11, 2019).

[6] If Question G were revised as suggested, it would require the applicant to disclose whether it has been the subject of any order issued by or a party to any agreement with a U.S. or non-U.S. regulatory authority (other than the CFTC), including but not limited to a licensing authority, or self-regulatory organization (other than NFA or a U.S. futures exchange).

[7] The revisions to Form 7–R do not change the existing estimated number of respondents under OMB control numbers 3038–0023 and 3038–0072. This estimate includes the collection burdens associated with Forms 7–R, 7–W, 8–R and 8–T, based on the historical practice of the Commission of addressing the burden estimates in aggregate, rather than separately on a form-by-form basis, for all of the registration forms: Forms 7–R, 7–W, 8–R, and 8–W.

[8] As noted above and in the 60-day notice, the revisions to Form 7–R do not change the existing estimated number of respondents under OMB control numbers 3038–0023 and 3038–0072. However, regarding the estimated number of respondents for OMB control number 3038–0023, the estimate in the 60-Day Notice incorrectly stated that there were 78.055 respondents. The correct estimate is 78,055 respondents. There is no change in the estimated total annual burden on respondents for collection 3038–0023, which is 7,735 hours.

DEPARTMENT OF DEFENSE

Office of the Secretary

Defense Innovation Board; Notice of Federal Advisory Committee Meeting

AGENCY: Under Secretary of Defense for Research and Engineering, Department of Defense.

ACTION: Notice of Federal Advisory Committee meeting.

SUMMARY: The Department of Defense (DoD) is publishing this notice to announce that the following Federal Advisory Committee meeting of the Defense Innovation Board, will take place.

DATES: Wednesday, July 10, 2019 from 9:30 a.m. to 12:00 p.m.

ADDRESSES: Defense Innovation Unit (DIU) Auditorium, 230 RT Jones Road, Mountain View, CA 94043.

FOR FURTHER INFORMATION CONTACT: Maj Travis H. Sheets, U.S. Air Force, 703–695–9516 (Voice), (Facsimile), *travis.h.sheets.mil@mail.mil* (Email). Mailing address is Defense Innovation Board, 9010 Defense Pentagon, Room 5E572, Washington, DC 20301–9010. Website: *http://innovation.defense.gov.* The most up-to-date changes to the meeting agenda can be found on the website.

SUPPLEMENTARY INFORMATION: This meeting is being held under the provisions of the Federal Advisory Committee Act (FACA) of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.140 and 102–3.150.

This meeting is being held under the provisions of the Federal Advisory

Committee Act (FACA) of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.140 and 102–3.150.

Purpose of the Meeting: The mission of the DIB is to examine and provide the Secretary of Defense and the Deputy Secretary of Defense independent advice and recommendations on innovative means to address future challenges in terms of integrated change to organizational structure and processes, business and functional concepts, and technology applications. The DIB focuses on (a) technology and capabilities, (b) practices and operations, and (c) people and culture.

Agenda: During the meeting, the Science and Technology subcommittee will provide their work on principles for the ethical use of Artificial Intelligence and their work plan for the rest of the calendar year. The Workforce Behavior and Culture subcommittee will discuss talent management and their work plan for the rest of the calendar year. The DIB will also receive a progress update on implementation of the recommendations contained in the DIB's Software Acquisition and Practices (SWAP) study report. Additionally, Mr. Joshua Marcuse, on behalf of DoD, will brief the DIB on DoD's latest implementation activities related to DIB recommendations. Members of the public will have an opportunity to provide oral comments to the DIB regarding its deliberations and potential recommendations. See below for additional information on how to sign up to provide public comments.

Meeting Accessibility: Pursuant to Federal statutes and regulations (the FACA, the Sunshine Act, and 41 CFR 102–3.140 through 102–3.165) and the availability of space, the meeting is open to the public from 9:30 a.m. to 12:00 p.m. Seating is on a first-come basis. Members of the public wishing to attend the meeting or wanting to receive a link to the live stream webcast should register on the DIB website, *http://innovation.defense.gov,* no later than July 5, 2019. Members of the media should RSVP to the Office of the Assistant to the Secretary of Defense (Public Affairs), at *osd.pentagon.pa.list.dpo-atl@mail.mil.*

Special Accommodations: Individuals requiring special accommodations to access the public meeting should contact the Designated Federal Officer (DFO), see the **FOR FURTHER INFORMATION CONTACT** section for contact information, no later than July 5, 2019, so that appropriate arrangements can be made.

Written Statements: Pursuant to section 10(a)(3) of the FACA and 41 CFR 102–3.140, the public or interested organizations may submit written comments to the DIB about its approved agenda pertaining to this meeting or at any time regarding the DIB's mission. Individuals submitting a written statement must submit their statement to the DFO (see the **FOR FURTHER INFORMATION CONTACT** section for contact information). Written comments that do not pertain to a scheduled meeting may be submitted at any time. However, if individual comments pertain to a specific topic being discussed at the planned meeting, then such comments must be received in writing not later than July 5, 2019. The DFO will compile all written submissions and provide them to DIB members for consideration.

Oral Presentations: Individuals wishing to make an oral statement to the DIB at the public meeting may be permitted to speak for up to two minutes. Anyone wishing to speak to the DIB should submit a request by email at *osd.innovation@mail.mil* no later than July 5, 2019 for planning. Requests for oral comments should include a copy or summary of planned remarks for archival purposes. Individuals may also be permitted to submit a comment request at the public meeting; however, depending on the number of individuals requesting to speak, the schedule may limit participation. Webcast attendees will be provided instructions with the live stream link if they wish to submit comments during the open meeting.

Dated: June 14, 2019.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2019–13066 Filed 6–19–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN–2019–HQ–0009]

Submission for OMB Review; Comment Request

AGENCY: Office of the Secretary of the Navy, DoD.

ACTION: 30-Day information collection notice.

SUMMARY: The Department of Defense has submitted to OMB for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act.

DATES: Consideration will be given to all comments received by July 22, 2019.

ADDRESSES: Comments and recommendations on the proposed information collection should be emailed to Ms. Jasmeet Seehra, DoD Desk Officer, at *oira_submission@omb.eop.gov*. Please identify the proposed information collection by DoD Desk Officer, Docket ID number, and title of the information collection.

FOR FURTHER INFORMATION CONTACT: Angela James, 571–372–7574, or *whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil*.

SUPPLEMENTARY INFORMATION:

Title; *Associated Form; and OMB Number:* JAG Corps Student Program or Direct Accession Application; OPNAV 1070/3 Internship/Externship Program Application; Structured Interview Questions; OMB Control Number 0703–XXXX.

Type of Request: New.

Affected Public: Individuals or households.

Respondent's Obligation: Voluntary.

JAGC Student Program Direct Accession Application (Online System)

Affected Public: Individuals or Households.

Annual Burden Hours: 1,600.

Number of Respondents: 800.

Responses per Respondent: 1.

Annual Responses: 800.

Average Burden per Response: 2 hours.

Frequency: On occasion.

Structured Interviews

Affected Public: Individuals or Households.

Annual Burden Hours: 500.

Number of Respondents: 500.

Responses per Respondent: 1.

Annual Responses: 500.

Average Burden per Response: 1 hour.

Frequency: On occasion.

OPNAV Form 1070/3 Internship/Externship Program Application

Affected Public: Individuals or Households.

Annual Burden Hours: 100.

Number of Respondents: 100.

Responses per Respondent: 1.

Annual Responses: 100.

Average Burden per Response: 1 hour.

Frequency: On occasion.

Total

Annual Burden Hours: 2,200 hours.

Number of Respondents: 900 (the approximately 500 interview respondents are selected from the online system's existing pool of applicants).

Responses per Respondent: 1.556.

Annual Responses: 1,400.

Average Burden per Response: 1.5714 hours.

Needs and Uses: The online system application is used for both the U.S. Navy JAGC Student Program and Direct Accession Program. The Student Program offers law students an opportunity to apply for a commission to the JAGC. The Direct Accessions Program offers practicing attorneys the opportunity to apply for a commission to the JAGC. The structured interview is subsequently offered to applicants judged to be most competitive for the JAGC Student Program or Direct Accession Program. The Internship/Externship Program (OPNAV Form 10703/3), is available throughout the year for programs offered in the summer, fall and spring. The Internship/Externship Program offers law students the opportunity to intern with the JAGC while in law school.

OMB Desk Officer: Ms. Jasmeet Seehra.

You may also submit comments and recommendations, identified by Docket ID number and title, by the following method:

• *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

Instructions: All submissions received must include the agency name, Docket ID number, and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

DOD Clearance Officer: Ms. Angela James.

Requests for copies of the information collection proposal should be sent to Ms. James at *whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil.*

Dated: June 14, 2019.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2019–13039 Filed 6–19–19; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN–2019–HQ–0012]

Proposed Collection; Comment Request

AGENCY: Office of the Secretary of the Navy, DoD.

ACTION: Information collection notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Marine Corps Manpower and Reserve Affairs (M&RA), Business and Support Services Division (MR) announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by August 19, 2019.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Chief Management Officer, Directorate for Oversight and Compliance, 4800 Mark Center Drive, Mailbox #24, Suite 08D09, Alexandria, VA 22350–1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to Al Gorski, Supervisory Financial Analyst, Financial Operations System Support (FOSS), Business and Support Services Division (MR), Headquarters, U.S. Marine Corps, 3044 Catlin Ave, Quantico, VA 22134–5009 or 703–784–3857.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Response to the Marine Corps NAF Debt Collection Notice NAVMC 11787, OMB Control Number 0703–XXXX.

Needs and Uses: The information collection requirement is necessary to maintain a tracking and accounting system for the purpose of repayment management or to transfer the debt collection to the Treasury Offset Program, dependent on the response option elected by the respondent.

Affected Public: Individuals or households; and business or other for profit.

Annual Burden Hours: 173.

Number of Respondents: 2,080.

Responses per Respondent: 1.

Annual Responses: 2,080.

Average Burden per Response: 5 minutes.

Frequency: On occasion.

Respondents are authorized vendors and patrons indebted to MCCS businesses and services as well as applicable supported Marine Corps Nonappropriated Fund Instrumentalities (NAFIs). The completed form is maintained to manage the repayment option elected by the respondent. If the form was not completed, the outstanding alleged debt would be automatically submitted to the Treasury Offset Program to withhold or reduce federal payment (s) to satisfy the debt. Having a means to manage outstanding debt collection supports financial accountability.

Dated: June 14, 2019.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2019–13078 Filed 6–19–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Department of the Navy

Notice of Intent To Grant Partially Exclusive Patent License; Axis3

AGENCY: Department of the Navy, DoD.

ACTION: Notice of intent to grant license.

SUMMARY: The Department of the Navy hereby gives notice of its intent to grant to Axis3 a revocable, nonassignable, partially exclusive license to practice the Government-Owned inventions described in U.S. Patent No. 9804813.

DATES: Anyone wishing to object to the grant of this license has fifteen (15) days from the publication date of this notice to file written objections along with supporting evidence, if any.

ADDRESSES: Written objections are to be filed with the Office of Research and Technology Applications, Naval Information Warfare Center Pacific, Code 72120, 53560 Hull St., Bldg A33, Room 2531, San Diego, CA 92152–5001.

File an electronic copy of objections with *paul.a.herbert@navy.mil.*

FOR FURTHER INFORMATION CONTACT: Mr. Paul Herbert, 619–553–5118, *paul.a.herbert@navy.mil.*

(Authority: 35 U.S.C. 209(e); 37 CFR 404.7)

Dated: June 17, 2019.

Meredith Steingold Werner,

Commander, Judge Advocate General's Corps, U.S. Navy, Federal Register Liaison Officer.

[FR Doc. 2019–13119 Filed 6–19–19; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF DEFENSE

Department of the Navy

Certificate of Alternate Compliance for USS INDIANAPOLIS (LCS 17)

AGENCY: Department of the Navy, DoD.

ACTION: Notice of issuance of Certificate of Alternate Compliance.

SUMMARY: The U.S. Navy hereby announces that a Certificate of Alternate Compliance has been issued for USS INDIANAPOLIS (LCS 17). Due to the special construction and purpose of this vessel, the Deputy Assistant Judge Advocate General (DAJAG) (Admiralty and Maritime Law) has determined that it is a vessel of the Navy which, due to its special construction and purpose, cannot comply fully with the certain provisions of the International Regulations for Preventing Collisions at Sea, 1972 (72 COLREGS) without interfering with its special functions as a naval ship. The intended effect of this notice is to warn mariners in waters where 72 COLREGS apply.

DATES: This notice is effective June 20, 2019 and is applicable beginning June 14, 2019.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander James C. Sylvan, JAGC, U.S. Navy, Admiralty Attorney, Office of the Judge Advocate General, Admiralty and Maritime Law Division (Code 11), 1322 Patterson Ave. SE, Suite 3000, Washington Navy Yard, DC 20374–5066, telephone number: 202–685–5040, or *admiralty@navy.mil.*

SUPPLEMENTARY INFORMATION: Background and Purpose. Executive Order 11964 of January 19, 1977 and 33 U.S.C. 1605 provide that the requirements of the 72 COLREGS, as to the number, position, range, or arc of visibility of lights or shapes, as well as to the disposition and characteristics of sound-signaling appliances, shall not apply to a vessel or class of vessels of the Navy where the Secretary of the Navy shall find and certify that, by reason of special construction or purpose, it is not possible for such vessel(s) to comply fully with the provisions without interfering with the special function of the vessel(s). Notice of issuance of a Certificate of Alternate Compliance must be made in the **Federal Register**.

In accordance with 33 U.S.C. 1605, the DAJAG (Admiralty and Maritime Law), under authority delegated by the Secretary of the Navy, hereby finds and certifies that USS INDIANAPOLIS (LCS 17) is a vessel of special construction or purpose, and that, with respect to the position of the following navigational lights, it is not possible to comply fully with the requirements of the provisions enumerated in the 72 COLREGS without interfering with the special function of the vessel:

Annex I, paragraph 2(a)(i), pertaining to the vertical position of the forward masthead light; Annex I, paragraph 3(a), pertaining to the horizontal position of the forward masthead light; and Annex I, paragraph 3(a), pertaining to the horizontal separation between the forward and aft masthead lights.

The DAJAG (Admiralty and Maritime Law) further finds and certifies that these navigational lights are in closest possible compliance with the applicable provision of the 72 COLREGS.

Authority: 33 U.S.C. 1605(c), E.O. 11964.

Approved: June 14, 2019.

A.S. Janin,

Deputy Assistant Judge Advocate General (Admiralty and Maritime Law Division).

Dated: June 17, 2019.

M.S. Werner,

Commander, Judge Advocate General's Corps, U.S. Navy, Federal Register Liaison Officer.

[FR Doc. 2019–13114 Filed 6–19–19; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF EDUCATION

Applications for New Awards; School Climate Transformation Grant Program—Local Educational Agency Grants

AGENCY: Office of Elementary and Secondary Education, Department of Education.

ACTION: Notice; correction.

SUMMARY: On June 10, 2019, we published in the **Federal Register** a notice inviting applications (NIA) for new awards for fiscal year (FY) 2019 for the School Climate Transformation Grant Program—Local Educational Agency Grants (SCTG–LEA), Catalog of Federal Domestic Assistance (CFDA) number 84.184G. We inadvertently omitted a phrase in Absolute Priority 2. We are correcting Absolute Priority 2 and Absolute Priority 4, which repeats the language from Absolute Priority 2. The deadline for the transmittal of applications continues to be July 22, 2019. Instructions for submitting an application can be found in the NIA.

DATES: This correction is applicable June 20, 2019.

FOR FURTHER INFORMATION CONTACT: Carlette KyserPegram. Telephone: (202) 453–6732. Email: *LEA.SCTG19@ed.gov.*

If you use a telecommunications device for the deaf (TDD) or a text telephone (TTY), call the Federal Relay Service (FRS), toll free, at 1–800–877–8339.

SUPPLEMENTARY INFORMATION: On June 10, 2019, we published in the **Federal Register** a notice inviting applications for new awards for FY 2019 for SCTG–LEA grants (84 FR 26829). In the NIA, we inadvertently omitted a phrase in Absolute Priority 2. In number (2) under Absolute Priority 2, we are adding the words ''or more'' after ''one'' and changing the word ''Tribe'' to ''Tribes'' to reflect the possible plural use so that number (2) will read: ''(2) it predominantly serves members of one or more federally recognized Tribes.'' In addition, we are revising Absolute Priority 4 to match the updated language in Absolute Priority 2.

Corrections

In FR Doc. 2019–12101 appearing on page 26829 in the **Federal Register** of June 10, 2019, the following corrections are made:

1. On page 26830, in the third paragraph of the middle column, revise Absolute Priority 2 so that number (2) reads as follows:

(2) It predominantly serves members of one or more federally recognized Tribes.

2. On page 26830, in the seventh paragraph of the middle column, revise Absolute Priority 4 to read as follows:

An LEA meets this absolute priority if it indicates in its application that it is not a rural LEA, as defined in this notice, does not serve a Qualified Opportunity Zone, and does not predominantly serve members of one or more federally recognized Tribes.

Program Authority: Subpart 3 of Title IV, Part F of the ESEA (20 U.S.C. 7281).

Accessible Format: Individuals with disabilities can obtain this document and a copy of the application package in an accessible format (*e.g.,* braille, large print, audiotape, or compact disc) on request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**.

Electronic Access to This Document: The official version of this document is

the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at this site.

You may also access documents of the Department published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Dated: June 17, 2019.

Frank T. Brogan,

Assistant Secretary for Elementary and Secondary Education.

[FR Doc. 2019–13090 Filed 6–19–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2019–ICCD–0072]

Agency Information Collection Activities; Comment Request; Generic Clearance for Federal Student Aid Customer Satisfaction Surveys and Focus Groups Master Plan

AGENCY: Federal Student Aid (FSA), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing a revision of an existing information collection.

DATES: Interested persons are invited to submit comments on or before August 19, 2019.

ADDRESSES: To access and review all the documents related to the information collection listed in this notice, please use *http://www.regulations.gov* by searching the Docket ID number ED–2019–ICCD–0072. Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting the Docket ID number or via postal mail, commercial delivery, or hand delivery. If the *regulations.gov* site is not available to the public for any reason, ED will temporarily accept comments at *ICDocketMgr@ed.gov.* Please include the docket ID number and the title of the information collection request when requesting documents or submitting comments. *Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted.* Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 550 12th Street SW, PCP, Room 99086, Washington, DC 20202–0023.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Beth Grebeldinger, 202–377–4018.

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Generic Clearance for Federal Student Aid Customer Satisfaction Surveys and Focus Groups Master Plan.

OMB Control Number: 1845–0045.

Type of Review: A revision of an existing information collection.

Respondents/Affected Public: Individuals or Households.

Total Estimated Number of Annual Responses: 650,000.

Total Estimated Number of Annual Burden Hours: 50,000.

Abstract: The Higher Education Amendments of 1998 established Federal Student Aid (FSA) as the first Performance-Based Organization (PBO). One purpose of the PBO is to improve service to student and other participants in the student financial assistance programs authorized under title IV of the Higher Education Act of 1965, as amended, including making those programs more understandable to students and their parents. To do that, FSA has committed to ensuring that all people receive service that matches or exceeds the best service available in the private sector. The legislation's requires establish an on-going need for FSA to be engaged in an interactive process of collecting information and using it to improve program services and processes. The use of customer surveys and focus groups allows FSA to gather that information from the affected parties in a timely manner so as to improve communications with our product users.

Dated: June 14, 2019.

Kate Mullan,

PRA Coordinator, Information Collection Clearance Program, Information Management Branch, Office of the Chief Information Officer.

[FR Doc. 2019–13045 Filed 6–19–19; 8:45 am]

BILLING CODE 4000–01–P

ELECTION ASSISTANCE COMMISSION

Sunshine Act Meetings

Notice of Election Data Summit

TIME AND DATE: The Data Summit will be held on Thursday, June 27, 2019, from 9:00 a.m. until 5:00 p.m., EST time.

PLACE: The Russell Senate Office Building, Room 301, 2 Constitution Ave. NE, Washington, DC 20002.

STATUS: The event is open to the public and will be livestreamed on the EAC's website.

MATTERS TO BE CONSIDERED: The Data Summit coincides with the release of the 2018 Election Administration and Voting Survey (EAVS) and will feature expert speakers examining how to use data to help America vote. The day's keynote speakers and panel discussions will include a look at data within the newly released biennial EAVS survey, as well as broader panel conversations covering issues such as how data can be used to address election security, improve voter registration, modernize election management systems, and enact best practices for serving voters covered under the Uniformed and Overseas Citizens Absentee Voting (UOCAVA) Act. The final agenda will be available at *www.eac.gov.*

CONTACT PERSON FOR MORE INFORMATION: For additional Information Contact:

Brenda Bowser Soder—202–897–9285; *https://www.eac.gov/contact/*.

* * * * *

Clifford Tatum,

General Counsel, U.S. Election Assistance Commission.

[FR Doc. 2019–13151 Filed 6–18–19; 11:15 am]

BILLING CODE 6820–KF–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Sunshine Act Meeting

The following notice of meeting is published pursuant to section 3(a) of the government in the Sunshine Act (Pub. L. 94–409), 5 U.S.C. 552b:

AGENCY HOLDING MEETING: Federal Energy Regulatory Commission.

TIME AND DATE: June 20, 2019 10:00 a.m.

PLACE: Room 2C, 888 First Street NE, Washington, DC 20426

STATUS: Open.

MATTERS TO BE CONSIDERED: Agenda.

* NOTE—Items listed on the agenda may be deleted without further notice.

CONTACT PERSON FOR MORE INFORMATION: Kimberly D. Bose, Secretary, Telephone (202) 502–8400.

For a recorded message listing items struck from or added to the meeting, call (202) 502–8627.

This is a list of matters to be considered by the Commission. It does not include a listing of all documents relevant to the items on the agenda. All public documents, however, may be viewed on line at the Commission's website at *http://ferc.capitolconnection.org/* using the eLibrary link, or may be examined in the Commission's Public Reference Room.

1057TH—MEETING—OPEN MEETING

[June 20, 2019, 10:00 a.m.]

Item No.	Docket No.	Company
		Administrative
A–1	AD19–1–000	Agency Administrative Matters.
A–2	AD19–2–000	Customer Matters, Reliability, Security and Market Operations.
		Electric
E–1	EL08–14–012	Black Oak Energy, LLC, EPIC Merchant Energy, LP and SESCO Enterprises, LLC v. PJM Interconnection, L.L.C.
E–2	RD19–3–000	North American Electric Reliability Corporation.
E–3	RM19–10–000	Transmission Planning Reliability Standard TPL–001–5.
E–4	EL00–95–000	San Diego Gas & Electric Company v. Sellers of Energy and Ancillary Services Into Markets Operated by the California Independent System Operator Corporation and the California Power Exchange.
	EL00–98–000	Investigation of Practices of the California Independent System Operator and the California Power Exchange.
	EL01–10–000	Puget Sound Energy, Inc. v. Sellers of Energy and/or Capacity.
	PA02–2–000	Fact-Finding Investigation Into Possible Manipulation of Electric and Natural Gas Prices.
	IN03–10–000	Investigation of Anomalous Bidding Behavior and Practices in Western Markets.
	EL03–165–000	Portland General Electric Company.
E–5	EL19–39–000	Light Power & Gas of NY LLC v. New York Independent System Operator, Inc.
E–6	ER19–875–000, ER19–875–001	Midcontinent Independent System Operator, Inc.
E–7	ER18–614–003, ER18–614–004, ER18–614–005, EL18–173–001.	PJM Interconnection, L.L.C.; Monongahela Power Company; Potomac Edison Company; West Penn Power Company; AEP Indiana Michigan Transmission Company; Inc.; AEP Kentucky Transmission Company; Inc.; AEP Ohio Transmission Company; Inc.; AEP West Virginia Transmission Company, Inc.; Appalachian Power Company; Indiana Michigan Power Company; Kentucky Power Company; Kingsport Power Company; Ohio Power Company; Wheeling Power Company; Commonwealth Edison Company; Commonwealth Edison Company of Indiana, Inc.; Dayton Power and Light Company; Virginia Electric and Power Company; Public Service Electric and Gas Company; PECO Energy Company; PPL Electric Utilities Corporation; Baltimore Gas and Electric Company; Jersey Central Power & Light Company; Potomac Electric Power Company; Atlantic City Electric Company; Delmarva Power & Light Company; UGI Utilities Inc.; Allegheny Electric Cooperative, Inc.; CED Rock Springs, LLC; Old Dominion Electric Cooperative; Rockland Electric Company;Duquesne Light Company; Neptune Regional Transmission System, LLC; Trans-Allegheny Interstate Line Company; Linden VFT, LLC; American Transmission Systems, Incorporated; City of Cleveland, Department of Public Utilities; Division of Cleveland Public Power; Duke Energy Ohio, Inc.; Duke Energy Kentucky, Inc.; City of Hamilton, OH; Hudson Transmission Partners, LLC; East Kentucky Power Cooperative, Inc.; City of Rochelle; ITC Interconnection LLC; Mid-Atlantic Interstate Transmission, LLC; Southern Maryland Electric Cooperative, Inc.; Ohio Valley Electric Corporation.
E–8	ER15–2028–000, ER15–2028–001	Southwest Power Pool, Inc.
E–9	ER15–2115–000, ER15–2115–001	Southwest Power Pool, Inc.
E–10	ER17–910–001	Pacific Gas and Electric Company.
E–11	ER19–158–002	Ambit Norheast, LLC.
E–12	ER17–2323–002	Midcontinent Independent System Operator, Inc. and Ameren Illinois Company.
E–13	ER19–283–001	ALLETE, Inc.
E–14	ER10–1350–007	Entergy Services, Inc.

1057TH—MEETING—OPEN MEETING—Continued

[June 20, 2019, 10:00 a.m.]

Item No.	Docket No.	Company
E–15	EL18–142–001	Louisiana Public Service Commission v. System Energy Resources, Inc. and Entergy Services, Inc.
E–16	ER17–1198–000	Ameren Illinois Company.
	Miscellaneous	
M–1	RM19–12–000	Revisions to the Filing Process for Commission Forms.
	Hydro	
H–1	OMITTED.	
H–2	P–10808–066	Boyce Hydro Power, LLC.
H–3	P–2114–300	Public Utility District No. 2 of Grant County, Washington.
H–4	P–2290–117	Southern California Edison.
H–5	P–14896–001, P–14897–001, P–14898–001, P–14899–001, P–14900–001, P–14901–001, P–14902–001, P–14903–001, P–14904–001, P–14905–001, P–14906–001, P–14907–001, P–14908–001, P–14909–001, P–14910–001, P–14911–001, P–14912–001, P–14913–001, P–14914–001, P–14915–001, P–14916–001, P–14917–001, P–14918–001, P–14919–001, P–14920–001, P–14921–001, P–14922–001, P–14923–001, P–14924–001, P–14925–001, P–14926–001, P–14927–001, P–14928–001, P–14929–001, P–14930–001, P–14931–001, P–14932–001, P–14933–001, P–14934–001, P–14935–001, P–14936–001, P–14937–001, P–14938–001, P–14939–001, P–14940–001, P–14941–001, P–14942–001, P–14943–001, P–14944–001, P–14945–001, P–14946–001, P–14947–001, P–14948–001, P–14949–001, P–14950–001, P–14951–001, P–14952–001, P–14953–001, P–14954–001, P–14955–001..	Algignis, Inc.
H–6	P–9709–069	ECOsponsible, LLC.

Issued: June 13, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

A free webcast of this event is available through *http://ferc.capitolconnection.org/*. Anyone with internet access who desires to view this event can do so by navigating to *www.ferc.gov's* Calendar of Events and locating this event in the Calendar. The event will contain a link to its webcast. The Capitol Connection provides technical support for the free webcasts. It also offers access to this event via television in the DC area and via phone bridge for a fee. If you have any questions, visit *http://ferc.capitolconnection.org/* or contact Shirley Al-Jarani at 703–993–3104.

Immediately following the conclusion of the Commission Meeting, a press briefing will be held in the Commission Meeting Room. Members of the public may view this briefing in the designated overflow room. This statement is intended to notify the public that the press briefings that follow Commission meetings may now be viewed remotely at Commission headquarters, but will not be telecast through the Capitol Connection service.

[FR Doc. 2019–13240 Filed 6–18–19; 4:15 pm]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 14986–000]

Notice of Preliminary Permit Application Accepted for Filing and Soliciting Comments, Motions To Intervene, and Competing Applications; California State University Maritime Academy

On April 17, 2019, the California State University Maritime Academy (Cal Maritime) filed an application for a preliminary permit, pursuant to section 4(f) of the Federal Power Act (FPA), proposing to study the feasibility of the Cal Maritime Marine Hydrokinetic Project (project). The proposed project would be located in a navigable cove of the Sacramento San Joaquin River (Carquinez Strait), located in the City of

Vallejo, in Solano County, California. The sole purpose of a preliminary permit, if issued, is to grant the permit holder priority to file a license application during the permit term. A preliminary permit does not authorize the permit holder to perform any land-disturbing activities or otherwise enter upon lands or waters owned by others without the owners' express permission.

The proposed project would consist of a floating power platform located at Cal Maritime's property and use marine hydrokinetic technologies to generate approximately 41,610 megawatt hours annually. The floating platform would measure 120-feet-long by 40-feet-wide, and 14-feet-deep. Cal Maritime proposes to use the power generated by the project on its campus and distribute the excess power through an interconnect with Pacific Gas and Electric Company's Colgate-Oakland transmission line.

Applicant Contact: Franz Lozano, Vice President & CFO, California State University Maritime Academy, 200 Maritime Academy, Vallejo, CA 94590; phone: (707) 654–1038; or via email at: *flozano@csum.edu.*

FERC Contact: Kenneth Hogan; phone: (202) 502–8434; or email at: *Kenneth.Hogan@ferc.gov.*

Deadline for filing comments, motions to intervene, competing applications (without notices of intent), or notices of intent to file competing applications: 60 days from the issuance of this notice. Competing applications and notices of intent must meet the requirements of 18 CFR 4.36.

The Commission strongly encourages electronic filing. Please file comments, motions to intervene, notices of intent, and competing applications using the Commission's eFiling system at *http://www.ferc.gov/docs-filing/efiling.asp.* Commenters can submit brief comments up to 6,000 characters, without prior registration, using the eComment system at *http://www.ferc.gov/docs-filing/ecomment.asp.* You must include your name and contact information at the end of your comments. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov,* (866) 208–3676 (toll free), or (202) 502–8659 (TTY). In lieu of electronic filing, please send a paper copy to: Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426. The first page of any filing should include docket number P–14986–000.

More information about this project, including a copy of the application, can be viewed or printed on the ''eLibrary'' link of Commission's website at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number (P–14986–000) in the docket number field to access the document. For assistance, contact FERC Online Support.

Dated: June 14, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2019–13136 Filed 6–19–19; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2019–0075; FRL–9992–77]

Certain New Chemicals; Receipt and Status Information for March 2019

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA is required under the Toxic Substances Control Act (TSCA), as amended by the Frank R. Lautenberg Chemical Safety for the 21st Century Act, to make information publicly available and to publish information in the **Federal Register** pertaining to submissions under TSCA Section 5, including notice of receipt of a Premanufacture notice (PMN), Significant New Use Notice (SNUN) or Microbial Commercial Activity Notice (MCAN), including an amended notice or test information; an exemption application (Biotech exemption); an application for a test marketing exemption (TME), both pending and/or concluded; a notice of commencement (NOC) of manufacture (including import) for new chemical substances; and a periodic status report on new chemical substances that are currently under EPA review or have recently concluded review. This document covers the period from 03/01/2019 to 03/31/2019.

DATES: Comments identified by the specific case number provided in this document must be received on or before July 22, 2019.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPPT–2019–0075, and the specific case number for the chemical substance related to your comment, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.
- *Mail:* Document Control Office (7407M), Office of Pollution Prevention and Toxics (OPPT), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets/contacts.html.* Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT:

For technical information contact: Jim Rahai, Information Management Division (7407M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; telephone number: (202) 564–8593; email address: *rahai.jim@epa.gov.*

For general information contact: The TSCA-Hotline, ABVI-Goodwill, 422 South Clinton Ave., Rochester, NY 14620; telephone number: (202) 554–1404; email address: *TSCA-Hotline@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

What action is the Agency taking?

This document provides the receipt and status reports for the period from 03/01/2019 to 03/31/2019. The Agency is providing notice of receipt of PMNs, SNUNs and MCANs (including amended notices and test information); an exemption application under 40 CFR part 725 (Biotech exemption); TMEs, both pending and/or concluded; NOCs to manufacture a new chemical substance; and a periodic status report on new chemical substances that are currently under EPA review or have recently concluded review.

EPA is also providing information on its website about cases reviewed under the amended TSCA, including the section 5 PMN/SNUN/MCAN and exemption notices received, the date of receipt, the final EPA determination on the notice, and the effective date of EPA's determination for PMN/SNUN/MCAN notices on its website at: *https://www.epa.gov/reviewing-new-chemicals-under-toxic-substances-control-act-tsca/status-pre-manufacture-notices.* This information is updated on a weekly basis.

B. What is the Agency's authority for taking this action?

Under the TSCA, 15 U.S.C. 2601 *et seq.,* a chemical substance may be either an ''existing'' chemical substance or a ''new'' chemical substance. Any chemical substance that is not on EPA's

TSCA Inventory of Chemical Substances (TSCA Inventory) is classified as a ''new chemical substance,'' while a chemical substance that is listed on the TSCA Inventory is classified as an ''existing chemical substance.'' (See TSCA section 3(11).) For more information about the TSCA Inventory go to: *https://www.epa.gov/tsca-inventory.*

Any person who intends to manufacture (including import) a new chemical substance for a non-exempt commercial purpose, or to manufacture or process a chemical substance in a non-exempt manner for a use that EPA has determined is a significant new use, is required by TSCA section 5 to provide EPA with a PMN, MCAN or SNUN, as appropriate, before initiating the activity. EPA will review the notice, make a risk determination on the chemical substance or significant new use, and take appropriate action as described in TSCA section 5(a)(3).

TSCA section 5(h)(1) authorizes EPA to allow persons, upon application and under appropriate restrictions, to manufacture or process a new chemical substance, or a chemical substance subject to a significant new use rule (SNUR) issued under TSCA section 5(a)(2), for ''test marketing'' purposes, upon a showing that the manufacture, processing, distribution in commerce, use, and disposal of the chemical will not present an unreasonable risk of injury to health or the environment. This is referred to as a test marketing exemption, or TME. For more information about the requirements applicable to a new chemical go to: *http://www.epa.gov/oppt/newchems.*

Under TSCA sections 5 and 8 and EPA regulations, EPA is required to publish in the **Federal Register** certain information, including notice of receipt of a PMN/SNUN/MCAN (including amended notices and test information); an exemption application under 40 CFR part 725 (biotech exemption); an application for a TME, both pending and concluded; NOCs to manufacture a new chemical substance; and a periodic status report on the new chemical substances that are currently under EPA review or have recently concluded review.

C. Does this action apply to me?

This action provides information that is directed to the public in general.

D. Does this action have any incremental economic impacts or paperwork burdens?

No.

E. What should I consider as I prepare my comments for EPA?

1. *Submitting confidential business information (CBI).* Do not submit this information to EPA through *regulations.gov* or email. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD–ROM that you mail to EPA, mark the outside of the disk or CD–ROM as CBI and then identify electronically within the disk or CD–ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments.* When preparing and submitting your comments, see the commenting tips at *http://www.epa.gov/dockets/comments.html.*

II. Status Reports

In the past, EPA has published individual notices reflecting the status of TSCA section 5 filings received, pending or concluded. In 1995, the Agency modified its approach and streamlined the information published in the **Federal Register** after providing notice of such changes to the public and an opportunity to comment (See the **Federal Register** of May 12, 1995, (60 FR 25798) (FRL–4942–7). Since the passage of the Lautenberg amendments to TSCA in 2016, public interest in information on the status of section 5 cases under EPA review and, in particular, the final determination of such cases, has increased. In an effort to be responsive to the regulated community, the users of this information, and the general public, to comply with the requirements of TSCA, to conserve EPA resources and to streamline the process and make it more timely, EPA is providing information on its website about cases reviewed under the amended TSCA, including the section 5 PMN/SNUN/MCAN and exemption notices received, the date of receipt, the final EPA determination on the notice, and the effective date of EPA's determination for PMN/SNUN/MCAN notices on its website at: *https://www.epa.gov/reviewing-new-chemicals-under-toxic-substances-control-act-tsca/status-pre-manufacture-notices.* This information is updated on a weekly basis.

III. Receipt Reports

For the PMN/SNUN/MCANs that have passed an initial screening by EPA during this period, Table I provides the following information (to the extent that such information is not subject to a CBI claim) on the notices screened by EPA during this period: The EPA case number assigned to the notice that indicates whether the submission is an initial submission, or an amendment, a notation of which version was received, the date the notice was received by EPA, the submitting manufacturer (*i.e.,* domestic producer or importer), the potential uses identified by the manufacturer in the notice, and the chemical substance identity.

As used in each of the tables in this unit, (S) indicates that the information in the table is the specific information provided by the submitter, and (G) indicates that this information in the table is generic information because the specific information provided by the submitter was claimed as CBI. Submissions which are initial submissions will not have a letter following the case number. Submissions which are amendments to previous submissions will have a case number followed by the letter ''A'' (*e.g.,* P–18–1234A). The version column designates submissions in sequence as ''1'', ''2'', ''3'', etc. Note that in some cases, an initial submission is not numbered as version 1; this is because earlier version(s) were rejected as incomplete or invalid submissions. Note also that future versions of the following tables may adjust slightly as the Agency works to automate population of the data in the tables.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
J–19–0018	2	3/5/2019	CBI	(G) Protein production	(G) Protein-producing modified microorganism, with chromosomally-borne modifications.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
J–19–0019	1	3/20/2019	Danisco US, Inc.	(G) Production of an enzyme substance.	(G) Genetically modified microorganism for the production of an enzyme substance.
J–19–0020	1	3/20/2019	Danisco US, Inc	(G) Production of an enzyme substance.	(G) Genetically modified microorganism for the production of an enzyme substance.
P–16–0225A	2	3/14/2019	International Flavors.	(S) The notified substance will be used as a fragrance ingredient, being blended (mixed) with other fragrance ingredients to make fragrance oils that will be sold to industrial and commercial customers for their incorporation into soaps, detergents, cleaners, air fresheners, candles and other similar industrial, household and consumer products.	(S) isomer mixture of Cyclohexanol, 4-ethylidene-2-propoxy- (CAS 1631145–48–6) (35–45%) and Cyclohexanol, 5-ethylidene-2-propoxy.
P–16–0422A	4	3/20/2019	Polymer Additives Inc.	(G) Additive for Polymers	(S) 1,2-Cyclohexanedicarboxylic acid, 1-(phenylmethyl) ester, ester with 2,2,4-trimethyl-1,3-pentanediol mono(2-methylpropanoate).
P–16–0493A	7	2/7/2019	CBI	(G) Paint	(G) Dicarboxylic acids, polymers with alkyl prop-2-enoate, alkyl 2-methylprop-2-enoate, alkyl [(alkenyl) alkyl] alkanediol, alkanediol, alkanedioic acid, alkyl 2-methylprop-2-enoate, alkyl prop-2-enoic acid, alkylene [Isocyanatocarbomonocyle] and alkanediol, alkanolamine-blocked, compds with 2-(alkylamino)alkanol.
P–16–0593A	4	2/22/2019	Emery Oleochemicals.	(S) Aromatic polyester polyol for rigid foam.	(G) Aromatic Polyester Polyol.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–17–0108A	5	2/27/2019	Crison LLC	(G) The product of this PMN is typically added at a rate of 3–5% of the collector package. The product is added after the grinding of the ore, along with copious amounts of water to enable the flotation of the desired mineral. The product binds to the target mineral and makes it hydrophobic, enabling the dissolved gas flotation system to float the target mineral. The collected target mineral concentrate (with the product bound to them) is then sent to a metullurgy plant for further purification. The high temperature processing results in all the organics (including the product) being burned off. The resulting combustion products are scrubbed as required by the mettullurgical plants permits. A very small amount of product settles with the larger particles of ore that contain target mineral. This product goes with the gangue to the tailing ponds. The tailing ponds have their own set of permits but are isolated with various membrane and other groundwater protection methods that are beyond the scope of this application. It is worth noting that only 3–5% of the collector package at this time is made up of the product of this PMN. The chemistry is an incremental improvement on the currently commercially practiced collection method, containing the same functional groups and similar solubilities. Thus, the product of this PMN is readily detected or measured with current monitoring at the use sites. Because the product is added at a stage where large amounts of water are also added, the current international users wash the drums with large amounts of water, and the wash water is added to the process with the prime material as it is added.	(S) Carbonodithioic acid, O-[2-[(dithiocarboxy)amino]-2-methylpropyl] ester, sodium salt (1:2).
P–17–0240A	2	3/1/2019	Ashland, Inc	(G) Encapsulanting polymer	(G) Alkenoic acid, polymer with alkanepolyolpolyacrylate, 2,2′-azobis[2-methylbutanenitrile]-initiated.
P–17–0240A	3	3/7/2019	Ashland, Inc	(G) Encapsulanting polymer	(G) Alkenoic acid, polymer with alkanepolyolpolyacrylate, 2,2′-azobis[2-methylbutanenitrile]-initiated.
P–17–0312A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Organic acid, compds. with bisphenol A-epichlorohydrin-polypropylene glycol diglycidyl ether polymer-disubstituted polypropylene glycol reaction products.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–17–0313A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Phenol, 4,4′-(1-methylethylidene) bis-, polymer with 2-(chloromethyl) oxirane and alpha-(2-oxiranylmethyl)-omega-(2-oxiranylmethoxy) poly[oxy(methyl-1,2-ethanediyl)], reaction products with disubstituted amine and disubstituted polypropylene glycol, organic acid salts.
P–17–0314A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Organic acid, 2-substituted-, compds. with bisphenol A-epichlorohydrin-polypropylene glycol diglycidyl ether polymer-disubstituted aminedisubstituted polypropylene glycol reaction products.
P–17–0315A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Phenol, 4,4′-(1-methylethylidene) bis-, polymer with alpha-(2-substituted-methylethyl)-omega-(2-substituted-methylethoxy) poly[oxy(methyl-1,2-ethanediyl)], 2-(chloromethyl) oxirane and alpha-(2-oxiranylmethyl)-omega-(2-oxiranylmethoxy) poly[oxy(methyl-1,2-ethanediyl)], alkylphenyl ethers, reaction products with disubstituted amine, organic acid salts.
P–17–0316A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Organic acid, compds. with bisphenol A-epichlorohydrin-disubstituted polypropylene glycol-polypropylene glycol diglycidyl ether polymer alkylphenyl ethers-disubstituted amine reaction products.
P–17–0317A	7	2/20/2019	CBI	(G)Additive for electrocoat formulas	(G) Organic acid, compds. with bisphenol A-epichlorohydrin-polypropylene glycol diglycidyl ether polymer-disubstituted polypropylene glycol reaction products.
P–17–0375A	4	2/8/2019	CBI	(G) Paint additive	(G) 2-Oxepanone, polymer with diisocyanatohexane, alkyl-((hydroxyalkyl)-alkanediol and isocyanato-(isocyanatoalkyl)-trialkylcyclohexane, di-alkyl malonate- and polyalkylene glycol mono-Me ether-blocked, reaction products with (methylalkyl)-propanamine.
P–17–0395A	4	2/7/2019	CBI	(G) Water treatment additive	(G) Alkyl tri dithiocarbmate tri salt.
P–18–0036A	5	2/8/2019	CBI	(G) Water repellant	(S) Siloxanes and Silicones, di-Me, 3- [3-carboxy-2(or 3)- (octenyl)-1-oxopropoxy] propyl group-terminated.
P–18–0064A	2	2/25/2019	CBI	(G) Intermediate	(G) Fluorinated carboxylate esters and fluorinated alkoxyalkyl heterocycles.
P–18–0069A	2	2/20/2019	Sasol Chemicals (USA), LLC.	(G) Polymer performance additive	(G) Surface modified boehmite.
P–18–0085A	2	3/5/2019	CBI	(G) Industrial use in oilfield	(G) Fatty acids reaction products with ethyleneamines and dialkyl ester.
P–18–0106A	3	2/25/2019	CBI	(S) Process aid	(G) Perfluoro[(alkenyl)oxy] alkane-, manuf. of, by-products from, distn. residues.
P–18–0120A	4	3/19/2019	Designer Molecules, Inc.	(G) Adhesive component	(S) 1H-Pyrrole-2,5-dione, 1,1′-C36-alkylenebis-.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–18–0131A	4	3/5/2019	Coim USA, Inc	(S) Polyol prepolymer in polyester foam applications.	(G) Soybean oil, polymer with mixed difunctional glycols, glycerol, melamine, phthalic anhydride, poyethylene glycol, and terephathalic acid.
P–18–0169A	7	2/15/2019	C. L. Hauthaway & Sons Corp.	(G) Protective coating	(G) Propanoic acid, 3-hydroxy-2-(hydroxymethyl)-2-methyl-, polymer with dimethyl carbonate, 1,6-hexanediol, diamine and 1,1′-methylenebis[4-isocyanatocyclohexane], acrylate-blocked, compds. with triethylamine.
P–18–0175A	6	2/12/2019	Hexion, Inc	(S) Food can coating; (S) Non-food contact can coating	(S) Formaldehyde, polymer with 4-(1,1-dimethylethyl) phenol and phenol, Bu ether.
P–18–0219A	6	3/5/2019	CBI	(G) Intermediate for topcoat	(G) Polythioether, short chain diol polymer terminated with aliphatic diisocyanate.
P–18–0247A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(G) Isocyanic acid, polymethylenepolyphenylene ester, polymer with 2-ethyl-2-(hydroxymethyl)-1,3-propanediol, polyetherpolyol, ¿, ¿′-[(1-methylethylidene) di-4,1-phenylene] bis[¿-hydroxypoly(oxy-1,2-ethanediyl)] and 1,2-propanediol, iso-Bu alc.- and 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and Et alc.- and methanol- and 1-methoxy-2-propanol-blocked.
P–18–0248A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(G) Isocyanic acid, polymethylenepolyphenylene ester, polymer with polyetherpolyol, 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and methanolblocked.
P–18–0249A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(G) Isocyanic acid, polymethylenepolyphenylene ester, polymer with polyetherpolyol, 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and methanoland 1-methoxy-2-propanol-blocked.
P–18–0250A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(G) Isocyanic acid, polymethylenepolyphenylene ester, polymer with polyetherpolyol, 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and 1(or2) -(2-methoxymethylethoxy) propanol-blocked.
P–18–0251A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(S) Isocyanic acid, polymethylenepolyphenylene ester, 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and methanol- and 1(or2) -(2-methoxymethylethoxy) propanol-blocked.
P–18–0252A	3	3/13/2019	CBI	(S) Crosslinker for automotive electrocoat.	(S) Isocyanic acid, polymethylenepolyphenylene ester, 2-butoxyethanol- and 2-(2-butoxyethoxy) ethanol- and methanol- and 1-methoxy-2-propanol-blocked.
P–18–0258A	2	3/7/2019	CBI	(G) Copolyamide for packaging films; (G) Copolyamide for monofilamen; (G) Copolyamide for molding parts.	(G) Dioic acids, polymers with caprolactam and alkyldiamines.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–18–0259A	2	3/7/2019	CBI	(G) Copolyamide for packaging films; (G) Copolyamide for monofilamen; (G) Copolyamide for molding parts.	(G) Fatty acids, dimers, hydrogenated, polymers with caprolactam and alkyl diamine.
P–18–0262A	4	2/14/2019	Seppic	(S) Function: Stabilizer of suspensions, Applications: Detergency, treatment of physical surfaces, development of soaps; (S) Function: thickener, Applications: Paints, adhesive; (S) Function: polishes, Applications: Wood care, leather care.	(S) 2-Propenoic acid, 2-methyl-, dodecyl ester, polymer with ammonium 2-methyl-2-[(1-oxo-2-propen-1-yl) amino]-1-propanesulfonate (1:1), N, N-dimethyl-2-propenamide and. alpha-(2-methyl-1-oxo-2-propen-1-yl)-omega-(dodecyloxy) poly(oxy-1,2-ethanediyl).
P–18–0270A	4	3/8/2019	Specialty Elements, LLC.	(S) Active co-solvent for solvent-based coatings; (S) Coalescent for industrial water-based coatings; (S) Coupling agent and solvent in industrial cleaners, rust removers, hard surface cleaners, and disinfectants; (S) Primary solvent in solvent-based silk screen printing inks; (S) Coupling agent for resins and dyes in water-based printing inks; (S) Other uses include a co- solvent for agricultural pesticides and may be used in the production of a wide variety of products and commodities such as polyester resins, engine coolants, latex paints, heat transfer fluids and deicing compounds, lubricants, plasticizers and cement grinding additives.	(G) Ethanol, 2-butoxy-, 1,1′-ester.
P–18–0271A	4	3/8/2019	Specialty Elements, LLC.	(S) Film forming coalescent for architectural coatings; (S) Film forming coalescent for consumer architectural coatings; (S) Film forming coalescent for automotive OEM coatings (electrodeposition primers); (S) Film forming coalescent for can and coil coatings; (S) Film forming coalescent for industrial wood coatings; (S) Film forming coalescent for floor polishes; (S) Film forming coalescent for industrial maintenance coatings; (S) Film forming coalescent for marine and wood coatings; (S) Film forming coalescent for consumer marine and wood coatings; (S) Film forming coalescent for transportation coatings; (S) Other uses include Graphic Arts—Printing Inks (Lithographic and Letterpress oil-based inks), Reactive Intermediate—Ester Derivatives for Plasticizers.	(G) 2-Propanol, 1-butoxy-, 2,2′-ester.
P–18–0272A	2	2/26/2019	CBI	(G) Polymer composite additive	(G) Metal, alkylcarboxylate oxo complexes.
P–18–0274A	5	3/13/2019	CBI	(S) Chemical intermediate; (G) Additive.	(G) Heterocycle fluoroalkyl sulfonyl.
P–18–0275A	2	3/13/2019	CBI	(G) Polymer additive	(G) Methanone phenylene fluoroalkyl sulfonyl heterocycle.
P–18–0282A	11	3/7/2019	Ashland, Inc	(G) Adhesive	(G) Fatty acid ester, polyether, diisocyanate polymer.
P–18–0283A	4	3/1/2019	CBI	(G)Open, non-dispersive use	(G) Hydroxy alkanoic acid, compds. with aminoalkoxyalcohol-epoxy polymer-alkanolamine reaction products.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–18–0283A	5	3/11/2019	CBI	(G)Open, non-dispersive use	(G) Hydroxy alkanoic acid, compds. with aminoalkoxyalcohol-epoxy polymer-alkanolamine reaction products.
P–18–0284A	2	3/1/2019	CBI	(G) Polymer composite additive	(G) Inorganic acid, reaction products with alkyl alcohol.
P–18–0292A	2	2/19/2019	CBI	(G) Use in print resins	(G) Alkanediol, polymer with 5-isocyanato-1-(isocyanatomethyl)-1,3,3-trimethylcyclohexane, alkylaminoalkyl methacrylate-blocked.
P–18–0292A	3	3/21/2019	CBI	(G) Use in print resins	(G) Alkanediol, polymer with 5-isocyanato-1-(isocyanatomethyl)-1,3,3-trimethylcyclohexane, alkylaminoalkyl methacrylate-blocked.
P–18–0300A	2	2/8/2019	CBI	(S) Additive for automatic dish-washing detergent.	(G) Heteromonocycle, alkenoic 1:1 salt, polymer with alpha-(2-methyl-1-oxo-2-propen-1-y) l-omegamethoxypoly(oxy-1,2-ethanediyl) and methyl-alkenoic acid.
P–18–0313A	4	3/19/2019	Ashland Inc	(G) Adhesive	(G) Alkoxylated glycol ether with 1,2-propanediol, reaction products with alkyl alcohol blocked 1,1′-methylenebis [4-isocyanatobenzene] homopolymer and 1,1′-methylenebis [4-isocyanatobenzene].
P–18–0322A	6	2/7/2019	CBI	(G) The notified substance is used as a fragrance ingredient in consumer products.	(G) Heteromonocycle, 4,6-dimethyl-2-(1-phenylethyl)-.
P–18–0327A	4	3/21/2019	CBI	(G) Filler for non-dispersive resins	(G) Mixed metal oxide.
P–18–0341A	3	3/15/2019	CBI	(G) Component in coatings	(G) Alkane dicarboxylic acid, polymer with alkoxylated polyalcohol, alkyl polyglycol, alkyl dialcohol, and functionalized carboxylic acid.
P–18–0342A	3	3/15/2019	CBI	(G) Component in coatings	(G) Alkane dicarboxylic acid, polymer with alkyl polyglycol, alkyl dialcohol, and functionalized carboxylic acid.
P–18–0343A	3	3/15/2019	CBI	(G) Component in coatings	(G) Alkane dicarboxylic acid, polymer with alkoxylated polyalcohol, and alkyl dialcohol, (hydroxy alkyl) ester.
P–18–0344A	3	3/15/2019	CBI	(G) Component in coatings	(G) Aromatic dicarboxylic acid, polymer with alkane dicarboxylic acid, alkoxylated polyalcohol, and alkyl dialcohol.
P–18–0346A	3	3/4/2019	Chitec Technology Co., Ltd.	(S) Antioxidant compounded into various polymers to be used in extrusion processes to fabricate articles.	(S) 2,4,8,10-Tetraoxa-3,9-diphosphaspiro [5.5] undecane, 3,9-bis-[2-(1-methyl-1-phenylethyl)-4-(1,1,3,3-tetramethylbutyl) phenoxy]-.
P–18–0381A	2	3/19/2019	The Shepherd Color Company.	(G) For use in exterior paints and plastics; (G) For use in coatings; (G) For use in high temperature engineering polymers; (G) For use in artist materials.	(S) Indium manganese yttrium oxide.
P–18–0387A	3	2/11/2019	CBI	(G) Plastic additive	(G) Alkanal, reaction products with alkanediyl bis[alkyl-tris(alkyl-heterocycle)-1,3,5-triazine-2,4,6-triamine and hydrogen peroxide.
P–18–0388A	3	2/11/2019	CBI	(G) Plastic additive	(G) 1,3,5-triazine-2,4,6-triamine, alkanediyl bis[alkyl-tris(alkyl-heterocycle)-, allyl derivs., oxidized, hydrogenated.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–18–0389A	2	3/13/2019	CBI	(G) Component in package coatings	(G) Alkenoic acid, alkyl-substituted, epoxy ester, polymer with alkyl alkenoate, alkene, and polylactide.
P–18–0393A	2	3/15/2019	CBI	(G) Paint	(G) Alkenoic acid, alkyl, alkyl ester, polymer with alkyl propenoate, vinyl carbomonocyle, substituted alkyl propenoate, alkyl 2-alkyl 2-propenoate, alkanediol mono(2-alkyl-2-propenoate) and bicarbomonocylo alkyl 2-alkyl-2-alkenoate, tertiary alkyl substituted alkane peroxoate initiated.
P–18–0394A	2	2/25/2019	CBI	(G) Chemical Intermediate	(G) Substituted benzylic ether polyethylene glycol alkyl ether derivative.
P–18–0402A	3	3/11/2019	CBI	(G) Fuel additive	(G) Phenol, alkanepolyolbis (heteroalkylene)bis-, polyalkylene derivs.
P–19–0009A	4	2/7/2019	Allnex USA, Inc.	(S) The PMN substance is used as a coating resin additive for corrosion protection.	(G) Carbonmonocycles, polymer with haloalkyl substituted heteromonocycle and hydrohydroxypoly[oxy(alkyl-alkanediyl)], dialkyl-alkanediamineterminated, hydroxyalkylated, acetates (salts).
P–19–0012A	9	3/11/2019	CBI	(S) Resin component for the polyisocyanurate; (S) Resin component in specialty polyurethane kits and systems for aerospace and military applications.	(G) Benzenedicarboxylic acid, rection products with isobenzofurandione and diethylene glycol.
P–19–0015A	3	3/1/2019	CBI	(S) Emulsifier for use in asphalt applications.	(G) Alkyl cyclic amide.
P–19–0021A	2	2/13/2019	CBI	(G) Pigment ink	(G) Hydroxyalkyl carboxylic acid, polymer with alkylamine, alkylene carbonate, alkanediol, isocyanate, compd. with alkylamine.
P–19–0022A	2	2/13/2019	CBI	(G) Pigment ink	(G) Hydroxyalkyl carboxylic acid, polymer with alkylamine, alkyl carbonate, alkanediol, isocyanate, compd. with alkylamine.
P–19–0025A	2	2/21/2019	Bercen, Inc	(G) Hydrophobe formulation	(S) 11-Docosene.
P–19–0026A	4	2/27/2019	Allnex USA, Inc.	(S) The PMN substance is an isolated intermediate incorporated as a component in several imported allnex coating resin products that are only applied by Cathodic Electrodeposition (CED) and used as additives for corrosion protection.	(G) Alkanoic acid, compds. with substituted carbomonocycle-dialkyl-alkanediamine-halosubstitued heteromonocycle-polyalkylene glycol polymerdialkanolamine reaction products.
P–19–0028A	6	2/22/2019	CBI	(G) Lubricating oil additive	(G) Alkyl salicylate, metal salts.
P–19–0032A	4	3/18/2019	Presidium USA, Inc.	(G) Polyol used in the manufacture of articles made of a polyurethane thermoset material.	(G) Carbonic dichloride, polymer with 4,4′-(1-methylethylidene) bis[phenol] ester, polymer with tetrol and polyether tetrol.
P–19–0034A	3	3/15/2019	CBI	(G) Contained use as a component of tires.	(G) Metal, bis (2,4-pentanedionato-kO2, kO4)-, (T-4)-.
P–19–0038A	3	2/7/2019	Allan Chemical Corporation.	(S) Ink carrier for the ceramic industries.	(S) Fatty acids, coco, iso-Bu esters.
P–19–0050A	3	3/11/2019	Kimes Technologies International, Inc.	(S) Rust preventative	(S) Hydrocarbon waxes (petroleum), oxidized, Bu esters.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–19–0053A	2	3/13/2019	Wacker Chemical Corporation.	(S) Used as a surface treatment, sealant, caulk, and coating for mineral building materials such as concrete, brick, limestone, and plaster, as well as on wood, metal and other substrates. Formulations containing the cross-linker provide release and anti-graffiti properties, water repellency, weather proofing, and improved bonding in adhesive/sealant applications. The new substance is a moisture curing cross-linking agent which binds/joins polymers together when cured. Ethanol is released during cure, and once the cure reaction is complete, the product will remain bound in the cured polymer matrix.	(S) 1-Butanamine, N-butyl-N-[(triethoxysilyl)methyl]-.
P–19–0064	1	3/4/2019	The Sherwin Williams Company.	(G) Polymeric film former for coatings.	(G) 4,4′-methylenebis [2,6-dimethyl phenol] polymer with 2-(chloromethyl) oxirane, 1,4-benzyl diol, 2-methyl-2-propenoic acid, butyl 2-methyl 2-propenoate, ethyl 2-methyl 2-propenoate, and ethyl 2-propenoate, reaction products with 2-(dimethylamino) ethanol.
P–19–0064A	2	3/18/2019	The Sherwin Williams Company.	(G) Polymeric film former for coatings.	(G) 4,4′-methylenebis [2,6-dimethyl phenol] polymer with 2-(chloromethyl) oxirane, 1,4-benzyl diol, 2-methyl-2-propenoic acid, butyl 2-methyl 2-propenoate, ethyl 2-methyl 2-propenoate, and ethyl 2-propenoate, reaction products with 2-(dimethylamino) ethanol.
P–19–0065	4	3/22/2019	eScientia Technologies, LLC.	(S) Fire retardant for thermal plastics: Application: This product is the environmental protection Phosphazene flame retardant. It does not produce pollutants after burning. It is mainly used in PC and ABS resins. It has good flame retardancy on epoxy resin, it can be used to make EMC for IC Packaging, its flame retardancy is much better than Brominated flame retardant, the flame retardancy can reach UL–94V0 grade. Oxygen index could reach 33.1%. When it is used in Benzoxazine Resin glass cloth laminate, if the HPCTP is 10%, the grade of burning could reach V–0 grade, the parallel breakdown voltage is 47KV. When it is used in Polyethylene, the LOI of final flame retardancy polyethylene could reach 30–33. After used in viscose spinning solution, we could get the flame retardant viscose fiber with oxygen index 25.3–26.7. If the added amount is 12% in PC/ABS, it could pass the UL–94 V0 test. It also can be used in LED, powder coating, potting material and polymers.	(S) 2lambda5, 4lambda5, 6lambda5—1,3,5,2,4,6 Triazatriphosphorine, 2,2,4,4,6,6—hexaphenoxy-.
P–19–0066	4	3/22/2019	eScientia Technologies, LLC.	(S) Fire retardant	(S) 2lambda5, 4lambda5,—1,3,5,2,4,6 Triazatriphosphorine, 2,2,4,4,6,6, -hexaphenoxy.

TABLE I—PMN/SNUN/MCANS APPROVED* FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Version	Received date	Manufacturer	Use	Chemical substance
P–19–0067	2	3/19/2019	CBI	(G) On site consumption as a raw material in the production of downstream chemicals, (G) Production of water-soluble corrosion inhibitors; (G) Production of oil soluble corrosion inhibitors..	(G) Triglyceride, reactions products with diethylenetriamine.
P–19–0069	1	3/19/2019	CBI	(G) Curing agent for coatings	(G) Diisocyanatoalkane, homopolymer, di-alkyl malonate- and alkyl acetoacetate-blocked, isoalkyl methylalkyl esters.
P–19–0070	1	3/22/2019	CBI	(G) Curing agent for coatings	(G) Oxacyclanone, polymer with diisocyanatoalkane, and alkyl-(substitutedalkyl)-polyol, di-alkyl malonate- and alkyl acetoacetate-blocked, alkyl esters.
P–19–0071	1	3/22/2019	CBI	(S) Physical property modifier for polymers.	(G) Trimethylolpropane, alkenoic acid, triester.
P–19–0072	1	3/26/2019	CBI	(G) Raw material used in chemical manufacture.	(S) 1-Butanol, reaction products with 2-[(2-propen-1-yloxy)- methyl] oxirane.
SN–18–0005A	3	3/3/2019	CBI	(G) Monomer for industrial adhesives, coatings and inks.	(S) Butanoic acid, 3-mercapto-,1,1′-[2,2-bis[(3-mercapto-1-oxobutoxy) methyl]-1,3-propanediyl] ester.
SN–18–0013A	2	2/27/2019	CBI	(G) Intermediate	(G) Lithiated metal oxide.
SN–18–0016A	4	3/20/2019	Hexion, Inc	(G) Reactive polymer; (S) Reactive polyol for composites; (S) Reactive polyol for 2- part coatings; (S) Reactive polyol for 1- part coatings; (S) Reactive polyol for sealants; (S) Reactive modifier for bonded abrasives; (S) Reactive modifier for refractory; (S) Reactive modifier for glass inserts; (S) Reactive modifier for coated abrasives; (S) Reactive modifier for friction; (S) Reactive modifier for fiber bonding; (S) Reactive modifier for carbon (liquid EPF); (S) Reactive modifier for carbon (powder EPF).	(G) Modified phenol-formaldehyde resin.

*The term 'Approved' indicates that a submission has passed a quick initial screen ensuring all required information and documents have been provided with the submission prior to the start of the 90-day review period, and in no way reflects the final status of a complete submission review.

In Table II of this unit, EPA provides the following information (to the extent that such information is not claimed as CBI) on the NOCs that have passed an initial screening by EPA during this period: The EPA case number assigned to the NOC including whether the submission was an initial or amended submission, the date the NOC was received by EPA, the date of commencement provided by the submitter in the NOC, a notation of the type of amendment (*e.g.,* amendment to generic name, specific name, technical contact information, etc.) and chemical substance identity.

TABLE II—NOCS APPROVED * FROM 03/01/2019 TO 03/31/2019

Case No.	Received date	Commencement date	If amendment, type of amendment	Chemical substance
P–07–0541A	3/27/2019	11/14/2007	Generic chemical name updated.	(G) Diaminodiol, polymer with diisocyanate, polyether alcohol, polyether amine, benzyl chloride-quaternized.
P–11–0294	3/5/2019	3/24/2014	N	(S) Carbonic dichloride, polymer with 4,4′-(1-methylethylidene)bis(phenol) and 4,4′-(3,3,5-trimethylcyclohexylidene)bis(phenol)), bis(4-(1,1-dimethylethyl)phenyl) ester.
P–11–0450	2/28/2019	2/17/2019	N	(S) Fatty acids, carnauba-wax.
P–11–0451	2/28/2019	2/17/2019	N	(S) Fatty acids, carnauba wax, esters with 1,3-butanediol; (S) Fatty acids, Carnauba-wax, calcium salts.
P–11–0452	2/28/2019	2/17/2019	N	(S) Fatty acids, carnauba-wax, ethylene esters.
P–14–0382	3/8/2019	2/13/2019	N	(G) Quaternary ammonium compounds, tri-C8–10-alkylmethyl, hydrogen sulfates.

TABLE II—NOCS APPROVED * FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Received date	Commencement date	If amendment, type of amendment	Chemical substance
P–16–0360	3/22/2019	3/17/2019	N	(S) Poly (oxy-1,2-ethanediyl), alpha- (1-oxodocosyl)- omega- [(1-oxodocosyl)oxy]-.
P–16–0421	3/18/2019	2/20/2019	N	(S) Flue dust, glass manufacturing, desulfurization.
P–17–0354	3/4/2019	2/4/2019	N	(G) (substituted-dialkyl(C=1~7)silyl) alkanenitrile.
P–18–0030	3/22/2019	3/14/2019	N	(G) Poly[oxy(methyl-alkylendiyl)],alpha,alpha′,alpha″-1,2,3-alkanetriyltris[omega-hydroxy-, polymer with 1,1′-alkylenebis[4-isocyanatocarbomonocycle], 2-substituted ethyl acrylate- and 2-substituted ethyl metacrylate-blocked.
P–18–0123	3/6/2019	2/20/2019	N	(S) Hydrogen lithium nickel oxide.
P–18–0124	3/6/2019	2/21/2019	N	(S) Lithium nickel potassium oxide.
P–18–0136	3/22/2019	2/22/2019	N	(G) 1-Butanaminium,N,N,N-tributyl-,2(or5)-[[benzoyldihydrodioxo[(sulfophenyl)amino]heteropolycycle]oxy]-5(or2)-(1,1-dimethylpropyl)benzenesulfonate (2:1).
P–18–0233	3/4/2019	2/13/2019	N	(G) Alkyl Alkenoic acid, alkyl ester, telomer with alkylthiol, substituted carbomonocycle, substituted alkyl alkyl alkenoate and hydroxyalkyl alkenoate, tert-butyl alkyl peroxoate-initiated.
P–18–0318	3/5/2019	3/4/2019	N	(S) 1-Octadecanaminium, N,N-dimethyl-N-[3-(triethoxysilyl)propyl]-chloride.

* The term 'Approved' indicates that a submission has passed a quick initial screen ensuring all required information and documents have been provided with the submission.

In Table III of this unit, EPA provides the following information (to the extent such information is not subject to a CBI claim) on the test information that have passed an initial screening by EPA during this time period: The EPA case number assigned to the test information; the date the test information was received by EPA, the type of test information submitted, and chemical substance identity.

TABLE III—TEST INFORMATION RECEIVED FROM 03/01/2019 TO 03/31/2019

Case No.	Received date	Type of test information	Chemical substance
P–08–0087	3/15/2019	Hydrolysis as a Function (OECD 111)	(G) Alkyl acids, reaction products with metal salt of an alkanol.
P–08–0508	3/25/2019	In Vitro Mammalian Cytogenetic Test (OECD 473), Mutagenicity Testing of H–2O421 in the Salmonella Typhimurium Plate Incorporation Assay (OECD 473), Combined Two-Week Inhalation Toxicity and Micronucleus Studies, Thermal Transformation Byproduct, Determination of the Water Solubility and Vapor Pressure of H–28327 (OECD 104–105), Determination of the n-Octanol/Water Partition Coefficient of H–28327 (OPPTS 830.7560).	(S) Propanoic acid, 2,3,3,3-tetrafluoro-2-(1,1,2,2,3,3,3-heptafluoropropoxy).
P–08–0509	3/25/2019	In Vitro Mammalian Cytogenetic Test (OECD 473), Mutagenicity Testing of H–2O421 in the Salmonella Typhimurium Plate Incorporation Assay (OECD 473), Combined Two-Week Inhalation Toxicity and Micronucleus Studies, Thermal Transformation Byproduct, Determination of the Water Solubility and Vapor Pressure of H–28327 (OECD 104–105), Determination of the n-Octanol/Water Partition Coefficient of H–28327 (OPPTS 830.7560).	(S) Propanoic acid, 2,3,3,3-tetrafluoro-2-(1,1,2,2,3,3,3-heptafluoropropoxy)-, ammonium salt (1:1).
P–10–0060	3/21/2019	Studies for Triggered Testing: (OECD 421), Modified One-Generation Reproduction Test (Mice) (OPPTS 850.3050).	(G) Partially fluorinated alcohol substituted glycol.
P–15–0450	3/20/2019	90-Day Inhalation Toxicity Study (OECD 413)	(G) Lithium mixed metal oxide.
P–16–0543	3/14/2019	Exposure Monitoring Report	(G) Halogenophosphoric acid metal salt.
P–18–0060	3/26/2019	Sediment and Soil Adsorption/Desorption Isotherm (OECD 106), Acute Dermal Toxicity (OECD 402), Mammalian Erythrocyte Micronucleus Test (OECD 474).	(S) 1-butanaminium, 4-amino-N-(2-hydroxy-3-sulfopropyl)-N, N-dimethyl-4-oxo-, N-coco alkyl derivs., inner salts.
P–18–0093	3/1/2019	Dust Control, Analytical Test Results, Water Immersion Testing, H2O Immersion with Proton Pulse Sequence, Plastic Abrasions SEM Summary and SEM Images, Risks Identified in Focus Report.	(G) Pentacyclo [9.5.1.13,9.15,15.17,13] octasiloxane, 1,3,5,7,9,11,13,15-octakis (polyfluoroalkyl).
P–18–0177	3/5/2019	Solubility in Alga Growth Media (OECD 201)	(S) Waxes and waxy substances, rice bran, oxidized.
P–18–0286	3/8/2019	Supplemental Worker Exposure	(S) Propane, 1,1,1,3,3,3-hexafluoro-2-methoxy.
P–18–0293	3/21/2019	In Vitro Skin Sensitization Assays (OECD 422D)	(S) Propanedioic acid, 2-methylene-, 1,3-dihexyl ester.
P–18–0294	3/21/2019	In Vitro Skin Sensitization Assays (OECD 422D)	(S) Propanedioic acid, 2-methylene-, 1,3-dicyclohexyl ester.

TABLE III—TEST INFORMATION RECEIVED FROM 03/01/2019 TO 03/31/2019—Continued

Case No.	Received date	Type of test information	Chemical substance
P–18–0325	3/18/2019	Fish Acute Toxicity (OECD 203), Daphnia Acute Toxicity (OECD 202), Algae Acute Toxicity (OECD 201), Acute Oral Toxicity (OECD 401), Acute Dermal Toxicity (OECD 402), Dermal Irritation (OECD 404), Eye Irritation (OECD 405), Ready Biodegradability (OECD 301B), Activated Sludge Respiration Inhibition Tests (OECD 209), Ames Test (OECD 471), Skin Sensitization (OECD 406), Chromosome Aberration Test (OECD 473), 28-Day Oral Toxicity Study (OECD 407).	(G) Benzenesulfonic acid, alkyl derivs., compds. with diisopropanolamine.
SN–18–0003 ..	3/5/2019	Algae Growth Inhibition Study (OECD 201)	(S) Lithium nickel oxide (LiNiO2).

If you are interested in information that is not included in these tables, you may contact EPA's technical information contact or general information contact as described under **FOR FURTHER INFORMATION CONTACT** to access additional non-CBI information that may be available.

Authority: 15 U.S.C. 2601 *et seq.*

Dated: June 6, 2019.

Megan Carroll,

Acting Director, Information Management Division, Office of Pollution Prevention and Toxics.

[FR Doc. 2019–13099 Filed 6–19–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9995–46–OAR]

Alternative Methods for Calculating Off-Cycle Credits Under the Light-Duty Vehicle Greenhouse Gas Emissions Program: Application From Toyota Motor North America, Inc.

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA is requesting comment on an application from Toyota Motor North America, Inc. (''Toyota'') for off-cycle carbon dioxide (CO_2) credits under EPA's light-duty vehicle greenhouse gas emissions standards. ''Off-cycle'' emission reductions can be achieved by employing technologies that result in real-world benefits, but where that benefit is not adequately captured on the test procedures used by manufacturers to demonstrate compliance with emission standards. EPA's light-duty vehicle greenhouse gas program acknowledges these benefits by giving automobile manufacturers several options for generating ''off-cycle'' CO_2 credits. Under the regulations, a manufacturer may apply for CO_2 credits for off-cycle technologies that result in off-cycle benefits. In these cases, a manufacturer must provide EPA with a proposed methodology for determining the real-world off-cycle benefit. Toyota has submitted an application that describes methodologies for determining off-cycle credits from technologies described in their application. Pursuant to applicable regulations, EPA is making Toyota's off-cycle credit calculation methodologies available for public comment.

DATES: Comments must be received on or before July 22, 2019.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2019–0333, to the Federal eRulemaking Portal: *http://www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or withdrawn. The EPA may publish any comment received to its public docket. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. The EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.* on the web, cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on making effective comments, please visit *http://www2.epa.gov/dockets/commenting-epa-dockets.*

FOR FURTHER INFORMATION CONTACT: Roberts French, Environmental Protection Specialist, Office of Transportation and Air Quality, Compliance Division, U.S. Environmental Protection Agency, 2000 Traverwood Drive, Ann Arbor, MI 48105. Telephone: (734) 214–4380. Fax: (734) 214–4869. Email address: *french.roberts@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

EPA's light-duty vehicle greenhouse gas (GHG) program provides three pathways by which a manufacturer may accrue off-cycle carbon dioxide (CO_2) credits for those technologies that achieve CO_2 reductions in the real world but where those reductions are not adequately captured on the test used to determine compliance with the CO_2 standards, and which are not otherwise reflected in the standards' stringency. The first pathway is a predetermined list of credit values for specific off-cycle technologies that may be used beginning in model year 2014.[1] This pathway allows manufacturers to use conservative credit values established by EPA for a wide range of technologies, with minimal data submittal or testing requirements, if the technologies meet EPA regulatory definitions. In cases where the off-cycle technology is not on the menu but additional laboratory testing can demonstrate emission benefits, a second pathway allows manufacturers to use a broader array of emission tests (known as ''5-cycle'' testing because the methodology uses five different testing procedures) to demonstrate and justify off-cycle CO_2 credits.[2] The additional emission tests allow emission benefits to be demonstrated over some elements of real-world driving not adequately captured by the GHG compliance tests, including high speeds, hard accelerations, and cold temperatures. These first two methodologies were completely defined through notice and comment rulemaking and therefore no additional process is necessary for manufacturers to use these methods. The third and last pathway allows manufacturers to seek EPA approval to use an alternative methodology for determining the off-cycle CO_2 credits.[3] This option is only available if the benefit of the technology cannot be adequately demonstrated using the 5-cycle methodology. Manufacturers may

[1] See 40 CFR 86.1869–12(b).

[2] See 40 CFR 86.1869–12(c).

[3] See 40 CFR 86.1869–12(d).

also use this option for model years prior to 2014 to demonstrate off-cycle CO_2 reductions for technologies that are on the predetermined list, or to demonstrate reductions that exceed those available via use of the predetermined list.

Under the regulations, a manufacturer seeking to demonstrate off-cycle credits with an alternative methodology (*i.e.,* under the third pathway described above) must describe a methodology that meets the following criteria:

- Use modeling, on-road testing, on-road data collection, or other approved analytical or engineering methods;
- Be robust, verifiable, and capable of demonstrating the real-world emissions benefit with strong statistical significance;
- Result in a demonstration of baseline and controlled emissions over a wide range of driving conditions and number of vehicles such that issues of data uncertainty are minimized;
- Result in data on a model type basis unless the manufacturer demonstrates that another basis is appropriate and adequate.

Further, the regulations specify the following requirements regarding an application for off-cycle CO_2 credits:

- A manufacturer requesting off-cycle credits must develop a methodology for demonstrating and determining the benefit of the off-cycle technology and carry out any necessary testing and analysis required to support that methodology.
- A manufacturer requesting off-cycle credits must conduct testing and/or prepare engineering analyses that demonstrate the in-use durability of the technology for the full useful life of the vehicle.
- The application must contain a detailed description of the off-cycle technology and how it functions to reduce CO_2 emissions under conditions not represented on the compliance tests.
- The application must contain a list of the vehicle model(s) which will be equipped with the technology.
- The application must contain a detailed description of the test vehicles selected and an engineering analysis that supports the selection of those vehicles for testing.
- The application must contain all testing and/or simulation data required under the regulations, plus any other data the manufacturer has considered in the analysis.

Finally, the alternative methodology must be approved by EPA prior to the manufacturer using it to generate credits. As part of the review process defined by regulation, the alternative methodology submitted to EPA for consideration must be made available for public comment.[4] EPA will consider public comments as part of its final decision to approve or deny the request for off-cycle credits.

II. Off-Cycle Credit Applications

Using the alternative methodology approach discussed above, Toyota Motor North America (''Toyota'') is applying for credits for model years 2012 and later. Toyota has applied for off-cycle credits using the alternative demonstration methodology pathway for an occupant-based, targeted cooling system (the ''S-Flow'' system) and for a pulse width modulated brushless motor power controller air conditioning technology, which improves the efficiency of the air conditioning system.

III. EPA Decision Process

EPA has reviewed the applications for completeness and is now making the applications available for public review and comment as required by the regulations. The off-cycle credit applications submitted by the manufacturer (with confidential business information redacted) have been placed in the public docket (see **ADDRESSES** section above) and on EPA's website at *https://www.epa.gov/vehicle-and-engine-certification/compliance-information-light-duty-greenhouse-gas-ghg-standards.*

EPA is providing a 30-day comment period on the applications for off-cycle credits described in this notice, as specified by the regulations. The manufacturers may submit a written rebuttal of comments for EPA's consideration, or may revise an application in response to comments. After reviewing any public comments and any rebuttal of comments submitted by manufacturers, EPA will make a final decision regarding the credit requests. EPA will make its decision available to the public by placing a decision document (or multiple decision documents) in the docket and on EPA's website at the same manufacturer-specific pages shown above. While the broad methodologies used by these manufacturers could potentially be used for other vehicles and by other manufacturers, the vehicle specific data needed to demonstrate the off-cycle emissions reductions would likely be different. In such cases, a new application would be required, including an opportunity for public comment.

[4] See 40 CFR 86.1869–12(d)(2).

Dated: June 13, 2019.

Byron J. Bunker,

Director, Compliance Division, Office of Transportation and Air Quality, Office of Air and Radiation.

[FR Doc. 2019–13093 Filed 6–19–19; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meeting

TIME AND DATE: Tuesday, June 25, 2019 at 10:00 a.m. and its continuation on Thursday, June 27, 2019 at 10:00 a.m.

PLACE: 1050 First Street NE, Washington, DC.

STATUS: This meeting will be closed to the public.

MATTERS TO BE CONSIDERED: Compliance matters pursuant to 52 U.S.C. 30109.

Information the premature disclosure of which would be likely to have a considerable adverse effect on the implementation of a proposed Commission action.

Matters concerning participation in civil actions or proceedings or arbitration.

* * * * *

CONTACT PERSON FOR MORE INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Laura E. Sinram,

Acting Secretary and Clerk of the Commission.

[FR Doc. 2019–13260 Filed 6–18–19; 4:15 pm]

BILLING CODE 6715–01–P

FEDERAL RETIREMENT THRIFT INVESTMENT

Sunshine Act Meetings

TIME AND DATE: June 24, 2019, 8:30 a.m.

PLACE: 77 K Street NE, 10th Floor, Washington, DC 20002.

STATUS: Parts of these meetings will be closed and parts of these meetings will be closed.

MATTERS TO BE CONSIDERED:

Portions Open to the Public

1. Approval of the May 29, 2019 Board Meeting Minutes
2. Monthly Reports
   (a) Participant Activity Report
   (b) Investment Performance
   (c) Legislative Report
3. Quarterly Reports
   (d) Vendor Risk Management
4. Enterprise Risk Management Update
5. Internal Auditor Update
6. Audit Remediation Review
7. OI Annual Report

8. Withdrawal Project Update

Portions Closed to the Public

Information covered under 5 U.S.C. 552b (c)(4) and (c)(9)(B).

CONTACT PERSON FOR MORE INFORMATION: Kimberly Weaver, Director, Office of External Affairs, (202) 942–1640.

Dated: June 17, 2019.

Megan Grumbine,

General Counsel, Federal Retirement Thrift Investment Board.

[FR Doc. 2019–13150 Filed 6–18–19; 11:15 am]

BILLING CODE 6760–01–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0077; Docket No. 2019–0003; Sequence No. 11]

Information Collection; Quality Assurance Requirements

AGENCY: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for public comments regarding an extension to an existing OMB clearance.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 and the Office of Management and Budget (OMB) regulations, the FAR Council invites the public to comment upon a request to review and approve an extension of a previously approved information collection requirement concerning quality assurance requirements.

DATES: Submit comments on or before August 19, 2019.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to GSA, by any of the following methods:

• *Regulations.gov: http://www.regulations.gov.* Submit comments via the Federal eRulemaking portal by searching the OMB control number. Select the link ''Submit a Comment'' that corresponds with ''Information Collection 9000–0077, Quality Assurance Requirements''. Follow the instructions provided at the ''Submit a Comment'' screen. Please include your name, company name (if any), and ''Information Collection 9000–0077, Quality Assurance Requirements'' on your attached document.

• *Mail:* General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW, Washington, DC 20405. ATTN: Ms. Mandell/IC 9000–0077, Quality Assurance Requirements.

Instructions: Please submit comments only and cite Information Collection 9000–0077, Quality Assurance Requirements, in all correspondence related to this collection. Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal and/or business confidential information provided. To confirm receipt of your comment(s), please check *www.regulations.gov,* approximately two to three days after submission to verify posting (except allow 30 days for posting of comments submitted by mail).

FOR FURTHER INFORMATION CONTACT: Ms. Marilyn Chambers, Procurement Analyst, at 202–285–7380 or email *marilyn.chambers@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. Overview of Information Collection

Description of the Information Collection

1. Type of Information Collection: Revision/Renewal of a currently approved collection.

2. *Title of the Collection*—Quality Assurance Requirements.

3. *Agency form number,* if any: None.

Solicitation of Public Comment

Written comments and suggestions from the public should address one or more of the following four points: (1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

B. Purpose

Supplies and services acquired under Government contracts must conform to the contract's quality and quantity requirements. FAR Part 46 prescribes inspection, acceptance, warranty, and other measures associated with quality requirements. Standard inspection clauses require the contractor to provide and maintain an inspection system that is acceptable to the Government; give the Government the right to make inspections and test while work is in process; and require the contractor to keep complete, and make available to the Government, records of its inspection work. FAR clause 52.246–15, Certificate of Conformance, is not an inspection clause, but a requirement for the contractor to certify that supplies or services furnished are of the quality specified and conform in all respects with the contract requirements.

C. Annual Reporting Burden

1. Inspection Clauses

The FAR inspection clauses are used for quality assurance depending on the type of contract and the type of product or service being provided. The corresponding quality/inspection systems the contractors are required to implement have requirements for record keeping and in some cases documenting the quality or inspection system. These clauses do not require the transmittal or sending of documentation to the Government. Instead, the Government may review these records to confirm the contract quality requirements are being met. Definitive information was not available on how often the Government requests to see these records. The time required to provide the records is estimated as follows:

Respondents: 1,590.
Responses per Respondent: 1.
Total Responses: 1,590.
Hours per Response: 1.
Total Burden hours: 1,590.

2. Certificate of Conformance

FAR clause 52.246–15 is used in solicitations and contracts for supplies or services at the discretion of the contracting officer when it is in the Government's interest, small losses would be incurred in the event of a defect; or because of the contractor's reputation or past performance, it is likely that the supplies or services furnished will be acceptable and any defective work would be replaced, corrected, or repaired without contest. The clause requires the contractor to submit a prescribed certificate. The time required to submit the certificate is estimated as follows:

Respondents: 639.
Responses per Respondent: 1.
Total Responses: 639.

Hours per Response: .5.
Total Burden hours: 320.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW, Washington, DC 20405, telephone 202–501–4755. Please cite OMB Control No. 9000–0077, Quality Assurance Requirements, in all correspondence.

Dated: June 17, 2019.

Janet Fry,

Director, Federal Acquisition Policy, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

[FR Doc. 2019–13141 Filed 6–19–19; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0055; Docket No. 2019–0003; Sequence No. 7]

Information Collection; Freight Classification Description

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for public comments regarding an extension to an existing OMB clearance.

SUMMARY: Under the provisions of the Paperwork Reduction Act, the Regulatory Secretariat Division will be submitting to the Office of Management and Budget (OMB) a request to review and approve an extension of a previously approved information collection requirement concerning freight classification description.

DATES: Submit comments on or before August 19, 2019.

ADDRESSES: The FAR Council invites interested persons to submit comments on this collection by either of the following methods:

- *Federal eRulemaking Portal:* This website provides the ability to type short comments directly into the comment field or attach a file for lengthier comments. Go to *http://www.regulations.gov* and follow the instructions on the site.
- *Mail:* General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW, Washington, DC 20405. ATTN: Ms. Mandell/IC 9000–0053, Permits, Authorities, or Franchises.

Instructions: All items submitted must cite Information Collection 9000–0056, Report of Shipment. Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal and/or business confidential information provided. To confirm receipt of your comment(s), please check *www.regulations.gov,* approximately two to three days after submission to verify posting (except allow 30 days for posting of comments submitted by mail). This information collection is pending at the FAR Council. The Council will submit it to OMB within 60 days from the date of this notice.

FOR FURTHER INFORMATION CONTACT: Mr. Curtis E. Glover, Sr., Procurement Analyst, Office of Acquisition Policy, at 202–501–1448 or via email at *curtis.glover@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. Solicitation of Public Comment

Written comments and suggestions from the public should address one or more of the following four points:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

B. Purpose

The Government is required to provide, in solicitations, a complete description of the supplies to be acquired and the packing requirements to determine transportation (freight rate) charges for the evaluation of offers. Generally, the freight rate for supplies is based on the ratings applicable to the freight classification description published in the National Motor Freight Classification (for carriers) and the Uniform Freight Classification (for rail) filed with Federal and State regulatory bodies.

When the Government purchases supplies that are new to the supply system, nonstandard, or modifications of previously shipped supplies, and different freight classifications may apply, per FAR clause 52.247–53, offerors are requested to indicate the full Uniform Freight Classification or National Motor Freight Classification description applicable to the supplies. The Government will use these descriptions as well as other information available to determine the classification description most appropriate and advantageous to the government.

C. Annual Reporting Burden

Respondents: 3,000.
Responses per Respondent: 3.
Annual Responses: 9,000.
Hours per Response: .167.
Total Burden Hours: 1,503.
Affected Public: Business other for-profit entities and not-for-profit institutions.
Frequency: On occasion.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat Division (MVCB), 1800 First Street NW, Washington, DC 20405, telephone 202–501–4755. Please cite OMB Control No. 9000–0055, Freight Classification Description, in all correspondence.

Dated: June 14, 2019.

Janet Fry,

Director, Federal Acquisition Policy Division, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

[FR Doc. 2019–13137 Filed 6–19–19; 8:45 am]

BILLING CODE 6820–EP–P

GENERAL SERVICES ADMINISTRATION

[Notice–MA–2019–03; Docket No. 2019–0002, Sequence No. 4]

FMR Bulletin B–48, Exchange/Sale Financial Accounting

AGENCY: Office of Government-wide Policy (OGP), General Services Administration (GSA).

ACTION: Notice of Federal Management Regulation (FMR) Bulletin B–48, EXCHANGE/SALE FINANCIAL ACCOUNTING.

SUMMARY: FMR Bulletin B–48 provides guidance to agencies on the use of the exchange/sale authority as authorized by Title 40 United States Code (U.S.C.)

Section 503 and governed by regulations at FMR 102–39, Replacement of Personal Property Pursuant to the Exchange/Sale Authority (41 Code of Federal Regulations 102–39).

Agencies are encouraged to consider the use of this guidance when acquiring replacement assets via the exchange/sale authority. This Bulletin B–48 provides guidance on the use of this cost-saving strategy, as well as providing guidance for financial accounting of exchange/sale transactions. The Bulletin and additional guidance on the exchange/sale authority may be found at *www.gsa.gov/exchangesale.*

DATES: *Applicability date:* This notice is applicable beginning June 20, 2019 until otherwise revoked.

FOR FURTHER INFORMATION CONTACT: For clarification of content, please contact Mr. Bob Holcombe, Office of Government-wide Policy, Office of Asset and Transportation Management, at 202–501–3828, or by email at *Robert.Holcombe@gsa.gov.* Please cite Notice of FMR Bulletin B–48.

Jessica Salmoiraghi,

Associate Administrator, Office of Government-wide Policy.

[FR Doc. 2019–13012 Filed 6–19–19; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0163; Docket No. 2019–0003; Sequence No. 24]

Submission for OMB Review; Small Business Size Rerepresentation

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice.

SUMMARY: Under the provisions of the Paperwork Reduction Act, the Regulatory Secretariat Division has submitted to the Office of Management and Budget (OMB) a request to review and approve a revision of a previously approved information collection requirement regarding small business size rerepresentation.

DATES: Submit comments on or before July 22, 2019.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Office of Information and Regulatory Affairs of OMB, Attention: Desk Officer for GSA, Room 10236, NEOB, Washington, DC 20503. Additionally submit a copy to GSA by any of the following methods:

- *Federal eRulemaking Portal:* This website provides the ability to type short comments directly into the comment field or attach a file for lengthier comments. Go to *http://www.regulations.gov* and follow the instructions on the site.
- *Mail:* General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW, Washington, DC 20405. ATTN: Lois Mandell/IC 9000–0163, Small Business Size Rerepresentation.

Instructions: All items submitted must cite Information Collection 9000–0163, Small Business Size Rerepresentation. Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal and/or business confidential information provided. To confirm receipt of your comment(s), please check *www.regulations.gov,* approximately two to three days after submission to verify posting (except allow 30 days for posting of comments submitted by mail).

FOR FURTHER INFORMATION CONTACT: Ms. Mahruba Uddowla, Procurement Analyst, at telephone 703–605–2868, or *mahruba.uddowla@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. OMB Number, Title, and any Associated Form(s)

OMB Control No. 9000–0163, Small Business Size Rerepresentation.

B. Needs and Uses

Federal Acquisition Regulation (FAR) 19.301 and the FAR clause at 52.219–28, Post-Award Small Business Program Rerepresentation, implement the Small Business Administration's (SBA's) regulation at 13 CFR 121.404(g), requiring that a concern that initially represented itself as small at the time of its initial offer must recertify its status as a small business under the following circumstances:

- Within thirty days of an approved contract novation;
- Within thirty days in the case of a merger or acquisition, where contract novation is not required; or
- Within 120 days prior to the end of the fifth year of a contract, and no more than 120 days prior to the exercise of any option thereafter.

The contracting officer at his or her discretion, may also request the contractor to rerepresent its status as a small business for individual task or delivery orders.

The implementation of SBA's regulation in FAR 19.301 and the FAR clause at 52.219–28 require that contractors rerepresent size status by updating their representations at the prime contract level in the Representations and Certifications section of the System for Award Management (SAM) and notifying the contracting officer that it has made the required update.

The purpose of implementing small business rerepresentations in the FAR is to ensure that small business size status is accurately represented and reported over the life of long-term contracts. The FAR also provides for provisions designed to ensure more accurate reporting of size status for contracts that are novated, or performed by small businesses that have merged with or been acquired by another business. This information is used by the SBA, Congress, Federal agencies and the general public for various reasons such as determining if agencies are meeting statutory goals, set-aside determinations, and market research.

C. Annual Burden

Total Annual Responses: 3,970.

Hours per Response: 0.5.

Total Burden Hours: 1,985.

D. Public Comment

A 60 day notice was published in the **Federal Register** at 81 FR 88072, on December 6, 2016. No comments were received on the burden calculation for this information collection.

Obtaining Copies: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW, Washington, DC 20405, telephone 202–501–4755. Please cite OMB Control No. 9000–0163, Small Business Size Rerepresentation, in all correspondence.

Dated: June 17, 2019.

Janet Fry,

Director, Federal Acquisition Policy Division, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

[FR Doc. 2019–13139 Filed 6–19–19; 8:45 a.m.]

BILLING CODE 6820–EP–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Supplemental Evidence and Data Request on End-Stage Renal Disease in the Medicare Population

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Request for Supplemental Evidence and Data Submissions.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) is seeking scientific information submissions from the public. Scientific information is being solicited to inform our review on *End-stage Renal Disease in the Medicare Population,* which is currently being conducted by the AHRQ's Evidence-based Practice Centers (EPC) Program. Access to published and unpublished pertinent scientific information will improve the quality of this review.

DATES: Submission Deadline by July 22, 2019.

ADDRESSES:

Email submissions: epc@ahrq.hhs.gov.

Print submissions:

Mailing Address: Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E53A, Rockville, MD 20857.

Shipping Address (FedEx, UPS, etc.): Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E77D, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Jenae Benns, Telephone: 301–427–1496 or Email: *epc@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Agency for Healthcare Research and Quality has commissioned the Evidence-based Practice Centers (EPC) Program to complete a review of the evidence for *End-stage Renal Disease in the Medicare Population.* AHRQ is conducting this systematic review pursuant to Section 902(a) of the Public Health Service Act, 42 U.S.C. 299a(a).

The EPC Program is dedicated to identifying as many studies as possible that are relevant to the questions for each of its reviews. In order to do so, we are supplementing the usual manual and electronic database searches of the literature by requesting information from the public (*e.g.,* details of studies conducted). We are looking for studies that report on *End-stage Renal Disease in the Medicare Population,* including those that describe adverse events. The entire research protocol is available online at: *https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/ta/topicrefinement/esrd-protocol-2019.pdf.*

This is to notify the public that the EPC Program would find the following information on End-stage Renal Disease in the Medicare Population helpful:

- A list of completed studies that your organization has sponsored for this indication. In the list, please *indicate whether results are available on ClinicalTrials.gov along with the ClinicalTrials.gov trial number.*
- *For completed studies that do not have results on ClinicalTrials.gov,* a summary, including the following elements: Study number, study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, primary and secondary outcomes, baseline characteristics, number of patients screened/eligible/enrolled/lost to follow-up/withdrawn/analyzed, effectiveness/efficacy, and safety results.
- *A list of ongoing studies that your organization has sponsored for this indication.* In the list, please provide the ClinicalTrials.gov trial number or, if the trial is not registered, the protocol for the study including a study number, the study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, and primary and secondary outcomes.
- Description of whether the above studies constitute *ALL Phase II and above clinical trials* sponsored by your organization for this indication and an index outlining the relevant information in each submitted file.

Your contribution is very beneficial to the Program. Materials submitted must be publicly available or able to be made public. Materials that are considered confidential; marketing materials; study types not included in the review; or information on indications not included in the review cannot be used by the EPC Program. This is a voluntary request for information, and all costs for complying with this request must be borne by the submitter.

The draft of this review will be posted on AHRQ's EPC Program website and available for public comment for a period of 4 weeks. If you would like to be notified when the draft is posted, please sign up for the email list at: *https://www.effectivehealthcare.ahrq.gov/email-updates.*

The systematic review will answer the following questions. This information is provided as background. AHRQ is not requesting that the public provide answers to these questions.

The Key Questions

Key Question 1

In studies of frequency and duration of hemodialysis in non-institutionalized individuals, what are the characteristics of the patients and dialysis modality (including home or dialysis center setting and flow rate)? What is the length of follow up on patients in the studies? How does this compare to the general population of patients on dialysis?

Key Question 2

In hemodialysis patients, does more frequent hemodialysis (more than 3 times a week) improve objective outcomes (including hypertension control, mortality, QOL) over the long term (more than 6 months) compared to usual hemodialysis frequency (3 times a week)? What is the impact of patient characteristics and modality of dialysis used in the studies on outcomes?

Key Question 3

In hemodialysis patients, does extended hemodialysis duration (daytime, 4 or more hours per session, or nocturnal, overnight) improve objective outcomes (including hypertension control, mortality, QOL) over the long term (more than 6 months) compared to usual length hemodialysis duration (less than 4 hours)? What is the impact of patient characteristics and modality used in the studies on outcomes?

TABLE 1—EXPLANATION OF DURATION AND FREQUENCY OF HEMODIALYSIS UNDER CONSIDERATION FOR KQS 1–3

		Duration (hours per session)	
		Less than 4 hours	4 hours and more
Frequency (treatment N) per week	3 sessions	9-<12* hours per week	>= 12 hours per week

TABLE 1—EXPLANATION OF DURATION AND FREQUENCY OF HEMODIALYSIS UNDER CONSIDERATION FOR KQS 1–3—Continued

		Duration (hours per session)	
		Less than 4 hours	4 hours and more
	4 or more sessions	9- to <16** hours per week	>=16 hours per week

* Usual care involves 3 sessions per week with 3–4 hours per session.
** The duration of each dialysis session is generally shorter when dialysis is done more frequently.

Key Question 4

What instruments have been used to measure QOL in studies of people with ESRD treated by dialysis?

Subquestion 4a: What are the psychometric properties of instruments used to measure QOL in studies of people with ESRD treated by dialysis?

Subquestion 4b: What is the minimal clinically important difference for instruments used to measure QOL in studies of people with ESRD treated by dialysis?

Subquestion 4c: How have instruments used to measure QOL in studies of people with ESRD treated by dialysis been validated?

Subquestion 4d: What is the impact of placebo effect in studies used to measure QOL in people with ESRD treated by dialysis and what study designs are needed to mitigate the impact?

PICOTS (Populations, Interventions, Comparators, Outcomes, Timing, Settings)

Population(s)

- *All KQs:* US ESRD Medicare population (non-institutionalized)
- *KQ 1:* Adults and children with ESRD on hemodialysis (no age restriction)
- *KQs 2 and 3:* Adults and children with ESRD on hemodialysis
- *KQ 4:* Adults and children with ESRD treated with any dialysis or other non-transplant treatment

Interventions

- *KQ 1:* Different frequency or duration of hemodialysis
- *KQ 2:* More frequent hemodialysis (3 versus > 3 sessions/week)
- *KQ 3:* Increased duration of hemodialysis sessions (12 hours versus > 12 hours per week; or daytime versus night time)
- *KQ 4:* For this question, we will include studies of QOL in people with ESRD receiving any type of dialysis.
- We will abstract data on all home hemodialysis machines (2008K@ Home Hemodialysis Machines, NxStage® System One, NxStage® System S) as well as all devices used in-center (a large variety of machines used in center exist and all will be considered for data collection)

Comparators (see Table 1)

- *KQs 1 and 4:* Usual care (3 times per week and 3–4 hours per treatment)
- *KQ 2:* More frequent hemodialysis (>3 session/week); usual care
- *KQ 3:* Increased duration of hemodialysis sessions (> 12 hours per week, or nocturnal, overnight); usual care

Outcomes

- *KQ 1:* Not applicable (see Appendix A for a list of the patient characteristics that will be considered for this KQ)
  - *KQs 2 and 3:*
    - *Final health outcomes (see Appendix B for a detailed list of outcomes):* Clinical outcomes including cardiovascular events, hospitalizations, QOL, pregnancy outcomes, and mortality
    - *Adverse events (see Appendix B for a detailed list of outcomes):* Intradialytic hypotension, access complications, loss of residual kidney function, infectious events, myocardial stunning hospitalizations, and patient and caregiver burden
    - *Intermediate outcomes (see Appendix B for a detailed list of outcomes):* Metabolic/inflammatory control, blood pressure control, dialysis recovery time
- *KQ 4:*
  - Instruments used to measure QOL in dialysis patients
  - Psychometric properties of these instruments
  - Minimal clinically important difference for these instruments
  - Validation of these instruments
  - Placebo effect in studies of QOL in dialysis patients and what study designs are needed to mitigate the impact

Timing

- *KQs 1–3:* Minimum of 6 months of follow-up after the intervention is initiated
- *KQ 4:* No minimum follow-up

Setting

- Home dialysis, and dialysis center (Non Institutionalized)

Virginia Mackay-Smith,

Associate Director, Office of the Director, AHRQ.

[FR Doc. 2019–12650 Filed 6–19–19; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–19–16JO]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled Pregnancy Risk Assessment Monitoring System (PRAMS) to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on August 31, 2018 to obtain comments from the public and affected agencies. CDC received four comments related to the previous notice, two non-substantive, two in support of the data collection; no modifications were made to the PRAMS plan in response to comments. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information,

including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

The Pregnancy Risk Assessment Monitoring System (PRAMS)—Existing Collection in Use without an OMB Control Number—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. Developed in 1987, PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The Centers for Disease Control and Prevention (CDC) seeks OMB approval to collect information through the Pregnancy Risk Assessment Monitoring System (PRAMS) for three years.

PRAMS provides data not available from other sources. These data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. PRAMS data are used by researchers to investigate emerging issues in the field of reproductive health and by federal, state and local governments to plan and review programs and policies aimed at reducing health problems among mothers and babies.

PRAMS is a state customized survey conducted in 51 sites and covers 83% of all live births in the United States. Information is collected by 2–6 months after live birth or stillbirth by mail survey with telephone follow-up for non-responders. In addition, call back surveys may be implemented as a follow up to the initial survey to gather additional information on post-pregnancy experiences and infant and toddler health. Because PRAMS uses standardized data collection methods, it allows data to be compared among states. States can implement the survey on an ongoing basis or as a point-in-time survey. In participating states, a sample of women who have recently given birth to a live born or stillborn infant is selected from birth certificates or fetal death files. The sample is stratified based on the state's population of interest to ensure high-risk populations are adequately represented in the data.

The PRAMS survey instrument for live births is based on a core set of questions common across all states that remain the same for each three-year phase of data collection. PRAMS is currently in Phase 8, which began in 2016. In addition, CDC provides optional standardized modules (pre-grouped questions on a select topic) that states may use to customize survey content at the beginning of each phase of data collection. For each state, the time for a respondent with a recent live birth to complete the core and selected standard module questions does not exceed 35 minutes in length. Topics for both the core and standard modules include health conditions (which includes chronic conditions such as diabetes, hypertension, mental health, oral health, cancer, as well as pregnancy-induced health conditions and family history of select conditions); health behaviors (including tobacco and alcohol use, substance use [licit and illicit], injury prevention and safety, nutrition, and physical activity); health care services (such as preconception care, prenatal care, postpartum care, contraceptive care, vaccinations, access to care and insurance coverage, receipt of recommended services and provider counseling received); infant health and development; infant care practices (such as breastfeeding, safe sleep practices); social services received (such as WIC or home visiting); the social context of child bearing (such as intimate partner violence, social support, adverse childhood experiences, stressful life experiences and racism); attitudes and feeling about the pregnancy including pregnancy intentions.

At times, states may also be funded to address emerging topics of interest with supplemental modules (pre-grouped questions on a select topic). These supplemental modules address national and state-specific priorities and are typically fielded for one year. In the recent past, they have been used to address pandemic influenza H1N1 (2009), electronic cigarettes (2014), marijuana (2016), Zika (2017), and emergency preparedness and response as they impact pregnancy (2017). Supplemental modules planned for collection for 2019 births will include family history of breast and ovarian cancer, disabilities and prescription and illicit opioid use. Additional supplemental modules (estimated respondents and burden the same each year) may be developed to address other emergent issues as they arise, such as paternal involvement, emerging infectious diseases, environmental disasters, and other public health problems affecting women of reproductive age and their pregnancies. The estimated time for a respondent to complete supplemental modules is five minutes. Because PRAMS infrastructure was developed to access a specific and vulnerable subpopulation, the PRAMS infrastructure can be rapidly adapted for targeted information collection that would not be feasible with other surveillance methods.

PRAMS can also be adapted to do call back surveys. Women who respond to the PRAMS survey may be re-contacted (opt-out consent process used) later (approximately nine months post-birth) to collect additional information about post-pregnancy experiences and infant and toddler health. The currently planned call back survey will be targeted to areas with a high burden of opioid overdose deaths and include topics such as opioid misuse and access to medication assisted therapy, experiences with respectful care, postpartum care, rapid repeat pregnancy, infant feeding practices, infant health and social services such as well child visit attendance, home visitation, developmental delays, and social supports. The time for a respondent to complete the call back survey is 30 minutes. Additional call back surveys (estimated burden assumed the same each year) may be developed to address other emergent issues as they arise.

The stillbirth survey, administered in the state of Utah only at this current time, only includes a core survey instrument. Total time estimated for women with a recent stillbirth completing the survey, inclusive of informed consent is 25 minutes.

As part of the questionnaire development process, field testing will be conducted prior to implementation of new supplemental modules and call back surveys, as well as new or substantively revised questions for the core module prior to a new phase. Field testing will be conducted among women with infants one year or younger in health clinics to identify issues that may affect implementation or quality of the data collected. Field testing will only be conducted for new or substantively changed questions. Total time estimated to complete the field testing process inclusive of verbal consent, survey administration and debriefing questions is approximately 20 minutes.

The burden estimate for PRAMS includes five types of information collection: (1) Information collection associated with the PRAMS data collection for women with recent live births (PRAMS core questions and state-selected standard modules); (2) supplemental modules for emerging issues; (3) call back surveys; (4) PRAMS data collection for women with recent stillbirths; and (5) PRAMS field testing data collection to inform questionnaire development. Participation is voluntary and there are no costs to respondents other than their time. The total estimated annualized burden hours are 29,765.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Women who recently delivered a live birth	PRAMS Phase 8 (Core Questions plus state selected standard modules).	52,076	1	26/60
	Supplemental modules	61,230	1	5/60
	Call Back Surveys	3,961	1	30/60
	Field Testing	150	1	20/60
Women who recently delivered a still birth	PRAMS Stillbirth Questionnaire	160	1	25/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2019–13053 Filed 6–19–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–19–19BDE; Docket No. CDC–2019–0051]

Proposed Data Collection Submitted for Public Comment and Recommendations

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies the opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled Maternal Mortality Review Information Application (MMRIA). MMRIA is a standardized data collection system that allows Maternal Mortality Review Committees (MMRCs) to abstract relevant data from a variety of sources, document committee decisions, and analyze data to better understand the contributing factors and preventability of maternal deaths in order to develop recommendations for prevention.

DATES: CDC must receive written comments on or before August 19, 2019.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2019–0051 by any of the following methods:

- *Federal eRulemaking Portal: Regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS–D74, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to *Regulations.gov.*

Please note: Submit all comments through the Federal eRulemaking portal (regulations.gov) or by U.S. mail to the address listed above.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS–D74, Atlanta, Georgia 30329; phone: 404–639–7570; Email: *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. In addition, the PRA also requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology,

e.g., permitting electronic submissions of responses.

5. Assess information collection costs.

Proposed Project

The Maternal Mortality Review Information Application (MMRIA) –New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) seeks OMB approval to collect information through the Maternal Mortality Review Information Application (MMRIA) for three years. MMRIA is a standardized data collection system that allows Maternal Mortality Review Committees (MMRCs) across the country to abstract relevant data (clinical and non-clinical) from a variety of sources, document committee decisions, and analyze data in order to better understand the contributing factors and preventability of maternal deaths and thus to develop recommendations for prevention.

About 700 women die each year in the United States as a result of pregnancy or delivery complications, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Furthermore, considerable racial disparities exist, with black women almost four times more likely to die from pregnancy-related complications than white women. Findings from MMRCs indicate that more than half of maternal deaths are preventable.

Maternal Mortality Review is a process by which a multidisciplinary committee at the jurisdiction level identifies and reviews cases of maternal death within one year of end of pregnancy. Members of MMRCs typically represent public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, and other relevant stakeholders. Through a partnership among the MMRC, state vital records office, and epidemiologists, deaths among women of reproductive age are examined to determine if they occurred during pregnancy or within one year of the end of pregnancy (*i.e.,* pregnancy-associated deaths). Through this process, potential cases of pregnancy-related deaths (*i.e.,* maternal death from any cause related to or aggravated by pregnancy or its management) are then identified. Review committees access multiple sources of clinical and non-clinical information to understand the circumstances surrounding a maternal death in order to develop recommendations for action to prevent similar deaths in the future.

MMRIA is a standardized data collection system designed to collect timely, accurate, and standardized information about deaths to women during pregnancy and within one year of end of pregnancy, including opportunities for prevention, within and across jurisdictions. Data will be abstracted and entered into MMRIA from various sources, including death certificates, autopsy reports, birth certificates, prenatal care records, emergency room visit records, hospitalization records, records from other medical office visits, medical transport records, social and environmental profiles, mental health profiles, and informant interviews. Case narratives for committee reviews are auto-populated from the abstracted data entered into MMRIA to facilitate committee review, and committee decisions will also be entered into MMRIA.

The data collected in MMRIA will be used to facilitate an understanding of the drives of maternal mortality and complications of pregnancy and associated disparities; determine what interventions at patient, provider, facility, system, and community levels will have the most impact; and implement data driven recommendations.

The burden estimates presented here are applicable to the estimated 25 awardees of the cooperative agreement *Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees* (CDC–RFA–DP19–1908); these awardees are required to compile a defined set of information about maternal deaths into MMRIA. It is estimated that information will be collected for a total of 740 pregnancy-associated deaths on average, annually, among the 25 awardees. Burden is estimated based on each awardee's total staff time to enter the abstracted data into MMRIA and enter the committee decision.

ESTIMATED ANNUALIZED BURDEN HOURS

Types of respondents	Form name	Number of respondents	Number of responses per respondent	Average hours per response (in hours)	Total burden hours
Awardees	Data abstraction	25	30	15	11,250
	Committee decision	25	30	24/60	300
Total					11,550

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2019–13055 Filed 6–19–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–19–1108]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled *Paul Coverdell National Acute Stroke Program (PCNASP)* to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on February 7, 2019 to obtain comments from the public and affected agencies. CDC did not receive comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project.

The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Paul Coverdell National Acute Stroke Program (PCNASP) (OMB No. 0920–1108, exp. 03/31/2019)—Reinstatement with Change—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Stroke is the fifth leading cause of death in the United States and results in approximately 145,000 deaths per year. Additionally, approximately 800,000 stroke events are reported each year, including approximately 185,000 recurrent strokes. However, many strokes are preventable, and patient outcomes can be improved through coordinated care that begins at stroke onset and is delivered in a timely manner.

Stroke outcomes depend upon the rapid recognition of signs and symptoms of stroke, prompt transport to a treatment facility, and early rehabilitation. Improving outcomes requires a coordinated systems approach involving pre-hospital care, emergency department and hospital care, prevention of complications, post-stroke rehabilitation, and ongoing secondary prevention. Through the Paul Coverdell National Acute Stroke Program (PCNASP), CDC has been continuously working to measure and improve acute stroke care using well-known quality improvement strategies coupled with frequent evaluation of results. PCNASP awardees are state health departments who work with participating hospitals, Emergency Medical Services (EMS) agencies, and other healthcare partners (*e.g.,* post-stroke recovery facilities) in their jurisdictions to improve quality of care and transitions of care for stroke patients. During initial cooperative agreement cycles, PCNASP awardees focused on improving in-hospital quality of care (QoC) with technical assistance provided by CDC. Through lessons learned during this process and other supporting evidence in the field, it has become evident that it is also important to examine pre- and post-hospital transitions of care to link the entire continuum of stroke care when improving QoC for stroke patients.

The PCNASP's current five-year cooperative agreement started on July 1, 2015 and includes nine awardees and their selected partners (hospitals, EMS agencies, other healthcare facilities). This current funding reflects additional emphasis on pre-hospital quality of care as well as the post-hospital transition of care setting from hospital to home or other healthcare facility. With technical assistance provided by CDC, awardees have worked on identifying and using data systems to systematically collect and report data on all three phases of the stroke care continuum and on hospital capacity.

PCNASP had OMB approval for the collection of pre-hospital (EMS), in-hospital, and post-hospital patient care data, as well as hospital inventory data (OMB No. 0920–1108). This approval expired on 3/31/2019, and awardees have discontinued data submission. The lapsed information collection will resume after OMB approval of a reinstatement package.

When possible, in-hospital patient care data continues to align with standards set by The Joint Commission (TJC) and the American Heart Association's Get With The Guidelines (GWTG) program. There are no changes to the estimated burden for the collection of in-hospital data. The average burden per response remains 30 minutes for awardees, for a total of 18 hours annually.

Data collection methods for pre- and post-hospital care data are revised to allow for information collection through existing data systems, including GWTG and the National Emergency Medical Services Information System (NEMSIS). CDC has worked with awardees, the American Heart Association and NEMSIS to identify areas of alignment and new collaboration to reduce the burden of pre-hospital data collection. The average burden per response will vary from 30 minutes to two hours. Thus, the burden for pre-hospital data is being reduced from 96 to 60 burden hours annually. Similarly, the burden for post-hospital data is reduced from 38 to 22 burden hours annually, because data collection will occur using GWTG or another similar mechanism, and data will be transmitted automatically to awardees. The average burden per response will vary from 30 minutes to two hours per quarter for post-hospital data collection.

Primary data collection of hospital inventory data is collected to understand the capacity and infrastructure of the hospitals that admit and treat stroke patients. The average burden per response remains 30 minutes for hospitals, and eight hours for each PCNASP awardee to prepare an aggregate hospital inventory file. The number of respondents is increasing from 315 to 378 hospital partners due to increased participation in PCNASP. Thus, the burden for hospital inventory data is increasing from 230 to 261 hours annually.

These requested changes will result in a net decrease in total average burden from 382 to 361 hours. All patient, hospital, and EMS provider data that is submitted to CDC by PCNASP awardees will be de-identified and transmitted through secure data systems. Proposed data elements and quality indicators may be updated over time to include new or revised items based on evolving recommendations and standards in the field to improve the quality of stroke care.

OMB approval is requested for three years. Participation is voluntary and there are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
PCNASP Awardee	Hospital inventory	9	1	8
—	In-hospital care data	9	4	30/60
	Pre-hospital care data	2	4	30/60
	7	4	2	
	Post-hospital transition of care data	7	4	30/60
	2	4	1	
PCNASP Hospital Partners	Hospital Inventory	378	1	30/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2019–13054 Filed 6–19–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2019–N–1482]

Scientific Data and Information About Products Containing Cannabis or Cannabis-Derived Compounds; Extension of Comment Period

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; extension of comment period.

SUMMARY: The Food and Drug Administration (FDA or we) is extending the comment period for the notice that appeared in the **Federal Register** of April 3, 2019. The notice announced a public hearing to obtain scientific data and information about the safety, manufacturing, product quality, marketing, labeling, and sale of products containing cannabis or cannabis-derived compounds. In addition, it notified the public that FDA was establishing a docket for public comment on this hearing and that the docket would close on July 2, 2019. We are extending the comment period to give interested parties more time to comment.

DATES: FDA is extending the comment period on the notice published in the **Federal Register** of April 3, 2019 (84 FR 12969). Submit either electronic or written comments by July 16, 2019.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. Electronic comments must be submitted on or before July 16, 2019. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of July 16, 2019. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are postmarked or the delivery service acceptance receipt is on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

• *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*

• If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

• *Mail/Hand delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

• For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2019–N–1482 for ''Scientific Data and Information About Products Containing Cannabis or Cannabis-Derived Compounds.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday.

• Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' We will review this copy, including the claimed confidential information, in our consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.gpo.gov/fdsys/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the

electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: April Alexandrow, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Room 3147, Silver Spring, MD 20993, 301–796–5363.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of April 3, 2019, FDA published a notice announcing a public hearing to obtain scientific data and information about the safety, manufacturing, product quality, marketing, labeling, and sale of products containing cannabis or cannabis-derived compounds. In addition, we notified the public that FDA was establishing a docket for public comment on this hearing. The information from the hearing and comments provided to the docket will inform our regulatory oversight of these products and is an important step in our continued evaluation of cannabis and cannabis-derived compounds in FDA-regulated products. We asked that comments be submitted by July 2, 2019.

At the public hearing, we received requests for a 30-day extension of the comment period for the notice. The requests conveyed concern that the current 60-day comment period does not allow sufficient time to develop meaningful or thoughtful responses to the questions that appeared in the notice requesting data and other evidence in support of answers.

We have considered the requests and are extending the comment period for another 14 days, until July 16, 2019. We believe that a 14-day extension allows adequate time for interested persons to submit comments without significantly delaying any potential further action on these important issues.

Dated: June 14, 2019.

Lowell J. Schiller,

Principal Associate Commissioner for Policy.

[FR Doc. 2019–13122 Filed 6–19–19; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Privacy Act of 1974; System of Records

AGENCY: Department of Health and Human Services.

ACTION: Notice of a new system of records, and rescindment of related systems.

SUMMARY: In accordance with the Privacy Act of 1974, as amended, the Department of Health and Human Services (HHS) is establishing a new department-wide system of records, titled HHS Correspondence, Customer Service, and Contact List Records, system no. 09–90–1901. The new system of records replaces 13 existing systems of records which are rescinded in this notice, and it includes additional records not currently covered by any SORN. Two other related systems of records are also rescinded in this notice, but not replaced by the new SORN, because those records no longer exist.

DATES: In accordance with 5 U.S.C. 552a(e)(4) and (11), this notice is applicable June 20, 2019, subject to a 30-day period in which to comment on the routine uses, described below. Please submit any comments by July 22, 2019.

ADDRESSES: The public should submit written comments on this notice, by mail or email, to Beth Kramer, HHS Privacy Act Officer, 200 Independence Ave. SW, Suite 729H, Washington, DC 20201, or *beth.kramer@hhs.gov.* Comments will be available for public viewing at the same location. To review comments in person, please contact Beth Kramer at *beth.kramer@hhs.gov* or 202–690–6941.

FOR FURTHER INFORMATION CONTACT: General questions may be submitted to Beth Kramer, HHS Privacy Act Officer, at 200 Independence Ave. SW, Suite 729H, Washington, DC 20201, or *beth.kramer@hhs.gov,* or 202–690–6941.

SUPPLEMENTARY INFORMATION:

I. Background on New SORN 09–90–1901

HHS is establishing this new department-wide system of records to cover records about individuals within or outside HHS which are retrieved by personal identifier and used in managing HHS correspondence and customer service functions, including help desk and call center activities, dissemination of publications, studies, opinions, unrestricted datasets, and other information, and mailing and contact lists, unless covered by a more specific system of records notice (SORN). It will include the records currently covered in 13 related SORNs, in order to replace and rescind those SORNs, but with revisions where needed to provide updated descriptions of those records. It will also include other functionally similar records not currently covered by any SORN. The up-to-date records descriptions used in the new SORN differ from the descriptions used in the replaced SORNs in these respects:

- The System Manager contact information has been updated and is grouped by record type.
- The System Location section refers to the contact information shown in the System Manager section.
- The Authorities section now cites 5 U.S.C. 301, 305; 21 U.S.C. 301 *et seq.;* 31 U.S.C. 1115(b)(6); 40 U.S.C. 11313; 42 U.S.C. 201 *et seq.;* 44 U.S.C. 3101; E.O. 11583; and E.O. 13571. This differs from the authorities cited in each replaced SORN as follows:

a. OS SORNs 09–37–0001, 09–90–0027, 09–90–0037, 09–90–0038, and 09–90–0072 and HRSA SORN 09–15–0059 cited only one of the authorities cited in the new SORN, 5 U.S.C. 301.

b. NIH SORN 09–25–0106 cited two authorities cited in the new SORN, 5 U.S.C. 301 and 44 U.S.C. 3101.

c. OS SORN 09–90–0001 cited 5 U.S.C. 301 and one authority not cited in the new SORN: 40 U.S.C. 486(c).

d. FDA SORN 09–10–0004 cited 42 U.S.C. 201 *et seq.,* which is cited in the new SORN, and two authorities not cited in the new SORN: 21 U.S.C. 321 *et seq.* and 21 CFR part 5.

e. SAMHSA SORN 09–30–0033 cited portions of title 42 of the United States Code, which is cited in the new SORN, and these authorities not cited in the new SORN: 8 U.S.C. 1522 note, as amended by sec. 501(c) of Public Law 96–422; E.O. 12341; and sec. 413 of Public Law 93–288 as amended and redesignated as sec. 416 by Public Law 100–107 [sic; probably should be Public Law 101–707, amending 42 U.S.C. 5183].

f. These SORNs cited none of the authorities cited in the new SORN:

i. OS SORN 09–90–0161 cited 42 U.S.C. 300u-6;

ii. CDC SORN 09–20–0059 cited 29 U.S.C. 670;

iii. CMS SORN 09–70–3005 cited 42 U.S.C. 1306(a) and 42 CFR 401.101–401.148; and

iv. SAMHSA SORN 09–30–0051 cited sec. 501 of the Public Health Service Act (42 U.S.C. 290a) as amended by Public Law 102–321 and Public Law 106–310.

- The new SORN provides broader and more detailed descriptions of the categories of records and the purposes for which the records are used than were in each replaced SORN, in recognition that some of the records interrelate with each other and may be maintained and used together, and by more than one office, to achieve certain purposes. Each replaced SORN

described how a particular office or component used a particular set of records.

• The categories of individuals are effectively the same as in the replaced SORNs, except that the description in the new SORN is not limited to individuals who are the subject of a particular set of records, yet is worded to avoid including individuals who don't qualify as record subjects for Privacy Act purposes. For example, it does not include individuals whose personal identifiers are used to retrieve records that are not, in fact, about them, which was an error in OS SORNs 09–90–0027 and 09–90–0072.

• Unnecessary routine uses (*e.g.,* for disclosures that would be made with consent or that are not in fact made) are not included. Routine uses 3 and 4 are worded to apply to only certain records; the other routine uses apply to all records in the new SORN, but were not in some of the replaced SORNs; *i.e.:*

a. Routine use 10 was not in any of the replaced SORNs.

b. Routine use 2 was not in FDA SORN 09–10–0004.

c. Routine uses 6 and 8 were not in OS SORN 09–90–0027.

d. Routine uses 2, 6, and 8 were not in OS SORNs 09–90–0037, 09–90–0038, and 09–90–0072; HRSA SORN 09–15–005; CDC SORN 09–20–0059; SAMHSA SORN 09–30–0051; and CMS SORN 09–70–3005.

e. Routine uses 2, 5, 6, and 8 were not in OS SORNs 09–90–0001 and 09–90–0161.

f. Routine uses 1, 2, 6, and 8 were not in OS SORN 09–37–0001, NIH SORN 09–25–0106, and SAMHSA SORN 09–30–0036.

• The disposal section identifies applicable disposition schedules (some of the replaced SORNs did not).

• The storage and safeguards sections are up-to-date, and were not up-to-date in some of the replaced SORNs.

II. Background on the Rescinded SORNs

A. HHS is rescinding the following two systems of records because the records no longer exist:

1. *09–90–1201 ONC Health IT Dashboard.* This SORN covered records containing identifying information, retrieved by National Provider Identifier (NPI), about health care providers who registered to receive health IT implementation assistance from grantees of the Office of the National Coordinator for Health IT (ONC), which were used by the grantees to provide that assistance and by HHS/ONC to evaluate the status of electronic health record implementation and validate grantees' claims for grant payments. The SORN reflected that the records would be retained for approximately two years after the completion of the grant program. The grant program ended in 2014, and the records that were retrieved by NPI were destroyed when business use ceased.

2. *09–90–0041 Consumer Mailing List.* This SORN was established by an office which was transferred from the Office of the Secretary (OS) to the Centers for Medicare & Medicaid Services (CMS) in 2011 and renamed the Center for Consumer Information and Insurance Oversight (CCIIO). It covered a list which was used to distribute information on current consumer topics to consumers, academicians, librarians, business and government officials, and the media. The list is no longer maintained, and the records no longer exist.

B. HHS is rescinding these 13 systems of records and replacing them with the new department-wide SORN 09–90–1901:

3. *09–37–0001 OASH Correspondence Control System.* These records pertain to individuals who have contacted, or have been contacted in writing by, the Assistant Secretary for Health (OASH) or a subordinate official. The records consist of copies of correspondence and tracking records which are used to control, track, and ensure timely and appropriate attention to correspondence addressed to or initiated by such officials. The routine uses authorize disclosures to contractors and other non-employees engaged to perform functions for HHS and disclosures for purposes of responding to or handling litigation and security incidents.

4. *09–90–0001 Telephone Directory/Locator System.* This SORN covers HHS office contact records for HHS employees, other federal agency employees, and HHS contractor personnel located at HHS, which are retrieved by the personnel members' names and used to locate the individuals, route mail, and produce departmental telephone (and now also email) directories. The routine uses authorize disclosures to contractors and other non-employees engaged to perform functions for HHS and disclosures for purposes of responding to or handling litigation and security incidents.

5. *09–90–0027 Congressional Correspondence Unit.* This SORN covers records of constituent requests received from members of Congress and HHS' responses to same, and any associated work papers, which are about individual constituents and retrieved by constituent name (the SORN misdescribes them as being about members of Congress and as retrieved by only member of Congress name). The records are maintained by the Assistant Secretary for Legislation (ASL). The routine uses authorize disclosures to contractors and other non-employees engaged to perform functions for HHS, to another federal agency in order to route a misdirected request to that agency for response, to the member of Congress in responding to the request, to the Department of Justice for litigation purposes, and to other federal agencies and parties in responding to security incidents.

6. *09–90–0037 Secretariat's Correspondence Control System.* These department-wide records, which were formerly maintained by the Immediate Office of the Secretary (OS/IOS), are now maintained by HHS' Administration for Children and Families (ACF), and are now retrieved by the subject individual's first or last name, city or state, or correspondence tracking number. The records are about individuals who have contacted, or have been contacted in writing by, an HHS official, and consist of control information from official correspondence, including a narrative subject description, organization drafting the response, and type of action required from the Department. The routine uses authorize disclosures to contractors and other non-employees engaged to perform functions for HHS and disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

7. *09–90–0038 Secretary's Official Files.* These records are about individuals who have contacted, or have been contacted in writing by, the Secretary or Under Secretary (currently referred to as the Deputy Secretary), and include copies of documents signed or initialed by one of those officials. The routine uses authorize disclosures to contractors and other non-employees engaged to perform functions for HHS and disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

8. *09–90–0072 Congressional Grants Notification Unit.* This SORN covers correspondence maintained by the Assistant Secretary for Legislation (ASL) notifying members of Congress of grants and other contracts that HHS has awarded to recipients in their districts. (The SORN erroneously states that the records are about members of Congress; however, the records are about awardees, not members of Congress.) The routine uses authorize disclosures

to contractors and other non-employees engaged to perform functions for HHS, to members of Congress in responding to constituent inquiries, to the Department of Justice for litigation purposes, and to other federal agencies and parties for purposes of responding to security incidents.

9. *09–90–0161 Minority Health Information Services.* These records are used by the Office of Minority Health (OMH) within the Office of the Assistant Secretary for Health (OASH) to track and respond to requests from members of the public who ask to receive health information in the form of OMH's electronic newsletter and intermittent email updates. At times, OMH may also maintain records about individuals who volunteer to serve as resource persons to provide pro bono technical assistance to community organizations or government agencies working on aspects of minority health or in an OMH campaign. The routine uses in this SORN authorize disclosures to (and web postings meant to reach) parties seeking assistance from a resource person; disclosures to contractors; and disclosures for the purposes of responding to or handling litigation and security incidents.

10. *09–10–0004 [FDA] Communications (Oral and Written) with the Public.* This SORN covers records of information requests, consumer complaints, and other correspondence from or about individuals (other than employees of Food & Drug Administration (FDA)-regulated enterprises) who communicate with or are the subject of communications with FDA. The records include FDA-related Secretarial correspondence and congressional correspondence which is also covered in other SORNs listed above. The records are retrieved by the correspondent's (or other individual record subject's) name, and are used to track and respond to the correspondence. The routine uses authorize disclosures to refer potential law violations to the Department of Justice, a state food and drug enforcement health agency or licensing authority or the government of a foreign country for investigation; to a member of Congress for purposes of responding to a constituent request; to the Department of Justice for litigation purposes; and to other federal agencies and parties for purposes of responding to a security incident.

11. *09–15–0059 [HRSA] Strategic Work Information and Folder Transfer System (SWIFT).* The records covered by this SORN are about individuals who have contacted, or have been contacted, in writing by the Administrator of the Health Resources and Services Administration (HRSA) or a subordinate official (excluding FOIA and Privacy Act access request-related correspondence, which is maintained in the SWIFT information technology system but is covered under a more specific SORN, 09–90–0058 Tracking Records and Case Files for FOIA and Privacy Act Requests and Appeals). The records are retrieved by the correspondent's (or other record subject's) name, and are used to control and track the correspondence to ensure the correspondence receives timely and appropriate attention. The routine uses authorize disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

12. *09–20–0059 [CDC] Division of Training Mailing List.* This SORN covers a mailing list maintained by the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health (CDC/NIOSH), which contains the name, mailing address, and student number of each individual who has taken a NIOSH training course or who has asked to be placed on the list. The records are retrieved by student name and number. The list is used to advise the individuals of upcoming NIOSH training courses. The routine uses authorize disclosures to contractors providing computer support for the system of records and disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

13. *09–25–0106 Administration: Office of the NIH Director and Institute/Center Correspondence Records.* These records consist of correspondence, other supporting documents, and mailing lists pertaining to individuals who have contacted, or who have been contacted in writing by, the Director of the National Institutes of Health (NIH) or a subordinate. The records include NIH-related Secretarial correspondence and congressional correspondence which is also covered in other SORNs listed above. The records are retrieved by the correspondent's name and are used to control, address and track the correspondence to assure timely and appropriate attention. The routine uses authorize disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

14. *09–30–0033 [SAMHSA] Correspondence Files.* This SORN covers records of correspondence from individuals who request information about Substance Abuse and Mental Health Services Administration (SAMHSA) programs, and includes SAMHSA-related Secretarial correspondence and congressional correspondence which is also covered in other SORNs listed above. The records are retrieved by the correspondent's name and are used for reference purposes and to assure timely and appropriate attention. The routine uses authorize disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

15. *09–30–0051 SAMHSA Information Mailing System (SIMS).* This SORN covers records of correspondence from individuals who request publications and other information from the SAMHSA internet site, which is used to maintain a mailing list for purposes of providing the individuals with SAMHSA publications and other print materials they have identified as of interest to them and to inform them of new and upcoming publications. The records contain the individual's name (which is used for retrieval), contact information, title, occupation, organization type, ethnic group, level of education, and SAMHSA topics or areas of interest. The routine uses authorize disclosures to SAMHSA contractors, experts, and consultants and disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

16. *09–70–3005 [CMS] Correspondence Tracking Management System (CTMS).* This SORN covers records of correspondence from or about individuals who request information about Centers for Medicare & Medicaid Services (CMS) programs or who are the subject of such correspondence from others. These records include CMS-related Secretarial correspondence and congressional correspondence which is also covered in other SORNs listed above. The records are retrieved by the correspondent's (or other record subject's) name and are used to track the correspondence and to support regulatory, reimbursement, and policy functions. The routine uses authorize disclosures to agency contractors and consultants and disclosures for purposes of responding to or handling congressional inquiries, litigation, and security incidents.

Dated: May 30, 2019.

Michael S. Marquis,

Director, FOIA/Privacy Act Division, Office of Assistant Secretary for Public Affairs.

SYSTEM NAME AND NUMBER:

HHS Correspondence, Customer Service, and Contact List Records, 09–90–1901.

SECURITY CLASSIFICATION:

Unclassified.

SYSTEM LOCATION:

The address of each agency component responsible for this system of records is as shown in the System Manager(s) section below.

SYSTEM MANAGER(S):

The System Managers are as follows:

• *Congressional correspondence:* HHS Assistant Secretary for Legislation, Congressional Liaison Office, Rm. 406G, 200 Independence Ave. SW, Washington, DC 20201, (202) 690–7627.

• *HHS Secretarial and Deputy Secretary correspondence:* HHS Executive Secretariat, Rm. 603H, 200 Independence Ave. SW, Washington, DC 20201, (202) 690–7000.

• *Other official correspondence (managed by ACF for HHS):* Administration for Children and Families Executive Secretariat Office, Deputy Director, 330 C St. SW, Washington, DC 20201, *linda.hitt@acf.hhs.gov.*

• *Information product ordering and distribution records:*

a. AHRQ: Director, Office of Communications and Knowledge Transfer, Agency for Healthcare Research and Quality, 5600 Fishers Ln., 7th Floor, Rockville, MD 20857, (301) 427–1364.

b. CMS: Director, Office of Communications, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, (410) 786–1338.

c. FDA Privacy Act Coordinator, Food and Drug Administration, 5630 Fishers Ln., Rm. 1035, Rockville, MD 20857, (301) 796–3900.

d. SAMHSA: Director, Office of Communications, Substance Abuse and Mental Health Services Administration, 5600 Fishers Ln., Rockville, MD 20857, (240) 276–2201.

• *Call center, ombudsman, and help desk records:*

a. ONE–DHHS: FedResponse Service Director, Program Support Center, 7700 Wisconsin Ave., Bethesda, MD 20814, (877) 696–6775.

b. FDA Call Centers: FDA Privacy Act Coordinator, Food and Drug Administration, 5630 Fishers Ln., Rm. 1035, Rockville, MD 20857, (301) 796–3900.

• *Mailing list and contact list records:*

a. OASH/OMH mailing and contact list records: Office of Minority Health, The Tower Building, 1101 Wootton Pkwy, Suite 600, Rockville, MD 20852, (240) 453–2882.

b. FDA mailing and contact list records: FDA Privacy Act Coordinator, Food and Drug Administration, 5630 Fishers Ln., Rm. 1035, Rockville, MD 20857, (301) 796–3900.

• *Any other records not accounted for above:* see ONE–DHHS contact information, under Call center, above.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 301, 305; 21 U.S.C. 301 *et seq.;* 31 U.S.C. 1115(b)(6); 40 U.S.C. 11313; 42 U.S.C. 201 *et seq.;* 44 U.S.C. 3101; E.O. 11583; E.O. 13571.

PURPOSE(S) OF THE SYSTEM:

The records in this system of records are used for the purpose of managing HHS correspondence, information dissemination, and customer service functions; *i.e.,* to maintain, track, control, route, and locate information and documents created, received, requested, and used in managing those functions, in order to provide timely and appropriate actions, responses, notices, services, coordination, referrals, or other follow-up, avoid duplicate entries, and ensure consistency. Correspondence, information dissemination, and customer service functions include non-law enforcement-related help desk and call center activities; handling of consumer complaints; dissemination of publications, unrestricted datasets, and other information; and maintenance of mailing and contact lists. The records may also be used to compile aggregate statistics for the purpose of evaluating and improving these functions.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

The records are about individuals within and outside HHS who contact HHS to request or offer information, information products, or services or to communicate a complaint or other information, or who receive correspondence from HHS, or who are the author or subject of such publications, communications, or correspondence by or with HHS, or who are included in mailing and contact lists maintained by HHS, when the records are used to support HHS correspondence, customer service, and/or contact and mailing list functions and are retrieved by the individuals' names or other personal identifiers (unless the records are covered by a more specific system of records notice (SORN)).

CATEGORIES OF RECORDS IN THE SYSTEM:

The categories of records include:

• *Secretarial and other official correspondence, congressional correspondence, and other correspondence.* These records include copies of requests or other communications addressed or routed to an HHS official for response or other follow-up; copies of correspondence initialed or signed by an HHS official; tracking and control records (indicating, *e.g.,* the date and subject of the correspondence; the name of the correspondent and/or other individual record subject—for example, a constituent identified in congressional correspondence; the action required; the organization drafting the response); and associated work papers.

• *Records used in disseminating or filling orders for publications, stock photographs, audio visual productions, unrestricted datasets, and other information products.* These include indexes to repositories of informational materials, request records, and order fulfilment records. Indexes may contain names of individuals (such as authors or subjects) used to retrieve materials when needed for distribution or to fulfill a request. Request records identify the date of the request, the product requested, the requester, and the address to use for delivery. Order fulfillment records contain proof of delivery, including the delivery date and address used for delivery, which may be a mailing address or email address if delivery was through a public access web portal or link. Any associated payment records (if a fee is charged for the information product) are covered by system of records 09–90–0024 HHS Financial Management System Records.

• *Call center and help desk records.* These include contact records (containing the name of the individual who contacted the call center or help desk, his or her contact information, and location information if relevant, unless the individual wishes to be anonymous) and request records (containing the date and nature of the request, complaint, or report, the name of the call center staff member who handled the request, complaint, or report, and actions taken, such as providing an answer from a call center script, documenting the report, or assigning and routing the request to the appropriate program office to handle). Note that recordings of ONE–DHHS telephone calls are destroyed after 90 days and are not retrieved by personal identifier so are not covered by this SORN.

• *Mailing list records.* These include the lists and any records used to compile and maintain the lists (*e.g.,* existing contact lists; invitations to join and requests to be added to or removed from a list; address changes) containing an individual's contact information (*e.g.,* mailing address or email address) and indicating the particular information or notices the individual

would receive or would like to receive from HHS (*e.g.,* publications on particular health topics; an electronic newsletter; notice of upcoming training courses; notice when new material is added to a website). The records may also include information that the particular program requires or requests individuals to provide about themselves (*e.g.,* characteristics such as profession, employing organization, educational level, practice setting, geographic location, age, ethnicity) to enable the agency to aggregate or organize the information or compile statistics on the types of individuals receiving the information distributed through the list.

• *Contact list records.* These include the lists and any records used to compile and maintain the lists, containing names, contact information, and any other relevant information (*e.g.,* expertise type, primary language, geographic region) for individuals who HHS regularly contacts (such as, authors and sole proprietor media stakeholders) and/or individuals who have agreed to be included on or have asked to be removed from a particular list of contacts HHS maintains and distributes or posts for HHS and/or non-HHS parties to use to obtain assistance from or share information with the individuals on the list (for example, outside medical and research experts who wish to exchange knowledge and best practices and share studies, opinions, and training materials with each other); and any written consents from subject individuals permitting HHS to disclose their contact or other information to specific types of non-HHS parties, or to the public, for specific purposes.

RECORD SOURCE CATEGORIES:

Most information is obtained directly from the individual who contacts or is contacted by HHS. Information may also be obtained from a third party who contacts HHS about or on behalf of a subject individual, or from records HHS compiles or persons HHS consults in order to provide a response, provide assistance, or otherwise follow up on the request or communication.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND PURPOSES OF SUCH USES:

In addition to other disclosures authorized directly in the Privacy Act at 5 U.S.C. 552a(b)(4) through (11), information about an individual may be disclosed from this system of records to parties outside HHS without the individual's prior, written consent, for these routine uses:

1. Records may be disclosed to agency contractors and to student volunteers, interns, and other individuals who do not have the status of agency employees but have been engaged by HHS to assist in accomplishment of an HHS function relating to the purposes of this system of records and who need to have access to the records in order to assist HHS. Such individuals and contractors will be required to comply with the requirements of the Privacy Act.

2. Records may be disclosed to other federal agencies and HHS partner agencies and organizations for the purpose of referring a request or issue to them for handling or obtaining their assistance with a response or issue.

3. Notice of an award that HHS has made to an individual awardee in a particular congressional district may be disclosed to the member of Congress serving that district.

4. Names of and biographical information about the individuals who authored, created, appear in, or are the subjects of information products may be disclosed with the products or in descriptions of the products used to publicize them, but would be disclosed without consent only if and to the extent that the names and biographical information would be required to be released to a requester under the Freedom of Information Act (FOIA).

5. Records may be disclosed to a member of Congress or a congressional staff member in response to a written inquiry of the congressional office made at the written request of the constituent about whom the record is maintained. The congressional office does not have any greater authority to obtain records than the individual would have if requesting the records directly.

6. Records may be disclosed to representatives of the National Archives and Records Administration during records management inspections conducted pursuant to 44 U.S.C. 2904 and 2906.

7. Information may be disclosed to the Department of Justice (DOJ) or to a court or other adjudicative body in litigation or other proceedings, when:

a. HHS or any of its component thereof, or

b. any employee of HHS acting in the employee's official capacity, or

c. any employee of HHS acting in the employee's individual capacity where the DOJ or HHS has agreed to represent the employee, or

d. the United States Government, is a party to the proceeding or has an interest in such proceeding and, by careful review, HHS determines that the records are both relevant and necessary to the proceeding.

8. Where a record, either alone or in conjunction with other information, indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature, and whether arising by general statute or by regulation, rule, or order issued pursuant thereto, the relevant records in the system of records may be referred, as a routine use, to the agency concerned, whether federal, state, local, tribal, territorial, or foreign, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute, or the rule, regulation, or order issued pursuant thereto.

9. Records may be disclosed to appropriate agencies, entities, and persons when (1) HHS suspects or has confirmed that there has been a breach of the system of records, (2) HHS has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, HHS (including its information systems, programs, and operations), the Federal Government, or national security, and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with HHS efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.

10. Records may be disclosed to another federal agency or federal entity, when HHS determines that information from this system of records is reasonably necessary to assist the recipient agency or entity in (1) responding to a suspected or confirmed breach or (2) preventing, minimizing, or remedying the risk of harm to individuals, the recipient agency or entity (including its information systems, programs, and operations), the Federal Government, or national security, resulting from a suspected or confirmed breach.

11. Records may be disclosed to the Department of Homeland Security (DHS) if captured in an intrusion detection system used by HHS and DHS pursuant to a DHS cybersecurity program that monitors internet traffic to and from federal government computer networks to prevent a variety of types of cybersecurity incidents.

POLICIES AND PRACTICES FOR STORAGE OF RECORDS:

The records are stored in hard-copy files and/or electronic media.

POLICIES AND PRACTICES FOR RETRIEVAL OF RECORDS:

Records are retrieved by the individual requester's, correspondent's,

author's, or other record subject's name or other personal identifier, such as email address, request tracking number, user ID number, or other unique identifying number. Call center records may be retrieved by the name of the individual who contacted the call center.

POLICIES AND PRACTICES FOR RETENTION AND DISPOSAL OF RECORDS:

I. Official Correspondence (Including Significant White House and Congressional Correspondence)

Official correspondence and tracking records are transferred to the custody of the National Archives in four-year blocks and permanently retained. See, for example, these schedules:

A. *Office of the Secretary (OS):* DAA–0468–2011–0006–0003 (IOS); N1–468–10–0001 (DAB); DAA–0468–2012–0003 (OMHA); DAA–0468–2011–0007 (ONC); N1–514–92–1 (OASH); DAA–0468–2013–009 (other OS Staff Divisions).

B. *Other Operating Divisions:* DAA–0292–2016–0008 (ACF); DAA–510–2017–003 and N1–510–94–1, Item 9 (AHRQ); DAA–0440–2015–0001, Item 1.2.2 (CMS); N1–088–06–03, Items 4.1 and 4.2 (FDA); DAA–0512–2014–004, Item 6.3 (HRSA); N1–513–92–005, Items 6–1 and 6–12 (IHS); DAA–0443–2017–0003, Item 0001 (NIH).

II. Nonsignificant or Routine Correspondence:

A. OS:

a. *OASH:* N1–514–92–1, Item 9. Routine congressional correspondence: Destroy when 7 years old, unless needed longer due to incumbent's continuance in office. Other routine correspondence: Cut off annually, and destroy when 5 years old.

b. *ONC:* DAA–0468–2011–0007–003. Administrative correspondence files: Destroy 5 years after cutoff.

c. *OMHA:* DAA–0468–2012–0003–0003. Working correspondence files: Destroy 3 years after cutoff.

d. *All other OS staff divisions:* DAA–0468–2013–0009–0002. Routine files: destroy 5 years after cutoff.

B. OTHER OPERATING DIVISIONS:

a. *ACF and AHRQ:* Treated as official correspondence; see I.B. for schedules.

b. *CMS:* DAA–0440–2015–0002–0002. Cut off at end of calendar year, and destroy no sooner than 3 years after cutoff; longer retention is authorized.

c. *FDA:* N1–088–06–03. Cut off at end of calendar year, and destroy 10 years after cutoff (Item 1.1.2) or 5 years after cutoff (Item 1.2.2).

d. *HRSA:* DAA–0512–2014–004, Items 6.3.1.2 and 6.3.1.3: Correspondence: Cut off at end of calendar year, and destroy 7 years after cutoff. Tracking records: Retain permanently.

e. *IHS:* N1–513–92–005, Item s 6–1 b., 6–1 c., 6–12 b., and 11–12. Destroy when 6 years old if at the division level or higher. Destroy when 2 years old if below the division level.

f. *NIH:* DAA–0443–2012–0007, Item 0003. Cut off annually at termination of project/program, and destroy 7 years after cutoff.

g. *CDC and SAMHSA:* See OASH schedule N1–514–92–1, Item 9 (3) (CDC and SAMHSA were once part of OASH).

III. Call Center, Help Desk, and Similar Customer Service Records

- *FDA Ombudsman records:* N1–088–05–001, Item 2. Case files maintained by the Center Ombudsman Office (Item 2.3): Cut off 3 months after the end of the calendar year in which the case is closed or the appeal is completed, and destroy 3 years after cutoff. All other case files (Item 2.1) and finding aids (Item 2.2): Cut off at the end of the calendar year in which the final action is taken or the appeal is completed, and destroy 10 years after cutoff.
- *Other customer service operations records:* GRS 6.5 Item 010 and GRS 5.8 Item 0101. Destroy 1 year after resolved or when no longer needed for business use, whichever is appropriate.

IV. Mailing and Contact List Records

- GRS 6.5 Item 020. Delete when superseded or obsolete or when the customer requests that the agency remove the records.

ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS:

Safeguards conform to the HHS Information Security and Privacy Program, *https://www.hhs.gov/ocio/securityprivacy/index.html.* Information is safeguarded in accordance with applicable laws, rules and policies, including the HHS Information Technology Security Program Handbook; all pertinent National Institutes of Standards and Technology (NIST) publications, and OMB Circular A–130, Managing Information As a Strategic Resource. Records are protected from unauthorized access through appropriate administrative, physical, and technical safeguards. These safeguards include protecting the facilities where records are stored or accessed with security guards, badges and cameras, securing hard-copy records in locked file cabinets, file rooms or offices during off-duty hours, limiting access to electronic databases to authorized users based on roles and two-factor authentication (user ID and password), using a secured operating system protected by encryption, firewalls, and intrusion detection systems, requiring encryption for records stored on removable media, and training personnel in Privacy Act and information security requirements. Records that are eligible for destruction are disposed of using destruction methods prescribed by NIST SP 800–88.

RECORD ACCESS PROCEDURES:

An individual seeking access to records about him or her in this system of records must submit a written request to the relevant System Manager indicated above. An access request must contain the name and address of the requester, email address or other identifying information, and his/her signature. To verify the requester's identity, the signature must be notarized or the request must include the requester's written certification that he/she is the person he/she claims to be and that he/she understands that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a fine of up to $5,000. An individual may also request an accounting of disclosures that have been made of the records about him or her, if any.

CONTESTING RECORD PROCEDURES:

An individual seeking to amend a record about him or her in this system of records must submit a written request to the relevant System Manager indicated above. An amendment request must include verification of the requester's identity in the same manner required for an access request, and must reasonably identify the record and specify the information being contested, the corrective action sought, and the reasons for requesting the correction, along with supporting information to show how the record is inaccurate, incomplete, untimely, or irrelevant.

NOTIFICATION PROCEDURES:

An individual who wishes to know if this system of records contains records about him or her must submit a written request to the relevant System Manager indicated above and verify his or her identity in the same manner required for an access request.

EXEMPTIONS PROMULGATED FOR THE SYSTEM:

None.

HISTORY:

None.

Notice of Rescindment

For the reasons explained in the **SUPPLEMENTARY INFORMATION** section at

II., the following 15 systems of records are rescinded:

These two SORNs are rescinded because the records no longer exist:

SYSTEM NAME AND NUMBER:

ONC Health IT Dashboard, 09–90–1201

HISTORY:

76 FR 79685 (Dec. 22, 2011); updated 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Consumer Mailing List, 09–90–0041

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

These 13 SORNs are rescinded because they have been replaced by new SORN 09–90–1901:

SYSTEM NAME AND NUMBER:

OASH Correspondence Control System, 09–37–0001

HISTORY:

51 FR 42352 (Nov. 24, 1986); updated 53 FR 47302 (Nov. 22, 1988), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Telephone Directory/Locator System, 09–90–0001

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Congressional Correspondence Unit, 09–90–0027

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Secretariat's Correspondence Control System, 09–90–0037

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Secretary's Official Files, 09–90–0038

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Congressional Grants Notification Unit, 09–90–0072

HISTORY:

47 FR 45514 (Oct. 13, 1982); updated 59 FR 55845 (Nov. 9, 1994), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

Minority Health Information Services, 09–90–0161

HISTORY:

75 FR 18837 (Apr. 13, 2010); updated 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

[FDA] Communications (Oral and Written) with the Public, 09–10–0004

HISTORY:

51 FR 42524 (Nov. 24, 1986); updated 54 FR 47912 (Nov. 17, 1989), 79 FR 36536 (June 17, 2014), 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

[HRSA] Strategic Work Information and Folder Transfer System (SWIFT), 09–15–0059

HISTORY:

75 FR 57806 (Sept. 22, 2010); updated 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

[CDC] Division of Training Mailing List, 09–20–0059

HISTORY:

51 FR 42449 (Nov. 24, 1986); updated 58 FR 69048 (Dec. 29, 1993); 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

[NIH] Administration: Office of the NIH Director and Institute/Center Correspondence Records, 09–25–0106

HISTORY:

67 FR 60742 at 60758 (Sept. 26, 2002); updated 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

[SAMHSA] Correspondence Files, 09–30–0033

HISTORY:

75 FR 28268 (May 20, 2010); 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

SAMHSA Information Mailing System (SIMS), 09–30–0051

HISTORY:

75 FR 28272 (May 20, 2010); updated 83 FR 6591 (Feb. 14, 2018)

SYSTEM NAME AND NUMBER:

CMS Correspondence Tracking Management System (CTMS), 09–70–3005

HISTORY:

67 FR 57020 (Sept. 6, 2002); updated 83 FR 6591 (Feb. 14, 2018)

[FR Doc. 2019–13112 Filed 6–19–19; 8:45 am]

BILLING CODE 4150–25–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Privacy Act of 1974; System of Records

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice of a modified system of records and rescindment of a system of records notice.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, the HHS is modifying a system of records maintained by HRSA, Healthcare Systems Bureau (HRSA/HSB), System No. 09–15–0056, ''National Vaccine Injury Compensation Program'' (VICP), and renaming it ''Injury Compensation Programs, HHS/HRSA/HSB.'' The primary purpose of the modification is to include records covered by a related system of records also maintained by HRSA/HSB, System No. 09–15–0071, ''Countermeasures Injury Compensation Program, HHS/HRSA/HSB'' (CICP), in order to consolidate the two systems of records and rescind System No. 09–15–0071.

DATES: In accordance with 5 U.S.C. 552a(e)(4) and (11), this notice is applicable June 20, 2019, subject to a 30-day period in which to comment on the new and revised routine uses, described below. Please submit any comments by July 22, 2019.

ADDRESSES: Please address written comments to the Director, Division of Injury Compensation Programs, HSB, HRSA, 5600 Fishers Lane, Rm. 8N146B, Rockville, MD 2085 or *VaccineCompensation@hrsa.gov.* Comments received will be available for inspection at this same address from 9:00 a.m. to 3:00 p.m. (Eastern Standard Time), Monday through Friday.

FOR FURTHER INFORMATION CONTACT: General questions about the system of records may be submitted to Dr. Narayan Nair, Director, Division of Injury Compensation Programs, HSB, HRSA, HHS, 5600 Fishers Lane, Rm. 8N146B, Rockville, MD 20857. General questions about the system of records may also be submitted to Dr. Narayan Nair via telephone at 1–800–338–2382 or email at *VaccineCompensation@hrsa.gov.*

SUPPLEMENTARY INFORMATION: System No. 09–15–0056 currently covers records about individuals who file claims with the Vaccine Injury Compensation Program (VICP) seeking compensation for alleged vaccine-related injuries. In addition to other changes, the system is being modified to include the records covered by a related system of records that is being rescinded, System No. 09–15–0071, which is about individuals requesting benefits from the Countermeasures Injury Compensation Program (CICP) for injuries alleged to have been caused by administration or use of covered countermeasures, such as the 2009 H1N1 vaccine.

I. Explanation of Modifications to System No. 09–15–0056

The modifications to the System of Records Notice (SORN) for System No. 09–15–0056 are as follows:

- The SORN has been reformatted to comply with OMB Circular A–108.
- The name of the system of records has been changed from ''National Vaccine Injury Compensation Program'' to ''Injury Compensation Programs, HHS/HRSA/HSB,'' to reflect its expanded scope.
- The System Location and System Manager contact information has been updated with a new room number.
- CICP-related descriptions have been added to the Authority, Purpose, Categories of Individuals, Categories of Records, Records Source Categories, Routine Uses, and Policies and Practices for Retrieval of Records sections.
- Two unnecessary routine uses, numbered as 11 and 12 in the current SORN, have been removed. They permitted records about an individual record subject who is a minor or incompetent adult to be disclosed to the individual's parent or guardian. Such disclosures are considered to be disclosures to the individual record subject under 5 U.S.C. 552a(h) and therefore do not require a routine use.
- Routine uses 2 and 13 have been added:
  - New routine use 2 applies to both VICP and CICP records (it previously applied to only CICP records, and was numbered as 2 in the CICP SORN).
  - New routine use 13 applies to CICP records only. It was numbered as 5 in the CICP SORN.
- The following routine uses have been revised or renumbered:
  - Routine use 1 (authorizing disclosures to contractors, medical experts and consultants, another federal agency, or others engaged to assist the agency) combines routine uses which were numbered as 3 and 8 in the VICP SORN and as 3 and 4 and in the CICP SORN.
  - Routine use 3 (numbered as 9 in the VICP SORN) authorizes disclosures for research purposes and the wording has been changed to the wording in routine use 9 in the CICP SORN.
  - Routine use 4 (authorizing disclosures to the U.S. Department of Justice (DOJ) or a court or other tribunal in proceedings) combines routine uses which were numbered as 2 and 4 in the VICP SORN and as 7 in the CICP SORN. The word ''litigation'' has been changed to ''proceedings.''
  - Routine use 5 (authorizing disclosures to congressional offices) was numbered 1 in the VICP SORN and as 1 in the CICP SORN.
  - Routine use 6 (authorizing disclosures in the event of a violation or potential violation of law) was numbered 13 in the VICP SORN and 8 in the CICP SORN.
  - Routine uses 7 (numbered as 14 in the VICP SORN, and as 10 in the CICP SORN) and 8 (not previously numbered) are breach response-related routine uses which were previously revised or added as required by OMB Memorandum M–17–12 (see 83 FR 6591 published Feb. 14, 2018).
  - Routine use 9 (numbered as 10 in the VICP SORN) previously applied to only VICP records. The words ''program award'' has been changed to ''program award or benefit,'' in order to make this one routine use apply to both VICP and CICP records (to avoid providing separate, nearly identical routine uses). The words ''local, state and the Federal'' have been added before ''government.''
  - Routine use 10 was numbered 5 in the VICP SORN.
  - Routine use 11 was numbered 6 in the VICP SORN.
  - Routine use 12 was numbered 7 in the VICP SORN.
- The Storage section has been revised to change ''disks'' to ''portable electronic media.''
- The Retrieval section has been revised to remove docket number and case number, which are not direct personal identifiers.
- The Retention section has been revised to remove language referring to the ''Records Control Schedule of HRSA'' and to add the term ''disposition schedule.''

II. Reason for Rescinding Related System No. 09–15–0071

The CICP records previously maintained in system of records 09–15–0071 are now covered in modified system of records 09–15–0056. Accordingly, HHS is rescinding System No. 09–15–0071 as duplicative of System No. 09–15–0056.

Dated: June 14, 2019.

George Sigounas,

Administrator.

SYSTEM NAME AND NUMBER:

Injury Compensation Programs, HHS/HRSA/HSB, 09–15–0056.

SECURITY CLASSIFICATION:

Unclassified.

SYSTEM LOCATION:

The address of the agency component responsible for the system is Division of Injury Compensation Programs (DICP), Healthcare Systems Bureau (HSB), Health Resources and Services Administration (HRSA), 5600 Fishers Ln., Rm. 8N146B, Rockville, MD 20857.

SYSTEM MANAGER(S):

Director, Division of Injury Compensation Programs, Healthcare Systems Bureau, Health Resources and Services Administration, 5600 Fishers Ln., Rm. 8N146B, Rockville, MD 20857, or the Director's designee.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

National Vaccine Injury Compensation Program (VICP): National Childhood Vaccine Injury Act of 1986, as amended (Vaccine Act), 42 U.S.C. 300aa–10, *et seq.*

Countermeasures Injury Compensation Program (CICP): Public Readiness and Emergency Preparedness Act of 2005 (PREP Act), 42 U.S.C. 247d–6e.

PURPOSE(S) OF THE SYSTEM:

VICP records are used to determine eligibility of petitioners to receive compensation, and to compensate successful petitioners in the amount and in the manner determined by the U.S. Court of Federal Claims (Court). CICP records are used to determine eligibility for benefits and to provide benefits to certain individuals who have sustained a covered injury as a result of the administration or use of a covered countermeasure, and to provide benefits to the survivors and/or estates of deceased injured countermeasure recipients. Note that any overpayment or other debt-related information arising from VICP or CICP may be used and disclosed for debt management and collection purposes as described in the SORN published for HHS' Debt Management and Collection System, System No. 09–40–0012, last published in full at 63 FR 68596 (Dec.11, 1998), updated at 80 FR 67767 (Nov. 3, 2015) and 83 FR 6591 (Feb. 14, 2018).

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

The records in this system of records are about:

- Individuals who file claims with the VICP (VICP Petitioners); and
- Individuals who request benefits from the CICP (CICP requesters or their representatives).

CATEGORIES OF RECORDS IN THE SYSTEM:

The records consist of medical records, including medical expense records, employment records, and other documents used to support injury compensation claims and to make program recommendations and decisions. Records may contain the following information about each category of individual:

- *VICP petitioners:* Claim or petition for compensation, including petitioner's name and name of person vaccinated if different from petitioner, and all relevant medical records (including autopsy reports and slides, radiological films, and home videos, if any), assessments, evaluations, prognoses, and such other records and documents as are reasonably necessary for the determination of eligibility for and the amount of compensation to be paid to, or on behalf of, the person who suffered such injury or who died from the administration of the vaccine, payment information, general or congressional correspondence, HHS responses to correspondence, and other related case processing documents.
- *CICP requesters:* Request for benefits, including requester's name and name of injured countermeasure recipient if different from requester, case number assignment, medical and legal documentation, employment documentation, documentation concerning services or benefits available from the United States or any third party (including any state or local governmental entity, private insurance carrier, or employer), payment information, general or congressional correspondence, HHS responses to correspondence, and other related case processing documents.

RECORD SOURCE CATEGORIES:

Records about a VICP petitioner are obtained from the petitioner, petitioner's legal representative, health care providers, and other interested persons. Records about a CICP requester are obtained from the requester, requester's representative, health care providers, and other interested persons. Sources of VICP records include, but are not limited to the petitioner, petitioner's legal representative, health care providers and other interested parties. Sources of CICP records include, but are not limited to, countermeasure recipients and/or their legal or personal representatives under the Countermeasures Injury Compensation Program, and any other sources of information or documentation submitted by any other person or entity for inclusion in a request for the purpose of determining eligibility for, or amount of benefits and/or compensation under, the Program (*e.g.,* federal, state, or local government or private health care entities participating in the administration of covered countermeasures under a Secretarial declaration).

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING RECORD SOURCE CATEGORIES AND CATEGORIES OF USERS AND PURPOSES OF SUCH USES:

Information about an individual VICP petitioner or CICP requester may be disclosed from this system of records to parties outside the agency without the individual's prior, written consent pursuant to these routine uses:

1. Records may be disclosed to an agency contractor, another federal agency, agency consultants, or others who have been engaged by HHS to assist with accomplishment of an HHS function relating to the purposes of this system of records and who need to have access to the records in order to assist HHS. For example:

a. HRSA will contract with expert medical consultants to obtain advice on petitioner's eligibility for compensation. To the extent necessary, relevant records may be disclosed to such consultants. The consultants shall be required to maintain Privacy Act safeguards concerning such records and return all records to HRSA.

b. To the extent necessary, a record may be disclosed to agency contractors for the purpose of providing medical review, analysis, and determination as to whether petitions meet the medical requirements for compensation. Contractors will be required to maintain Privacy Act safeguards concerning such records.

c. Disclosure of records may be made to contractors engaged by the Department who need access to the records to assist the Department in evaluating the effectiveness of the CICP.

2. Disclosure may be made to federal, state or local government entities or to private entities for the purpose of requesting, and enabling them to locate and provide information relevant to medical, legal, or financial (*e.g.,* insurance, payment) documentation required for determinations of eligibility or payment.

3. A record may be disclosed to researchers for a scientific research purpose, only when the Department has determined:

(A) That the use or disclosure does not violate legal or policy limitations under which the record was provided, collected, or obtained;

(B) That the research purpose is consistent with the purpose for which the program was formed;

(C) That the proposed research is scientifically sound in its methods and analyses and is likely to answer the proposed research question;

(D) That the information sought is not available from any other source;

(E) That the record made available for scientific research is redacted of all personal identifiers regarding injured individuals, health care practitioners, and employers that are not essential for the accomplishment of the approved research purpose, and;

(F) That the recipient of records for scientific research purposes:

(1) Establishes strict limitations acceptable to the Department concerning the receipt and use of any patient-identifiable data;

(2) Establishes reasonable administrative, technical, and physical safeguards and/or protocols acceptable to the Department to protect the confidentiality of the data and to prevent the unauthorized use or disclosure of the record;

(3) Removes or destroys the information that identifies an individual at the earliest time that removal or destruction can be accomplished consistent with the purpose of the research project;

(4) Makes no further use or disclosure of the record, except when required by law; and

(5) Provides a written statement (approved by the agency) attesting to the recipient's understanding of, and agreement to abide by, these conditions of disclosure and that violation of these provisions is subject to penalties set forth under 5 U.S.C. 552a(i)(3) and any other applicable federal law.

4. Records may be disclosed to DOJ or to a court or other tribunal when: (a) HHS or any of its components; or (b) any employee of HHS acting in the employee's official capacity; or (c) any employee of HHS acting in the employee's individual capacity where the DOJ or HHS has agreed to represent the employee; or (d) the United States Government, is a party to a proceeding or has an interest in such proceeding and the disclosure of such records is deemed by the agency to be relevant and necessary to the proceeding. For example:

a. HRSA will release the petitioner's complete medical file and may release a consultant(s)' report to the DOJ and the court for adjudication of a VICP compensation claim.

5. Disclosures may be made to a congressional office from the record of an individual, in response to a written inquiry from the congressional office made at the written request of the individual or his/her legal or personal representative.

6. Where a record, either alone or in combination with other information, indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature, and whether arising by general statute or particular program statute or by regulation, rule, or order issued pursuant thereto, the relevant records may be referred to the appropriate agency, whether federal, state, local, tribal, territorial, or foreign, charged with the responsibility of investigating or prosecuting such violation, or charged with enforcing or implementing the statute, rule, regulation, or order issued pursuant thereto.

7. Records may be disclosed to appropriate agencies, entities, and persons when (1) HHS suspects or has confirmed that there has been a breach of the system of records, (2) HHS has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, HHS (including its information systems, programs, and operations), the federal government, or national security, and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with HHS's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.

8. Records may be disclosed to another federal agency or federal entity, when HHS determines that information from this system of records is reasonably necessary to assist the recipient agency or entity in: (1) Responding to a suspected or confirmed breach or (2) preventing, minimizing, or remedying the risk of harm to individuals, the recipient agency or entity (including its information systems, programs, and operations), the federal government, or national security, resulting from a suspected or confirmed breach.

9. To the extent necessary, a record may be disclosed for the purpose of ensuring that a government reversionary trust or government-owned annuity established in connection with a program award or benefit is being properly administered. Such disclosures may be made to institutions serving as trustees and medical administrators concerning such trusts, to insurance companies administering such government-owned annuities, to individuals serving as guardians of the estate of individuals compensated by the program, and to attorneys representing such parties (or representing local, state, tribal, territorial, foreign and the federal government). Organizations or individuals to which information is disclosed for this use will be required to maintain Privacy Act safeguards concerning such records. Records may also be disclosed for the same purpose to courts of competent jurisdiction in which trust administration or government-owned annuity issues arising out of program claims are raised.

10. Consistent with its obligation under the Vaccine Act, HRSA will disclose for publication in the **Federal Register** the following information from VICP records: The name of the petitioner; the name of the person vaccinated, if not the petitioner; the city and State where the vaccine was administered (if unknown, then the city and state of the person or attorney filing the claim); and the court's docket number.

11. VICP records may be disclosed to organizations deemed qualified by the Secretary of Health and Human Services (Secretary) for the purpose of evaluating the administration, process, or outcomes of the VICP (as required by Congress). The purpose of the disclosure is to document the extent to which the VICP is satisfying the goals and objectives of its authorizing legislation, *i.e.,* maintaining a system for compensating those who have been injured by a vaccine that is fair and expeditious. Organizations to which information is disclosed for this use shall be required to maintain Privacy Act safeguards concerning such records.

12. To the extent necessary, VICP records may be disclosed to annuity brokers, reversionary trust banks/trustees, and to employees of life insurance companies to obtain financial advice and for the purchase of contracts to provide compensation to eligible petitioners under the Program. Organizations to which information is disclosed for this use will be required to maintain Privacy Act safeguards concerning such records and return all records to HRSA without retaining any copies.

13. Disclosure of records may be made to individuals and/or entities as necessary for the purposes of obtaining financial advice and providing benefits to requesters approved for payment under the CICP. All individuals and/or entities permitted disclosure for this use shall be required to maintain Privacy Act safeguards with respect to such records and return all records to HRSA without retaining any copies.

The disclosures authorized by publication of the above routine uses pursuant to 5 U.S.C. 552a(b)(3) are in addition to other disclosures authorized directly in the Privacy Act at 5 U.S.C. 552a(b)(4)–(11).

POLICIES AND PRACTICES FOR STORAGE OF RECORDS:

Records are stored in the Injury Compensation System (ICS), portable electronic media storage, and paper file folders.

POLICIES AND PRACTICES FOR RETRIEVAL OF RECORDS:

- *VICP:* Records are retrieved by the name of the petitioner and/or the name of the individual vaccinated.
- *CICP:* Records are retrieved by the name of the requester and/or the individual who was administered or used a countermeasure.

POLICIES AND PRACTICES FOR RETENTION AND DISPOSAL OF RECORDS:

Records are disposed of 25 years after the case file is closed, in accordance with records disposition schedule N1–512–96–1.

ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS:

1. *Authorized users:* Access is limited to the System Manager, authorized HRSA/HSB personnel responsible for administering these programs, and authorized HHS Office of the General Counsel personnel responsible for advising these programs. HRSA/HSB maintains a current list of authorized users.

2. *Physical safeguards:* All hard copy files are stored in filing cabinets which are kept in locked and secured rooms during non-work hours; portable electronic storage and computer equipment are retained in areas where fire and safety codes are strictly enforced. All electronic and hard copy documents are protected on a 24-hour basis in security areas. Security guards perform random checks of the physical security of the record storage area.

3. *Procedural safeguards:* HRSA/HSB has established stringent safeguards in line with the sensitivity of the records. These include: Transmitting records to consultants by Federal Express, United Parcel Service, or another courier service to ensure that a signature is required upon receipt of the records; escorting visitors into areas where records are maintained; utilizing two-

factor authentication for computer access; and securing areas where records are stored. Job-specific assigned roles control the release of data only to authorized users. All users of personal information in connection with the performance of their jobs protect information from public view and unauthorized personnel entering an unsupervised office.

4. *Risk assessment:* Risk assessments and continuous monitoring activities ensure that vulnerabilities, risks, and other security concerns are identified and addressed in the system design and throughout the life cycle of the project.

RECORD ACCESS PROCEDURES:

Record access procedures are the same as Requests in Person procedures below.

CONTESTING RECORD PROCEDURES:

To contest a record in the system, contact the System Manager at the address specified above and reasonably identify the record, stipulate the information being contested, state the corrective action sought and the reason(s) for requesting the correction, along with supporting documentation to show how the record is inaccurate, incomplete, untimely, or irrelevant.

NOTIFICATION PROCEDURES:

Requests must be made to the System Manager.

Requests by mail: Requests for information and/or access to records received by mail must contain information providing the identity of the writer, and a reasonable description of the record desired, and who it concerns. Written requests must contain the name and address of the requester, his/her date of birth and his/her signature for comparison purposes. Requests must be notarized to verify the identity of the requester, or the requester must certify that (s)he is the individual who (s)he claims to be and that (s)he understands that to knowingly and willfully request or acquire a record pertaining to another individual under false pretenses is a criminal offense under the Privacy Act subject to a $5,000 fine. The requester should provide a reasonable description of the contents of the record being sought. Records will be mailed only to the requester's address that is on file unless a different address is demonstrated by official documentation.

Requests in person: An individual who makes a request in person shall provide to the System Manager at least one piece of tangible identification such as a driver's license, passport, alien or voter registration card, or union card to verify his/her identity. If an individual does not have identification papers to verify identity, (s)he must certify in writing that (s)he is the individual (s)he claims to be and that (s)he understands that the knowing and willful request for, or acquisition of, a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

Requests on behalf of a minor/legally incompetent person: A parent or guardian who makes a request on behalf of a minor/legally incompetent person must verify his/her relationship to the minor/legally incompetent person as well as his/her own identity. If requesting a minor or legally incompetent person's medical records, the parent or guardian of a minor/legally incompetent person must designate a family physician or other health professional (other than a family member) to whom the records, if any, will be sent.

Requests by telephone/facsimile/electronic mail: Since positive identification of the requester cannot be established, telephone, facsimile, or electronic mail (email) requests will not be honored.

EXEMPTIONS PROMULGATED FOR THE SYSTEM:

None.

HISTORY:

75 FR 60468 (Sept. 30, 2010), 83 FR 6591 (Feb. 14, 2018).

Notice of Rescindment

For the reason explained in the **SUPPLEMENTARY INFORMATION** section at II., the following system of records is rescinded:

SYSTEM NAME AND NUMBER:

Countermeasures Injury Compensation Program, HHS/HRSA/HSB, 09–15–0071.

HISTORY:

76 FR 28991 (May 19, 2011), 83 FR 6591 (Feb. 14, 2018).

[FR Doc. 2019–13091 Filed 6–19–19; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Biomedical Imaging and Bioengineering; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Institute of Biomedical Imaging and Bioengineering Special Emphasis Panel.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Biomedical Imaging and Bioengineering Special Emphasis Panel; Career Development (Ks), Conference (R13) and Research Education (R25) Applicants Review.

Date: July 18, 2019.

Time: 9:30 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, Suite 920, 6707 Democracy Boulevard, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: John P. Holden, Ph.D., Scientific Review Officer, National Institute of Biomedical Imaging and Bioengineering, National Institutes of Health, 6707 Democracy Boulevard, Suite 920, Bethesda, MD 20892, 301–496–8775, *john.holden@nih.gov.*

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13062 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Arthritis and Musculoskeletal and Skin Diseases; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel; BACPAC U24 Review.

Date: July 18, 2019.
Time: 8:00 a.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, One Democracy Plaza, 6701 Democracy Boulevard, Bethesda, MD 20892.
Contact Person: Kan Ma, Ph.D., Scientific Review Officer, Scientific Review Branch, National Institute of Arthritis, Musculoskeletal and Skin Diseases, NIH, 6701 Democracy Boulevard, Suite 814, Bethesda, MD 20892, 301–451–4838, *mak2@mail.nih.gov.*

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

(Catalogue of Federal Domestic Assistance Program Nos. 93.846, Arthritis, Musculoskeletal and Skin Diseases Research, National Institutes of Health, HHS)

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13065 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Biomedical Imaging and Bioengineering; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Institute of Biomedical Imaging and Bioengineering Special Emphasis Panel.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Biomedical Imaging and Bioengineering Special Emphasis Panel; P41 BTRC Review B SEP.
Date: July 8–10, 2019.
Time: 6:00 p.m. to 1:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Sheraton Imperial Hotel Raleigh-Durham Airport, 4700 Emperor Blvd., Durham, NC 27703.
Contact Person: Ruixia Zhou, Ph.D., Scientific Review Officer, 6707 Democracy Boulevard, Democracy Two Building, National Institutes of Health, Suite 957, Bethesda, MD 20892, 301–496–4773, *zhour@mail.nih.gov.*

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13064 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Deafness and Other Communication Disorders; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Deafness and Other Communication Disorders Special Emphasis Panel; Clinical Research Center Review.
Date: July 9, 2019.
Time: 1:00 p.m. to 4:00 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, Neuroscience Center Building (NSC), 6001 Executive Boulevard, Rockville, MD 20852 (Telephone Conference Call).
Contact Person: Eliane Lazar-Wesley, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, 6001 Executive Boulevard, Room 8339, MSC 9670, Bethesda, MD 20892–8401, 301–496–8683, *el6r@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.173, Biological Research Related to Deafness and Communicative Disorders, National Institutes of Health, HHS)

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13063 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: Mechanisms of Disparities in Chronic Liver Diseases and Cancer.
Date: July 9, 2019.
Time: 10:00 a.m. to 4:00 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).
Contact Person: Delia Olufokunbi Sam, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3158, MSC 7770, Bethesda, MD 20892, 301–435–0684, *olufokunbisamd@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Panel Name: Molecular and Cellular Causal Aspects of Alzheimer's Disease.
Date: July 10, 2019.
Time: 10:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).
Contact Person: Afia Sultana, Ph.D., Scientific Review Officer, National Institutes of Health, Center for Scientific Review, 6701 Rockledge Drive, Room 4189, Bethesda, MD 20892, (301) 827–7083, *sultanaa@mail.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Cardiovascular Small Business.
Date: July 11, 2019.
Time: 8:00 a.m. to 7:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Wyndham Grand Chicago Riverfront, 71 E Wacker Dr., Chicago, IL 60601.
Contact Person: Margaret Chandler, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4126,

MSC 7814, Bethesda, MD 20892, (301) 435–1743, *margaret.chandler@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Cardiometabolic, Kidney and Behavioral Health Epidemiology.

Date: July 15, 2019.

Time: 2:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Suzanne Ryan, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3139, MSC 7770, Bethesda, MD 20892, (301) 435–1712, *ryansj@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13061 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Human Genome Research Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the Center for Inherited Disease Research Access Committee.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Inherited Disease Research Access Committee.

Date: July 19, 2019.

Time: 11:30 a.m. to 1:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, NHGRI, 6700B Rockledge Drive, Room 3185, Bethesda, MD 20817 (Telephone Conference Call).

Contact Person: Barbara J. Thomas, Ph.D., Scientific Review Officer, Scientific Review Branch, National Human Genome Research Institute, National Institutes of Health, 5635 Fishers Lane, Ste. 4076, MSC 9306, Bethesda, MD 20892–9306, 301–402–0838, *barbara.thomas@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.172, Human Genome Research, National Institutes of Health, HHS)

Dated: June 14, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–13060 Filed 6–19–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Transportation Security Administration

Intent To Request Revision From OMB of One Current Public Collection of Information: TSA infoBoards

AGENCY: Transportation Security Administration, DHS.

ACTION: 60-Day notice.

SUMMARY: The Transportation Security Administration (TSA) invites public comment on one currently approved Information Collection Request (ICR), Office of Management and Budget (OMB) control number 1652–0065, abstracted below that we will submit to OMB for a revision in compliance with the Paperwork Reduction Act (PRA). The ICR describes the nature of the information collection and its expected burden. TSA infoBoards (formerly WebBoards) are an information-sharing environment designed to serve stakeholders in the transportation security community and are used to disseminate mission-critical information. It provides stakeholders with an online portal, which allows authorized users to obtain, post, and exchange information, access common resources, and communicate with similarly situated individuals. Utilizing and inputting information into TSA infoBoards is completely voluntary.

DATES: Send your comments by August 19, 2019.

ADDRESSES: Comments may be emailed to *TSAPRA@tsa.dhs.gov* or delivered to the TSA PRA Officer, Information Technology (IT), TSA–11, Transportation Security Administration, 601 South 12th Street, Arlington, VA 20598–6011.

FOR FURTHER INFORMATION CONTACT: Christina A. Walsh at the above address, or by telephone (571) 227–2062.

SUPPLEMENTARY INFORMATION:

Comments Invited

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The ICR documentation is available at *www.reginfo.gov* upon its submission to OMB. Therefore, in preparation for OMB review and approval of the following information collection, TSA is soliciting comments to—

(1) Evaluate whether the proposed information requirement is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including using appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Consistent with the requirements of Executive Order (E.O.) 13771, Reducing Regulation and Controlling Regulatory Costs, and E.O. 13777, Enforcing the Regulatory Reform Agenda, TSA is also requesting comments on the extent to which this request for information could be modified to reduce the burden on respondents.

Information Collection Requirement

Purpose of Data Collection

TSA infoBoards were developed by TSA as part of its broad responsibilities and authorities under the Aviation and Transportation Security Act (ATSA), and delegated authority from the Secretary of Homeland Security, for ''security in all modes of transportation . . . including security responsibilities . . . over modes of transportation that are exercised by the Department of Transportation.'' [1]

The TSA infoBoards are a data management system that provides coordination and collaboration with

[1] *See* Public Law 107–71 (115 Stat. 597, Nov. 19, 2001), codified at 49 U.S.C. 114(d). The TSA Assistant Secretary's current authorities under ATSA have been delegated to him by the Secretary of Homeland Security. Section 403(2) of the Homeland Security Act (HSA) of 2002, Public Law 107–296 (116 Stat. 2315, Nov. 25, 2002), transferred all functions of TSA, including those of the Secretary of Transportation and the Under Secretary of Transportation of Security related to TSA, to the Secretary of Homeland Security. Pursuant to DHS Delegation Number 7060.2, the Secretary delegated to the Assistant Secretary (then referred to as the Administrator of TSA), subject to the Secretary's guidance and control, the authority vested in the Secretary with respect to TSA, including that in section 403(2) of the HSA.

parties that have a relevant interest in transportation security and an appropriate level of need to access transportation security information–such as, regulated parties and other industry stakeholders, Federal agencies, and state and local governments. This system also integrates other security-related information and communications at the sensitive security information (SSI) level. It is located in a secure online environment and is accessible from the Homeland Security Information Network (HSIN) and TSA (for TSA staff only). It disseminates mission-critical information to users inside and outside of the TSA organization. It provides an online portal allowing authorized users to obtain, post, and exchange information, access common resources, and communicate with similarly situated individuals.

TSA infoBoards are primarily used for disseminating TSA mission-critical information, such as Security Directives (SD), compliance status, policy updates, and watchlists; however, some groups of stakeholders utilize infoBoards for collaboration and to upload transportation security information. InfoBoards allow stakeholders to filter alerts and information based on their particular needs, such as their regulated areas of operation or their treaty relationship for foreign government staff.

TSA intends TSA infoBoards to be used primarily by individuals with transportation security responsibilities, such as aircraft operators, airport security coordinators, and international transportation security coordinators. These individuals can voluntarily contact TSA to request access to TSA infoBoards; TSA does not require participation in TSA infoBoards.

Description of Data Collection

TSA will collect two types of information through TSA infoBoards, as described below. The collection is voluntary. TSA infoBoards users are not required to provide all information requested, but users who choose to withhold information may not receive the benefits of TSA infoBoards associated with that information collection.

1. *User registration information.* TSA will collect this information to ensure only those members of the transportation community with a relevant interest in transportation security and with an appropriate level of need to access transportation security information can be allowed onto TSA infoBoards. Such registration information will include the user's name, professional contact information, agency/company, job title, employer, airport (optional), citizenship, regulatory interest, and employment verification contact information.

2. *User's choice of infoBoards.* TSA will collect this information to select TSA infoBoards community(ies) appropriate for the particular user. Users are asked to submit their transportation security interest(s) and desired infoBoard(s) (to assess the user's qualifications and needs together with the user registration information).

Use of Results

Using feedback from the infoBoards community, TSA is revising the collection instrument, TSA Form 1427, TSA infoBoards User Account Request/Renewal. The form will now reference an additional instrument, TSA Form 1430, Computer Access Agreement (CAA) External Personnel Only. This form is intended for the public, non-Department and TSA infoBoards users, and certifies understanding and acceptance of applicable policy and legal requirements concerning access to network resources within DHS/TSA. TSA also corrected typographical errors in TSA Form 1427.

Based on data observed since the previous approval, TSA estimates that there will be approximately 5,000 public users annually. Given this information, the total annual hour burden for this information collection for all respondents is estimated to be approximately 10,000 hours.

Dated: June 17, 2019.

Christina A. Walsh,

TSA Paperwork Reduction Act Officer, Information Technology.

[FR Doc. 2019–13145 Filed 6–19–19; 8:45 am]

BILLING CODE 9110–05–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–6169–N–01]

Updates to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This notice describes the requirements to prevent duplication of benefits applicable to Community Development Block Grant disaster recovery (CDBG–DR) grants received in response to a disaster declared between 2015 and 2021. It updates existing duplication of benefits requirements to reflect recent CDBG–DR supplemental appropriations acts and amendments to the Robert T. Stafford Disaster Relief and Emergency Assistance Act impacting certain grantees. The notice also includes minor clarifications regarding the duplication of benefits calculation.

DATES: *Applicability Date:* June 25, 2019.

FOR FURTHER INFORMATION CONTACT: Claudette Fernandez, Director, Office of Block Grant Assistance, Department of Housing and Urban Development, 451 7th Street SW, Room 10166, Washington, DC 20410, telephone number 202–708–5287. Persons with hearing or speech impairments may access this number via TTY by calling the Federal Relay Service at 800–877–8339. Facsimile inquiries may be sent to Ms. Fernandez at 202–708–0033. (Except for the ''800'' number, these telephone numbers are not toll-free). Email inquiries may be sent to *disaster_recovery@hud.gov.*

SUPPLEMENTARY INFORMATION:

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I. Introduction

Community Development Block Grant disaster recovery (CDBG–DR) grants are one of multiple Federal sources which assist disaster recovery. These sources of Federal assistance often can be used for the same purposes by grantees and disaster survivors. For this reason, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121–5207) (Stafford Act) and CDBG–DR appropriations acts require HUD and its grantees to coordinate with other Federal agencies that provide disaster assistance to prevent the duplication of benefits (DOB). The Stafford Act's prohibition on DOB aims to ensure that federal assistance serves only to ''supplement insurance and other forms of disaster assistance.'' (42 U.S.C. 5170).

CDBG–DR grantees must prevent DOB when carrying out eligible activities. A duplication occurs when a person, household, business, or other entity receives disaster assistance from multiple sources for the same recovery purpose, and the total assistance received for that purpose is more than the total need. The amount of the DOB is the amount received in excess of the total need for the same purpose. When total need for eligible activities is more than total assistance for the same purpose, the difference between these amounts is an ''unmet need.'' Grantees must limit their assistance to unmet needs for eligible activities to prevent a DOB. When reimbursement is permitted by the CDBG–DR grant requirements, unmet needs can include amounts needed for reimbursement.

This notice has been developed in consultation with the Federal Emergency Management Agency (FEMA) and the Small Business Administration (SBA), which provide the most common forms of Federal disaster assistance to homeowners and businesses. As the agency that administers the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121–5207) (Stafford Act), HUD looks to FEMA to ensure uniformity in the prevention of DOB across Federal agencies that provide disaster assistance.

This notice implements a provision of the Disaster Recovery Reform Act of 2018 (DRRA) (division D of Pub. L. 115–254) that changes the treatment of loans under the Stafford Act for disasters declared between January 1, 2016 and December 31, 2021, so that when certain conditions are met, the loans are no longer a DOB. This notice also responds to pending requests from grantees to authorize the use of CDBG–DR funds to reimburse homeowners and businesses for the costs of eligible activities paid with subsidized loans provided by the U.S. Small Business Administration (SBA) or other sources.

The DRRA amendment did not directly address the use of CDBG–DR funds to reimburse costs paid with subsidized loans. However, the corollary request from grantees to permit reimbursement presents a range of policy and fiscal implications. CDBG–DR funds are provided for long-term disaster recovery to assist activities under title I of the Housing and Community Development Act of 1974. The primary objective of title I is the development of viable communities by the provision of decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income. In authorizing the use of CDBG–DR funds for the reimbursement of costs paid with subsidized loans, the Department must ensure that a grantee's CDBG–DR resources will remain available principally to benefit low- and moderate-income persons, a group that often has difficulty qualifying for subsidized loan assistance. The Department notes that many CDBG–DR grantees face challenges in meeting this requirement. The Department recognizes, however, that CDBG–DR funds are provided as a federal block grant to States and local governments with an understanding that these grantees are best positioned to address the long-term disaster recovery needs of their communities by working within the requirements of the CDBG program, including the overall low- and moderate-income benefit requirement and the requirement that the use of all funds meet a national objective.

Further, in determining the amount of CDBG–DR funding provided to a grantee, one of the key factors for HUD is an estimate of severe unmet housing need. This estimation deducts out SBA loan proceeds in a manner that is unaffected by the DRRA amendment. As a result, any CDBG–DR funds directed to reimburse eligible costs paid with subsidized loans are funds that are not directed to severe unmet housing needs or economic revitalization needs as estimated by HUD.

This notice incorporates a range of safeguards to ensure that CDBG–DR funds are used for reimbursement of eligible costs of meeting the housing rehabilitation needs or economic revitalization needs of applicants that applied for, were approved for, and borrowed SBA loans funds. The Department, in consultation with partner Federal agencies, has developed these safeguards to promote a responsible approach to requests to use CDBG–DR funds to reimburse for eligible recovery costs originally paid with subsidized loan funds.

Accordingly, the Department has structured this notice and the companion **Federal Register** notice governing its implementation to: (i) Require CDBG–DR grantees to fully inform the public of the proposed use of CDBG–DR funds for reimbursement of costs paid with subsidized loans through its citizen participation process and through an amendment to the grantee's action plan; (ii) to preserve the primary mission of CDBG–DR funds to assist low- and moderate-income persons by maintaining a grantee's requirement to use its CDBG–DR funds principally to benefit low- and moderate-income persons; and (iii) to provide the Department with a means of evaluating the impact of this policy on the recovery of low- and moderate-income persons if it is used for DRRA Qualifying Disasters.

II. Applicability

This notice describes DOB requirements for CDBG–DR grants received in response to a disaster declared between January 1, 2015 and December 31, 2021. It includes information about preventing and collecting a DOB. The requirements of this notice will apply once it is made applicable to a grant by a **Federal Register** notice or grant agreement. This notice reflects the requirements of recent CDBG–DR supplemental appropriations acts and amendments to the Stafford Act, which impact DOB for certain grantees.

This notice does not change the DOB requirements applicable to grantees receiving awards in response to disasters declared before 2015.[1]

This notice does not apply to grants under the State CDBG program, the Entitlement CDBG program, Insular Areas CDBG program, or the HUD

[1] This notice does not amend the **Federal Register** notice requirements applicable to grantees that received funds under the Disaster Relief Appropriations Act, 2013 (Pub. L. 113–2) for disasters declared in 2011, 2012, or 2013, including requirements related to the July 25, 2013 memorandum ''*HUD Guidance on Duplication of Benefit Requirements and Provision of CDBG–DR Assistance.*''

Administered Small Cities CDBG Program in Hawaii.

III. Applicable Law

Section 312 of the Stafford Act and CDBG–DR appropriations acts require that CDBG–DR grantees prevent DOB when administering grants. **Federal Register** notices governing CDBG–DR awards impose these DOB requirements on grantees. The ''necessary and reasonable'' cost principles in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards in subpart E of 2 CFR part 200 (the Cost Principles) similarly prohibit grantees from charging to the grant a cost paid by another source.

III.A. Stafford Act

The Stafford Act is the primary legal authority establishing the framework for the Federal government to provide disaster and emergency assistance.

Section 312 of the Stafford Act directs Federal agencies that provide disaster assistance to assure that people, businesses, or other entities do not receive financial assistance that duplicates any part of their disaster loss covered by insurance or another source (42 U.S.C. 5155(a)). That section also makes recipients of Federal disaster assistance liable for repayment of the amount of Federal disaster assistance that duplicates benefits available for the same purpose from another source (42 U.S.C. 5155(c)).

The Stafford Act also provides that when assistance covers only a part of the recipient's disaster needs, additional assistance to cover needs not met by other sources will not cause a DOB (42 U.S.C. 5155(b)(3)). CDBG–DR assistance may only pay for eligible activities to address unmet needs. This notice advises grantees on the calculation of unmet needs through a duplication of benefits analysis.

On October 5, 2018, the DOB provision in section 312 of the Stafford Act was amended by section 1210 of the DRRA. This notice describes corresponding changes in HUD's policies and grant requirements. Those changes are discussed in detail in section V.B.2. and V.B.3. of this notice.

*III.B. CDBG–DR Appropriations Acts and **Federal Register** Notices*

CDBG–DR funds are made available for ''necessary expenses'' by appropriations acts that contain statutory requirements on the use of the grant funds.[2] HUD allocates funds and publishes grant requirements in **Federal Register** notices. Grantees are subject to the requirements of the appropriations acts and the **Federal Register** notices.

Since 2013, as a condition of making any CDBG–DR grant, the Secretary must certify that the grantee has established adequate procedures to prevent DOB. Grantees subject to this requirement must submit DOB policies to HUD for review before HUD signs the grant agreement. ''Adequate'' procedures meet the standards HUD publishes in a **Federal Register** notice and related checklists that are available online. They require grantees to establish DOB policies that incorporate certain steps before committing or awarding assistance. Typically, the steps include determining a total need, verifying total assistance available from all sources of disaster assistance (using recent data available from FEMA, SBA, and other sources), excluding non-duplicative assistance from total assistance to calculate DOB, reducing the total award by the amount of the DOB, and obtaining an agreement from applicants to repay duplicative assistance.

The **Federal Register** notices that identify CDBG–DR grant requirements also require CDBG–DR grantees to consider projected sources of disaster assistance in the needs assessment that is part of an action plan for disaster recovery. Consideration of other potential sources of assistance when planning for the use of grant funds helps to limit the possibility of duplication between CDBG–DR and other assistance.

III.C. Necessary and Reasonable Requirements

The Cost Principles applicable to all CDBG–DR grantees and their subrecipients require that costs are necessary and reasonable. The Cost Principles are made applicable to States by 24 CFR 570.489(p) and to local governments through 24 CFR 570.502. State grantees are also subject to 24 CFR 570.489(d), which requires that states shall have fiscal and administrative requirements to ensure that grant funds are used ''for reasonable and necessary costs of operating programs.''

Under the Cost Principles, a cost assigned to a grant ''is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost'' (2 CFR 200.404).

Grantees must consider factors described at 2 CFR 200.404(a) through (e) when determining which types and amounts of cost items are necessary and reasonable. Based on these factors, HUD generally presumes that if a cost has been paid by another source, charging it to the Federal award violates the necessary and reasonable standard unless grant requirements permit reimbursement.

IV. Basic Duplication of Benefits Calculation Framework

The Stafford Act requires a fact specific inquiry into assistance received by each applicant. This notice refers to the subject of a DOB review as an ''applicant'' or ''CDBG–DR applicant'' and uses the term ''applicant'' to include individuals, businesses, households, or other entities that apply to the grantee or a subrecipient for CDBG–DR assistance, as well as entities that use CDBG–DR assistance for an activity without submitting an application (*e.g.,* the department or agency of the grantee administering the grant, other state or local departments or agencies, or local governments).

A grantee is prohibited from making a blanket determination that CDBG–DR assistance under one of its programs or activities does not duplicate another category or source of assistance. The grantee must conduct an individualized review of each applicant to determine that the amount of assistance will not cause a DOB by exceeding the unmet needs of that applicant. A review specific to each applicant is necessary because assistance available to each applicant varies widely based on individual insurance coverage, eligibility for various sources of assistance, and other factors.

This section establishes the primary considerations that must be part of a DOB analysis when providing CDBG–DR assistance, and a framework for analyzing need and avoiding DOB when calculating awards. CDBG–DR grantees have discretion to develop policies and procedures that tailor their DOB analyses to their own programs and activities so long as the grantee's policies and procedures are consistent with the requirements of this notice. If the **Federal Register** notices governing the CDBG–DR grant require the Secretary to certify that the grantee's DOB procedures are adequate, the grantee's procedures must meet standards HUD adopts to determine adequacy.

IV.A. Assess Applicant Need

A grantee must determine an applicant's total need. Total need is

[2] Appropriations acts, **Federal Register** notices governing the use of CDBG–DR grants, and related checklists are available online: *https://www.hudexchange.info/programs/CDBG-DR/CDBG-DR-laws-regulations-and-federal-register-notices/.*

calculated based on need estimates at a point in time; total need is the current need. However, if the grantee's action plan permits CDBG–DR assistance to reimburse costs of CDBG–DR eligible activities undertaken by the applicant before submitting an application (see section V.B.3. for a discussion of reimbursement) the total need also includes these costs. Generally, total need is calculated without regard to the grantee's program-specific caps on the amount of assistance.

For rehabilitation, reconstruction, or new construction activities, the need is relatively easy to determine from construction cost estimates.

For recovery programs of the grantee that do not entail physical rebuilding, such as special economic development activities to provide an affected business with working capital, the total need will be determined by the requirements or parameters of the program or activity. For special economic development activities, total need should be guided by standard underwriting guidelines (some CDBG–DR grants require grantees and subrecipients to comply with the underwriting guidelines in Appendix A to 24 CFR part 570 when assisting a for-profit entity as part of a special economic development project).

The grantee's assessment of total need must consider in-kind donations of materials or services that are known to the grantee at the time it calculates need and makes the award. In-kind donations are non-cash contributions, such as donations of professional services, use of construction equipment, or contributions of building materials. In-kind donations are not ''financial assistance'' that creates a DOB under the Stafford Act, but they do reduce the amount of CDBG–DR assistance for unmet need because the donated goods or services reduce activity costs.

IV.B. Identify Total Assistance

To calculate DOB, grantees are required to identify ''total assistance.'' For this notice, total assistance includes all reasonably identifiable financial assistance available to an applicant.

IV.B.1. Types of Resources Included in Total Assistance

Total assistance includes resources such as cash awards, insurance proceeds, grants, and loans received by or available to each CDBG–DR applicant, including awards under local, state or federal programs, and from private or nonprofit charity organizations. At a minimum, the grantee's efforts to identify total assistance must include a review to determine whether the applicant received FEMA, SBA, insurance, and any other major forms of assistance (*e.g.,* State disaster assistance programs) generally available to applicants.

Total assistance does not include personal assets such as money in a checking or savings account (excluding insurance proceeds or disaster assistance deposited into the applicant's account); retirement accounts; credit cards and lines of credit; in-kind donations (although these non-cash contributions known to the grantee reduce total need); and private loans.

For this notice, a private loan is a loan that is not provided by or guaranteed by a governmental entity, and that requires the CDBG–DR applicant (the borrower) to repay the full amount of the loan (principal and interest) under typical commercial lending terms, *e.g.,* the loan is not forgivable. For DOB calculations, private loans are not financial assistance and need not be considered in the DOB calculation, regardless of whether the borrower is a person or entity.

By contrast, subsidized loans for the same purpose are to be included in the DOB calculation unless an exception applies (see discussion below in section V.B.2.).

IV.B.2. Availability of Resources Included in Total Assistance

Total assistance includes available assistance. Assistance is available if an applicant: (1) Would have received it by acting in a reasonable manner, or in other words, by taking the same practical steps toward funding recovery as would disaster survivors faced with the same situation but not eligible to receive CDBG–DR assistance; or (2) has received the assistance and has legal control over it. Available assistance includes reasonably anticipated assistance that has been awarded and accepted but has not yet been received. For example, if a local government seeks CDBG–DR assistance to fund part of a project that also has been awarded FEMA Hazard Mitigation Grant Program (HMGP) assistance, the entire HMGP award must be included in the calculation of total assistance even if FEMA obligates the first award increment for the project, but subsequent increments remain unfunded until certain project milestones are met.

Applicants for CDBG–DR assistance are expected to seek insurance or other assistance to which they are legally entitled under existing policies and contracts, and to behave reasonably when negotiating payments to which they may be entitled. For example, it may be reasonable for an applicant to elect to receive an immediate lump sum insurance settlement based on estimated cost of rehabilitation instead of waiting for a longer period of time for the insurance company to calculate reimbursement based on actual replacement costs, even if the reimbursement based on actual costs would exceed the lump sum insurance settlement.

HUD generally considers assistance to be available if it is awarded to the applicant but is administered by another party instead of being directly deposited with the applicant. For example, if an entity administering homeowner rehabilitation assistance pays a contractor directly to complete the rehabilitation, the assistance is still considered available to the applicant.

By contrast, funds that are not available to an applicant must be excluded from the final CDBG–DR award calculation. For example, insurance or rehabilitation assistance received by a previous owner of a disaster damaged housing unit is not available to a current owner that acquired the unit by sale or transfer (including a current owner that inherited the unit as a result of the death of the previous owner) unless the current owner is a co-recipient of that assistance.

Funds are not available to an applicant if the applicant does not have legal control of the funds when they are received. For example, if a homeowner's mortgage requires insurance proceeds to be applied to reduce the unpaid mortgage principal, then the lender/mortgage holder (not the homeowner) has legal control over those funds. The homeowner is legally obligated to use insurance proceeds for the purpose of reducing the unpaid mortgage principal and does not have a choice in using them for any other purpose, such as to rehabilitate the house. Under these circumstances, insurance proceeds do not reduce CDBG–DR rehabilitation assistance eligibility.

Alternatively, if a lender requires use of insurance for rehabilitation, or a disaster-affected homeowner chooses to apply insurance proceeds received for damage to the building to reduce an unpaid mortgage principal, these insurance proceeds are treated as a DOB and reduce the amount of CDBG–DR funds the grantee may provide for rehabilitation.

IV.C. Exclude Non-Duplicative Amounts

Once a grantee has determined the total need and the total assistance, it determines which sources it must exclude as non-duplicative for the DOB calculation. Grantees must exclude amounts that are: (1) Provided for a

different purpose; or (2) provided for the same purpose (eligible activity), but for a different, allowable use (cost). Below, each of these categories is explained in greater detail.

IV.C. 1. Funds for a Different Purpose

Any assistance provided for a different purpose than the CDBG–DR eligible activity, or a general, non-specific purpose (*e.g.,* ''disaster relief/recovery'') and not used for the same purpose must be excluded from total assistance when calculating the amount of the DOB.

Insurance proceeds for damage or destruction of a building are for the same purpose as CDBG–DR assistance to rehabilitate or reconstruct that building. On the other hand, grantees may exclude, as non-duplicative, insurance provided for a different purpose (*e.g.,* insurance proceeds for loss of contents and personal property, or insurance proceeds for loss of buildings (such as a detached garage) that the grantee has determined it will not assist with CDBG–DR funds). However, a grantee may treat all insurance proceeds as duplicative if it is impractical to identify the portion of insurance proceeds that are non-duplicative because they are for a different purpose than the CDBG–DR assistance.

Similarly, CDBG–DR assistance paid to a homeowner as a housing incentive for the purpose of inducing the homeowner to sell the home to the grantee (*e.g.,* in conjunction with a buyout) are for a different purpose than funds provided for interim housing (*e.g.,* temporary assistance for rental housing during a period when a household is unable to reside in its home). In such a case, interim housing assistance may be excluded from the final DOB calculation as non-duplicative of funds paid for the housing incentive.

IV.C.2. Funds for Same Purpose, Different Allowable Use

Assistance provided for the same purpose as the CDBG–DR purpose (the CDBG–DR eligible activity) must be excluded when calculating the amount of the DOB if the applicant can document that actual specific use of the assistance was an allowable use of that assistance and was different than the use (cost) of the CDBG–DR assistance (*e.g.,* the purpose is housing rehabilitation, the use of the other assistance was roof replacement and the use of the CDBG–DR assistance is rehabilitation of the interior of the house). Grantees are advised to consult with HUD to determine what documentation is appropriate in this circumstance. As a starting point, grantees should consider whether the source of the assistance requires beneficiaries to maintain documentation of how the assistance was used.

Whether the use of the non-CDBG–DR assistance is an allowable use depends on the rules imposed by the source that provided the assistance. For example, assume that a CDBG–DR grantee is administering a homeowner rehabilitation program and an applicant to the program can document that he/she previously received and used FEMA funds for interim housing costs (*i.e.,* rent). If FEMA permitted the applicant to use its assistance for the general purpose of meeting any housing need, the CDBG–DR grantee can exclude the FEMA assistance used for interim housing as non-duplicative of the CDBG–DR assistance for rehabilitation.

If, on the other hand, FEMA limited the use of FEMA funds to housing rehabilitation, then the full amount of the FEMA assistance must be considered for the specific purpose of housing rehabilitation and cannot be excluded if the applicant used those funds for interim housing. If interim housing is not an allowable use, the amount of the FEMA housing rehabilitation assistance used for interim housing is considered a DOB. If the grantee thinks the actual use of the FEMA assistance may be allowable, the CDBG–DR grantee should contact FEMA for clarification.

Assistance provided for the purpose of housing rehabilitation, including assistance provided for temporary or minor rehabilitation, is for the same purpose as CDBG–DR rehabilitation assistance. However, the grantee can exclude assistance used for different costs of the rehabilitation, which are a different allowable use (rehabilitation costs not assisted with CDBG–DR). For example, if the other assistance is used for minor or temporary rehabilitation which enabled the applicant family to live in their home instead of moving to temporary housing until rehabilitation can be completed, the grantee can undertake remaining work necessary to complete rehabilitation. The grantee's assessment of total need at the time of application may include the costs of replacing temporary materials with permanent construction and of completing mold remediation by removing drywall installed with other assistance. These types of costs to modify partially completed rehabilitation that the grantee determines are necessary to comply with the requirements of CDBG–DR assistance do not duplicate other assistance used for the partial rehabilitation.

Grantees are encouraged to contact HUD for further guidance in cases when it is unclear whether non-CDBG–DR assistance for the same general purpose can be excluded from the DOB calculation because it was used for a different allowable use.

IV.D. Identify DOB Amount and Calculate the Total CDBG–DR Award

The total DOB is calculated by subtracting non-duplicative exclusions from total assistance. Therefore, to calculate the total maximum amount of the CDBG–DR award, the grantee must: (1) Identify total need; (2) identify total assistance; (3) subtract exclusions from total assistance to determine the amount of the DOB; and (4) subtract the amount of the DOB from the amount of the total need to determine the maximum amount of the CDBG–DR award.

Three considerations may change the maximum amount of the CDBG–DR award.

First, the grantee may impose a program cap that limits the amount of assistance an applicant is eligible to receive, which may reduce the potential CDBG–DR assistance available to the applicant.

Second, the grantee may increase the amount of an award if the applicant agrees to repay duplicative assistance it receives in the future (unless prohibited by a statutory order of assistance, as discussed in section V.C.). Section 312(b) of the Stafford Act permits a grantee to provide CDBG–DR assistance to an applicant who is or may be entitled to receive assistance that would be duplicative if: (1) The applicant has not received the other assistance at the time the CDBG–DR grantee makes its award; and (2) the applicant agrees to repay the CDBG–DR grantee for any duplicative assistance once it is received. The agreement to repay from future funds may enable a faster recovery in cases when other sources of assistance are delayed (*e.g.,* due to insurance litigation). HUD requires all grantees to enter agreements with applicants that require applicants to repay duplicative assistance before receiving CDBG–DR assistance, as discussed in section VII of this notice.

Third, the applicant's CDBG–DR award may increase if a reassessment shows that the applicant has additional unmet need, as discussed in section IV.E. of this notice.

IV.E. Reassess Unmet Need When Necessary

Although long-term recovery is a process, disaster recovery needs are calculated at points in time. As a result, a subsequent change in an applicant's

circumstances can affect that applicant's remaining unmet need, meaning the need that was not met by CDBG–DR and other sources of assistance. Oftentimes, unmet need does not become apparent until after CDBG–DR assistance has been provided. Examples may include: A subsequent disaster that causes further damage to a partially rehabilitated home or business; an increase in the cost of construction materials; vandalism; contractor fraud; or theft of materials. Unmet need may also change if other resources become available to pay for costs of the activity (such as FEMA or Army Corps), and reduce the need for CDBG–DR.

To the extent that an original disaster recovery need was not fully met or was exacerbated by factors beyond the control of the applicant, the grantee may provide additional CDBG–DR funds to meet the increased unmet need.

Grantees must be able to identify and document additional unmet need, for example, by completing a professional inspection to verify the revised estimate of costs to rehabilitate or reconstruct damaged property.

V. Special Considerations

V.A. Programmatic Considerations Related to Each Type of Assistance

The potential for DOB arises most frequently under homeowner rehabilitation programs but is not limited solely to that type of activity. The following examples do not form an exhaustive list of all CDBG–DR funded programs or activities. They are included to illustrate instances when duplicative assistance can occur when assisting other recovery activities:

1. Assistance to businesses. Many grantees carry out economic revitalization programs that provide working capital assistance to businesses. Generally, working capital assistance is calculated after assessing a business's ability to use its current assets to pay its current liabilities. The grantee's DOB analysis must consider total assistance, which includes all sources of financial assistance available to the applicant to pay a portion of liabilities that will become due. For example, a downtown business alliance might award business recovery grants from its funds to cover some of the same liabilities. Even if the downtown business alliance does not call its assistance ''working capital'' assistance, the amount the business received from the downtown business alliance to pay the same costs as the CDBG–DR funds is a DOB. Therefore, a grantee's basis for calculating CDBG–DR economic development assistance and the purposes for which the applicant can use the assistance should be clearly identified so that grantees can prevent a DOB. As discussed above, assets such as cash and cash equivalents (excluding deposits of insurance proceeds or other disaster assistance), inventories, short-term investments and securities, accounts receivable, and other assets of the business are not financial assistance, although those assets may be relevant to underwriting.

2. Assistance for infrastructure. State grantees may assist state or local government entities by providing funding to restore infrastructure (public facilities and improvements) after a disaster. CDBG–DR funds used directly by state and local governments for public facilities and improvements or other purposes are also subject to the DOB requirements of the Stafford Act. For example, a wastewater treatment facility owned by a local government may need to be rehabilitated. In this instance, total assistance, for a DOB analysis, would not only include any other federal assistance available to rehabilitate the facility, but it must also include any local funds that are available for this activity. And if local funds were previously designated or planned for the activity, but are no longer available, the grantee should document that the local government recipient does not have funds set aside for the activity in any capital improvement plan (or similar document showing planned use of funds).

3. Payments made under the Uniform Relocation Assistance and Real Property Acquisition Act (URA). Grantees may provide a displaced person (as defined under 24 CFR 570.606) with rental assistance payments under the URA. To comply with CDBG–DR DOB requirements, before issuance of rental assistance payments required by the URA, grantees must complete a DOB analysis. For example, a CDBG–DR grantee must check FEMA assistance data to determine that FEMA did not provide rental assistance payments during the same time period (under the URA or as part of a FEMA Individual Assistance Award). The URA also prohibits payments for the same ''purpose and effect'' as another payment to a displaced person (49 CFR 24.3).

V.B. Subsidized Loans

This notice updates guidance on the treatment of subsidized loans in a DOB analysis as the result of recent statutory changes. Private loans are not ''assistance'' and therefore are not a duplication (see section IV.B.1 above for a discussion of private loans).

The full amount of a subsidized loan available to the applicant for the same purpose as CDBG–DR assistance is assistance that must be included in the DOB calculation unless one of the exceptions in section V.B.2. applies, including the exception in V.B.2(iii) authorized in the DRRA amendments to section 312 of the Stafford Act (which applies to disasters occurring between January 1, 2016 and December 31, 2021, until the amendment sunsets October 5, 2023). A subsidized loan is available when it is accepted, meaning that the borrower has signed a note or other loan document that allows the lender to advance loan proceeds.

CDBG–DR grantees are reminded that CDBG–DR supplemental appropriation acts typically provide that CDBG–DR funds ''may not be used for activities reimbursable by, or for which funds are made available by, the Federal Emergency Management Agency or the Army Corps of Engineers.'' This prohibition (or similar prohibitions) in CDBG–DR appropriations acts applies to loans even if the loans would not be treated as a DOB under the exceptions in V.B.2. below.

V.B.1. Subsidized Loans

For this notice, subsidized loans (including forgivable loans) are loans other than private loans. Both SBA and FEMA provide subsidized loans for disaster recovery. Subsidized loans may also be available from other sources. Subsidized loans are assistance that must be included in the DOB analysis, unless an exception applies.

V.B.2 Exceptions When Subsidized Loans Are Not a Duplication

(i) Short-term subsidized loans for costs later reimbursed with CDBG–DR. **Federal Register** notices governing CDBG–DR grants generally permit grantees to reimburse costs of the grantee or subrecipient for eligible activities on or after the date of the disaster. If the grantee or subrecipient obtained a subsidized short-term loan to pay for eligible costs before CDBG–DR funds became available (for example, a low-interest loan from a local tax increment financing fund), the reimbursement of the costs paid by the loan does not create a duplication.

(ii) Declined or cancelled subsidized loans. The amount of a subsidized loan that is declined or cancelled is not a DOB. To exclude declined or cancelled loan amounts from the DOB calculation, the grantee must document that all or a portion of the subsidized loan is cancelled or declined unless the loan qualifies under the exclusion discussed in (iii) below.

Declined SBA Loans: Declined loan amounts are loan amounts that were approved or offered by a lender in response to a loan application, but were turned down by the applicant, meaning the applicant never signed loan documents to receive the loan proceeds. The CDBG–DR supplemental appropriation for 2017 disasters [3] provides ''the Secretary and any grantee . . . shall not take into consideration or reduce the amount provided to any applicant for assistance from the grantee where such applicant applied for and was approved, but declined assistance related to such major declared disasters that occurred in 2014, 2015, 2016, and 2017 from the Small Business Administration under section 7(b) of the Small Business Act (15 U.S.C. 636(b)).''

CDBG–DR grantees shall not treat declined subsidized loans, including declined SBA loans, as a DOB (but are not prohibited from considering declined subsidized loans for other reasons, such as underwriting). If a grantee's DOB policies and procedures treat declined loans as a DOB, the grantee must update its policies and procedures.

A grantee is only required to document declined loans if information available to the grantee (*e.g.,* the data the grantee receives from FEMA, SBA, or other sources) indicates that the applicant received an offer for subsidized loan assistance, and the grantee is unable to determine from that available information that the applicant declined the loan. If the grantee is aware that the applicant received an offer of loan assistance and cannot ascertain from available data that the applicant declined the loan, the grantee must obtain a written certification from the applicant that the applicant did not accept the subsidized loan by signing loan documents and did not receive the loan.

Cancelled Loans: Cancelled loans are loans (or portions of loans) that were initially accepted, but for a variety of reasons, all or a portion of the loan amount was not disbursed and is no longer available to the applicant. The cancelled loan amount is the amount that is no longer available. The loan cancellation may be due to default of the borrower, agreement by both parties to cancel the undisbursed portion of the loan, or expiration of the term for which the loan was available for disbursement.

The following documentation is sufficient to demonstrate that any undisbursed portion of an accepted subsidized loan is cancelled and no longer available: (a) A written communication from the lender confirming that the loan has been cancelled and undisbursed amounts are no longer available to the applicant; or (b) a legally binding agreement between the CDBG–DR grantee (or local government or subrecipient administering the CDBG–DR assistance) and the applicant that indicates that the period of availability of the loan has passed and the applicant agrees not to take actions to reinstate the loan or draw any additional undisbursed loan amounts. The documentation described above must be maintained by the grantee. Without this documentation, any approved but undisbursed portion of a subsidized loan must be included in the grantee's calculation of the total assistance amount unless another exception applies.

For cancelled SBA loans, the grantee must notify the SBA that the applicant has agreed to not take any actions to reinstate the cancelled loan or draw any additional undisbursed loan amounts.

(iii) The subsidized loan meets the requirements for a statutory exception under the DRRA's amendments to the Stafford Act. The DRRA amendments apply only to major disasters or emergencies declared between January 1, 2016, and December 31, 2021 (DRRA Qualifying Disasters). However, the DRRA also provides that the amendment sunsets (*i.e.,* the Stafford Act is amended to remove this provision) on the date that is 5 years after the date the DRRA's enactment, therefore, the exception for DRRA Qualifying disasters no longer applies after October 5, 2023. Grantees shall continue to treat loans accepted in response to disasters declared in 2015 as a duplication of benefits, unless another exception applies.

For DRRA Qualifying Disasters, FEMA has advised that a loan is not a prohibited duplication of benefits under section 312(b)(4)(C) of the Stafford Act, as amended by section 1210 of the DRRA, provided that all Federal assistance is used toward a loss suffered as a result of a major disaster or emergency.[4]

a. Treatment of Disbursed Loans That Meet the Statutory Exception Under the DRRA Amendments

FEMA also advised that the DRRA amendments do not automatically require or authorize repayment of existing loan amounts. Instead, FEMA advised ''whether particular federal grant funds are available for the purpose of paying down a loan provided for disaster losses is a determination reserved for the grant awarding agency, pursuant to its statutory program authorities and appropriations.'' HUD requirements on the reimbursement of costs paid with subsidized loans is provided in section V.B.3, below.

b. Treatment of Undisbursed Loans That Meet the Statutory Exception Under the DRRA Amendments

For subsidized loans made in response to DRRA Qualifying Disasters, accepted but undisbursed loan amounts (*e.g.,* accepted but undisbursed SBA loan amounts) are not considered a DOB. Grantees that received a CDBG–DR grant in response to a DRRA Qualifying Disaster may revise awards to applicants with undisbursed subsidized loan assistance from SBA or other sources to provide additional CDBG–DR assistance. The amount of additional CDBG–DR assistance must be based on a revised DOB analysis that excludes accepted but undisbursed loan amounts from total assistance when calculating the maximum CDBG–DR award. If the grantee provides additional CDBG–DR assistance, the grantee must notify the lender and must obtain a written agreement from the applicant that the applicant will not make additional draws from the subsidized loan without the grantee's approval. The grantee must review and approve any subsequent draws to determine whether all Federal assistance is used toward a loss suffered as a result of a major disaster or emergency, as required by the DRRA.

If providing additional assistance in the amount of undisbursed loans would be inconsistent with the grantee's approved CDBG–DR action plan, the grantee must amend its action plan.

V.B.3 Use of CDBG–DR for Reimbursement of Costs Paid by Subsidized Loans Following DRRA Qualifying Disasters

As a general rule, CDBG–DR grant funds are available only to pay for new activities. However, most **Federal Register** notices governing CDBG–DR grants permit payment of costs dating back to the date of the disaster that led to the CDBG–DR grant award. These **Federal Register** notices require grantees to adhere to reimbursement requirements previously established by HUD when reimbursing applicants'

[3] Further Additional Supplemental Appropriations for Disaster Relief Requirements Act, 2018 (Pub. L. 115–123, approved February 9, 2018).

[4] *https://www.fema.gov/media-library-data/1551126628749-68761acce84dda93f590eb91676ce63e/Section_1210_FactSheet_Final_Draft_2019.pdf.*

costs.[5] Reimbursement is not permitted if payment of the cost with CDBG–DR funds will cause a DOB because an exception does not apply or violate the requirement that CDBG–DR funds shall not be used for activities reimbursable by, or for which funds are made available by, FEMA or the Army Corps of Engineers.

This notice establishes a new policy for grantees that received CDBG–DR grants made in response to DRRA Qualifying Disasters. Subject to conditions of this notice, grantees that received CDBG–DR grants in response to DRRA Qualifying Disasters may grant CDBG–DR funds to reimburse individuals and businesses (other than the grantee or subrecipients) for some costs of CDBG–DR eligible activities that were paid with subsidized loans. The conditions for payment of these costs are:

(i) The grantee must document in the applicant's file that all federal assistance (including CDBG–DR and subsidized loan assistance) is used toward a loss suffered as a result of the major disaster or emergency. If the subsidized loan is used to carry out a CDBG–DR eligible activity that addresses a loss suffered as a result of a major disaster or emergency, HUD considers reimbursement of eligible costs paid with that loan to be used toward a loss suffered as a result of the major disaster or emergency. Under the terms of the DRRA amendments to the Stafford Act, if a federal loan is used for a purpose other than disaster losses, the subsidized loan still duplicates other sources provided for the same purpose.

(ii) The grantee must meet all grant requirements for reimbursement of costs, which are imposed by **Federal Register** notices that govern CDBG–DR grants.

(iii) If the grantee has already received the application and completed an initial DOB analysis, the grantee must complete a revised DOB analysis that updates the applicant's unmet needs and assistance from all sources, and excludes subsidized loans used for disaster losses and other nonduplicative assistance from the total assistance to calculate the revised DOB amount.

(iv) The grantee must document that the reimbursed cost was for an activity that was a CDBG–DR eligible activity on the effective date of this notice, such as housing rehabilitation costs paid with SBA loan proceeds, or for an activity that is otherwise eligible pursuant to a waiver provided by the Department. Grantees are prohibited from reimbursing costs that are not otherwise eligible for CDBG–DR assistance, such as compensation for personal property loss or late fees. Payment of interest is not generally an eligible activity, but if permitted by an applicable **Federal Register** notice granting a waiver, grantees may pay interest due at the time of reimbursement for eligible activities (*e.g.,* interest incurred by the applicant for the portion of an SBA loan used for a CDBG–DR eligible activity).

(v) Statutes or loan documents governing subsidized loans may require the lender to receive payments that reimburse costs paid with subsidized loans. The reimbursement award to the applicant must require the applicant to comply with any requirements in the loan documents that the applicant use amounts received for reimbursement to repay the loan's outstanding principal and interest. When a grantee reimburses costs paid by SBA loans, SBA has determined that it is required to receive the payment. The grantee must notify the SBA of the reimbursement and issue a joint payment to the SBA and the applicant.

(vi) Grantees must advise applicants (either collectively or individually) that submitting an application for CDBG–DR reimbursement assistance does not relieve the applicant of a duty to make payments on a subsidized loan, and that until a subsidized loan is satisfied in full, failure to make principal and interest payments when due could result in a referral to collection agencies, reporting to credit bureaus, or other significant consequences.

(vii) The grantee must document compliance with environmental requirements at 24 CFR part 58 prior to reimbursement for a CDBG–DR eligible activity. Grantees are required to consult with the State Historic Preservation Officer, Fish and Wildlife Service and National Marine Fisheries Service, to obtain formal agreements for compliance with section 106 of the National Historic Preservation Act (54 U.S.C. 306108) and section 7 of the Endangered Species Act (16 U.S.C. 1536) when designing a reimbursement program.

(viii) CDBG–DR funds are provided principally to benefit low- and moderate-income persons. Therefore, as a condition of reimbursing costs paid with SBA loans, the grantee must submit a substantial action plan amendment to HUD describing the activity and must meet the following requirements:

a. The needs analysis in the action plan must include an updated unmet housing needs assessment to reflect the remaining total number of housing units with damage

b. The grantee's action plan must identify the number of eligible households yet to be served who have applied to the grantee's CDBG–DR housing assistance programs and identify how the grantee shall address all remaining unmet needs of its applicants for housing assistance;

c. The grantee shall reimburse costs paid with subsidized loans for all low- and moderate-income applicants before reimbursing applicants with incomes greater than 80 percent of area median income (AMI) but less than or equal to 120 percent AMI;

d. The total aggregate amount the grantee designates for reimbursement of costs paid with subsidized loans to applicants with incomes over 80 percent AMI shall not reduce the overall low- and moderate-income benefit applicable to the grant.

e. The grantee shall only grant CDBG–DR funds to reimburse costs paid with subsidized loans for applicants with incomes that exceed 120 percent of AMI when the grantee requests, and HUD approves, a hardship exception for the applicants.

Before requesting a hardship exception, the grantee must specify in its action plan the criteria it will use to define a hardship for applicants with incomes that exceed 120 percent AMI and establish a policy that provides full or partial reimbursement to alleviate the hardship. The grantee's hardship criteria must include the following elements: (1) A demonstration of the applicant's financial necessity for full or partial reimbursement of costs paid with subsidized loans; (2) a definition of financial necessity that is sufficient to distinguish between applicants with significant need for full or partial reimbursement to enable the applicant to pay for basic household or business expenses, and applicants who are not eligible for a hardship exception because they seek reimbursement for reasons other than financial necessity; and (3) a requirement that the amount of the full or partial reimbursement shall not exceed the amount needed to address the applicant's financial necessity. The grantee must also develop policies and procedures that

[5] The most recent CPD notice made applicable by **Federal Register** notices governing CDBG–DR grants is CPD Notice 2015–07, ''Guidance for Charging Pre-Application Costs of Homeowners, Businesses, and Other Qualifying Entities to CDBG Disaster Recovery Grants'' (*https://files.hudexchange.info/resources/documents/Notice-CPD-15-07-Guidance-for-Charging-Pre-Application-Costs.pdf*). HUD may update this notice and amend reimbursement requirements in **Federal Register** notices from time to time. This notice applies to reimbursement of applicants other than the grantee and subrecipient. The requirements on reimbursement of costs of the grantee or subrecipient are described in the **Federal Register** notices governing the grants.

identify the information the grantee will use to make the determination of financial necessity.

HUD will consider requests for hardship exceptions for applicants based on HUD's determination that the grantee's hardship criteria in its action plan comply with this notice, and the hardship exception requests are consistent with the grantee's hardship criteria as provided for in its action plan. Hardship exceptions shall only be authorized until October 5, 2023, for applicants that received assistance in response to disasters declared between January 1, 2016, and December 31, 2021, consistent with the DRRA.

(ix) Before October 5, 2023, HUD will evaluate the impact of policies provided in this Notice using data provided by its grantees. To conduct this evaluation, one year from the approval of the substantial action plan amendment required in paragraph (viii) above, the grantee shall submit to HUD an assessment and supporting data that provides: (1) The total amount of CDBG–DR funds used for the reimbursement of SBA and other subsidized loans; (2) the total number of households and the number of low-to moderate-income households that have been reimbursed; and (3) the SBA loan number and the FEMA Registrant ID of each individual household that was reimbursed for its SBA loan costs. HUD will also coordinate with FEMA on reports required by section 1210(a)(5) of Public Law 115–254, which will report on efforts to improve coordination between Federal agencies and clarify the sequence of delivery of disaster assistance to individuals.

Any future grantee request for a waiver of the overall benefit requirement applicable to a CDBG–DR grant will be evaluated by HUD in light of the amount of assistance the grantee has or plans to use to reimburse applicants with incomes in excess of 80 percent AMI for costs paid by SBA and other subsidized loans.

V.C. Order of Assistance

CDBG–DR appropriations acts generally include a statutory order of assistance for Federal agencies. Although the language may vary among appropriations, the statutory order of assistance typically provides that CDBG–DR funds may not be used for activities reimbursable by or for which funds are made available by FEMA or the Army Corps. This means that grantees must verify whether FEMA or Army Corps funds are available for an activity (*i.e.* the application period is open) or the costs are reimbursable by FEMA or Army Corps (*i.e.,* the grantee will receive FEMA or Army Corps assistance to reimburse the costs of the activity) before awarding CDBG–DR assistance for costs of carrying out the same activity. If FEMA or Army Corps are accepting applications for the activity, the applicant must seek assistance from those sources before receiving CDBG–DR assistance. If the applicant's costs for the activity will be reimbursed by FEMA or the Army Corps, the grantee cannot provide the CDBG–DR assistance for those costs. In the event that FEMA or Army Corps assistance is awarded after the CDBG–DR to pay the same costs, it is the CDBG–DR grantee's responsibility to recapture CDBG–DR assistance that duplicates assistance from FEMA or the Army Corps.

Under the Stafford Act, a federal agency that provides duplicative assistance must collect that assistance. For CDBG–DR grants, the CDBG–DR grantee must collect duplicative assistance it provides.

FEMA regulations at 44 CFR 206.191 set forth a delivery sequence that establishes which source of assistance is duplicative for certain programs. CDBG–DR assistance is not listed in FEMA's sequence, but as a practical matter, CDBG–DR assistance duplicates other sources received before the CDBG–DR for the same purpose and portion of need. Any amount received from other sources before the CDBG–DR assistance that is determined to be duplicative must be collected by the grantee. The mandatory agreement to repay (discussed in VII. below) can be used to prevent duplication by assistance that is available, but not yet received. If the duplicative assistance is received after CDBG–DR, the grantee must collect the DOB or contact HUD if it has questions about whether another Federal agency is responsible for collecting the duplication.

V.D. Multiple Disasters

When multiple disasters occur in the same location, and the applicant has not recovered from the first disaster at the time of a second disaster, the assistance provided in response to the second disaster may duplicate assistance for the same purpose and need as assistance provided after the first disaster. HUD recognizes that in this scenario, DOB calculations can be complicated. Damage from a second disaster, for example, may destroy work funded and completed in response to the first disaster. The second disaster may also damage or destroy receipts and other documentation of how applicants expended assistance provided after the first disaster.

Therefore, HUD is adopting the following policy that is applicable to circumstances when two disasters occur in the same area, and the applicant has not fully recovered from the first disaster before the second disaster occurs: Applicants are not required to maintain documentation related to the use of public disaster assistance (Federal, State, and local) beyond the period required by the agency that provided the assistance. If documentation cannot be provided, the grantee may accept a self-certification regarding how the applicant used the other agency's assistance, provided that the applicant is advised of the criminal and civil penalties that apply in cases of false claims and fraud, and the grantee determines that the applicant's total need is consistent with data the grantee has about the nature of damage caused by the disasters (*e.g.,* flood inundation levels). For example, a second disaster strikes three years after an agency provided assistance in response to the first disaster, and that agency required applicants to maintain documentation for two years, the grantee may accept a self-certification regarding how the applicant used the other agency's assistance.

Applicants must continue to follow all requirements to obtain and maintain flood insurance as a condition of receiving Federal flood disaster assistance. No Federal disaster relief assistance made available in a flood disaster area may be used to make a payment to a person for repair, replacement, or restoration for damage to any personal, residential, or commercial property if that person at any time has received flood disaster assistance that was conditional on the person first having obtained flood insurance under applicable Federal law and subsequently having failed to obtain and maintain flood insurance as required under applicable Federal law on such property. See 42 U.S.C. 5154a.

VI. Recordkeeping

The Grantee must document compliance with DOB requirements. Policies and procedures for DOB should may be specific for each program funded by the CDBG–DR grantee and should be commensurate with risk. Grantees should be especially careful to sufficiently document the DOB analysis for activities they are carrying out directly. Insufficient documentation on DOB can lead to findings, which can be difficult to resolve if records are missing, inadequate, or inaccurate to demonstrate compliance with DOB requirements.

When documenting its DOB analysis, grantees cannot rely on certification alone for proof of other sources of funds for the same purpose (unless authorized by this notice, see V.D. above). Any certification by an applicant must be based on supporting evidence that will be kept available for inspection by HUD. For example, if an applicant certifies that other sources of funds were received and expended for a different purpose than the CDBG–DR funds, grantees must substantiate this assertion with an additional source of information (*e.g.,* physical inspections, credit card statements, work estimates, contractor invoices, flood inundation records, or receipts). For these reasons, HUD recommends that as soon as possible after a disaster, grantees advise the public and potential applicants to retain all receipts that document expenditures for recovery needs. Grantees should consult their CPD representative with questions about the sufficiency of documentation.

VII. Agreement To Repay

The Stafford Act requires grantees to ensure that applicants agree to repay all duplicative assistance to the agency providing that Federal assistance. To address any potential DOB, each applicant must also enter into an agreement with the CDBG–DR grantee to repay any assistance later received for the same purpose for which the CDBG–DR funds were provided. This agreement can be in the form of a subrogation agreement or similar document and must be signed by every applicant before the grantee disburses any CDBG–DR assistance to the applicant.

In its policies and procedures, the grantee must establish a method to monitor each applicant's compliance with the agreement for a reasonable period after project completion (*i.e.,* a time period commensurate with risk). Additionally, if required by the **Federal Register** notice governing the use of the CDBG–DR grant funds, the grantee's agreement must also include the following language: ''Warning: Any person who knowingly makes a false claim or statement to HUD may be subject to civil or criminal penalties under 18 U.S.C. 287, 1001 and 31 U.S.C. 3729.'' If the **Federal Register** notice governing the use of a grantee's CDBG–DR grant does not require that language to be added, grantees may include this or similar language at their discretion.

VIII. Collecting a Duplication

If a potential DOB is discovered after CDBG–DR assistance has been provided, the grantee must reassess the applicant's need at that time (see section IV.E.). If additional need is not demonstrated, CDBG–DR funds shall be recaptured to the extent they are in excess of the remaining need and duplicate other assistance received by the applicant for the same purpose. This determination, however, may depend on what sources of assistance were last received by the applicant.

If a grantee fails to recapture funds from an applicant, HUD may impose corrective actions pursuant to 24 CFR 570.495, 24 CFR 570.910, and **Federal Register** notices, as applicable. Also, HUD reminds grantees that the Stafford Act states that ''A person receiving Federal assistance for a major disaster or emergency shall be liable to the United States to the extent that such assistance duplicates benefits available to the person for the same purpose from another source.'' If the grantee does not recapture the duplicative assistance, that individual applicant will still be liable to the United States government.

The grantee may refer to any relevant guidance or the debt collection procedures in place for the state or local government. HUD is available to provide guidance to grantees in establishing or revising the grantee's duplication of benefits policies and procedures.

IX. Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers for the disaster recovery grants under this Notice are as follows: 14.218 for Units of General Local Governments (UGLG); 14.228 for States.

X. Finding of No Significant Impact

A Finding of No Significant Impact (FONSI) with respect to the environment has been made in accordance with HUD regulations at 24 CFR part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332). The FONSI is available for public inspection between 8 a.m. and 5 p.m. weekdays in the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW, Room 10276, Washington, DC 20410–0500. Due to security measures at the HUD Headquarters building, an advance appointment to review the docket file must be scheduled by calling the Regulations Division at 202–708–3055 (this is not a toll-free number). Hearing or speech-impaired individuals may access this number through TTY by calling the toll-free Federal Relay Service at 800–877–8339.

Dated: June 14, 2019.

Brian D. Montgomery,

Acting Deputy Secretary.

Appendix A: Example DOB and CDGB–DR Award Calculations

Table 1 illustrates a basic way to complete a duplication of benefits analysis and apply a program cap to calculate a CDBG–DR housing rehabilitation award. In this example, the total unmet need is greater than the program cap set by the grantee.

TABLE 1—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE

1. Identify Applicant's Total Need Calculated at a Point in Time	$100,000
Grantee estimates $100,000 to rehabilitate a damaged home. This estimate was done after the removal of a tree but before any construction and represents current need for rehabilitation costs.	
2. Identify Total Assistance Available	30,000
Homeowner received the following assistance:	
$20,000 from insurance for damage to the home.	
$10,000 from FEMA for rehabilitation of the home.	
3. Identify the Amount to Exclude as Non-Duplicative (Amounts used for a different purpose, or same purpose, different allowable use)	5,000
Homeowner can document that she used $5,000 to remove a large tree that fell on the home, and still has $25,000 of insurance and FEMA assistance unexpended.	
Total exclusions = $5,000. Exclude $5,000 used for the same purpose, different allowable use.	
4. Identify Total DOB Amount (Total Assistance Minus Non-Duplicative Exclusions)	25,000
$30,000 in total assistance minus $5,000 for non-duplicative exclusions.	
5. Calculate Maximum Award (Total Need Minus Total DOB Amount)	75,000
$100,000 in total need based on estimate minus $25,000 identified as the total DOB in step 4.	
6. Program Cap (if applicable)	50,000

TABLE 1—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE—Continued

In this example, the grantee has a rehabilitation program cap in its policies and procedures of $50,000. Program caps are set by the grantee in its discretion.	
7. Final Award (Program Cap = Final Award if Maximum Award is Greater than the Program Cap)	50,000

Table 2, below, uses the same basic framework to calculate a CDBG–DR homeowner rehabilitation award when the applicant received insurance, FEMA assistance, and an SBA loan for housing rehabilitation. In this example, the homeowner received the full SBA loan amount. The SBA loan amount is a DOB because the loan is for the same purpose as the CDBG–DR award, and no exception applies to exclude the SBA loan amount from the duplication (*e.g.,* the loan was made in response to a disaster that occurred in 2015, so the DRRA exception does not apply):

TABLE 2—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE WHEN SUBSIDIZED LOANS ARE A DUPLICATION OF BENEFITS

1. Identify Applicant's Total Need Calculated at a Point in Time	$100,000
Grantee estimates $100,000 to finish rehabilitating a damaged home. This estimate represents remaining rehabilitation costs after the homeowner used $40,000 of non-CDBG–DR assistance for partial rehabilitation and tree removal.	
Total need = $100,000 for rehabilitation not yet completed at the point in time that need was assessed.	
2. Identify Total Assistance Available	70,000
Homeowner received the following assistance:	
$5,000 from insurance for loss of contents.	
$25,000 from insurance for damage to the home.	
$15,000 from FEMA for rehabilitation of the home.	
$25,000 from SBA for rehabilitation. The DRRA exception does not apply, so the SBA amounts are included in total assistance.	
3. Identify the Amount to Exclude as Non-Duplicative (Amounts used for a different purpose, or same purpose, different allowable use)	45,000
Homeowner can show that $5,000 of insurance proceeds was a payment for loss of contents.	
Homeowner can document that she used $5,000 to remove a large tree that fell on the home.	
Homeowner can document that she paid a contractor $35,000 for partial rehabilitation so that she could live in her home until rehabilitation was completed.	
Total exclusions = $45,000. Exclude $5,000 for different purpose (insurance payment for contents) and exclude $40,000 used for the same purpose, different allowable use (tree removal and partial rehabilitation).	
4. Identify Total DOB Amount (Total Assistance Minus Non-Duplicative Exclusions)	25,000
$70,000 in total assistance minus $45,000 for non-duplicative exclusions.	
5. Calculate Maximum Award (Total Need Minus Total DOB Amount)	75,000
6. Program Cap (if applicable)	150,000
In this example, the grantee has a rehabilitation program cap in its policies and procedures of $150,000. Program caps are set by the grantee in its discretion.	
7. Final Award (Program Cap = Final Award if Maximum Award is equal to or greater than the Program Cap)	75,000
In this case, the program cap is greater than the maximum award, so the applicant can receive the maximum award.	

Table 3 modifies the example in Table 2 to illustrate how the analysis would change if an exception applies to exempt the loan from treatment as a DOB, and if the maximum award is greater than the program cap. In this example, the applicant received a subsidized loan from SBA for the same purpose (housing rehabilitation) as the CDBG–DR assistance, and the assistance was provided in response to a DRRA Qualifying Disaster (a disaster occurring between January 1, 2016 and December 31, 2021). The loan is not a DOB because the applicant can document that all of the loan proceeds were used for a disaster-related loss and therefore the DRRA exception applies.

TABLE 3—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE WHEN SUBSIDIZED LOANS ARE NOT A DUPLICATION OF BENEFITS

1. Identify Applicant's Total Need Calculated at a Point in Time	$ 125,000
Grantee estimates $100,000 to finish rehabilitating a home damaged by a 2016 disaster. This estimate represents remaining rehabilitation costs after the homeowner completed $25,000 in partial rehabilitation with SBA loan proceeds, $5,000 in tree removal with insurance proceeds, and $35,000 in rehabilitation with FEMA and insurance ($65,000 total rehabilitation costs since the date of the disaster).	
Total need = $100,000 in rehabilitation not yet completed at the point in time that need was assessed + $25,000 in reimbursement for costs of CDBG–DR eligible activities paid with an SBA loan received in response to a DRRA Qualifying Disaster.	
2. Identify Total Assistance Available	50,000
Homeowner received the following assistance:	
$5,000 from insurance for loss of contents.	
$30,000 from insurance for damage to the home.	
$15,000 from FEMA for rehabilitation of the home.	
Because the homeowner can document that the SBA loan proceeds of $25,000 were used for rehabilitation, the DRRA exception applies and the SBA loan funds are not included in total assistance and do not need to be considered in the DOB analysis. Even though the grantee does not need to consider the SBA loan in the DOB analysis, the grantee must follow the requirements of this notice before reimbursing costs paid with SBA loans for DRRA Qualifying Disasters (reimbursement is described section V.B.3.).	

TABLE 3—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE WHEN SUBSIDIZED LOANS ARE NOT A DUPLICATION OF BENEFITS—Continued

3. Identify the Amount of Total Assistance to Exclude as Non-Duplicative (Amounts used for a different purpose, or same purpose, different allowable use)	45,000
Homeowner can show that $5,000 of insurance proceeds was a payment for loss of contents.	
Homeowner can document that she used $5,000 to remove a large tree that fell on the home.	
Homeowner can document that she paid a contractor $35,000 for partial rehabilitation with FEMA and insurance funds so that she could live in her home until rehabilitation was completed (in addition to the $25,000 in rehabilitation completed with SBA loan proceeds, which is excluded from the DOB calculation because the DRRA exception applies).	
Total exclusions = $45,000. Exclude $5,000 for different purpose (insurance payment for contents) and $40,000 used for the same purpose, different allowable use ($35,000 partial rehabilitation completed with insurance and FEMA assistance, and $5,000 for tree removal).	
4. Identify Total DOB Amount (Total Assistance Minus Non-Duplicative Exclusions)	5,000
$50,000 in total assistance minus $45,000 for non-duplicative exclusions.	
5. Calculate Maximum Award (Total Need Minus Total DOB Amount)	120,000
If the grantee did not have a program cap, the maximum award would be less than total need by $5,000 (the amount of the DOB). Therefore, absent a program cap, the grantee would be able to complete the remaining $100,000 rehabilitation work and reimburse $20,000 in rehabilitation costs paid with SBA loan proceeds.	
6. Program Cap (if applicable)	115,000
In this example, the grantee has a rehabilitation program cap in its policies and procedures of $115,000. Program caps are set by the grantee in its discretion.	
7. Final Award (Program Cap = Final Award if Maximum Award is equal to or greater than the Program Cap)	115,000
In this case, the program cap is less than the maximum award, so the applicant can receive only the amount of the program cap. The grantee can award the applicant $100,000 to complete the rehabilitation (so that the applicant can occupy the home and the rehabilitation activity can meet a national objective) and the grantee can also award the applicant $15,000 to reimburse rehabilitation costs paid with SBA loan proceeds if the grantee complies with the reimbursement requirements of this notice.	

Table 4 provides an example of a DOB calculation when the applicant seeks rehabilitation assistance to recover from damage caused by two disasters that occurred within three years. The applicant has completed some rehabilitation, but still has remaining rehabilitation need.

TABLE 4—BASIC FRAMEWORK FOR DOB CALCULATION—HOMEOWNER REHABILITATION EXAMPLE WHEN A HOMEOWNER EXPERIENCES MULTIPLE DISASTERS

1. Identify Applicant's Total Need Calculated at a Point in Time	$100,000
Grantee estimates $100,000 to finish rehabilitating a home damaged by a 2018 disaster. This home was also damaged by a 2015 disaster. It is impossible to tell from the inspection if the damage was caused by the 2015 disaster or the 2018 disaster. This is the first time the grantee has done an inspection on this home.	
This estimate represents remaining rehabilitation costs after the homeowner completed $50,000 in partial rehabilitation with other sources of assistance. $30,000 in rehabilitation was from sources in response to the 2018 disaster and $15,000 in rehabilitation was from sources in response to the 2015 disaster.	
Total need = $100,000 in rehabilitation not yet completed at the point in time that need was assessed.	
2. Identify Total Assistance Available	50,000
Homeowner received the following assistance for the 2015 disaster:	
$5,000 from insurance for loss of contents.	
$15,000 from the State housing agency for rehabilitation of the home.	
Homeowner received the following assistance for the 2018 disaster:	
$30,000 from FEMA for rehabilitation of the home.	
3. Identify the Amount to Exclude as Non-Duplicative (Amounts used for a different purpose, or same purpose, different allowable use)	50,000
Homeowner can show that $5,000 of insurance proceeds was a payment for loss of contents	
Homeowner no longer has the documentation for the FEMA assistance given in response to the 2015 disaster. Because the application for assistance was submitted more than two years after the homeowner received assistance from the State housing agency to recover from the 2015 disaster, and the State housing agency only required the homeowner to keep records for two years, the homeowner self-certifies that she paid a contractor $15,000 for rehabilitation after the 2015 disaster but before the 2018 disaster	
Homeowner can document that she paid a contractor $30,000 for partial rehabilitation so that she could live in the home until rehabilitation was completed, in response to the 2018 disaster.	
Total exclusions = $50,000. Exclude $5,000 for different purpose (insurance payment for contents), $15,000 self-certification for rehabilitation completed for 2015 disasters that was also damaged by the 2018 disaster, $30,000 used for the same purpose, different allowable use (partial rehabilitation completed with FEMA assistance following the 2018 disaster).	
4. Identify Total DOB Amount (Total Assistance Minus Non-Duplicative Exclusions)	0
5. Calculate Maximum Award (Total Need Minus Total DOB Amount)	100,000
6. Program Cap (if applicable).	
In this example, the grantee has a rehabilitation program cap in its policies and procedures of $115,000. Program caps are set by the grantee in its discretion.	100,000
7. Final Award (Program Cap = Final Award if Maximum Award is equal to or greater than the Program Cap)	100,000

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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–6169–N–02]

Applicability of Updates to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: Elsewhere in the **Federal Register**, the Department published the notice '' Updates to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees,'' which reflects the requirements of recent CDBG disaster recovery (CDBG–DR) supplemental appropriations acts and amendments to the Robert T. Stafford Disaster Relief and Emergency Assistance Act. This notice makes conforming amendments to notices governing CDBG–DR grants received in response to a disaster declared between January 1, 2015 and December 31, 2017. It advises existing grantees of the applicability of the revised duplication of benefits notice to their existing CDBG–DR activities.

DATES: *Applicability Date:* June 25, 2019.

FOR FURTHER INFORMATION CONTACT: Claudette Fernandez, Director, Office of Block Grant Assistance, Department of Housing and Urban Development, 451 7th Street SW, Room 10166, Washington, DC 20410, telephone number 202–708–5287. Persons with hearing or speech impairments may access this number via TTY by calling the Federal Relay Service at 800–877–8339. Facsimile inquiries may be sent to Ms. Fernandez at 202–708–0033. (Except for the''800'' number, these telephone numbers are not toll-free). Email inquiries may be sent to *disaster_recovery@hud.gov.*

SUPPLEMENTARY INFORMATION:

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I. Introduction

Federal Register notices governing Community Development Block Grant disaster recovery (CDBG–DR) grants received in response to major disasters occurring in 2015, 2016, and 2017 require grantees to comply with the notice ''*Clarification to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees*'' (November 16, 2011, 76 FR 71060) (2011 DOB Notice).

Elsewhere in the **Federal Register**, the Department has published the notice ''*Updates to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees*'' (2019 DOB Notice). The 2019 DOB Notice updates the 2011 DOB Notice in part to reflect the requirements of recent CDBG–DR supplemental appropriations acts and amendments to the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121–5207) (the Stafford Act).

This notice amends notices governing CDBG–DR grants in response to major disasters occurring in 2015, 2016, and 2017 to impose the requirements of the 2019 DOB Notice in lieu of the 2011 DOB notice for: (a) New programs and activities added to the action plan after the date of this notice; and (b) existing programs and activities, to the extent that the grantee amends its action plan to change its treatment of loans in accordance with the 2019 DOB Notice.

II. Applicability and Waiver Authority

This notice only applies to CDBG–DR grants made in response to major disasters occurring in 2015, 2016, and 2017. Authority for the grants was provided under the ''Community Development Fund'' heading in the following appropriations acts: Public Laws 114–113; 114–223; 114–254; 115–31; 115–56; and 115–123.

These appropriations acts provide that the Secretary may waive, or specify alternative requirements for, any provision of any statute or regulation that the Secretary administers in connection with the obligation by the Secretary or the use by the recipient of these funds (except for requirements related to fair housing, nondiscrimination, labor standards, and the environment). As required by the appropriations acts, waivers and alternative requirements provided in this notice are based upon a determination by the Secretary that good cause exists and that the waiver or alternative requirement is not inconsistent with the overall purposes of title I of the Housing and Community Development Act of 1974.

III. Conforming Amendments to Federal Register Notices and CPD Notices

This notice amends the following notices that apply to the grants (Prior **Federal Register** Notices).

- 2015 Disasters: 81 FR 39687 (as amended by 82 FR 36812);
- 2016 Disasters: 81 FR 83254 (as amended by 82 FR 5591 and 82 FR 36812); and
- 2017 Disasters: 82 FR 61320 (as amended by 83 FR 5844 and 83 FR 40314).

This notice also amends the following notice published by the Office of Community Planning and Development (CPD):

- CPD Notice 2015–07, ''Guidance for Charging Pre-Application Costs of Homeowners, Businesses, and Other Qualifying Entities to CDBG Disaster Recovery Grants.''

This notice makes the following changes to the Prior Notices:

- The 2019 DOB Notice shall supersede the 2011 DOB Notice for any new activities submitted to HUD in an action plan or action plan amendment on or after the effective date of this notice, and for existing activities, to the extent that the grantee amends its action plan to change its treatment of loans in accordance with the 2019 DOB Notice. If a grantee opts to revise its policies and procedures for one or more existing programs that were included in an action plan for disaster recovery before the effective date of this notice, the grantee must amend its action plan to reflect any resulting changes in benefits to program participants or to correct any resulting inconsistencies with duplication of benefits policies described in the action plan.
- The 2011 DOB Notice shall continue to apply to activities that were included in an action plan for disaster recovery before the effective date of this notice and were not amended to change treatment of loans in accordance with the 2019 DOB Notice.
- Grants are subject to the requirement under the tenth proviso following the Community Development Fund heading of Public Law 115–123 (Declined Loans Provision) and the requirements for its implementation in the 2019 DOB Notice. The Declined Loans Provision states: ''Provided further, That with respect to any such duplication of benefits, the Secretary and any grantee under this section shall not take into consideration or reduce the amount provided to any applicant for assistance from the grantee where such

applicant applied for and was approved, but declined assistance related to such major declared disasters that occurred in 2014, 2015, 2016, and 2017 from the Small Business Administration under section 7(b) of the Small Business Act (15 U.S.C. 636(b)).''

• For grants in response to disasters occurring in 2016 and 2017 *only,* grantees are subject to the duplication of benefits provision in section 312 of the Stafford Act, as amended by section 1210 of the Disaster Recovery Reform Act of 2018 (DRRA) (division D of Pub. L. 115–254), and the related provisions of the 2019 DOB Notice.

• Before making a grant, the Secretary must issue a certification that the grantee has adequate procedures to prevent the duplication of benefits. This notice amends the Prior Notices to make conforming amendments to the standard for determining which policies and procedures are adequate to prevent the duplication of benefits. Specifically, a grantee's policies and procedures are adequate if they reflect treatment of loans that is consistent with the requirements of the Declined Loans Provision and the DRRA. Grantees must use the most recent data available from FEMA and SBA to make a duplication of benefits determination, including a determination of whether a loan is a duplication. Grantees that revise their duplication of benefits policies and procedures to conform to the requirements of this notice and the 2019 DOB Notice must resubmit their policies and procedures to HUD for review. The grantee must amend or update policies and procedures that HUD determines are inadequate.

• The Prior Notices are amended to remove the prohibition on use of CDBG–DR funds to repay an SBA home or business loan. CDBG–DR funds may be used to reimburse CDBG–DR eligible costs that were paid with subsidized loan proceeds in accordance with the 2019 DOB Notice. However, grantees are not required to reimburse the costs paid with subsidized loan proceeds and may design their eligibility criteria to appropriately meet the needs within their most impacted and distressed areas.

• The Prior Notices are amended to add the following waivers and alternative requirements:

Waiver to require additional information in the grantee's Action Plan for Disaster Recovery. For the Prior Notices, HUD is amending the waivers of requirements for CDBG actions plans, located at 42 U.S.C. 5304(a)(1), 42 U.S.C. 5304(m), 42 U.S.C. 5306(d)(2)(C)(iii), 42 U.S.C. 5306(a)(1), 42 U.S.C. 12705(a)(2), and 24 CFR 91.320, are waived for these disaster recovery grants. In addition to the waivers and alternative requirements in the Prior Notices, HUD is adding the following additional alternative requirement: Grantees action plans must include the information required by this notice and the 2019 DOB notice.

Waiver to permit payment of limited interest costs. Section 105(a) is waived to the extent it limits activities to only those activities listed in section 105(a)(1)—(26), and HUD is imposing the following alternative requirement to create a new eligible activity to allow the use of CDBG–DR to pay interest due on subsidized loans in limited circumstances described in this paragraph. Homeowners, businesses, and other entities that received subsidized loans to pay the costs of eligible rehabilitation, demolition, and reconstruction of single family, multifamily, and nonresidential buildings (including commercial properties) are eligible for reimbursement, subject to the requirements of the 2019 DOB Notice, the Prior Notices, and CPD Notice 2015–07 (as may be amended or replaced from time to time). When the grantee reimburses homeowners, businesses, or other entities for these costs, the grantee may also pay any outstanding interest due on the portion of the principal of subsidized loans used to pay the costs eligible for reimbursement. CDBG–DR funds cannot be used to pay fees or the portion of interest attributable to activities that are ineligible for reimbursement.

Waiver and alternative reporting requirement. In addition to other reports required pursuant to the Prior Notices, one year from the approval of the substantial action plan amendment required for the use of CDBG–DR funds to reimburse subsidized loan costs as provided in **Federal Register** notice entitled ''Updates to Duplication of Benefits Requirements Under the Stafford Act for Community Development Block Grant (CDBG) Disaster Recovery Grantees,'' the grantee shall submit to HUD an assessment and supporting data that provides: (i) The total amount of CDBG–DR funds used for the reimbursement of SBA and other subsidized loans; (ii) the total number of households and the number of low-to moderate-income households that have been reimbursed; and (iii) data on each individual household that was reimbursed for its SBA loan costs, including the household's FEMA Registrant ID, the SBA loan number, the amount of the initial SBA real property loan; the amount of the initial SBA personal property loan; the amount of the loan costs paid by CDBG–DR; and the household's income.

This notice makes the following amendment to CPD Notice 2015–07:

• The requirement that ''Grantees may only charge the costs for rehabilitation, demolition, and reconstruction of single family, multifamily, and nonresidential buildings, including commercial properties, owned by private individuals and entities, incurred before the owner applies to a CDBG–DR grantee, recipient, or subrecipient for CDBG–DR assistance'' is revised. This requirement was imposed when loans were considered a duplication. Grantees and applicants did not contemplate the availability of CDBG–DR assistance for costs paid with subsidized loans. For grantees that have accepted applications for the reimbursement of costs paid with a subsidized loan prior to the implementation date of this notice, the date of application for reimbursement shall be the effective date of the action plan amendment that authorizes such reimbursement, or if a new application is received after the action plan amendment, the date of application shall be the date that the new application is submitted. For grantees in receipt of CDBG–DR funds for 2016 or 2017 disasters, the provision of CPD-Notice 2015–07 that limits reimbursement to those costs incurred within one year of the disaster shall not apply to reimbursement of costs paid by a subsidized loan.

IV. Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers for the disaster recovery grants under this Notice are as follows: 14.218 for units of local government; 14.228 for States.

V. Finding of No Significant Impact

A Finding of No Significant Impact (FONSI) with respect to the environment has been made in accordance with HUD regulations at 24 CFR part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332). The FONSI is available for public inspection between 8 a.m. and 5 p.m. weekdays in the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW, Room 10276, Washington, DC 20410–0500. Due to security measures at the HUD Headquarters building, an advance appointment to review the docket file must be scheduled by calling the Regulations Division at 202–708–3055 (this is not a toll-free number). Hearing

or speech-impaired individuals may access this number through TTY by calling the toll-free Federal Relay Service at 800–877–8339.

Dated: June 14, 2019.

Brian D. Montgomery,

Acting Deputy Secretary.

[FR Doc. 2019–13146 Filed 6–19–19; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R4–ES–2019–N037; FXES11130900000C2–190–FF09E32000]

Endangered and Threatened Wildlife and Plants; Initiation of 5-Year Status Reviews for 53 Southeastern Species

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of initiation of reviews; request for information.

SUMMARY: We, the U.S. Fish and Wildlife Service, are initiating 5-year status reviews of 53 species under the Endangered Species Act, as amended. A 5-year review is an assessment of the best scientific and commercial data available at the time of the review. We are requesting submission of information that has become available since the last reviews of these species.

DATES: To allow us adequate time to conduct these reviews, we must receive your comments or information on or before August 19, 2019. However, we will continue to accept new information about any listed species at any time.

ADDRESSES: For instructions on how to submit information and review information that we receive on these species, see *Request for New Information* under **SUPPLEMENTARY INFORMATION.**

FOR FURTHER INFORMATION CONTACT: For species-specific information, see *Request for New Information* under **SUPPLEMENTARY INFORMATION.** Individuals who are hearing impaired or speech impaired may call the Federal Relay Service at 800–877–8339 for TTY assistance.

SUPPLEMENTARY INFORMATION:

Why do we conduct 5-year reviews?

Under the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*), we maintain lists of endangered and threatened wildlife and plant species in title 50 of the Code of Federal Regulations (CFR) at 50 CFR 17.11 (for wildlife) and 17.12 (for plants: List). Section 4(c)(2)(A) of the ESA requires us to review each listed species' status at least once every 5 years. Our regulations at 50 CFR 424.21 require that we publish a notice in the **Federal Register** announcing those species under active review. For additional information about 5-year reviews, go to *http://www.fws.gov/endangered/what-we-do/recovery-overview.html.*

Which species are under review?

This notice announces our active 5-year reviews of the species in the following table.

Common name/scientific name	Contact person, email, phone	Status (endangered or threatened)	States where the species is known to occur	Final listing rule (**Federal Register** citation and publication date)	Contact's mailing address
ANIMALS					
Mammals					
Squirrel, Carolina northern flying (*Glaucomys sabrinus coloratus*).	Sue Cameron, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	North Carolina, Tennessee, Virginia.	50 FR 26999; 7/1/1985	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Birds					
Scrub-jay, Florida (*Aphelocoma coerulescens*).	Todd Mecklenborg, *northflorida@fws.gov,* 904–731–3045.	Threatened ...	Florida	52 FR 20715; 6/3/1987	USFWS, 7915 Baymeadows Way, Suite 200, Jacksonville, FL 32256.
Sparrow, Florida grasshopper (*Ammodramus savannarum floridanus*).	Roxanna Hinzman, *FLgrasshoppersparrow_5-yearreview@fws.gov,* 772–469–4310.	Endangered ..	Florida	51 FR 27492; 7/31/1986 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Stork, wood (*Mycteria americana*) U.S.breeding population.	Bill Brooks, *northflorida@fws.gov,* 904–731–3136.	Threatened ...	Florida	49 FR 7332; 2/28/1984, 79 FR 37077; 6/30/14.	USFWS, 7915 Baymeadows Way, Suite 200, Jacksonville, FL 32256.
Reptiles					
Boa, Mona (*Epicrates monensis monensis*).	Felix Lopez, *caribbean_es@fws.gov,* 787–851–7297.	Threatened ...	Puerto Rico	43 FR 4618; 2/3/1978	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Tortoise, gopher (*Gopherus polyphemus*) western population.	Matthew Hinderliter, *mississippi_field_office@fws.gov,* 601–321–1132.	Threatened ...	Alabama, Louisiana, Mississippi.	52 FR 25376; 7/7/1987	USFWS, 6578 Dogwood View Pkwy., Jackson, MS 39213.
Turtle, flattened musk (*Sternotherus depressus*).	Daniel Drennen, *mississippi_field_office@fws.gov,* 601–321–1127.	Threatened ...	Alabama	52 FR 22418; 6/11/1987 ..	USFWS, 6578 Dogwood View Pkwy., Jackson, MS 39213.
Amphibians					
Salamander, Red Hills (*Phaeognathus hubrichti*).	Matt Laschet, *alabama@fws.gov,* 251–441–5184.	Threatened ...	Alabama	41 FR 53032; 12/3/1976 ..	USFWS, 1208B Main Street, Daphne, AL 36526.
Fishes					
Chub, slender (*Erimystax cahni*)	Warren Stiles, *cookeville@fws.gov,* 931–528–6481.	Threatened ...	Tennessee	42 FR 45526; 9/9/1977	USFWS, 446 Neal Street, Cookeville, TN 38501.
Shiner, palezone (*Notropis albizonatus*).	Mike Floyd, *kentuckyes@fws.gov,* 502–695–0468.	Endangered ..	Alabama, Kentucky	58 FR 25758; 4/27/1993 ..	USFWS, 330 W Broadway, Ste. 265, Frankfort, KY 40601.

Common name/scientific name	Contact person, email, phone	Status (endangered or threatened)	States where the species is known to occur	Final listing rule (**Federal Register** citation and publication date)	Contact's mailing address
Clams					
Monkeyface, Cumberland (*Quadrula intermedia*).	Andrew Henderson, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	Alabama, Georgia, North Carolina, Tennessee, Virginia.	41 FR 24062; 6/14/1976 ..	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Pigtoe, rough (*Pleurobema plenum*).	Stephanie Chance, *cookeville@fws.gov,* 931–528–6481.	Endangered ..	Alabama, Indiana, Kentucky, Tennessee, Virginia.	41 FR 24062; 6/14/1976 ..	USFWS, 446 Neal Street, Cookeville, TN 38501.
Pigtoe, shiny (*Fusconaia cor*) ...	Andrew Henderson, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	Alabama, Tennessee, Virginia.	41 FR 24062; 6/14/1976 ..	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Riffleshell, tan (*Epioblasma florentina walkeri*).	Andrew Henderson, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	Alabama, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, Virginia.	42 FR 42351; 8/23/1977 ..	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Spinymussel, Tar River (*Elliptio steinstansana*).	Sarah McRae, *raleigh_admin@fws.gov,* 919–856–4520.	Endangered ..	North Carolina	50 FR 26572; 6/27/1985 ..	USFWS, 551 Pylon Drive, #F, Raleigh, NC 27606.
Insects					
Butterfly, Bartram's scrub-hairstreak, (*Strymon acis bartrami*).	Roxanna Hinzman, *Bartrams_5-yearreview@fws.gov,* 772–469–4316.	Endangered ..	Florida	79 FR 47221; 8/12/2014 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Butterfly, Florida leafwing (*Anaea troglodyta floridalis*).	Roxanna Hinzman, *FLleafwing_5-yearreview@fws.gov,* 772–469–4311.	Endangered ..	Florida	79 FR 47221; 8/12/2014 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Arachnids					
Spider, spruce-fir moss (*Microhexura montivaga*).	Sue Cameron, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	North Carolina, Tennessee, Virginia.	60 FR 6968; 2/6/1995	USFWS, 160 Zillicoa St., Asheville, NC 28801.
PLANTS					
Flowering Plants					
Agave eggersiana (no common name).	Jaime Yrigoyen, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Virgin Islands	79 FR 53303; 9/9/2014	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Asimina tetramera (four-petal pawpaw).	Roxanna Hinzman, *Fourpetalpawpaw_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	51 FR 34415; 9/26/1986 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Brickellia mosieri (Florida brickell-bush).	Roxanna Hinzman, *FLbrickellbush_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	79 FR 52567; 9/4/2014	USFWS, 1339 20th St., Vero Beach, FL 32960.
Cereus eriophorus var. *fragrans* (fragrant prickly-apple).	Roxanna Hinzman, *fragrantprickly_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	50 FR 45618; 11/1/1985 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Conradina brevifolia (short-leaved rosemary).	Roxanna Hinzman, *Shortleavedrosemary_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	58 FR 37432; 7/12/1993 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Consolea corallicola (Florida semaphore cactus).	Roxanna Hinzman, *Floridasemaphore_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	78 FR 63795; 10/24/2013	USFWS, 1339 20th St., Vero Beach, FL 32960.
Cornutia obovata (palo de nigua).	Angel Colon, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Puerto Rico	53 FR 11610; 4/7/1988	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Cucurbita okeechobeensis ssp. *okeechobeensis* (Okeechobee gourd).	Roxanna Hinzman, *Okeechobeegourd_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	58 FR 37432; 7/12/1993 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Deeringothamnus pulchellus (Beautiful pawpaw).	Roxanna Hinzman, *beautifulpawpaw_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	51 FR 34415; 9/26/1986 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Eryngium cuneifolium (snakeroot).	Roxanna Hinzman, *snakeroot_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	52 FR 2227; 1/21/1987	USFWS, 1339 20th St., Vero Beach, FL 32960.
Eugenia haematocarpa (uvillo)	Omar Monsegur, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Florida	59 FR 60565; 11/25/1994	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Gonocalyx concolor (no common name).	Carlos Pacheco, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Puerto Rico	79 FR 53303; 9/9/2014	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.

Common name/scientific name	Contact person, email, phone	Status (endangered or threatened)	States where the species is known to occur	Final listing rule (**Federal Register** citation and publication date)	Contact's mailing address
Helianthus verticillatus (whorled sunflower).	Scott Wiggers, *mississippi_field_office@fws.gov,* 228–475–0765.	Endangered ..	Alabama, Georgia, Mississippi, Tennessee.	79 FR 44712; 8/1/2014	USFWS, 6578 Dogwood View Pkwy., Jackson, MS 39213.
Leavenworthia crassa (fleshy-fruit gladecress).	Shannon Holbrook, *alabama@fws.gov,* 251–441–5184.	Endangered ..	Alabama	79 FR 44712; 8/1/2014	USFWS, 1208B Main Street, Daphne, AL 36526.
Leavenworthia exigua var. *laciniata* (Kentucky glade cress).	Mike Floyd, *kentuckyes@fws.gov,* 502–695–0468.	Threatened ...	Kentucky	79 FR 25683; 5/6/2014	USFWS, 330 W Broadway, Ste. 265, Frankfort, KY 40601.
Liatris helleri (Heller's blazingstar).	Rebekah Reid, *fw4esasheville@fws.gov,* 828–258–3939.	Threatened ...	North Carolina	52 FR 44397; 11/19/1987	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Liatris ohlingerae (scrub blazingstar).	Roxanna Hinzman, *Scrubblazingstar_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	54 FR 31190; 7/27/1989 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Lindera melissifolia (pondberry)	Scott Wiggers, *mississippi_field_office@fws.gov,* 228–475–0765.	Endangered ..	Alabama, Arkansas, Georgia, Mississippi, Missouri, North Carolina, South Carolina.	51 FR 27495; 7/31/1986 ..	USFWS, 6578 Dogwood View Pkwy., Jackson, MS 39213.
Linum carteri carteri (Carter's small-flowered flax).	Roxanna Hinzman, *cartersflax_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	79 FR 52567; 9/4/2014	USFWS, 1339 20th St., Vero Beach, FL 32960.
Peperomia wheeleri (Wheeler's peperomia).	Carlos Pacheco, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Puerto Rico	52 FR 1459; 1/14/1987	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Physaria globosa (Short's bladderpod).	Geoff Call, *cookeville@fws.gov,* 931–528–6481.	Endangered ..	Indiana, Kentucky, Tennessee.	79 FR 44712; 8/1/2014	USFWS, 446 Neal Street, Cookeville, TN 38501.
Pilosocereus robinii (Key tree-cactus).	Roxanna Hinzman, *keytreecactus_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	49 FR 29234; 7/19/1984 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Pleodendron macranthum (Chupacallos).	Angel Colon, *caribbean_es@fws.gov,* 787–851–7297.	Endangered ..	Puerto Rico	59 FR 60565; 11/25/1994	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Polygala lewtonii (Lewton's polygala).	Roxanna Hinzman, *Lewtonspolygala_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	58 FR 25746; 4/27/1993 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Polygonella basiramia (wireweed).	Roxanna Hinzman, *wireweed_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	52 FR 2227; 1/21/1987	USFWS, 1339 20th St., Vero Beach, FL 32960.
Polygonella myriophylla (sandlace).	Roxanna Hinzman, *sandlace_5-yearreview@fws.gov,* 772–469–4307.	Endangered ..	Florida	58 FR 25746; 4/27/1993 ..	USFWS, 1339 20th St., Vero Beach, FL 32960.
Rhus michauxii (Michaux's sumac).	Dale Suiter, *raleigh_admin@fws.gov,* 919–856–4520.	Endangered ..	Georgia, North Carolina, South Carolina, Virginia.	54 FR 39850; 9/28/1989 ..	USFWS, 551 Pylon Drive, #F, Raleigh, NC 27606.
Sagittaria fasciculata (bunched arrowhead).	Rebekah Reid, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	North Carolina, South Carolina.	44 FR 43700; 7/25/1979 ..	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Sagittaria secundifolia (Kral's water-plantain).	Shannon Holbrook, *alabama@fws.gov,* 251–441–5184.	Threatened ...	Alabama, Georgia ..	55 FR 13907; 4/13/1990 ..	USFWS, 1208B Main Street, Daphne, AL 36526.
Sarracenia oreophila (green pitcher-plant).	Scott Wiggers, *mississippi_field_office@fws.gov,* 228–475–0765.	Endangered ..	Alabama, Georgia, North Carolina.	44 FR 54922; 9/21/1979 ..	USFWS, 6578 Dogwood View Pkwy., Jackson, MS 39213.
Sarracenia rubra ssp. *jonesii* (mountain sweet pitcher-plant).	Rebekah Reid, *fw4esasheville@fws.gov,* 828–258–3939.	Endangered ..	North Carolina, South Carolina.	53 FR 38470; 9/30/1988 ..	USFWS, 160 Zillicoa St., Asheville, NC 28801.
Stahlia monosperma (cobana negra).	Jose G. Martinez, *caribbean_es@fws.gov,* 787–851–7297.	Threatened ...	Puerto Rico	55 FR 12790; 4/5/1990	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Varronia rupicola (no common name).	Omar Monsegur, *caribbean_es@fws.gov,* 787–851–7297.	Threatened ...	Puerto Rico	79 FR 53303; 9/9/2014	USFWS, Road 301, Km 5.1, P.O. Box 491, Boquerón, PR 00622.
Xyris tennesseensis (Tennessee yellow-eyed grass).	Shannon Holbrook, *alabama@fws.gov,* 251–441–5184.	Endangered ..	Alabama, Georgia, Tennessee.	56 FR 34151; 7/26/1991 ..	USFWS, 1208B Main Street, Daphne, AL 36526.
Ferns					
Thelypteris pilosa var. *alabamensis* (Alabama streak-sorus fern).	Shannon Holbrook, *alabama@fws.gov,* 251–441–5184.	Threatened ...	Alabama	57 FR 30164; 7/8/1992	USFWS, 1208B Main Street, Daphne, AL 36526.

What information do we consider in our review?

A 5-year review considers the best scientific and commercial data that have become available since the current listing determination or most recent status review of each species, such as:

A. Species biology, including, but not limited to, population trends, distribution, abundance, demographics, and genetics;

B. Habitat conditions, including, but not limited to, amount, distribution, and suitability;

C. Conservation measures that have been implemented to benefit the species;

D. Threat status and trends (see the five factors under *How Do We Determine Whether a Species is Endangered or Threatened?*); and

E. Other new information, data, or corrections, including, but not limited to, taxonomic or nomenclatural changes, identification of erroneous information contained in the Lists of Endangered and Threatened Wildlife and Plants, and improved analytical methods.

We request any new information concerning the status of any of these 53 species. Information submitted should be supported by documentation such as maps; bibliographic references; methods used to gather and analyze the data; and/or copies of any pertinent publications, reports, or letters by knowledgeable sources.

We may conduct a species status assessment (SSA) for some of these species. An SSA is a biological risk assessment to aid decision makers who must use the best available scientific information to make policy decisions or recommendations under the ESA. The SSA provides decisionmakers with a scientifically rigorous characterization of a species' status, and of the likelihood that the species will sustain populations, along with key uncertainties in that characterization. It presents a compilation of the best available information on a species, as well as its ecological needs, based on environmental factors. An SSA also describes the current condition of the species' habitat and demographics, and probable explanations for past and ongoing changes in abundance and distribution within the species' range. Finally, it forecasts the species' response to probable future scenarios of environmental conditions and conservation efforts. Overall, an SSA uses the conservation biology principles of resiliency, redundancy, and representation (collectively known as the ''3 Rs'') to evaluate the current and future condition of the species. As a result, the SSA characterizes a species' ability to sustain populations in the wild over time based on the best scientific understanding of current and future abundance and distribution within the species' ecological settings.

Definitions

A. *Species* means any species or subspecies of fish, wildlife, or plant, and any distinct population segment of any species of vertebrate fish or wildlife which interbreeds when mature.

B. *Endangered* means any species that is in danger of extinction throughout all or a significant portion of its range.

C. *Threatened* means any species that is likely to become an endangered species within the foreseeable future throughout all or a significant portion of its range.

How do we determine whether a species is endangered or threatened?

Section 4(a)(1) of the ESA requires that we determine whether a species is endangered or threatened based on one or more of the following five factors:

A. The present or threatened destruction, modification, or curtailment of its habitat or range;

B. Overutilization for commercial, recreational, scientific, or educational purposes;

C. Disease or predation;

D. The inadequacy of existing regulatory mechanisms; or

E. Other natural or manmade factors affecting its continued existence.

Request for New Information

To do any of the following, contact the person associated with the species you are interested in under the table in *Which species are under review?,* above:

A. To get more information on a species;

B. To submit information on a species; or

C. To review information we receive, which will be available for public inspection by appointment, during normal business hours, at the listed addresses.

Public Availability of Comments

Comments and materials received will be available for public inspection, by appointment, during normal business hours at the offices where the comments are submitted. Comments we receive become part of the administrative record associated with this action. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can request in your comment that we withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so. All submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, will be made available for public disclosure in their entirety.

Availability of Status Reviews

All completed status reviews under the ESA are available via the Service website, at *https://www.fws.gov/endangered/species/us-species.html*.

Authority

This document is published under the authority of the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Dated: April 18, 2019.

Mike Oetker,

Acting Regional Director, Southeast Region.

[FR Doc. 2019–13155 Filed 6–19–19; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLNVC02000.L71220000.FR0000; NVN094919; 13–08807; MO # 4500123319]

Notice of Realty Action: Recreation and Public Purposes Act Classification: Nevada

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: The Bureau of Land Management (BLM) has examined certain public lands in Lyon County, and has found them suitable for classification for lease and conveyance to the Nevada Department of Transportation (NDOT) under the provisions of the Recreation & Public Purpose (R&PP) Act, as amended; Sec. 7 of the Taylor Grazing Act; and Executive Order No. 6910. The NDOT proposes to use the land as a highway maintenance station.

DATES: Submit written comments regarding this proposed classification on or before August 5, 2019. Comments may be mailed or hand delivered to the BLM office address below. Comments may be emailed or faxed to the contacts below. The BLM will not consider comments received via telephone calls.

ADDRESSES: Mail written comments to Environmental Coordinator, Carson City District Office, 5665 Morgan Mill Road, Carson City, Nevada 89701, or submit via email at *blm_nv_ccdowebmail@blm.gov,* or fax to 775–885–6147. The BLM has made available detailed information including, but not limited to, a proposed development and management plan and documentation relating to compliance with applicable environmental and cultural resource laws, for review during business hours, 7:30 a.m. to 4:30 p.m. Pacific Time, Monday through Friday, except during

Federal holidays, at the BLM Carson City District Office at 5665 Morgan Mill Road, Carson City, Nevada 89701.

FOR FURTHER INFORMATION CONTACT: Terah Malsam, Realty Specialist, at 775–885–6153. Persons who use a telecommunications device for the deaf may call the Federal Relay Service (FRS) at 1–800–877–8339 to leave a message or question for the above individual. The FRS is available 24 hours a day, 7 days a week. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: The lands consist of approximately 20 acres, must conform to the official plat of survey, and are legally described below.

The NDOT has not applied for more than the 6,400-acre limitation for recreation uses in a year (or 640 acres if a nonprofit corporation or association), nor more than 640 acres for each of the programs involving public resources other than recreation.

The NDOT has submitted a statement in compliance with the regulations at 43 CFR 2741.4(b). The NDOT proposes to use the land as a highway maintenance station. The maintenance station will support constructing, reconstructing, improving, operating, managing, and maintaining highways and ancillary facilities. NDOT may use the maintenance station for staging, as needed, for highway construction projects in the vicinity.

The lands examined and identified as suitable for lease and conveyance under the R&PP Act are legally described as:

Mount Diablo Meridian, Nevada

T. 18 N., R. 24 E.,
Sec. 24, NE¼NW¼SW¼ and NW¼NE¼SW¼.

The areas described aggregate 20 acres.

The lands are not needed for any Federal purposes. The BLM Carson City Field Office Consolidated Resource Management Plan, dated May 2001, addresses lease and conveyance of the lands for recreational or public purposes, and lease and conveyance of the subject lands would be in the national interest.

The BLM will provide a copy of this notice to all interested parties once the BLM publishes the Notice in the **Federal Register**. The BLM will publish a copy of the **Federal Register** Notice with information about this proposed realty action in a newspaper of local circulation once a week for three consecutive weeks. The regulations at 43 CFR Subpart 2741 addressing requirements and procedures for conveyances under the R&PP Act do not require a public meeting.

Upon publication of this notice in the **Federal Register**, this notice will segregate the lands from all other forms of appropriation under the public land laws, including locations under the mining laws, except for lease and conveyance under the R&PP Act and leasing under the mineral leasing laws.

The lease and conveyance of the land will be subject to the following terms, conditions, and reservations:

1. A right-of-way thereon for ditches and canals constructed by the authority of the United States Act of August 30, 1890 (26 Stat. 391; 43 U.S.C. 945).
2. Provisions of the R&PP Act and to all applicable regulations of the Secretary of the Interior.
3. All mineral deposits in the land so patented, and the right to prospect for, mine, and remove such deposits from the same under applicable law and regulations as established, by the Secretary of the Interior, are reserved to the United States, together with all necessary access and exit rights.
4. Valid existing rights.
5. An appropriate indemnification clause protecting the United States from claims arising out of the lessee's/patentee's use, occupancy, or occupations on the leased/patented lands.
6. Any other reservations that the authorized officer determines appropriate to ensure public access and proper management of Federal lands and interests therein.

The NDOT has requested that the BLM allow the NDOT to relinquish the southern 20 acres of a BLM mineral material permit (NVCC 021630) that is currently sited over the proposed lease and conveyance lands.

Classification Comments: Interested persons may submit comments involving the suitability of the land for development of a highway maintenance station. Comments on the classification are restricted to whether the land is physically suited for the proposal, whether the use will maximize the future use or uses of the land, whether the use is consistent with local planning and zoning, or if the use is consistent with state and Federal programs.

Application Comments: Interested persons may submit comments regarding the specific use proposed in the application and plan of development and management, whether the BLM followed proper administrative procedures in reaching the decision, or any other factor not directly related to the suitability of the lands for a highway maintenance station.

Before including your address, phone number, email address, or other personally identifiable information in any comment, be aware that your entire comment including your personally identifiable information may be made publicly available at any time. While you can ask us in your comment to withhold your personally identifiable information from public review, we cannot guarantee that we will be able to do so.

Any adverse comments will be reviewed by the BLM State Director or other authorized official of the Department of the Interior, who may sustain, vacate, or modify this realty action. In the absence of any adverse comments, the classification will become effective on August 19, 2019. The BLM will not offer the lands for lease or conveyance until after the classification becomes effective.

Authority: 43 CFR 2741.5.

Victoria Wilkins,
Acting Field Manager, Sierra Front Field Office.

[FR Doc. 2019–13092 Filed 6–19–19; 8:45 am]

BILLING CODE 4310–HC–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[19X.LLAK930000.L13100000.EI0000.241A]

Call for Nominations and Comments for the National Petroleum Reserve in Alaska 2019 Oil and Gas Lease Sale

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Land Management (BLM) Alaska State Office is issuing a call for nominations and comments on all available unleased tracts for the upcoming National Petroleum Reserve—Alaska (NPR–A) 2019 Oil and Gas Lease Sale.

DATES: BLM Alaska must receive all nominations and comments on these tracts for consideration on or before July 22, 2019.

ADDRESSES: Mail nominations and/or comments to: State Director, Bureau of Land Management, Alaska State Office, 222 West 7th Avenue, #13, Anchorage, AK 99513–7504.

FOR FURTHER INFORMATION CONTACT: Wayne Svejnoha, BLM Alaska Energy and Minerals Branch Chief, 907–271–4407. People who use a telecommunications device for the deaf (TDD) may call the Federal Relay Service (FRS) at 1–800–877–8339 to contact the above individual during normal business hours. The FRS is available 24 hours a day, 7 days a week, to leave a message or question with the

above individual. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: The BLM is issuing this call for nominations and comments on all available tracts within the NPR–A for leasing under the upcoming NPR–A Oil and Gas Lease Sale, pursuant to 43 CFR 3131.2. To identify tracts to nominate for leasing, or to provide comments, please use the following: (a) NPR–A maps, (b) legal descriptions of the tracts, and (c) any additional information available through the BLM Alaska website at *https://www.blm.gov/programs/energy-and-minerals/oil-and-gas/leasing/regional-lease-sales/alaska.* The BLM also requests comments on tracts that should receive special consideration or analysis.

Before including your address, phone number, email address, or other personal identifying information in your nominations and/or comments, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Chad B. Padgett,

State Director, Alaska.

[FR Doc. 2019–13095 Filed 6–19–19; 8:45 am]

BILLING CODE 4310–JA–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1139]

Certain Electronic Nicotine Delivery Systems and Components Thereof; Commission Decision Not To Review an Initial Determination Granting a Joint, Unopposed Motion To Amend the Amended Complaint and Notice of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission has determined not to review an initial determination (''ID'') (Order No. 26) of the administrative law judge (''ALJ'') granting a joint, unopposed motion to amend the amended complaint and notice of investigation (''NOI'').

FOR FURTHER INFORMATION CONTACT: Houda Morad, Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 708–4716. Copies of non-confidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 205–2000. General information concerning the Commission may also be obtained by accessing its internet server at *https://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: On December 13, 2018, the Commission instituted this investigation under section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337 (''section 337''), based on a complaint filed by Juul Labs, Inc. of San Francisco, California (''Complainant''). *See* 83 FR 64156–57 (Dec. 13, 2018). The complaint, as amended and supplemented, alleges a violation of section 337 based upon the importation into the United States, the sale for importation, and the sale within the United States after importation of certain electronic nicotine delivery systems and components thereof by reason of infringement of certain claims of U.S. Patent Nos. 10,070,669; 10,076,139; 10,045,568; 10,058,130; and 10,104,915. *See id.* The NOI names numerous respondents, including Ziip Lab Co., Ltd. of Shenzhen City, China (''Respondent''). *See id.* The Office of Unfair Import Investigations (''OUII'') is also a party to the investigation. *See id.*

On May 9, 2019, Complainant and Respondent filed a joint motion (''Motion'') to amend the amended complaint and NOI to correct the name of Respondent from its alias ''Ziip Lab Co., Ltd.'' to its legal name ''SS Group Holdings.'' OUII and certain respondents indicated that they do not oppose the Motion while other respondents indicated that they take no position with respect to the Motion.

On May 21, 2019, the ALJ issued the subject ID (Order No. 26) granting the Motion. The ID finds that, under Commission Rule 210.14(b), 19 CFR 210.14(b), ''good cause exists to amend the amended complaint and notice of investigation to conform to the correct information.'' *See* ID at 2. In addition, the ID finds that ''this amendment would not prejudice the public interest or the rights of the parties to the investigation.'' *See id.*

No petition for review of the subject ID was filed. The Commission has determined not to review the ID.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.

Issued: June 14, 2019.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2019–13080 Filed 6–19–19; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–623 and 731–TA–1449 (Preliminary)]

Vertical Metal File Cabinets From China

Determinations

On the basis of the record [1] developed in the subject investigations, the United States International Trade Commission (''Commission'') determines, pursuant to the Tariff Act of 1930 (''the Act''), that there is a reasonable indication that an industry in the United States is materially injured by reason of imports of vertical metal file cabinets (''VMFCs'') from China, provided for in subheading(s) 9403.10.00 of the Harmonized Tariff Schedule of the United States, that are alleged to be sold in the United States at less than fair value (''LTFV'') and to be subsidized by the government of China.[2]

Commencement of Final Phase Investigations

Pursuant to section 207.18 of the Commission's rules, the Commission also gives notice of the commencement of the final phase of its investigations. The Commission will issue a final phase notice of scheduling, which will be published in the **Federal Register** as provided in section 207.21 of the Commission's rules, upon notice from the U.S. Department of Commerce (''Commerce'') of affirmative preliminary determinations in the investigations under sections 703(b) or 733(b) of the Act, or, if the preliminary

[1] The record is defined in sec. 207.2(f) of the Commission's Rules of Practice and Procedure (19 CFR 207.2(f)).

[2] 84 FR 24089 (May 24, 2019) and 84 FR 24093 (May 24, 2019).

determinations are negative, upon notice of affirmative final determinations in those investigations under sections 705(a) or 735(a) of the Act. Any parties that filed entries of appearance in the preliminary phase of the investigations need not enter a separate appearance for the final phase of the investigations. Industrial users, and, if the merchandise under investigation is sold at the retail level, representative consumer organizations have the right to appear as parties in Commission antidumping and countervailing duty investigations. The Secretary will prepare a public service list containing the names and addresses of all persons, or their representatives, who are parties to the investigations.

Background

On April 30, 2019, Hirsh Industries LLC (''Hirsh''), Des Moines, IA, filed petitions with the Commission and Commerce, alleging that an industry in the United States is materially injured or threatened with material injury by reason of subsidized imports of VMFCs from China and LTFV imports of VMFCs from China. Accordingly, effective April 30, 2019, the Commission, pursuant to sections 703(a) and 733(a) of the Act (19 U.S.C. 1671b(a) and 1673b(a)), instituted countervailing duty investigation No. 701–TA–623 and antidumping duty investigation No. 731–TA–1449 (Preliminary).

Notice of the institution of the Commission's investigations and of a public conference to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** of May 7, 2019 (84 FR 19958). The conference was held in Washington, DC, on May 21, 2019, and all persons who requested the opportunity were permitted to appear in person or by counsel.

The Commission made these determinations pursuant to sections 703(a) and 733(a) of the Act (19 U.S.C. 1671b(a) and 1673b(a)). It completed and filed its determinations in these investigations on June 14, 2019. The views of the Commission are contained in USITC Publication 4914 (June 2019), entitled *Vertical Metal File Cabinets from China: Investigation Nos. 701–TA–623 and 731–TA–1449 (Preliminary).*

By order of the Commission.

Issued: June 14, 2019.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2019–13044 Filed 6–19–19; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1097]

Certain Solid State Storage Drives, Stacked Electronics Components, And Products Containing Same Commission Determination Not To Review an Initial Determination Granting a Joint Motion To Terminate the Investigation With Respect to Certain Respondents; Termination of the Investigation In Its Entirety

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission has determined not to review an initial determination (''ID'') (Order No. 47) of the presiding administrative law judge (''ALJ''), granting a joint motion to terminate the investigation as to respondents SK hynix Inc.; SK hynix America, Inc.; Dell Inc.; Dell Technologies Inc.; HP Inc.; Hewlett Packard Enterprise Co.; ASUSTeK Computer Inc.; ASUS Computer International; Acer Inc.; Acer America Corp.; Lenovo Group Ltd.; and Lenovo (United States) Inc. The investigation is terminated in its entirety.

FOR FURTHER INFORMATION CONTACT: Cathy Chen, Esq., Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 205–2392. Copies of non-confidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 205–2000. General information concerning the Commission may also be obtained by accessing its internet server at *https://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation on January 26, 2018, based on a complaint filed by BiTMICRO, LLC (''BiTMICRO'') of Reston, Virginia. 83 FR 3771 (Jan. 26, 2018). The complaint, as amended, alleges violations of section 337 based upon the importation into the United States, the sale for importation, and the sale within the United States after importation of certain solid state storage drives, stacked electronics components, and products containing the same by reason of infringement of one or more of claims 1, 2, 11, and 12 of U.S. Patent No. 7,826,243; claims 1–20 of U.S. Patent No. 6,529,416; claims 1–101 of U.S. Patent No. 9,135,190; and claims 12 and 16 of U.S. Patent No. 8,093,103. *Id.* The complaint also alleges that an industry in the United States exists as required by 19 U.S.C. 1337(a)(2). *Id.* The notice of investigation named as respondents Samsung Electronics Co., Ltd. of Gyeonggi-do, Republic of Korea; Samsung Semiconductor, Inc. of San Jose, California; and Samsung Electronics America, Inc. of Ridgefield Park, New Jersey (collectively, ''Samsung''); VAIO Corporation of Azumino, Japan (''VAIO''); Transcosmos America Inc. of Gardena, California (''transcosmos''); SK hynix Inc. of Gyeonggido, Republic of Korea; and SK hynix America Inc. of San Jose, California (collectively, ''SK hynix); Dell Inc. of Round Rock, Texas; Dell Technologies Inc. of Round Rock, Texas; Lenovo Group Ltd. of Beijing, China; Lenovo (United States) Inc. of Morrisville, North Carolina; HP Inc. of Palo Alto, California; Hewlett Packard Enterprise Co. of Palo Alto, California; ASUSTeK Computer Inc. of Taipei, Taiwan; ASUS Computer International of Fremont, California; Acer Inc. of New Taipei City, Taiwan; and Acer America Corp. of San Jose, California (collectively, ''Remaining Respondents''). *Id.* at 3772. The Office of Unfair Import Investigations (''OUII'') is also a party to the investigation. *Id.* Respondents Samsung, VAIO, and transcosmos were terminated from the investigation based on a settlement agreement. *See* Order No. 45 (Apr. 26, 2019), *not reviewed by* Comm'n Notice (May 15, 2019).

On January 30, 2019, Respondents filed a motion for summary determination with respect to the technical prong of the domestic industry requirement. BiTMICRO and OUII each filed a response opposing the motion. Thereafter, Respondents filed a reply brief.

On March 26, 2019, the ALJ issued Order No. 31 (Mar. 26, 2019), granting-

in-part Respondents' motion for summary determination with respect to the technical prong of the domestic industry requirement. BiTMICRO filed a petition for review of Order No. 31. Respondents and OUII each filed a response to the petition.

On April 9, 2019, BiTMICRO, SK hynix, and the Remaining Respondents filed a joint motion to stay the procedural schedule by four weeks to allow time to finalize a settlement agreement. The next day the ALJ issued Order No. 44 (Apr. 10, 2019), granting the joint motion to stay. The stay was extended pursuant to Order No. 46 (May 9, 2019).

On May 17, 2019, BiTMICRO, SK hynix, and the Remaining Respondents filed a joint motion to terminate the investigation in its entirety based on a settlement agreement between BiTMICRO and SK hynix pursuant to 19 CFR 210.21(b). On May 23, 2019, OUII filed a response supporting the motion.

On May 28, 2019, the ALJ issued the subject ID granting the motion to terminate. Order No. 47 at 1 (May 28, 2019). The ALJ found that the motion complies with the Commission Rules, and that no public interest factors prohibit the termination of this investigation as to SK hynix and the Remaining Respondents, who are downstream customers of SK hynix. *Id.* at 2–3. The ALJ found that the settlement agreement appears to resolve the disputes between BiTMICRO, SK hynix, and the Remaining Respondents. *Id.* at 2. No petitions for review were filed.

The Commission has determined not to review the subject ID. The Commission's determination renders the ALJ's findings in Order No. 31 moot. The Commission has determined to review and take no position on Order No. 31. The investigation is terminated in its entirety.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in Part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.

Dated: June 17, 2019.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2019–13121 Filed 6–19–19; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Proposed Bankruptcy Settlement Agreement Under the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA)

On June 12, 2019, the Debtors lodged a proposed Bankruptcy Settlement Agreement with the United States Bankruptcy Court for the Western District of North Carolina in the bankruptcy proceeding of *Kaiser Gypsum Company, Inc. and Hanson Permanente Cement, Inc.* (collectively, the ''Debtors''), jointly administered at Case No. 16–31602, [Docket No. 1719]. A fully executed version of the proposed Bankruptcy Settlement Agreement was lodged on June 17, 2019, [Docket No. 1735].

The proposed Bankruptcy Settlement Agreement resolves certain claims on behalf of the United States Environmental Protection Agency asserted against the Debtors under the Comprehensive Environmental Response, Compensation and Liability Act (''CERCLA'') for costs incurred and to be incurred by the United States in connection with 5 parcels of property formerly owned and operated by the Debtors. Under the proposed Bankruptcy Settlement Agreement EPA will have an allowed general unsecured claim of $3.25 million for the Lower Duwamish Waterway Site (''LDW Site'') in Seattle, Washington. In addition, the proposed Bankruptcy Settlement resolves Natural Resource Damage claims against Debtors related to the Lower Duwamish River, on behalf of the United States Department of Interior (''DOI'') and the National Oceanic and Atmospheric Administration (''NOAA''), for an allowed general unsecured claim of $1 million.

The Settlement Agreement includes certain covenants not to sue under Sections 106 and 107 of CERCLA, 42 U.S.C. 9606 or 9607, with respect to the LDW Site. DOI and NOAA are providing a covenant not to sue under Section 107 of CERCLA, 42 U.S.C. 9607 with respect to the Lower Duwamish River.

The publication of this notice opens a period for public comment on the Bankruptcy Settlement Agreement. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and should refer to *In re Kaiser Gypsum Company, Inc.,* D.J. Ref. No. 90–11–3–11737 and 90–11–3–11737/1. All comments must be submitted no later than thirty (30) days after the publication date of this notice. Comments may be submitted either by email or by mail:

To submit comments:	*Send them to:*
By email	*pubcomment-ees.enrd@usdoj.gov.*
By mail	Assistant Attorney General, U.S. DOJ—ENRD, P.O. Box 7611, Washington, DC 20044–7611.

During the public comment period, the Bankruptcy Settlement Agreement may be examined and downloaded at this Justice Department website: *https://www.justice.gov/enrd/consent-decrees.* We will provide a paper copy of the Bankruptcy Settlement Agreement upon written request and payment of reproduction costs. Please mail your request and payment to: Consent Decree Library, U.S. DOJ—ENRD, P.O. Box 7611, Washington, DC 20044–7611.

Please enclose a check or money order for $8.50 (25 cents per page reproduction cost) payable to the United States Treasury.

Susan M. Akers,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2019–13165 Filed 6–19–19; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Office of Justice Programs

[OMB Number 1121–0341]

Agency Information Collection Activities; Proposed eCollection eComments Requested: Revision of a Currently Approved Collection; Office for Victims of Crime Training and Technical Assistance Center (OVC TTAC) Feedback Form Package

AGENCY: Office for Victims of Crime, Office of Justice Programs, Department of Justice.

ACTION: 30-Day notice.

SUMMARY: The Department of Justice, Office of Justice Programs, Office for Victims of Crime will submit the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The proposed information collection is published to obtain comments from the public and affected agencies. This proposed information collection was previously published in the **Federal Register**, allowing for a 60 day comment period.

DATES: The purpose of this notice is to allow for an additional 30 days for public comment until July 22, 2019.

FOR FURTHER INFORMATION CONTACT: If you have additional comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Shelby Jones Crawford, (202) 532–3612, Program Manager, Office for Victims of Crime, Office of Justice Programs, Department of Justice, 810 7th Street NW, Washington, DC 20530. Written comments and/or suggestions can also be sent to the Office of Management and Budget, Office of Information and Regulatory Affairs, Attention Department of Justice Desk Officer, Washington, DC 20503 or sent to *OIRA_submissions@omb.eop.gov*.

SUPPLEMENTARY INFORMATION: Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Office of Justice Programs, Office for Victims of Crime including whether the information will have practical utility;
—Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
—Evaluate whether and if so how the quality, utility, and clarity of the information to be collected can be enhanced; and
—Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of This Information Collection

1. *Type of Information Collection:* Revision of Existing Collection.
2. *The Title of the Form/Collection:* OVC TTAC Feedback Form Package.
3. *The agency form number:* N/A. Office for Victims of Crime, Office of Justice Programs, Department of Justice.
4. *Affected public who will be asked or required to respond, as well as a brief abstract:* Primary: State, Local, or Tribal agencies/organizations. Other: Federal Government; Individuals or households; Not-for-profit institutions; Businesses or other for-profit. Abstract: The Office for Victims of Crime Training and Technical Assistance Center (OVC TTAC) Feedback Form Package is designed to collect the data necessary to continuously assess the satisfaction and outcomes of assistance provided through OVC TTAC for both monitoring and accountability purposes to continuously meet the needs of the victim services field. OVC TTAC will give these forms to recipients of training and technical assistance, scholarship applicants, users of the website and call center, consultants/instructors providing training, agencies requesting services, and other professionals receiving assistance from OVC TTAC. The purpose of this data collection will be to capture important feedback on the respondents' satisfaction and outcomes of the resources provided. The data will then be used to advise OVC on ways to improve the support that it provides to the victim services field at-large.
5. *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* There are approximately 25,425 respondents who will require an average of 10 minutes (ranging from 5 to 15 minutes across all forms) to respond to a single form each year.
6. *An estimate of the total public burden (in hours) associated with the collection:* The total annual public burden hours for this information collection are estimated to be 4,609 hours (1,152 hours per year).

If additional information is required contact: Melody Braswell, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE, 3E.405A, Washington, DC 20530.

Dated: June 14, 2019.

Melody Braswell,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2019–13032 Filed 6–19–19; 8:45 am]

BILLING CODE 4410–14–P

DEPARTMENT OF JUSTICE

Federal Bureau of Prisons

Notice of Withdrawal of Record of Decision: Proposed United States Penitentiary and Federal Prison Camp in Letcher County, Kentucky

AGENCY: Federal Bureau of Prisons, U.S. Department of Justice.

ACTION: Notice.

A record of decision (ROD) regarding the proposal by the United States Department of Justice, Federal Bureau of Prisons (Bureau) to acquire a site up to 800 acres in size and construct and operate a United States Penitentiary and Federal Prison Camp in Letcher County, Kentucky, was signed by Mark S. Inch, Director of the Bureau, and the ROD was published in the **Federal Register** (Vol. 83, No. 71, Page 15870) on Thursday, April 12, 2018.

Based on new information which may be relevant to the environmental analysis for the proposed action, Hugh J. Hurwitz, Acting Director of the Bureau, has withdrawn the ROD published in the **Federal Register** on Thursday, April 12, 2018, in order to more fully evaluate the new information. This Notice of Withdrawal of Record of Decision is published to inform the public that the ROD for the proposed action described above has been withdrawn.

FOR FURTHER INFORMATION CONTACT: If you have additional questions about this notice, please contact Issac Gaston, Site Selection Specialist; phone: 202–514–6470.

Issac Gaston,

Site Selection Specialist, Construction and Environmental Review Branch.

[FR Doc. 2019–13148 Filed 6–19–19; 8:45 am]

BILLING CODE P

NATIONAL SCIENCE FOUNDATION

Sunshine Act Meetings; National Science Board

The National Science Board's Committee on Oversight (CO), pursuant to NSF regulations (45 CFR part 614), the National Science Foundation Act, as amended (42 U.S.C. 1862n–5), and the Government in the Sunshine Act (5 U.S.C. 552b), hereby gives notice of the scheduling of a teleconference for the transaction of National Science Board business, as follows:

TIME & DATE: Tuesday, June 25, 2019 at 10:00–10:30 a.m. EDT.

PLACE: This meeting will be held by teleconference at the National Science Foundation, 2415 Eisenhower Avenue, Alexandria, VA 22314. An audio link will be available for the public. Members of the public must contact the Board Office to request the public audio link by sending an email to *nationalsciencebrd@nsf.gov* at least 24 hours prior to the teleconference.

STATUS: Open.

MATTERS TO BE CONSIDERED: Chair's opening remarks; discussion of status of 2018 merit review report and module planning.

CONTACT PERSON FOR MORE INFORMATION: Point of contact for this meeting is: Ann Bushmiller (*abushmil@nsf.gov*), 703/292–7000.

Meeting information and updates (time, place, subject matter or status of meeting) may be found at *http://www.nsf.gov/nsb/meetings/notices.jsp#sunshine.* Please refer to the National Science Board website *www.nsf.gov/nsb* for additional information.

Christopher Blair,

Executive Assistant, National Science Board Office.

[FR Doc. 2019–13201 Filed 6–18–19; 11:15 am]

BILLING CODE 7555–01–P

NATIONAL SCIENCE FOUNDATION

Sunshine Act Meetings; National Science Board

The National Science Board's Executive Committee (EC), pursuant to National Science Foundation regulations (45 CFR part 614), the National Science Foundation Act, as amended (42 U.S.C. 1862n–5), and the Government in the Sunshine Act (5 U.S.C. 552b), hereby gives notice of the scheduling of a teleconference for the transaction of National Science Board business, as follows:

TIME & DATE: Wednesday, June 26, 2019, from 4:00–5:00 p.m. EDT.

PLACE: This meeting will be held by teleconference at the National Science Foundation, 2415 Eisenhower Avenue, Alexandria, VA 22314. An audio link will be available for the public. Members of the public must contact the Board Office to request the public audio link by sending an email to *nationalsciencebrd@nsf.gov* at least 24 hours prior to the teleconference.

STATUS: Open.

MATTERS TO BE CONSIDERED: Committee Chair's opening remarks; approval of Executive Committee minutes of April 10, 2019; and discuss issues and topics for an agenda of the NSB meeting scheduled for July 17–18, 2019.

CONTACT PERSON FOR MORE INFORMATION: Point of contact for this meeting is: James Hamos, 2415 Eisenhower Avenue, Alexandria, VA 22314. Telephone: 703/292–8000. Meeting information and updates may be found at *http://www.nsf.gov/nsb/notices/.jsp#sunshine.* Please refer to the National Science Board website at *www.nsf.gov/nsb* for general information.

Christopher Blair,

Executive Assistant to the National Science Board Office.

[FR Doc. 2019–13209 Filed 6–18–19; 11:15 am]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2011–0266]

Evaluations of Uranium Recovery Facility Surveys of Radon and Radon Progeny

AGENCY: Nuclear Regulatory Commission.

ACTION: Interim staff guidance; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is issuing Interim Staff Guidance (ISG) DUWP–ISG–01, ''Evaluations of Uranium Recovery Facility Surveys of Radon and Radon Progeny in Air and Demonstrations of Compliance with 10 CFR 20.1301.'' This ISG provides guidance to the NRC staff for evaluating uranium recovery (UR) licensee demonstrations of compliance with the public dose limits. This action is necessary because there is insufficient existing guidance on this topic. This action will benefit NRC staff and UR licensees by providing detailed descriptions of methods acceptable to the NRC staff to meet the public dose limit requirement.

DATES: This guidance goes into effect on July 22, 2019.

ADDRESSES: Please refer to Docket ID NRC–2011–0266 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2011–0266. Address questions about NRC docket IDs to Jennifer Borges; telephone: 301–287–9127; email: *Jennifer.Borges@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents*'' and then select ''*Begin Web-based ADAMS Search.*'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The final ISG, DUWP–ISG–01, ''Evaluations of Uranium Recovery Facility Surveys of Radon and Radon Progeny in Air and Demonstrations of Compliance with 10 CFR 20.1301,'' is available in ADAMS under Accession No. ML15051A002.
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: David Brown, Office of Nuclear Material Safety and Safeguards; U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–7677; email: *David.Brown@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Discussion

Uranium recovery facility licensees, including in-situ recovery facilities and conventional uranium mills, are required to perform surveys of radiation levels in unrestricted and controlled areas, and to perform surveys of radioactive materials in effluents released to unrestricted and controlled areas to demonstrate compliance with the dose limits for individual members of the public provided in § 20.1301 of title 10 of the *Code of Federal Regulations* (10 CFR). The NRC's regulations in 10 CFR 20.1302 permit the use of alternative approaches to demonstrate compliance with the public dose limits.

This ISG was developed to document the criteria to be used by the NRC to review radon and radon progeny surveys and evaluations of dose to members of the public submitted by licensees under 10 CFR 20.1302 to demonstrate compliance with the NRC's public dose limits of 10 CFR 20.1301. Specifically, this final ISG provides guidance to the NRC staff for reviewing licensee evaluations of doses to members of the public from radon-222 and radon-222 progeny from UR facilities including: (1) Surveys of environmental and effluent radon and radon progeny in air; and (2) radon-related aspects of demonstrations of compliance with the NRC's public dose limits of 10 CFR 20.1301. This ISG also may be used by the NRC in evaluating portions of license applications, renewals, or amendments dealing with radon and radon progeny surveys and compliance. The NRC published an initial draft version of this ISG for public comment on November 21, 2011

(76 FR 72006). The NRC considered the public comments in preparing a revised draft report, published for public comment on March 27, 2014 (79 FR 17194). The NRC then considered the public comments on the revised draft in preparing the final report. This ISG was also the subject of an NRC staff non-concurrence. A completed NRC Non-Concurrence Process Form 757 is available in ADAMS under Accession No. ML19121A171.

The NRC has prepared a regulatory analysis for this ISG. The analysis examines the costs and benefits of the alternatives considered by the NRC. The regulatory analysis can be found in ADAMS under Accession No. ML19057A490.

This ISG is a rule as defined in the Congressional Review Act (5 U.S.C. 801–808). However, the Office of Management and Budget has not found it to be a major rule as defined in the Congressional Review Act.

Dated at Rockville, Maryland, this 14th day of June, 2019.

For the Nuclear Regulatory Commission.

Bo M. Pham,

Deputy Director, Division of Decommissioning, Uranium Recovery and Waste Programs, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2019–13005 Filed 6–19–19; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86109; File No. SR–MIAX–2019–28]

Self-Regulatory Organizations; Miami International Securities Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Its Fee Schedule

June 14, 2019.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on May 31, 2019, Miami International Securities Exchange LLC (''MIAX'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') a proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange is filing a proposal to amend the MIAX Options Fee Schedule (the ''Fee Schedule'') to waive certain non-transaction fees applicable to Market Makers[3] that trade solely in Proprietary Products[4] until September 30, 2019.

While changes to the Fee Schedule pursuant to this proposal are effective upon filing, the Exchange has designated these changes to be operative on June 1, 2019.

The text of the proposed rule change is available on the Exchange's website at *http://www.miaxoptions.com/rule-filings,* at MIAX's principal office, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Background

On October 12, 2018, the Exchange received approval from the Commission to list and trade on the Exchange, options on the SPIKES® Index, a new index that measures expected 30-day volatility of the SPDR S&P 500 ETF Trust (commonly known and referred to by its ticker symbol, ''SPY'').[5] The Exchange adopted its initial SPIKES transaction fees on February 15, 2019.[6]

Proposal

The Exchange now proposes to amend its Fee Schedule to waive certain non-transaction fees applicable to Market Makers that trade solely in Proprietary Products (including options on the SPIKES Index) until September 30, 2019. In particular, the Exchange proposes to amend Section (1)(a)(xi) of the Fee Schedule to add a definition for Proprietary Product. The Exchange also proposes to amend Sections (3)(a), (3)(b), (4)(a), and (5)(d)(ii) of the Fee Schedule to adopt language that the Exchange will waive Membership Application Fees, monthly Market Maker Trading Permit Fees, Member Application Programming Interface (''API'') Testing and Certification Fees, and monthly MEI Port Fees (as defined below) that are assessed to Market Makers that trade solely in Proprietary Products (including options on SPIKES) until September 30, 2019.

Definition for Proprietary Product

Exchange Rule 100 currently provides a definition for Proprietary Product.[7] The Exchange now proposes to amend Section (1)(a)(xi) of the Fee Schedule to insert the symbol ''Δ'' immediately following the SPIKES Simple and Complex Fees table, followed by the definition for Proprietary Product. The Exchange also proposes to adopt text for the symbol ''Δ'' explicitly stating that SPIKES is a Proprietary Product. The purpose of this proposal is to clarify that SPIKES is a Proprietary Product of MIAX and, together with the other proposed changes, that the Exchange will waive certain non-transaction fees applicable to Market Makers that trade solely in Proprietary Products (including options on SPIKES), until September 30, 2019.

Membership Application Fees

MIAX currently assesses Membership fees for applications of potential Members. MIAX assesses a one-time Membership Application Fee on the earlier of (i) the date the applicant is certified in the membership system, or (ii) once an application for MIAX membership is finally denied. The one-time application fee is based upon the applicant's status as either a Market Maker or an Electronic Exchange

[3] The term ''Market Makers'' refers to ''Lead Market Makers'', ''Primary Lead Market Makers'' and ''Registered Market Makers'' collectively. *See* Exchange Rule 100.

[4] The term ''Proprietary Product'' means a class of options that is listed exclusively on the Exchange. *See* Exchange Rule 100.

[5] *See* Securities Exchange Act Release No. 84417 (October 12, 2018), 83 FR 52865 (October 18, 2018) (SR–MIAX–2018–14) (Order Granting Approval of a Proposed Rule Change by Miami International Securities Exchange, LLC to List and Trade on the Exchange Options on the SPIKES™ Index).

[6] *See* Securities Exchange Release No. 85283 (March 11, 2019), 84 FR 9567 (March 15, 2019) (SR–MIAX–2019–11). (The Exchange initially filed the proposal on February 15, 2019 (SR–MIAX–2019–04). That filing was withdrawn and replaced with (SR–MIAX–2019–11)).

[7] *See supra* note 4.

Member (''EEM''). A Market Maker is assessed a one-time Membership Application Fee of $3,000.00.

MIAX proposes that the one-time Membership Application Fee of $3,000.00 for Market Makers that trade solely in Proprietary Products (including options on SPIKES) will be waived until September 30, 2019, which the Exchange proposes to state in the Fee Schedule. The purpose of this proposed change is provide an incentive for potential Market Makers to submit membership applications, which should result in increasing potential liquidity in MIAX Proprietary Products, including options on SPIKES. Even though the Exchange is proposing to waive this particular fee for Market Makers who will trade solely in Proprietary Products until September 30, 2019, the overall structure of the fee is outlined in the Fee Schedule so that there is general awareness that the Exchange intends to assess such a fee after September 30, 2019.

Trading Permit Fees

MIAX issues Trading Permits that confer the ability to transact on the Exchange. MIAX Trading Permits are issued to Market Makers and EEMs. Members receiving Trading Permits during a particular calendar month are assessed monthly Trading Permit Fees as set forth in the Fee Schedule. As it relates to Market Makers, MIAX currently assesses a monthly Trading Permit Fee in any month the Market Maker is certified in the membership system, is credentialed to use one or more MEI Ports in the production environment and is assigned to quote in one or more classes. MIAX assesses its Market Makers the monthly Market Maker Trading Permit Fee based on the greatest number of classes listed on MIAX that the MIAX Market Maker was assigned to quote in on any given day within a calendar month and the applicable fee rate this is the lesser of either the per class basis or percentage of total national average daily volume measurements. A MIAX Market Maker is assessed a monthly Trading Permit Fee according to the following table:

Type of trading permit	Monthly MIAX trading permit fee	Market maker assignments (the lesser of the applicable measurements below)	
		Per class	% of national average daily volume
Market Maker (includes RMM, LMM, PLMM).	$7,000.00	Up to 10 Classes	Up to 20% of Classes by volume.
	12,000.00	Up to 40 Classes	Up to 35% of Classes by volume.
	*17,000.00	Up to 100 Classes	Up to 50% of Classes by volume.
	*22,000.00	Over 100 Classes.	Over 50% of Classes by volume up to all Classes listed on MIAX.

*For these Monthly MIAX Trading Permit Fee levels, if the Market Maker's total monthly executed volume during the relevant month is less than 0.060% of the total monthly executed volume reported by OCC in the market maker account type for MIAX-listed option classes for that month, then the fee will be $15,500 instead of the fee otherwise applicable to such level.

MIAX proposes that the monthly Trading Permit Fee for Market Makers that trade solely in Proprietary Products (including options on SPIKES) will be waived until September 30, 2019, which the Exchange proposes to state in the Fee Schedule. The purpose of this proposed change is to provide an incentive for Market Makers to provide liquidity in Proprietary Products on the Exchange, which should result in increasing potential order flow and volume in MIAX Proprietary Products, including options on SPIKES. Even though the Exchange is proposing to waive this particular fee for Market Makers trading solely in Proprietary Products until September 30, 2019, the overall structure of the fee is outlined in the Fee Schedule so that there is general awareness by potential Members seeking a Trading Permit on the Exchange that the Exchange intends to assess such a fee after September 30, 2019.

The Exchange also proposes that Market Makers who trade MIAX Proprietary Products (including options on SPIKES) along with multi-listed classes will not have Proprietary Products (including SPIKES) counted toward those Market Makers' class assignment count or percentage of total national average daily volume. The Exchange proposes to note this exclusion by inserting the new symbol ''Ω'' following the table that shows the monthly Trading Permit Fees currently assessed for Market Makers in Section (3)(b) of the Fee Schedule.

API Testing and Certification Fee

MIAX assesses an Application Programming Interface (''API'') Testing and Certification Fee on all Members depending upon the type of Member. An API makes it possible for Members' software to communicate with MIAX software applications, and is subject to Members testing with, and certification by, MIAX. The Exchange offers four types of interfaces: (i) The Financial Information Exchange (''FIX'') Port, which enables the FIX Port user (typically an EEM or a Market Maker) to submit simple and complex orders electronically to MIAX; (ii) the MIAX Express Interface (''MEI'') Port, which enables Market Makers to submit simple and complex electronic quotes to MIAX; (iii) the Clearing Trade Drop (''CTD'') Port, which provides real-time trade clearing information to the participants to a trade on MIAX and to the participants' respective clearing firms; and (iv) the FIX Drop Copy (''FXD'') Port, which provides a copy of real-time trade execution, correction and cancellation information through a FIX Port to any number of FIX Ports designated by an EEM to receive such messages.

API Testing and Certification Fees for Market Makers are assessed (i) initially per API for CTD and MEI in the month the Market Maker has been credentialed to use one or more ports in the production environment for the tested API and the Market Maker has been assigned to quote in one or more classes, and (ii) each time a Market Maker initiates a change to its system that requires testing and certification. API Testing and Certification Fees will not be assessed in situations where the Exchange initiates a mandatory change to the Exchange's system that requires testing and certification. A Market Maker is assessed an API Testing and Certification Fee of $2,500.00. The fees represent costs incurred by the Exchange as it works with each Member for testing and certifying that the Member's software systems communicate properly with MIAX's interfaces.

MIAX proposes that the API Testing and Certification Fee for Market Makers that trade solely in Proprietary Products (including options on SPIKES) will be waived until September 30, 2019, which the Exchange proposes to state in the Fee Schedule. The purpose of this proposed change is provide an incentive for potential Market Makers to develop

software applications to trade in MIAX Proprietary Products, including options on SPIKES. Even though the Exchange is proposing to waive this particular fee for Market Makers who will trade solely in Proprietary Products until September 30, 2019, the overall structure of the fee is outlined in the Fee Schedule so that there is general awareness that the Exchange intends to assess such a fee after September 30, 2019.

MEI Port Fees

MIAX provides four (4) Port types, including (i) the FIX Port, which enables the FIX Port user (typically an EEM or a Market Maker) to submit simple and complex orders electronically to MIAX; (ii) the MEI Port, which enables Market Makers to submit simple and complex electronic quotes to MIAX;; [sic] (iii) the CTD Port, which provides real-time trade clearing information to the participants to a trade on MIAX and to the participants' respective clearing firms; and (iv) the FXD Port, which provides a copy of real-time trade execution, correction and cancellation information through a FIX Port to any number of FIX Ports designated by an EEM to receive such messages.

MIAX assesses monthly MEI Port Fees on Market Makers in each month the Member has been credentialed to use the MEI Port in the production environment and has been assigned to quote in at least one class. The amount of the monthly MEI Port Fee is based upon the number of classes in which the Market Maker was assigned to quote on any given day within the calendar month, and upon the class volume percentages set forth in the above table. The class volume percentage is based on the total national average daily volume in classes listed on MIAX in the prior calendar quarter. Newly listed option classes are excluded from the calculation of the monthly MEI Port Fee until the calendar quarter following their listing, at which time the newly listed option classes will be included in both the per class count and the percentage of total national average daily volume. The Exchange assesses MIAX Market Makers the monthly MEI Port Fee based on the greatest number of classes listed on MIAX that the MIAX Market Maker was assigned to quote in on any given day within a calendar month and the applicable fee rate that is the lesser of either the per class basis or percentage of total national average daily volume measurement. MIAX assesses MEI Port Fees on Market Makers according to the following table:

Monthly MIAX MEI fees	Market maker assignments (the lesser of the applicable measurements below)	
	Per class	% of national average daily volume
$5,000.00	Up to 5 Classes	Up to 10% of Classes by volume.
$10,000.00	Up to 10 Classes	Up to 20% of Classes by volume.
$14,000.00	Up to 40 Classes	Up to 35% of Classes by volume.
$17,500.00*	Up to 100 Classes	Up to 50% of Classes by volume.
$20,500.00*	Over 100 Classes	Over 50% of Classes by volume up to all Classes listed on MIAX.

* For these Monthly MIAX MEI Fees levels, if the Market Maker's total monthly executed volume during the relevant month is less than 0.060% of the total monthly executed volume reported by OCC in the market maker account type for MIAX-listed option classes for that month, then the fee will be $14,500 instead of the fee otherwise applicable to such level.

MIAX proposes that the monthly MEI Port Fee for Market Makers that trade solely in Proprietary Products (including options on SPIKES) will be waived until September 30, 2019, which the Exchange proposes to state in the Fee Schedule. The purpose of this proposal is to provide an incentive to Market Makers to connect to MIAX through the MEI Port such that they will be able to trade in MIAX Proprietary Products. Even though the Exchange is proposing to waive this particular fee for Market Makers trading solely in Proprietary Products until September 30, 2019, the overall structure of the fee is outlined in the Fee Schedule so that there is general awareness that the Exchange intends to assess such a fee after September 30, 2019.

The Exchange notes that for the purposes of this proposed change, other Market Makers who trade MIAX Proprietary Products (including options on SPIKES) along with multi-listed classes will not have Proprietary Products (including SPIKES) counted toward those Market Makers' class assignment count or percentage of total national average daily volume. The Exchange proposes to note this exclusion by inserting the new symbol ''Ω'' following the table that shows the monthly MEI Port Fees currently assessed for Market Makers in Section (5)(d)(ii) of the Fee Schedule.

The proposed fee waivers are targeted at market participants, particularly market makers, who are not currently members of MIAX, who may be interested in being a Market Maker in Proprietary Products on the Exchange. The Exchange estimates that there are fewer than ten (10) such market participants that could benefit from these fee waivers. The proposed fee waivers do not apply differently to different sizes of market participants, however they do only apply to Market Makers (and not EEMs). The Exchange believes it is reasonable to only offer fee waivers to market makers because the Exchange is seeking additional liquidity providers for Proprietary Products, in order to enhance liquidity and spreads in Proprietary Products, which is traditionally provided by Market Makers, as opposed to EEMs.

2. Statutory Basis

The Exchange believes that its proposal to amend its Fee Schedule is consistent with Section 6(b) of the Act [8] in general, and furthers the objectives of Section 6(b)(4) of the Act [9] in particular, in that it is an equitable allocation of reasonable fees and other charges among its members and issuers and other persons using its facilities. The Exchange also believes the proposal furthers the objectives of Section 6(b)(5) of the Act in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest and is not designed to permit unfair discrimination between customers, issuers, brokers and dealers.

The Exchange believes the proposed fee waivers are reasonable and equitable because they waive non-transaction fees for a limited period of time in order to enable the Exchange to improve its overall competitiveness and strengthen its market quality for all market participants in MIAX's Proprietary Products, including options on SPIKES.

[8] 15 U.S.C. 78f(b).

[9] 15 U.S.C. 78f(b)(4) and (5).

The proposed fee waivers are fair and equitable and not unreasonably discriminatory because they will apply equally to the market participants not currently registered as Market Makers at the Exchange. Any market participant may choose to satisfy the additional requirements and obligations of being a Market Maker and trade solely in Proprietary Products in order to qualify for the fee waivers.

The Exchange believes that it is equitable and not unfairly discriminatory to waive certain non-transaction fees for Market Makers as compared to EEMs because Market Makers, unlike other market participants, take on a number of obligations, including quoting obligations that other market participants do not have. Further, Market Makers have added market making and regulatory requirements, which normally do not apply to other market participants. For example, Market Makers have obligations to maintain continuous markets, engage in a course of dealings reasonably calculated to contribute to the maintenance of a fair and orderly market, and to not make bids or offers or enter into transactions that are inconsistent with a course of dealing.

The Exchange believes it is reasonable and equitable to waive the one-time Membership Application Fee, monthly Trading Permit Fee, API Testing and Certification Fee, and monthly MEI Port Fee for Market Makers that trade solely in Proprietary Products (including options on SPIKES) until September 30, 2019, since the waiver of such fees provides incentives to interested market participants to trade in Proprietary Products. This should result in increasing potential order flow and liquidity in MIAX Proprietary Products, including options on SPIKES.

MIAX believes it is reasonable and equitable to waive the API Testing and Certification fee assessable to Market Makers that trade solely in Proprietary Products (including options on SPIKES) since the waiver of such fees provides incentives to interested Members to develop and test their APIs sooner. Determining system operability with the Exchange's system will in turn provide MIAX with potential order flow and liquidity providers in Proprietary Products.

The Exchange believes it is reasonable, equitable and not unfairly discriminatory that Market Makers who trade in Proprietary Products along with multi-listed classes will not have Proprietary Products counted toward those Market Makers' class assignment count or percentage of total national average daily volume for monthly Trading Permit Fees and monthly MEI Port Fees in order to incentivize existing Market Makers who currently trade in multi-listed classes to also trade in Proprietary Products, without incurring certain additional fees.

The Exchange believes that the proposed fee waivers constitute an equitable allocation of reasonable fees and other charges among its members and issuers and other persons using its facilities. The proposed fee waivers are available to all prospective market makers that wish to become Market Maker Members of the Exchange and quote solely in Proprietary Products. The proposed fee waivers do not apply to potential EEMs, because the Exchange is seeking to enhance the quality of its markets in Proprietary Products through introducing more competition among market makers in Proprietary Products. In order to increase the competition, the Exchange believes that it must waive entry type fees for such market makers. EEMs do not provide the benefit of enhanced liquidity which is provided by market makers, therefore the Exchange believes it is reasonable and not unfairly discriminatory to only offer the proposed fee waivers to market makers (and not EEMs). Further, the Exchange believes it is reasonable and not unfairly discriminatory to exclude Proprietary Products from an existing Market Maker's permit fees and port fees, in order to incentive such Market Makers to quote in Proprietary Products. The amount of a Market Maker's permit and port fee is determined by the number of classes quoted and volume of the Market Maker. By excluding Proprietary Products from such fees, the Exchange is able to incentivize Market Makers to quote in Proprietary Products. EEMs do not pay permit and port fees based on the classes traded or volume, so the Exchange believes it is reasonable, equitable, and not unfairly discriminatory to only offer the exclusion to market makers (and not EEMs).

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. The Exchange believes that the proposed changes would increase intramarket competition by incentivizing new potential market makers to quote in Proprietary Products, which will enhance the quality of quoting and increase the volume of contracts in Proprietary Products traded on MIAX. To the extent that this purpose is achieved, all the Exchange's market participants should benefit from the improved market liquidity for the Exchange's Proprietary Products. Enhanced market quality and increased transaction volume in Proprietary Products that results from the anticipated increase in Market Maker activity on the Exchange will benefit all market participants and improve competition on the Exchange.

The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the proposed changes for each separate type of market participant (new market makers and existing market makers) will be assessed equally to all such market participants. While different fees are assessed to different market participants in some circumstances, these different market participants have different obligations and different circumstances as discussed above. For example, Market Makers have quoting obligations that other market participants (such as EEMs) do not have.

The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the propose fee waivers relate solely to Proprietary Products, which are traded exclusively on the Exchange.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act,[10] and Rule 19b–4(f)(2) [11] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine

[10] 15 U.S.C. 78s(b)(3)(A)(ii).

[11] 17 CFR 240.19b–4(f)(2).

whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–MIAX–2019–28 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–MIAX–2019–28. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–MIAX–2019–28 and should be submitted on or before July 11, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13070 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86110; File No. SR–MIAX–2019–29]

Self-Regulatory Organizations; Miami International Securities Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Its Fee Schedule

June 14, 2019.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on May 31, 2019, Miami International Securities Exchange LLC (''MIAX'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') a proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange is filing a proposal to amend the MIAX Options Fee Schedule (the ''Fee Schedule'') to adopt a rebate program for Market Makers[3] that submit aggressively priced quotes in SPIKES options.

While changes to the Fee Schedule pursuant to this proposal are effective upon filing, the Exchange has designated these changes to be operative on June 1, 2019.

The text of the proposed rule change is available on the Exchange's website at *http://www.miaxoptions.com/rule-filings,* at MIAX's principal office, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The term ''Market Makers'' refers to ''Lead Market Makers'', ''Primary Lead Market Makers'' and ''Registered Market Makers'' collectively. *See* Exchange Rule 100.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Background

On October 12, 2018, the Exchange received approval from the Commission to list and trade on the Exchange, options on the SPIKES® Index, a new index that measures expected 30-day volatility of the SPDR S&P 500 ETF Trust (commonly known and referred to by its ticker symbol, ''SPY'').[4] The Exchange adopted its initial SPIKES transaction fees on February 15, 2019.[5]

Proposal

The Exchange now proposes to amend Section (1)(a)(xi) of the Fee Schedule to adopt a Market Turner Incentive Program (the ''Program'') that will provide rebates to Market Makers that submit aggressively priced quotes in options on SPIKES. The term ''Market Turner'' will mean a Market Maker simple quote (not eQuote) that establishes and maintains the new MIAX best bid (the ''MBB'') or the MIAX best offer (''MBO'') in a SPIKES option. Under the Program, the Exchange will pay a per contract rebate to the Market Turner for each contract that executes as the MBB (MBO). The amount of the rebate shall be (i) $0.20 per executed contract, for options having a premium price greater than $0.10, or (ii) $0.05 per executed contract, for options having a premium price of $0.10 or less. The Exchange

[4] *See* Securities Exchange Act Release No. 84417 (October 12, 2018), 83 FR 52865 (October 18, 2018) (SR–MIAX–2018–14) (Order Granting Approval of a Proposed Rule Change by Miami International Securities Exchange, LLC to List and Trade on the Exchange Options on the SPIKES™ Index).

[5] *See* Securities Exchange Release No. 85283 (March 11, 2019), 84 FR 9567 (March 15, 2019) (SR–MIAX–2019–11). (The Exchange initially filed the proposal on February 15, 2019 (SR–MIAX–2019–04). That filing was withdrawn and replaced with (SR–MIAX–2019–11)).

notes that a Market Maker who is also a Maker but not a Market Turner will not receive the Market Turner rebate and will receive the Maker rate currently prescribed in the Simple and Complex Fee table in Section (xi) of the Fee Schedule. The purpose of the Program is to encourage Market Makers to submit aggressively-priced quotes in SPIKES options, which will enable the Exchange to strengthen its market quality for all market participants in SPIKES options.

Under the Program, a Market Turner must submit a resting quote that sets a more aggressive price, and subsequently does not become inferior to another quote or order. A Market Turner will lose its Market Turner status if a more aggressively priced resting quote or order price improves the current Market Turner's quote. Market Turner status will also be lost if the Market Turner's quote becomes inferior. Market Turner quote size changes without any price change will not affect Market Turner status. The Exchange also proposes that, under the Program, Market Turner status is not available for quotes coming out of the opening, reopening after a trading halt, or uncrossing. Further, the Exchange proposes that there will not be Market Turner status for a Taker, except when there is remaining interest that rests (becomes the Maker).

The Program is similar to a NBBO setter incentive plan in place at Cboe BZX Exchange, Inc. (''Cboe BZX'').[6] However, the Exchange notes that there are several differences between MIAX's proposal and the plan adopted by Cboe BZX: (1) The Program only includes rebates for Market Makers in SPIKES options (a Proprietary Product) while Cboe BZX's plan includes multi-listed options; (2) the Program will not require an ADV threshold while Cboe BZX requires certain thresholds to be met; (3) the Program has one level of rebate while Cboe BZX has different tier levels; and (4) the Program requires that a ''Market Turner must submit a resting quote that sets a more aggressive price, and subsequently does not become inferior to another quote or order'' whereas under Cboe BZX's plan, ''[a]n order that is entered at the most aggressive price both on the [Cboe BZX] book and according to then current OPRA data will be determined to have set the NBB or NBO for purposes of the NBBO Setter Rebate without regard to whether a more aggressive order is entered prior to the original order being executed.'' [7]

The proposed rebates are targeted at Market Makers in SPIKES options. There are currently fewer than five (5) Market Makers in SPIKES options that could benefit from these rebates, however the Program is also designed to attract additional market makers (both existing Market Maker members of MIAX as well as non-members to join MIAX) to quote in SPIKES options. Thus, the Exchange estimates that, overall, there would be fewer than fifteen (15) such market participants that could benefit from these rebates. The proposed rebates do not apply differently to different sizes of market participants, however they do only apply to Market Makers (and not EEMs). The Exchange believes it is reasonable to only offer rebates to Market Makers because the Exchange is seeking continuous, two-sided quoting liquidity providers for SPIKES options, in order to enhance liquidity and spreads in SPIKES Options, which is traditionally provided by Market Makers, as opposed to EEMs.

The proposed rule change is to become operative June 1, 2019.

2. Statutory Basis

The Exchange believes that its proposal to amend its Fee Schedule is consistent with Section 6(b) of the Act [8] in general, and furthers the objectives of Section 6(b)(4) of the Act [9] in particular, in that it provides for the equitable allocation of reasonable dues, fees and other charges among Exchange Members [10] and issuers and other persons using its facilities. The Exchange also believes the proposal furthers the objectives of Section 6(b)(5) of the Act [11] in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest and is not designed to permit unfair discrimination between customer, issuers, brokers and dealers.

The Exchange believes that its proposal to adopt the Program for Market Makers in SPIKES options is consistent with Section 6(b)(4) of the Act in that the proposal is reasonable, equitable and not unfairly discriminatory. The proposed fee changes are reasonably designed because they are intended to incentivize Market Makers to quote aggressively in SPIKES options on the Exchange, which will enable the Exchange to strengthen its market quality for all market participants in SPIKES options. In particular, the proposed changes are designed to incentivize Market Makers in SPIKES options to enter quotes which establish and maintain a new MBB or MBO on the Exchange in an effort to qualify for a rebate as a Market Turner under the Program.

The Exchange believes that it is equitable and not unfairly discriminatory to have the Program rebates apply only to Market Makers (as compared to Electronic Exchange Members [12] (''EEMs'')) because Market Makers, unlike other market participants, take on a number of obligations, including quoting obligations that other market participants do not have. In particular, the proposed rebates will encourage Market Maker quotes at the MBB or MBO, and is therefore directly focused on encouraging aggressively priced liquidity in SPIKES options. Further, Market Makers have added market making and regulatory requirements, which normally do not apply to other market participants. For example, Market Makers have obligations to maintain continuous markets, engage in a course of dealings reasonably calculated to contribute to the maintenance of a fair and orderly market, and to not make bids or offers or enter into transactions that are inconsistent with a course of dealing.

The Exchange believes that it is reasonable to establish a separate incentive program for Market Makers in SPIKES options in order to encourage trading in SPIKES options on the Exchange. Defining the proposed Program on the Fee Schedule promotes just and equitable principles of trade, removes impediments to and perfects the mechanism of a free and open market and a national market system, and, in general protects investors and the public interest by creating a clear understanding of the Program.

The proposed Program rebates are reasonable, equitable, and not unfairly discriminatory because they will apply similarly to all Market Makers who trade in SPIKES options and establish a Market Turner quote. All similarly

[6] *See* Securities Exchange Act Release No. 63632 (January 3, 2011), 76 FR 1205 (January 7, 2011) (SR–BATS–2010–038).

[7] *See supra* note 6.

[8] 15 U.S.C. 78f(b).

[9] 15 U.S.C. 78f(b)(4).

[10] The term ''Member'' means an individual or organization approved to exercise the trading rights associated with a Trading Permit. Members are deemed ''members'' under the Exchange Act. *See* Exchange Rule 100.

[11] 15 U.S.C. 78f(b)(5).

[12] The term ''Electronic Exchange Member'' or ''EEM'' means the holder of a Trading Permit who is not a Market Maker. Electronic Exchange Members are deemed ''members'' under the Exchange Act. *See* Exchange Rule 100.

situated Market Makers are subject to the same transaction rebate schedule, and access to the Exchange is offered on terms that are not unfairly discriminatory.

The Exchange believes that the proposed rebates constitute an equitable allocation of reasonable fees and other charges among its members and issuers and other persons using its facilities. The proposed rebates are available to all Market Maker Members of the Exchange that quote in SPIKES options. The proposed rebates do not apply to EEMs, because the Exchange is seeking to enhance the quality of its markets in SPIKES options through introducing more competition among market makers in SPIKES options. The Exchange believes that offering the proposed rebates to Market Turners will cause Market Makers to quote more aggressively, thus improving the overall market quality in SPIKES options, for the benefit of all market participants in SPIKES options. In order to increase competition among Market Makers, the Exchange believes that it must pay rebates to Market Makers. EEMs do not provide the same type of continuous, two-sided market liquidity which is provided by Market Makers, therefore the Exchange believes it is reasonable and not unfairly discriminatory to only offer the proposed rebates to Market Makers (and not EEMs).

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. The Exchange believes that the proposed changes would increase intramarket competition by incentivizing Market Makers to quote aggressively in SPIKES options, which will enhance the quality of quoting and increase the volume of contracts in SPIKES options traded on MIAX. To the extent that this purpose is achieved, all the Exchange's market participants should benefit from the improved market liquidity for the Exchange's SPIKES options. Enhanced market quality and increased transaction volume in SPIKES options that results from the anticipated increase in Market Maker activity on the Exchange will benefit all market participants and improve competition on the Exchange.

The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the proposed changes for Market Makers will be assessed equally to all such Market Makers. While different fees are assessed to different market participants in some circumstances, these different market participants have different obligations and different circumstances as discussed above. For example, Market Makers have quoting obligations that other market participants (such as EEMs) do not have.

The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the propose rebates relate solely to SPIKES options, which are traded exclusively on the Exchange.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act,[13] and Rule 19b–4(f)(2) [14] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–MIAX–2019–29 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–MIAX–2019–29. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–MIAX–2019–29 and should be submitted on or before July 11, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13071 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[13] 15 U.S.C. 78s(b)(3)(A)(ii).

[14] 17 CFR 240.19b–4(f)(2).

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86111; File No. SR–NYSEAMER–2018–39]

Self-Regulatory Organizations; NYSE American LLC; Notice of Withdrawal of Proposed Rule Change, as Modified by Amendment No. 2, To Allow Flexible Exchange Equity Options To Be Cash Settled Where the Underlying Security Is a Specified Exchange-Traded Fund

June 14, 2019.

On September 20, 2018, NYSE American LLC (''NYSE American'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to modify the rules related to Flexible Exchange (''FLEX'') Options to allow cash settlement for certain FLEX Equity Options. The proposal, as modified by Amendment No. 2, would allow FLEX Equity Options to be cash settled where the underlying security is one of 25 specified Exchange-Traded Funds (''ETF'').

The proposed rule change was published for comment in the **Federal Register** on October 11, 2018.[3] On November 19, 2018, pursuant to Section 19(b)(2) of the Act,[4] the Commission designated a longer period within which to either approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to disapprove the proposed rule change.[5] The Commission received one comment in response to the Original Notice.[6]

On December 19, 2018, the Commission instituted proceedings under Section 19(b)(2)(B) of the Act [7] to determine whether to approve or disapprove the proposed rule change.[8] On March 11, 2019, the Exchange filed Amendment No. 1 to the proposed rule change. On March 25, 2019, the Exchange withdrew Amendment No. 1 and filed Amendment No. 2 to the proposed rule change, which superseded and replaced the proposed rule change in its entirety.[9] On April 5, 2019, the Commission designated a longer period for Commission action on the proceedings to determine whether to approve or disapprove the proposed rule change.[10] The Commission published Amendment No. 2 for comment in the **Federal Register** on April 17, 2019.[11] The Commission received no comments in response to this solicitation for comments. On May 31, 2019, the Exchange withdrew the proposed rule change (SR–NYSEAMER–2018–39).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13072 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 84364 (October 4, 2018), 83 FR 51535 (October 11, 2018) (''Original Notice'').

[4] 15 U.S.C. 78s(b)(2).

[5] *See* Securities Exchange Act Release No. 84616 (November 19, 2018), 83 FR 60519 (November 26, 2018). The Commission designated January 9, 2019, as the date by which it should approve, disapprove, or institute proceedings to determine whether to disapprove the proposed rule change.

[6] *See* Letter to Brent J. Fields, Secretary, Commission, from Samara Cohen, Head of ETF Global Markets, BlackRock, dated November 27, 2018 (''BlackRock Letter'').

[7] 15 U.S.C. 78s(b)(2)(B).

[8] *See* Securities Exchange Act Release No. 84870 (December 19, 2018), 83 FR 66779 (December 27, 2018) (''Order Instituting Proceedings''). The Commission designated April 9, 2019, as the date by which the Commission shall approve or disapprove the proposed rule change.

[9] *See* Notice, *infra* note 11, at n.10, which describes the changes proposed in Amendment No. 2 from the original proposal.

[10] *See* Securities Exchange Act Release No. 85531 (April 5, 2019), 84 FR 14703 (April 11, 2019). The Commission extended the date by which the Commission shall approve or disapprove the proposed rule change to June 8, 2019.

[11] *See* Securities Exchange Act Release No. 85628 (April 11, 2019), 84 FR 16102 (April 17, 2019) (''Notice'').

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86113; File No. SR–DTC–2019–001]

Self-Regulatory Organizations; The Depository Trust Company; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend the Operational Arrangements Relating to Transfer Agent and Trustee Notices

June 14, 2019.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 13, 2019, The Depository Trust Company (''DTC'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II and III below, which Items have been prepared by the clearing agency. DTC filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act [3] and Rule 19b–4(f)(4) thereunder.[4] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change of DTC [5] consists of modifications to the DTC Operational Arrangements (Necessary for Securities to Become and Remain Eligible for DTC Services) (''OA'') [6] in order to amend DTC's Procedures [7] regarding (i) the available methods for a transfer agent [8] or trustee [9] to notify DTC of a change relating to ceasing to perform or assumption of transfer agent services on behalf of an Issuer of Securities (''Issuer'') or when the transfer agent or trustee is changing its name or address, (ii) the deadline by which a transfer agent must provide such a notice, (iii) the required timeframe for DTC to make such notices from transfer agents available to Participants, and (iv) other clarifying and technical changes, as described below.

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the clearing agency included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The clearing agency has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(4).

[5] Capitalized terms not defined herein are defined in the Rules, By-Laws and Organization Certificate of DTC (the ''Rules''), *available at http://www.dtcc.com/~/media/Files/Downloads/legal/rules/dtc_rules.pdf.*

[6] *Available at http://www.dtcc.com/~/media/Files/Downloads/legal/issue-eligibility/eligibility/operational-arrangements.pdf.*

[7] Pursuant to the Rules, the term ''Procedures'' means the Procedures, service guides, and regulations of DTC adopted pursuant to Rule 27, as amended from time to time. *See* Rule 1, Section 1, *supra* note 5.

[8] Transfer agents record changes of ownership, maintain the issuer's security holder records, cancel and issue certificates, and distribute dividends. Because transfer agents stand between issuing companies and security holders, efficient transfer agent operations are critical to the successful completion of secondary trades. *See https://www.sec.gov/divisions/marketreg/mrtransfer.shtml.* (describing transfer agents and related information).

[9] A trustee is hired by an issuer of debt securities and is responsible for registration, transfer and payment of the securities.

(A) Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The proposed rule change consists of modifications to the OA [10] in order to amend DTC's Procedures regarding (i) the available methods for a transfer agent or trustee to notify DTC of a change relating to ceasing to perform or assumption of transfer agent services on behalf of an Issuer or when the transfer agent or trustee is changing its name or address, (ii) the deadline by which a transfer agent must provide such a notice, (iii) the required timeframe for DTC to make such notices from transfer agents available to Participants, and (iv) other clarifying and technical changes, as described below.

Background

In 1995, the Securities and Exchange Commission (''Commission'') approved a DTC rule filing (''1995 Rule Filing'') [11] for DTC to be designated as the ''appropriate qualified registered securities depository'' to receive notices of transfer agent changes (''17Ad–16 Notice'') pursuant to Rule 17Ad–16 [12] (''Rule 17Ad–16'') of the Securities Exchange Act of 1934, as amended (''Act'').[13] Rule 17Ad–16 is designed to address transfer delays due to unannounced transfer agent changes, including the termination of the transfer agent services for a particular issue and the change of the name or address of a transfer agent.[14] Rule 17Ad–16 requires a registered transfer agent to send a 17Ad–16 Notice to the ''appropriate qualified registered securities depository'' (a) on or before the later of ten calendar days prior to the effective date of such termination or the day the transfer agent is notified of the effective date of such termination [15] and (b) on or before the later of ten calendar days prior to the effective date of a change in the transfer agent's name or address or when that transfer agent assumes transfer agent services on behalf of an issuer of securities.[16]

For purposes of submitting a 17Ad–16 Notice to DTC, the OA provides that a transfer agent should (i) use the template Notice of Assumption or Termination of Transfer Agent Services Form 17Ad–16 (''17Ad–16 Change Form'') designated for this purpose that is made available by DTC on DTCC's website,[17] and (ii) send the completed form, signed by the transfer agent, in a portable document format to a designated email address,[18] by the effective date of the change being reported on the form.[19]

The OA also provides that in the event of a change in trustee with respect to an issue of Securities, DTC requires that the new and prior trustee update the trustee information previously provided to DTC by the trustee for the issue using the 17Ad–16 Change Form and sending the form, signed by the trustee, in portable document format, to a designated email address.[20]

Once received, DTC would make the form submitted by the transfer agent or trustee available to its Participants by posting it to DTC's Legal Notice System (''LENS'').[21]

Proposed Rule Change

Electronic Submission of 17Ad–16 Change Forms

Pursuant to the proposed rule change, to facilitate the reduction of costs and administrative burdens associated with the processing of transfer agent and trustee notices, DTC would modify the OA to allow transfer agents and trustees to provide the applicable notices electronically through a designated link on the DTCC website,[22] as described below. In this regard, the proposed method would allow for the submission of a notice that follows the template of the 17Ad–16 Change Form that is electronically signed [23] and submitted by the transfer agent or trustee, as applicable, using the designated link. The OA would still allow for submission of such notices via email, as described above. However, DTC believes that also allowing for a wholly-electronic method for the completion, signing and submission of the 17Ad–16 Change Form would reduce costs and administrative burdens for transfer agents and trustees by eliminating the manual processing otherwise entailed with an email submission.[24]

Notification Timeframe for Transfer Agents To Provide Notices

The OA currently states that a transfer agent should notify DTC of the transfer agent's termination of services for an Issuer by the effective date and does not provide a deadline for notifications to DTC of other events that are reportable by the transfer agent to DTC pursuant to Rule 17Ad–16. Pursuant to the proposed rule change, in order to harmonize the timeframe stated in the OA in this regard with the requirements of Rule 17Ad–16,[25] discussed above, DTC would amend the OA to require that a transfer agent must notify DTC when terminating or assuming transfer agent services on behalf of an Issuer, or when the transfer agent is changing its name or address, before the later of (a) 10 calendar days prior to the effective date or (b) in the case of a termination or assumption, the date the transfer agent is (1) notified of the effective date, or (2) becomes aware of, the termination or assumption date, as applicable.

DTC believes that the proposed amendment to the timeframes for transfer agents to provide 17Ad–16 Notices, as set forth above, would promote the prompt and accurate clearance and settlement of securities by facilitating DTC's ability to distribute to its Participants via LENS, a transfer

[10] *Supra* note 6.

[11] See Securities Exchange Act Release No. 35378 (February 15, 1995), 60 FR 9875 (February 22, 1995) (File No. SR–DTC–95–02).

[12] 17 CFR 240.17Ad–16. Pursuant to Rule 17Ad–16, an ''appropriate qualified registered securities depository'' shall mean the qualified registered securities depository that the Commission so designates by order or, in the absence of such designation, the qualified registered securities depository that is the largest holder of record of all qualified registered securities depositories as of the most recent record date. 17 CFR 240.17Ad–16(f).

[13] 15 U.S.C. 78q–1.

[14] *See* Securities Exchange Act Release No. 35039 (December 1, 1994), 59 FR 63656 (December 8, 1994) (File No. S7–1–92).

[15] 17 CFR 240.17Ad–16(a).

[16] 17 CFR 240.17Ad–16(b).

[17] *Available at http://dtcc.com/matching-settlement-and-asset-services/agent-services/dtc-eligible-agent.*

[18] The address designated for this purpose is *TAServices@dtcc.com. See* OA, *supra* note 6, at 17.

[19] OA, *supra* note 6, at 17.

[20] OA, *supra* note 6, at 18.

[21] LENS enables Participants to choose from a menu on a secure interface with DTC certain notices received by DTC which they order. The Commission issued an order approving LENS on June 12, 1991. *See* Securities Exchange Act Release No. 29291 (June 12, 1991), 56 FR 28190 (June 19, 1991) (File No. SR–DTC–91–08). LENS was originally accessible through the DTC Participant Terminal System (''PTS''). *Id.* DTC subsequently implemented a web-based LENS interface. *See* Securities Exchange Act Release No. 43964 (February 14, 2001), 66 FR 11190 (February 22, 2001) (SR–DTC–00–18). The LENS PTS function was retired effective August 27, 2010, and Participants may access LENS via the web-based functionality mentioned above. *See* Securities Exchange Act Release No. 62686 (August 10, 2010), 75 FR 50032 (August 16, 2010) (SR–DTC–2010–10).

[22] *Supra* note 17.

[23] Pursuant to Rule 26, DTC may, at its option, in lieu of relying on an original signature, rely on a signature as if it were (and the signature shall be considered and have the same effect as) a valid and binding signature in the following circumstances: If such signature is transmitted, recorded or stored by an electronic, optical, or similar means (including but not limited to telecopy, imaging, xeroxing, electronic mail, electronic data interchange, telegram or telex). Rule 26, *supra* note 5.

[24] The manual processing that may be necessary for a transfer agent or trustee to make an email submission of a notice, which would be eliminated by instead using the proposed electronic method to submit the form, includes the transfer agent or trustee printing, completing, manually signing the notice and converting it to the portable document format currently required by the OA.

[25] 17 CFR 240.17Ad–16(a).

agent's notification made by it pursuant to Rule 17Ad–16 prior to the effective date, to the extent the notice is timely provided by the transfer agent, thus reducing the potential for transfer delays due to unannounced transfer agent changes.

Posting 17Ad–16 Notices to LENS

The 1995 Rule Filing stated that DTC would make 17Ad–16 Notices available to Participants via LENS no later than the Business Day [26] following DTC's receipt of such notice from the transfer agent.[27] Rule 17Ad–16 states that a qualified registered securities depository that receives notice pursuant to the requirements noted above, ''shall deliver a copy of such notices to its own participants within 24 hours.'' [28]

In order to provide enhanced transparency with regard to the timeframe for DTC to post notices consistent with 1995 Rule Filing, and reflecting the underlying requirement of Rule 17Ad–16 in this regard, DTC would add text to the OA to clarify that DTC would make each 17Ad–16 Notice available to Participants within 24 hours of DTC's receipt of a 17Ad–16 Notice from the transfer agent, not including weekends and holidays (*i.e.,* non-Business Days). For example, if DTC receives a 17Ad–16 Notice through the designated email or electronic methods described above at 6:00 p.m. Eastern Time (''ET'') on a Monday (that is not a holiday), DTC would make the 17Ad–16 Notice available for viewing by Participants on LENS no later than 5:59 p.m. ET on Tuesday. For weekends, if DTC receives a notice at or after 6:00 p.m. ET on a Friday, DTC would make the 17Ad–16 Notice available for viewing by Participants on LENS no later than 5:59 p.m. ET on Monday.

Proposed Changes to the Text of the OA

Pursuant to the proposed rule change, DTC would amend Section II (B)(4) of the OA to (i) provide for the electronic submission of applicable notices/forms by transfer agents, as described above, (ii) amend the OA to require that a transfer agent must notify DTC when terminating or assuming transfer agent services on behalf of an Issuer, or when the transfer agent is changing its name or address, before the later of (a) 10 calendar days prior to the effective date or (b) the date the transfer agent is (1) notified of the effective date, or (2), in the case of a termination or assumption, becomes aware of, the termination or assumption date, as applicable, and (iii) add a new subsection (f) that would state that DTC would make each 17Ad–16 Notice available to Participants within 24 hours of DTC's receipt of a 17Ad–16 Notice from the transfer agent, not including weekends and holidays (*i.e.,* non-Business Days), as described above. The text would also include an example illustrating the timeline pursuant to which the notices would be made available on LENS that is consistent with the example provided under ''Posting 17Ad–16 Notices to LENS'' above.

The proposed rule change would also amend the text of Section II (B)(4) of the OA to (i) correct a typographical error where the Act is not referred to by its full name, (ii) allow transfer agents to submit the 17Ad–16 Change Form in Word format, (iii) update the information that should be included on transfer agent notices to include the agent name, address, contact name, contact phone, contact email, and agent number, (iv) add a defined term for 17Ad–16 Notices, (v) note that notices sent to DTC, as described above, will be made available to Participants for viewing on LENS, (vi) modify text in two places that refer to the requirements of Rule 17Ad–16 to conform the OA text to the terminology in the rule regarding a transfer agent ''ceasing to perform'' [29] services on behalf of an issuer rather than referring to the transfer agent ''terminating'' such services as currently stated in the OA, (vii) conform the title of the 17Ad–16 Change Form as set forth in the OA to the title which appears on DTCC's website which is ''*Notice of Assumption or Termination of Transfer Agent Services Form 17Ad–16*'' followed by ''also known as 17Ad–16 Change Form'' (viii) clarify the location and name of the link where a template of the 17Ad–16 Change Form is available,[30] and (ix) make technical and clarifying changes to the text for enhanced flow and readability.

The proposed rule change would amend Section II (B)(5) to (i) conform the title of the 17Ad–16 Change Form as set forth in the OA to the title which appears on DTCC's website which is ''*Notice of Assumption or Termination of Transfer Agent Services Form 17Ad–16*'' followed by ''also known as 17Ad–16 Change Form'' (ii) clarify the location and name of the link where a template of the 17Ad–16 Change Form is available,[31] (iii) add a clarifying statement that DTC would make notices from trustees received pursuant to this section available for viewing by Participants on LENS, and (iv) make technical and clarifying changes to the text for enhanced flow and readability.

The proposed rule change would also add a note to the sections relating to posting of 17Ad–16 Notices and trustee notices (the new Section II (B)(4)(f) and Section II (B)(5), respectively) to state that (1) DTC does not screen the 17Ad–16 Notices for confidential information, and (2) it is the full and sole responsibility of the transfer agent or trustee, as applicable, submitting a 17Ad–16 Notice to ensure that the information contained in the 17Ad–16 Notice is correct and does not include any information that would otherwise be deemed as confidential or material non-public information.

The proposed rule change would revise text that indicates to the effect that a transfer agent or trustee, as applicable, ''should'' use or is required to use the template of the 17Ad–16 Change Form made available by DTC to notify DTC of a change relating to a transfer agent or trustee, as applicable, to instead state that the transfer agent or trustee, as applicable, ''may'' use the DTC template 17Ad–16 Change Form for this purpose. This change to the text reflects that Rule 17Ad–16 states the information that a transfer agent should include on a notice, but it does not mandate the use of a template of a qualified registered securities depository.[32]

In addition, DTC would make a technical change to Sections VI (E)(1)(a) and (b) to change the email address for Issuers and agents to submit notices submitted to DTC in accordance with those sections from *lensnotices@dtcc.com* to *LegalandTaxNotices@dtcc.com*.[33]

Effective Date

The proposed rule change would become effective upon filing with the Commission.

[26] Pursuant to Rule 1, the term Business Day means any day on which DTC is open for business. Rule 1, *supra* note 5.

[27] *See supra* note 11.

[28] 17 CFR 240.17Ad–16(d)(1).

[29] 17 CFR 240.17Ad–16(a).

[30] The revised OA text would state that a template of the *Notice of Assumption or Termination of Transfer Agent Services Form 17Ad–16* can be obtained from DTCC's website at: *http://dtcc.com/matching-settlement-and-asset-services/agent-services/dtc-eligible-agent and by clicking on the link titled* ''Notice of Assumption or Termination of Transfer Agent Services Form 17Ad–16.''

[31] *Id.*

[32] *See* 17 CFR 240.17Ad–16(a) and (b).

[33] These sections relate to the submission of consent notices and certain legal notices respectively. Consent notices are submitted by an issuer or agent via email to provide notices of record dates for the purpose of facilitating the solicitation of consents from or voting by beneficial owners of Securities. *See* OA, *supra* note 6, at 52. The legal notices to be submitted to DTC via email in accordance with Section VI (E)(1)(b) include notices to security holders of bankruptcies, litigation/class actions and defaults. *Id.*

2. Statutory Basis

Section 17A(b)(3)(F) [34] of the Act requires that the rules of the clearing agency be designed, *inter alia,* to promote the prompt and accurate clearance and settlement of securities transactions. DTC believes that the proposed rule change is consistent with this provision of the Act because, by amending DTC's Procedures regarding (i) the available methods for a transfer agent or trustee to notify DTC of a change relating to ceasing to perform or assumption of transfer agent services on behalf of an Issuer or when the transfer agent or trustee is changing its name or address, (ii) the deadline by which a transfer agent must provide such a notice, and (iii) the required timeframe for DTC to make such notices from transfer agents available to Participants, it would facilitate the prompt and accurate clearance and settlement of securities transactions by facilitating timely and efficient distribution of changes to information for transfer agents and trustees to DTC and Participants, as described above, and therefore promote the ability of DTC and Participants to interface with transfer agents and trustees with respect to functions performed by them, including the registration, transfer and payment of the securities.

DTC also believes that the proposed rule changes are consistent with Section 17A(b)(3)(F), cited above, because by making technical and clarifying changes to the text within the Procedures set forth in the OA regarding the (i) amendment to Section II (B) of the OA to (a) correct a typographical error where the Act is not referred to by its full name, (b) allow transfer agents and trustees to submit the 17Ad–16 Change Form in Word format, (c) update information that should be included on transfer agent notices to include the agent name, address, contact name, contact phone, contact email, and agent number, (d) add a defined term for 17Ad–16 Notices, (e) add a note that transfer agent notices and trustee notices provided by transfer agents and trustees, respectively, to DTC, as described above, are made available for viewing by Participants on LENS, and (f) add a note to the sections relating to responsibilities of transfer agents and trustees with respect to accuracy and confidentiality considerations relating to 17Ad–16 Notices and trustee notices (Sections II (B)(4)(f) and II (B)(5), respectively), as described above, and by (ii) providing a change in email address for issuers and agents to submit notices submitted to DTC in accordance with Sections VI (E)(1)(a) and (b) of the OA, as described above, the proposed rule change would provide enhanced transparency for transfer agents, trustees and Issuers with respect to the Procedures relating to submission and processing of notices that may be submitted by them, as applicable, in accordance with the sections of the OA mentioned above. Therefore, by providing transfer agents, trustees and Issuers with enhanced transparency with regard to the Procedures relating to the submission and processing of notices, and therefore facilitating the prompt posting of notices and distribution of information on LENS to Participants related to Securities held by the Participants, and that may be the subject of transactions processed through the DTC system, DTC believes that the proposed rule change would promote the prompt and accurate clearance and settlement of securities transactions consistent with the Act.

Rule 17Ad–16(d)(1) [35] requires that, *inter alia,* the appropriate qualified registered securities depository that receives 17Ad–16 Notices shall deliver a copy of such notices to its own participants within 24 hours. Rule 17Ad–16(d)(2) [36] provides that a qualified registered securities depository may comply with its notice requirements under Rule 17Ad–16(d)(1) [37] by making available the notice of all material information from the notice within 24 hours in a manner set forth in the rules of the qualified registered securities depository. DTC believes that the proposed rule change is consistent with Rule 17Ad–16(d)(1) because it would amend the text of the OA, as described above, to provide that DTC would make 17Ad–16 Notices that it receives available to Participants via LENS within 24 hours of receipt, not including weekends and holidays (*i.e.,* non-Business Days).[38] DTC believes the proposed rule change is consistent with Rule 17Ad–16(d)(2) because, as described above, the proposed rule change would add the text described in the sentence immediately above to the OA, which are Procedures filed as rules with the Commission.

(B) Clearing Agency's Statement on Burden on Competition

DTC does not believe that the proposed rule change would have any impact, or impose any burden, on competition. The proposed rule change would, (i) with respect to the proposed rule changes to amend the OA regarding notification timeframes relating to transfer agent notifications to DTC and the distribution of those notifications by DTC to its Participants, merely align and clarify the text of the OA in accordance with the applicable requirements relating to such notifications set forth in Rule 17Ad–16 and the provisions of the 1995 Rule Filing as described above, and (ii) with respect to the addition of an electronic method for the submission of notices by transfer agents and trustees, merely allow for an additional means for such notices to be submitted and not impact the existing email option, as described above. Therefore, the proposed rule change would not impact, or impose any burden on, competition.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

DTC has not received or solicited any written comments relating to this proposal. DTC will notify the Commission of any written comments received by DTC.

III. Date of Effectiveness of the Proposed Rule Change, and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [39] and paragraph (f) of Rule 19b–4 thereunder.[40] At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–DTC–2019–001 on the subject line.

[34] 15 U.S.C. 78q–1(b)(3)(F).

[35] 17 CFR 240.17Ad–16(d)(1).

[36] 17 CFR 240.17Ad–16(d)(2).

[37] 17 CFR 240.17Ad–16(d)(1).

[38] *Supra* note 26.

[39] 15 U.S.C. 78s(b)(3)(A).

[40] 17 CFR 240.19b–4(f).

Paper Comments

• Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549.

All submissions should refer to File Number SR–DTC–2019–001. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of DTC and on DTCC's website (*http://dtcc.com/legal/sec-rule-filings.aspx*). All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–DTC–2019–001 and should be submitted on or before July 11, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[41]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13074 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[41] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86112; File No. SR–NYSEArca–2019–28]

Self-Regulatory Organizations; NYSE Arca, Inc.; Order Granting Approval of a Proposed Rule Change, as Modified by Amendment No. 3, To List and Trade Shares of the Virtus WMC Risk-Managed Alternative Equity ETF Under NYSE Arca Rule 8.600–E

June 14, 2019.

I. Introduction

On April 15, 2019, NYSE Arca, Inc. (''NYSE Arca'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] a proposed rule change to list and trade shares (''Shares'') of the Virtus WMC Risk-Managed Alternative Equity ETF (''Fund'') under NYSE Arca Rule 8.600–E. The proposed rule change was published for comment in the **Federal Register** on May 3, 2019.[3] On May 14, 2019, the Exchange filed Amendment No. 1 to the proposed rule change. On May 16, 2019, the Exchange filed Amendment No. 2 to the proposed rule change, which amended and replaced the proposed rule change as modified by Amendment No. 1. On June 10, 2019, the Exchange filed Amendment No. 3 to the proposed rule change, which amended and replaced the proposed rule change as modified by Amendment No. 2.[4] The Commission has received no comments on the proposed rule change. This order approves the proposed rule change, as modified by Amendment No. 3.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 85751 (April 30, 2019), 84 FR 19141.

[4] In Amendment No. 3, the Exchange: (a) Clarified the permitted investments of the Fund; (b) clarified that the only OTC derivatives that the Fund may invest in are forward foreign currency contracts and OTC options on U.S. and foreign exchange-listed equity securities, U.S. and foreign exchange-listed equity securities indices, and interest rates; (c) stated that price information relating to currency forwards will be available from major market data vendors; and (d) made other clarifying, technical, and conforming changes. Amendment No. 3 is not subject to notice and comment because it does not materially alter the substance of the proposed rule change or raise unique or novel regulatory issues. Amendment No. 3 is available at: *https://www.sec.gov/comments/sr-nysearca-2019-28/srnysearca201928-5656834-185771.pdf.*

II. Description of the Proposal, as Modified by Amendment No. 3[5]

The Exchange proposes to list and trade Shares of the Fund under NYSE Arca Rule 8.600–E, which governs the listing and trading of Managed Fund Shares on the Exchange. The Fund is a series of ETFis Series I (''Trust'').[6] Virtus ETF Advisors LLC (''Adviser'') is the investment adviser for the Fund. Wellington Management Company LLP is the sub-adviser to the Fund (''Sub-Adviser'').[7] ETF Distributors LLC, a registered broker-dealer, will act as the distributor for the Fund's Shares and the Bank of New York Mellon will serve as the custodian, administrator, and transfer agent for the Fund.

A. Principal Investments of the Fund

According to the Exchange, the investment objective of the Fund is to seek to provide superior risk-adjusted total returns over the long term. The Fund will seek to achieve its investment objective, under normal market conditions,[8] by (i) investing in a broadly diversified portfolio of global equity securities in both developed and emerging markets, and (ii) implementing a beta management strategy by shorting futures contracts and purchasing and selling options, as further described below. Under normal market conditions, the Fund will invest at least 80% of its net assets (plus any

[5] For a complete description of the Exchange's proposal, *see* Amendment No. 3, *supra* note 4.

[6] According to the Exchange, on February 28, 2019, the Trust filed with the Commission a Post-Effective Amendment to the Trust's registration statement on Form N–1A under the Securities Act of 1933 and the 1940 Act relating to the Fund (File Nos. 333–187668 and 811–22819) (''Registration Statement''). The Exchange represents that the Trust will file an amendment to the Registration Statement as necessary to conform to the representations in this filing. In addition, the Exchange states that the Commission has issued an order granting certain exemptive relief to the Trust under the 1940 Act. *See* Investment Company Act Release No. 30607 (July 23, 2013) (File No. 812–14080).

[7] The Exchange states that the Adviser and the Sub-Adviser are not registered as broker-dealers but that each is affiliated with one or more broker-dealers and has implemented and will maintain a ''fire wall'' with respect to each such broker-dealer affiliate regarding access to information concerning the composition of and/or changes to the Fund's portfolio. In addition, in the event (a) the Adviser or the Sub-Adviser becomes registered as a broker-dealer or newly affiliated with a broker-dealer, or (b) any new adviser or sub-adviser is a registered broker-dealer or becomes affiliated with a broker-dealer, such entity will implement and maintain a ''fire wall'' with respect to its relevant personnel or broker-dealer affiliate regarding access to information concerning the composition of and/or changes to the portfolio, and will be subject to procedures designed to prevent the use and dissemination of material non-public information regarding such portfolio.

[8] The term ''normal market conditions'' is defined in NYSE Arca Rule 8.600–E(c)(5).

borrowings for investment purposes) in equity securities, listed derivatives and over-the-counter (''OTC'') derivatives, cash and cash equivalents, each as further described below.

The Fund will invest in the following U.S. and foreign exchange-listed equity securities of U.S. and foreign issuers: Common stock, preferred stock, convertible preferred stock, rights, warrants, American Depositary Receipts, Global Depositary Receipts, and real estate investment trusts.

The Fund may hold cash and cash equivalents.[9]

The Fund may hold U.S. and foreign exchange-traded futures and U.S. and foreign exchange-traded or OTC options on U.S. and foreign exchange-listed equity securities, U.S. and foreign exchange-listed equity securities indices, and interest rates.

The Fund may invest in forward foreign currency contracts and U.S. and foreign exchange-traded foreign currency futures contracts.

The Fund may enter into short sales of any securities and financial instruments in which the Fund may invest.

The Fund may use derivative instruments described above as a substitute for investing directly in an underlying security or other financial instrument, to seek to enhance returns, to seek to manage or reduce exposure/risk, or to seek to manage foreign currency risk.

B. Other Investments

While the Fund, under normal market conditions, will invest at least 80% in the securities and financial instruments described above, the Fund may invest its remaining assets in the following securities and financial instruments: Exchange-traded funds (''ETFs'');[10] convertible bonds; and U.S. government securities (that are not cash equivalents as defined in NYSE Arca Rule 8.600–E, Commentary .01(c)).[11]

C. Investment Restrictions

The Fund will not invest in securities or other financial instruments that have not been described in the proposed rule change.

The Fund's investments, including derivatives, will be consistent with the Fund's investment objective and will not be used to enhance leverage (although certain derivatives and other investments may result in leverage). That is, the Fund's investments will not be used to seek performance that is the multiple or inverse multiple (*e.g.,* 2X or −3X) of the Fund's primary broad-based securities benchmark index (as defined in Form N–1A).[12]

D. Use of Derivatives by the Fund

The Exchange represents that the Fund' investments in derivative instruments will be made in accordance with the 1940 Act and consistent with the Fund's investment objective and policies. To limit the potential risk associated with such transactions, the Fund will enter into offsetting transactions or segregate or ''earmark'' assets determined to be liquid by the Adviser in accordance with procedures established by the Trust's Board of Trustees and in accordance with the 1940 Act or as permitted by applicable Commission guidance. According to the Exchange, these procedures have been adopted consistent with Section 18 of the 1940 Act and related Commission guidance. In addition, the Exchange states that the Fund has included appropriate risk disclosure in its offering documents, including leveraging risk.

The Exchange states that the Adviser and Sub-Adviser will monitor counterparty credit risk exposure (including for OTC derivatives) and evaluate counterparty credit quality on a continuous basis.

The Exchange states that the Adviser and the Sub-Adviser believe that there will be minimal, if any, impact to the arbitrage mechanism as a result of the Fund's use of derivatives. According to the Exchange, the Adviser and the Sub-Adviser understand that market makers and participants should be able to value derivatives as long as the positions are disclosed with relevant information. The Adviser and the Sub-Adviser believe that the price at which Shares of the Fund trade will continue to be disciplined by arbitrage opportunities created by the ability to purchase or redeem Shares of the Fund at their net asset value (''NAV''), which should ensure that Shares of the Fund will not trade at a material discount or premium in relation to their NAV.

E. Application of Generic Listing Requirements

The Exchange states that the portfolio for the Fund will not meet all of the generic listing requirements set forth in Commentary .01 to NYSE Arca Rule 8.600–E applicable to the listing of Managed Fund Shares. The Exchange represents that the Fund's portfolio will meet all such requirements except for those set forth in Commentary .01(e) with respect to the Fund's investments in OTC derivatives.[13]

Specifically, the Exchange states that the aggregate gross notional value of the Fund's investments in OTC derivatives may exceed 20% of Fund assets, calculated as the aggregate gross notional value of such OTC derivatives. The Exchange proposes that up to 50% of the Fund's assets (calculated as the aggregate gross notional value) may be invested in OTC derivatives that are used to reduce currency, interest rate, or credit risk arising from the Fund's investments (*i.e.,* for hedging purposes). The Exchange states that the Fund's investments in OTC derivatives, other than OTC derivatives used to hedge the Fund's portfolio against currency, interest rate, or credit risk, will be limited to 20% of the assets in the Fund's portfolio, calculated as the aggregate gross notional value of such OTC derivatives. As discussed above, the only OTC derivatives that the Fund may invest in are forward foreign currency contracts and OTC options on U.S. and foreign exchange-listed equity securities, U.S. and foreign exchange-listed equity securities indices, and interest rates.

The Exchange states that the Adviser and Sub-Adviser represent that the proposed exception from the generics described above is consistent with the Fund's investment objective and will further assist the Adviser and Sub-Adviser to achieve such investment objective. The Exchange states that, other than Commentary .01(e), the Shares of the Fund will conform to the initial and continued listing criteria under NYSE Arca Rule 8.600–E and will meet all other requirements of NYSE Arca Rule 8.600–E.

[9] The term ''cash equivalents'' is defined in NYSE Arca Rule 8.600–E, Commentary .01(c).

[10] For purposes of this filing, the term ''ETFs'' includes Investment Company Units (as described in NYSE Arca Rule 5.2–E(j)(3)); Portfolio Depositary Receipts (as described in NYSE Arca Rule 8.100–E); and Managed Fund Shares (as described in NYSE Arca Rule 8.600–E). All ETFs will be listed and traded in the U.S. on a national securities exchange. While the Fund may invest in inverse ETFs, the Fund will not invest in leveraged (*e.g.,* 2X, −2X, 3X or −3X) ETFs.

[11] These are obligations guaranteed by the U.S. government and include U.S. Treasury notes, U.S. Treasury bonds, and U.S. Treasury bills.

[12] The Fund's broad-based securities benchmark index will be identified in a future amendment to the Registration Statement following the Fund's first full calendar year of performance.

[13] Commentary .01(e) to Rule 8.600–E provides that a portfolio may hold OTC derivatives, including forwards, options and swaps on commodities, currencies and financial instruments (*e.g.,* stocks, fixed income, interest rates, and volatility) or a basket or index of any of the foregoing; however, on both an initial and continuing basis, no more than 20% of the assets in the portfolio may be invested in OTC derivatives (calculated as the aggregate gross notional value of the OTC derivatives).

III. Discussion and Commission Findings

After careful review, the Commission finds that the proposed rule change, as modified by Amendment No. 3, is consistent with the Act and the rules and regulations thereunder applicable to a national securities exchange.[14] In particular, the Commission finds that the proposed rule change, as modified by Amendment No. 3, is consistent with Section 6(b)(5) of the Act,[15] which requires, among other things, that the Exchange's rules be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

As noted above, the aggregate gross notional value of the Fund's investments in OTC derivatives may exceed the 20% limit in Commentary .01(e) to NYSE Arca Rule 8.600–E. Specifically, the Exchange proposes that up to 50% of the Fund's assets may be invested in OTC derivatives that are used to hedge the Fund's portfolio, and that up to 20% of the Fund's assets may be invest in other OTC derivatives (in each case, calculated as the aggregate gross notional value of such OTC derivatives).

According to the Exchange, if the Fund were limited to investing up to 20% of its assets in OTC derivatives, the Fund would have to exclude or underweight its strategies utilizing OTC derivatives and the Fund would be less diversified, concentrating risk in the other strategies it plans to utilize.[16] In addition, the Exchange states that the inability of the Fund to adequately hedge its holdings could expose the Fund's shareholders to additional investment risk.[17] Furthermore, the Exchange states that OTC derivatives can provide the Fund with more flexibility to manage risk and may frequently be a more efficient hedging vehicle than listed derivatives.[18] The Exchange states that OTC derivatives can be customized to a greater degree than listed derivatives and can provide the Fund with more flexibility to negotiate the exact exposure the Fund requires, thereby providing a better hedge on Fund assets than listed derivatives.[19] In addition, the Exchange states that the use of OTC derivatives can mitigate trading costs because they allow for more control over the duration of a hedge and are not subject to costs of rolling that are associated with listed derivatives.[20]

On a daily basis, the Fund will disclose on its website the information regarding the Disclosed Portfolio required under NYSE Arca Rule 8.600–E(c)(2) to the extent applicable.[21] The website information will be publicly available at no charge.[22]

The Commission notes that, other than Commentary .01(e), the Fund will meet all the requirements of NYSE Arca Rule 8.600–E.

The Commission also finds that the proposal is consistent with Section 11A(a)(1)(C)(iii) of the Act,[23] which sets forth Congress's finding that it is in the public interest and appropriate for the protection of investors and the maintenance of fair and orderly markets to assure the availability to brokers, dealers, and investors of information with respect to quotations for, and transactions in, securities. Quotation and last sale information for the Shares will be available via the Consolidated Tape Association (''CTA'') high-speed line. The Portfolio Indicative Value (''PIV'') for the Fund, as defined in NYSE Arca Rule 8.600–E(c)(3), will be widely disseminated by one or more major market data vendors at least every 15 seconds during the Exchange's Core Trading Session. Information regarding market price and trading volume of the Shares will be continually available on a real-time basis throughout the day on brokers' computer screens and other electronic services. Information regarding the previous day's closing price and trading volume information for the Shares will be published daily in the financial section of newspapers.

Quotation and last sale information for ETFs and other U.S. exchange-traded equity securities will be available via the CTA high-speed line. Quotation and last sale information for options cleared via the Options Clearing Corporation are available via the Options Price Reporting Authority. Intra-day and closing price information regarding U.S and foreign exchange-traded options and futures will be available from the exchange on which such instruments are traded. Price information relating to OTC options and currency forwards will be available from major market data vendors. Intra-day price information for U.S. and foreign exchange-traded options on futures will be available from the applicable exchange and from major market data vendors. For U.S. and foreign exchange-listed equity securities, intraday price quotations will generally be available from broker-dealers and trading platforms (as applicable). Price information for cash equivalents and convertible bonds will be available from major market data vendors. Price information regarding U.S. government securities generally may be obtained from brokers and dealers who make markets in such securities or through nationally recognized pricing services through subscription agreements. Additionally, the Trade Reporting and Compliance Engine (''TRACE'') of the Financial Industry Regulatory Authority (''FINRA'') will be a source of price information for certain fixed income securities to the extent transactions in such securities are reported to TRACE.[24]

The Commission also believes that the proposal is reasonably designed to promote fair disclosure of information that may be necessary to price the Shares appropriately and to prevent trading when a reasonable degree of transparency cannot be assured. The Exchange has obtained a representation from the issuer of the Shares that the

[14] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[15] 15 U.S.C. 78f(b)(5).

[16] *See* Amendment No. 3, *supra* note 4, at 11–12. The Exchange states that the Adviser represents that it is not possible to implement its strategies efficiently using listed derivatives because the foreign exchange forward market is OTC. The Exchange also states that use of OTC options on U.S. and foreign exchange-listed equity securities and U.S. and foreign exchange-listed equity securities indices may be an important means to reduce risk in the Fund's equity investments or to enhance returns of such investments. *See id.* at 11.

[17] *See id.* at 18.

[18] *See id.*

[19] *See id.* at 10.

[20] *See id.*

[21] NYSE Arca Rule 8.600–E(c)(2) requires that the website for each series of Managed Fund Shares disclose the following information regarding the Disclosed Portfolio, to the extent applicable: (A) ticker symbol; (B) CUSIP or other identifier; (C) description of the holding; (D) with respect to holdings in derivatives, the identity of the security, commodity, index or other asset upon which the derivative is based; (E) the strike price for any options; (F) the quantity of each security or other asset held as measured by (i) par value, (ii) notional value, (iii) number of shares, (iv) number of contracts, and (v) number of units; (G) maturity date; (H) coupon rate; (I) effective date; (J) market value; and (K) percentage weighting of the holding in the portfolio.

[22] *See* Amendment No. 3, *supra* note 4, at 13.

[23] 15 U.S.C. 78k–1(a)(1)(C)(iii).

[24] Broker-dealers that are FINRA member firms have an obligation to report transactions in specified debt securities to TRACE to the extent required under applicable FINRA rules. Generally, such debt securities will have at issuance a maturity that exceeds one calendar year. For fixed income securities that are not reported to TRACE, (i) intraday price quotations will generally be available from broker-dealers and trading platforms (as applicable) and (ii) price information will be available from feeds from market data vendors, published or other public sources, or online information services, as described above. *See* Amendment No. 3, *supra* note 4, at 13, n. 14.

NAV per Share will be calculated daily and that the NAV and the Disclosed Portfolio will be made available to all market participants at the same time. Trading in the Shares will be halted if the circuit-breaker parameters in NYSE Arca Rule 7.12–E have been reached. Trading also may be halted because of market conditions or for reasons that, in the view of the Exchange, make trading in the Shares inadvisable. Moreover, trading in the Shares will be subject to NYSE Arca Rule 8.600–E(d)(2)(D), which sets forth circumstances under which Shares may be halted.

The Exchange states that it has a general policy prohibiting the distribution of material, non-public information by its employees. The Exchange states that neither the Adviser nor the Sub-Adviser are registered as a broker-dealer but each is affiliated with one or more broker-dealers and each has implemented and will maintain a ''fire wall'' with respect to such broker-dealer affiliate regarding access to information concerning the composition of and/or changes to the Fund's portfolio. Further, the Commission notes that the Reporting Authority that provides the Disclosed Portfolio must implement and maintain, or be subject to, procedures designed to prevent the use and dissemination of material, non-public information regarding the actual components of the portfolio.[25]

The Exchange deems the Shares to be equity securities, thus rendering trading in the Shares subject to the Exchange's existing rules governing the trading of equity securities. In support of this proposal, the Exchange represents that:

(1) Other than Commentary .01(e), as specifically described herein, the Fund will meet all other requirements of NYSE Arca Rule 8.600–E.

(2) A minimum of 100,000 Shares of the Fund will be outstanding at the commencement of trading on the Exchange.

(3) Trading in the Shares will be subject to the existing trading surveillances administered by the Exchange, as well as cross-market surveillances administered by FINRA on behalf of the Exchange, and these procedures are adequate to properly monitor Exchange trading of the Shares in all trading sessions and to deter and detect violations of Exchange rules and applicable federal securities laws.

(4) The Exchange or FINRA, on behalf of the Exchange, or both, will communicate as needed, and may obtain information, regarding trading in the Shares, certain exchange-traded equity securities (including ETFs), certain exchange-traded options, and certain futures with other markets and other entities that are members of the Intermarket Surveillance Group (''ISG''). In addition, the Exchange may obtain information regarding trading in the Shares, certain exchange-traded equity securities (including ETFs), certain exchange-traded options and certain futures from markets and other entities with which the Exchange has in place a comprehensive surveillance sharing agreement. FINRA, on behalf of the Exchange, is able to access, as needed, trade information for certain fixed income securities held by the Fund reported to FINRA's TRACE.

(5) Prior to the commencement of trading, the Exchange will inform its Equity Trading Permit Holders in an Information Bulletin of the special characteristics and risks associated with trading the Shares. Specifically, the Information Bulletin will discuss: (a) The procedures for purchases and redemptions of Shares in creation units (and that Shares are not individually redeemable); (b) NYSE Arca Rule 9.2–E(a), which imposes a duty of due diligence on its Equity Trading Permit Holders to learn the essential facts relating to every customer prior to trading the Shares; (c) the risks involved in trading the Shares during the Early and Late Trading Sessions when an updated PIV will not be calculated or publicly disseminated; (d) how information regarding the PIV and the Disclosed Portfolio is disseminated; (e) the requirement that Equity Trading Permit Holders deliver a prospectus to investors purchasing newly issued Shares prior to or concurrently with the confirmation of a transaction; and (f) trading information.

(6) The Exchange has appropriate rules to facilitate transactions in the Shares during all trading sessions.

(7) For initial and continued listing, the Fund will be in compliance with Rule 10A–3 under the Act.[26]

(8) The Fund's investments, including derivatives, will be consistent with the Fund's investment objective and will not be used to enhance leverage (although certain derivatives and other investments may result in leverage). That is, the Fund's investments will not be used to seek performance that is the multiple or inverse multiple (*e.g.,* 2X or −3X) of the Fund's primary broad-based securities benchmark index (as defined in Form N–1A).

(9) The only OTC derivatives that the Fund may invest in are forward foreign currency contracts and OTC options on U.S. and foreign exchange-listed equity securities, U.S. and foreign exchange-listed equity securities indices, and interest rates.

The Exchange represents that all statements and representations made in this filing regarding (a) the description of the portfolio or reference asset, (b) limitations on portfolio holdings or reference assets, or (c) the applicability of Exchange listing rules specified in the rule filing constitute continued listing requirements for listing the Shares on the Exchange. In addition, the issuer has represented to the Exchange that it will advise the Exchange of any failure by the Fund to comply with the continued listing requirements, and, pursuant to its obligations under Section 19(g)(1) of the Act, the Exchange will monitor[27] for compliance with the continued listing requirements. If the Fund is not in compliance with the applicable listing requirements, the Exchange will commence delisting procedures under NYSE Arca Rule 5.5–E(m).

This approval order is based on all of the Exchange's statements and representations, including those set forth above and in Amendment No. 3.

For the foregoing reasons, the Commission finds that the proposed rule change, as modified by Amendment No. 3, is consistent with Section 6(b)(5) of the Act[28] and Section 11A(a)(1)(C)(iii) of the Act[29] and the rules and regulations thereunder applicable to a national securities exchange.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[30] that the proposed rule change (SR–NYSEArca–2019–28), as modified by Amendment No. 3, be, and it hereby is, approved.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[31]

Vanessa A. Countryman,

Acting Secretary.

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[25] *See* NYSE Arca Rule 8.600–E(d)(2)(B)(ii).

[26] *See* 17 CFR 240.10A–3.

[27] The Commission notes that certain proposals for the listing and trading of exchange-traded products include a representation that the exchange will ''surveil'' for compliance with the continued listing requirements. *See, e.g.,* Securities Exchange Act Release No. 77499 (April 1, 2016), 81 FR 20428, 20432 (April 7, 2016) (SR–BATS–2016–04). In the context of this representation, it is the Commission's view that ''monitor'' and ''surveil'' both mean ongoing oversight of compliance with the continued listing requirements. Therefore, the Commission does not view ''monitor'' as a more or less stringent obligation than ''surveil'' with respect to the continued listing requirements.

[28] 15 U.S.C. 78f(b)(5).

[29] 15 U.S.C. 78k-1(a)(1)(C)(iii).

[30] 15 U.S.C. 78s(b)(2).

[31] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86106; File No. SR–CboeBZX–2019–055]

Self-Regulatory Organizations; Cboe BZX Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change, as Modified by Amendment No. 1, To Allow the Cambria Tail Risk ETF, a Series of the Cambria ETF Trust, To Hold Listed Options Contracts in a Manner That Does Not Comply With Rule 14.11(i), Managed Fund Shares

June 14, 2019.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 4, 2019, Cboe BZX Exchange, Inc. (''Exchange'' or ''BZX'') filed with the Securities and Exchange Commission (''Commission'') a proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. On June 7, 2019, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule, as modified by Amendment No. 1, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes a rule change to allow the Cambria Tail Risk ETF (the ''Fund''), a series of the Cambria ETF Trust (the ''Trust''), to hold listed options contracts in a manner that does not comply with Rule 14.11(i) (''Managed Fund Shares''). The shares of the Fund are referred to herein as the ''Shares.''

The text of the proposed rule change is also available on the Exchange's website (*http://markets.cboe.com/us/equities/regulation/rule_filings/bzx/*), at the Exchange's Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Fund began listing and trading on the Exchange pursuant to the generic listing standards under Rule 14.11(i) governing Managed Fund Shares on April 6, 2017 and remains currently listed on the Exchange pursuant to such rule.[4] The Exchange proposes to continue listing and trading the Shares. The Shares would continue to comply with all of the generic listing standards with the exception of the requirement of Rule 14.11(i)(4)(C)(iv)(b)[5] that prevents the aggregate gross notional value of listed derivatives based on any single underlying reference asset from exceeding 30% of the weight of the portfolio (including gross notional exposures) and the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets from exceeding 65% of the weight of the portfolio (including gross notional exposures) (the ''Concentration Restriction'').[6]

The Shares are offered by the Trust, a Delaware statutory trust which is registered with the Commission as an open-end management investment company.[7] The Fund's adviser, Cambria Investment Management, L.P. (the ''Adviser''), is not registered as a broker-dealer, and is not affiliated with a broker-dealer. Personnel who make decisions on the Fund's portfolio composition are currently and shall continue to be subject to procedures designed to prevent the use and dissemination of material non-public information regarding such portfolio. In the event that (a) the Adviser becomes registered as a broker-dealer or newly affiliated with a broker-dealer; or (b) any new adviser or sub-adviser is a registered broker-dealer or becomes affiliated with a broker-dealer, the Adviser or such new adviser or sub-adviser will implement and maintain a fire wall with respect to its relevant personnel or such broker-dealer affiliate, as applicable, regarding access to information concerning the composition and/or changes to the Fund's portfolio, and will be subject to procedures designed to prevent the use and dissemination of material non-public information regarding such portfolio.

The Fund intends to qualify each year as a regulated investment company under Subchapter M of the Internal Revenue Code of 1986, as amended.

Cambria Tail Risk ETF

The Fund seeks to provide income and capital appreciation from investments in the U.S. market while protecting against significant downside risk. In order to achieve its investment objective, under Normal Market Conditions,[8] the Fund invests in cash and U.S. Treasury Bonds, and utilizes a put option strategy to manage the risk of

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] In Amendment No. 1, the Exchange amended Item 2(a) of the proposed rule change to state that ''The Exchange's President (or designee) pursuant to delegated authority approved the proposed rule change on June 3, 2019.''

[4] The Commission originally approved BZX Rule 14.11(i) in Securities Exchange Act Release No. 65225 (August 30, 2011), 76 FR 55148 (September 6, 2011) (SR–BATS–2011–018) and subsequently approved generic listing standards for Managed Fund Shares under Rule 14.11(i) in Securities Exchange Act Release No. 78396 (July 22, 2016), 81 FR 49698 (July 28, 2016) (SR–BATS–2015–100).

[5] Rule 14.11(i)(4)(C)(iv)(b) provides that ''the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets shall not exceed 65% of the weight of the portfolio (including gross notional exposures), and the aggregate gross notional value of listed derivatives based on any single underlying reference asset shall not exceed 30% of the weight of the portfolio (including gross notional exposures).'' The Exchange is proposing that the Fund be exempt from both the 30% and 65% requirements of Rule 14.11(i)(4)(C)(iv)(b).

[6] The Exchange notes that this proposal is very similar to several previously submitted proposals to list and trade a series of Index Fund Shares (which are referred to as Investment Company Units under the rules of NYSE Arca, Inc.) and Managed Fund Shares with exposures to a single underlying reference asset that were either approved by the Commission or effective upon filing. *See* Securities Exchange Act Release Nos. 83146 (May 1, 2018), 83 FR 20103 (May 7, 2018) (SR–CboeBZX–2018–029); 83679 (July 20, 2018), 83 FR 35505 (July 26, 2018); 77045 (February 3, 2016), 81 FR 6916 (February 9, 2016) (SR–NYSEArca–2015–113) (the ''Amendment''); and 74675 (April 8, 2015), 80 FR 20038 (April 14, 2015) (SR–NYSEArca–2015–05) (collectively, with the Amendment, the ''Arca Filing'').

[7] The Trust is registered under the 1940 Act. The Trust filed a supplement to the Fund's prospectus included in its Registration Statement on May 9, 2019 (as supplemented, the ''Registration Statement''). *See* Registration Statement on Form N–1A for the Trust (File Nos. 333–180879 and 811–22704). The descriptions of the Fund and the Shares contained herein are based, in part, on information included in the Registration Statement. The Commission has issued an order granting certain exemptive relief to the Trust and affiliated persons under the Investment Company Act of 1940 (15 U.S.C. 80a–1). *See* Investment Company Act Release No. 30340 (January 4, 2013) (File No. 812–13959).

[8] The term ''Normal Market Conditions'' includes, but is not limited to, the absence of trading halts in the applicable financial markets generally; operational issues causing dissemination of inaccurate market information or system failures; or force majeure type events such as natural or man-made disaster, act of God, armed conflict, act of terrorism, riot or labor disruption, or any similar intervening circumstance.

a significant negative movement in the value of domestic equities (commonly referred to as tail risk) over rolling one-month periods. Specifically, in order to hedge against sharp declines in the U.S. stock market, each month, the Fund purchases U.S. exchange-listed protective ''out of the money'' put options on the S&P 500 Index (''S&P 500 Options'').

The Fund's holdings currently meet and will continue to meet the generic listing standards for fixed income securities under Rule 14.11(i)(4)(C)(ii) and cash and Cash Equivalents in Rule 14.11(i)(4)(C)(iii).[9] The Fund has the ability to buy S&P 500 Options. The options strategy is actively managed by the Adviser and will adapt to changing market environments and is currently not in compliance with the requirement under Rule 14.11(i)(4)(C)(iv)(b) that prevents the aggregate gross notional exposure of listed derivatives based on any single underlying reference asset from exceeding 30% of the weight of the portfolio (including gross notional exposures) and the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets from exceeding 65% of the weight of the portfolio (including gross notional exposures).[10]

As noted above, Rule 14.11(i)(4)(C)(iv)(b) prevents the Fund from holding listed derivatives based on any single underlying reference asset in excess of 30% of the weight of its portfolio (including gross notional exposures) and the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets from exceeding 65% of the weight of the portfolio (including gross notional exposures). As proposed, the Fund could hold up to 90% of the weight of its portfolio (including gross notional exposures) in S&P 500 Options in a manner that may not comply with Rule 14.11(i)(4)(C)(iv)(b). The put option strategy is designed to attempt to provide protection from significant market declines on a month-by-month basis. This protection comes in the form of S&P 500 Options. The Adviser generally intends to re-initiate new S&P 500 Options positions that make up the put option position each month and reinvest any gains from these activities into U.S. Treasury Bonds. The Adviser also may, at its discretion, liquidate and establish new S&P 500 Options positions intra-month, or liquidate option positions without establishing new positions. The put option strategy only includes S&P 500 Options. The ability to hold S&P 500 Options with exposure to a single reference asset up to 90% of the weight of the portfolio (including gross notional exposures) would allow the Fund the flexibility to fully implement its investment strategy while remaining in compliance with the continued listing standards.

As noted above, the Fund invests only in cash, U.S. Treasury Bonds, and S&P 500 Options. The Exchange represents that, except for the Concentration Restriction in Rule 14.11(i)(4)(C)(iv)(b) with respect to S&P 500 Options, the Fund's investments will continue to satisfy all of the generic listing standards under BZX Rule 14.11(i)(4)(C) and all other applicable requirements for Managed Fund Shares under Rule 14.11(i).

The Trust is required to comply with Rule 10A–3 [11] under the Act for the initial and continued listing of the Shares of the Fund. In addition, the Exchange represents that the Shares of the Fund will continue to comply with all other requirements applicable to Managed Fund Shares, which include the dissemination of key information such as the Disclosed Portfolio,[12] Net Asset Value,[13] and the Intraday Indicative Value,[14] suspension of trading or removal,[15] trading halts,[16] surveillance,[17] minimum price variation for quoting and order entry,[18] the information circular,[19] and firewalls [20] as set forth in Exchange rules applicable to Managed Fund Shares and the orders approving such rules. Moreover, the S&P 500 Options held by the Fund will trade on markets that are a member of Intermarket Surveillance Group (''ISG'') or affiliated with a member of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement.[21] All statements and representations made in this filing regarding the description of the portfolio or reference assets, limitations on portfolio holdings or reference assets, dissemination and availability of reference asset and intraday indicative values (as applicable), or the applicability of Exchange listing rules specified in this filing shall constitute continued listing requirements for the Shares. The Fund has represented to the Exchange that it will advise the Exchange of any failure by the Fund or Shares to comply with the continued listing requirements, and, pursuant to its obligations under Section 19(g)(1) of the Act, the Exchange will surveil for compliance with the continued listing requirements. FINRA conducts certain cross-market surveillances on behalf of the Exchange pursuant to a regulatory services agreement. The Exchange is responsible for FINRA's performance under this regulatory services agreement. If the Fund is not in compliance with the applicable listing requirements, the Exchange will commence delisting procedures with respect to the Fund under Exchange Rule 14.12.

Availability of Information

As noted above, the Fund will comply with the requirements under the Rule 14.11(i) related to Disclosed Portfolio, NAV, and the Intraday Indicative Value. Additionally, the intra-day, closing and settlement prices of S&P 500 Options will be readily available from Cboe Exchange, Inc. or online information services such as Bloomberg or Reuters. Quotation and last sale information for S&P 500 Options will be available via the Options Price Reporting Authority. Price information for U.S. Treasury Bonds will be available from major market data vendors. The Disclosed Portfolio will be available on the Fund's website (*www.cambriafunds.com*) free of charge. The Fund's website will include a form of the prospectus for the Fund and additional information related to NAV and other applicable quantitative information. Information

[9] The Exchange notes that certain of the Fund's holdings in U.S. Treasury Bonds may qualify as Cash Equivalents by virtue of their maturity, but the Adviser does not intend to invest in any Cash Equivalents that are not U.S. Treasury Bonds. As defined in Exchange Rule 14.11(i)(4)(C)(iii)(b), Cash Equivalents are short-term instruments with maturities of less than three months, which includes only the following: (i) U.S. Government securities, including bills, notes, and bonds differing as to maturity and rates of interest, which are either issued or guaranteed by the U.S. Treasury or by U.S. Government agencies or instrumentalities; (ii) certificates of deposit issued against funds deposited in a bank or savings and loan association; (iii) bankers acceptances, which are short-term credit instruments used to finance commercial transactions; (iv) repurchase agreements and reverse repurchase agreements; (v) bank time deposits, which are monies kept on deposit with banks or savings and loan associations for a stated period of time at a fixed rate of interest; (vi) commercial paper, which are short-term unsecured promissory notes; and (vii) money market funds.

[10] Because the Fund is not in compliance with Rule 14.11(i)(4)(C)(iv)(b), the Exchange has commenced delisting proceedings pursuant to Rule 14.12, including issuing a deficiency notification.

[11] 17 CFR 240.10A–3.

[12] *See* Rule 14.11(i)(4)(A)(ii) and 14.11(i)(4)(B)(ii).

[13] *See* Rule 14.11(i)(4)(A)(ii).

[14] *See* Rule 14.11(i)(4)(B)(i).

[15] *See* Rule 14.11(i)(4)(B)(iii).

[16] *See* Rule 14.11(i)(4)(B)(iv).

[17] *See* Rule 14.11(i)(2)(C).

[18] *See* Rule 14.11(i)(2)(B).

[19] *See* Rule 14.11(i)(6).

[20] *See* Rule 14.11(i)(7).

[21] For a list of the current members of ISG, *see www.isgportal.com.* The Exchange notes that not all components of the Disclosed Portfolio for the Fund may trade on markets that are members of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement.

regarding market price and trading volume of the Shares will be continuously available throughout the day on brokers' computer screens and other electronic services. Information regarding the previous day's closing price and trading volume for the Shares will be published daily in the financial section of newspapers. Trading in the Shares may be halted for market conditions or for reasons that, in the view of the Exchange, make trading inadvisable. The Exchange deems the Shares to be equity securities, thus rendering trading in the Shares subject to the Exchange's existing rules governing the trading of equity securities. The Exchange has appropriate rules to facilitate trading in the Shares during all trading sessions. The Exchange prohibits the distribution of material non-public information by its employees. Quotation and last sale information for the Shares will be available via the CTA high-speed line.

2. Statutory Basis

The Exchange believes that the proposal is consistent with Section 6(b) of the Act [22] in general and Section 6(b)(5) of the Act [23] in particular in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest in that the Shares will meet each of the continued listing criteria in BZX Rule 14.11(i) with the exception of the Concentration Restriction in Rule 14.11(i)(4)(C)(iv)(b), which requires that the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets shall not exceed 65% of the weight of the portfolio (including gross notional exposures), and the aggregate gross notional value of listed derivatives based on any single underlying reference asset shall not exceed 30% of the weight of the portfolio (including gross notional exposures).[24] The Exchange believes that the diversity, liquidity, and market cap of the securities underlying the S&P 500 Index are sufficient to protect against market manipulation of both the Fund's holdings and the Shares as it relates to the S&P 500 Options holdings. The Exchange also believes that the liquidity in the S&P 500 Options market [25] mitigates the concerns that Rule 14.11(i)(4)(C)(iv)(b) is intended to address and that such liquidity would also act to prevent other S&P 500 Options from being susceptible to manipulation, and thus, make the Shares less susceptible to manipulation. Further, allowing the Fund to hold a greater portion of its portfolio in S&P 500 Options would mean that the Fund would not be required to use over-the-counter (''OTC'') derivatives if the Adviser deemed it necessary to get exposure in excess of the Concentration Restriction in Rule 14.11(i)(4)(C)(iv)(b), which would reduce the Fund's operational burden by allowing the Fund to use listed options contracts to achieve its investment objective and would eliminate the counter-party risk associated with holding OTC derivative instruments.

The Exchange believes that its surveillance procedures are adequate to properly monitor the trading of the Shares on the Exchange during all trading sessions and to deter and detect violations of Exchange rules and the applicable federal securities laws. The S&P 500 Options held by the Fund will trade on markets that are a member of ISG or affiliated with a member of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement. The Exchange may obtain information regarding trading in the Shares and the S&P 500 Options held by the Fund via the ISG from other exchanges who are a member of ISG or affiliated with a member of ISG or with which the Exchange has entered into a comprehensive surveillance sharing agreement. The Exchange further notes that the Fund will meet and be subject to all other requirements of the generic listing rules and other applicable continued listing requirements for Managed Fund Shares under Rule 14.11(i), including those requirements regarding the dissemination of key information such as the Disclosed Portfolio, Net Asset Value, and the Intraday Indicative Value, suspension of trading or removal, trading halts, surveillance, minimum price variation for quoting and order entry, the information circular, and firewalls as set forth in Exchange rules applicable to Managed Fund Shares.

For the above reasons, the Exchange believes that the proposed rule change is consistent with the requirements of Section 6(b)(5) of the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purpose of the Act. The Exchange notes that the proposed rule change, rather, will facilitate the options strategy of an actively-managed exchange-traded product that will allow the Fund to better compete in the marketplace, thus enhancing competition among both market participants and listing venues, to the benefit of investors and the marketplace.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6) thereunder.[26]

A proposed rule change filed under Rule 19b–4(f)(6) [27] normally does not become operative for 30 days after the date of the filing. However, pursuant to Rule 19b–4(f)(6)(iii),[28] the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. In its filing with the Commission, the Exchange asked the Commission to

[22] 15 U.S.C. 78f(b).

[23] 15 U.S.C. 78f(b)(5).

[24] As noted above, the Exchange is proposing that the Fund be exempt from the Concentration Restriction of Rule 14.11(i)(4)(C)(iv)(b) that prevents the aggregate gross notional value of listed derivatives based on any five or fewer underlying reference assets from exceeding 65% of the weight of the portfolio (including gross notional exposures), and the aggregate gross notional value of listed derivatives based on any single underlying reference asset from exceeding 30% of the weight of the portfolio (including gross notional exposures).'' The Exchange is proposing that the Fund be exempt from both the 30% and 65% requirements of Rule 14.11(i)(4)(C)(iv)(b).

[25] In 2018, more than 1.48 million S&P 500 Options contracts were traded per day on Cboe Options, which is more than $350 billion in notional volume traded on a daily basis.

[26] In addition, Rule 19b–4(f)(6)(iii) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[27] 17 CFR 240.19b–4(f)(6).

[28] 17 CFR 240.19b–4(f)(6)(iii).

waive the 30-day operative delay to permit the Fund to immediately employ an investment strategy that would allow the Fund to hold listed derivatives based on a single underlying reference asset (*i.e.,* S&P 500 Options) in a manner that may not comply with the generic listing standards under Rule 14.11(i)(4)(C)(iv)(b). The Commission notes that the proposed rule change in this regard is similar to previously submitted proposals to list and trade series of Index Fund Shares and Managed Fund Shares with exposure to a single underlying reference asset (*i.e.,* the S&P 500 Index) that were either approved by the Commission or effective upon filing.[29] Thus, the Commission believes that waiver of the 30-day operative delay is consistent with the protection of investors and the public interest and hereby waives the 30-day operative delay and designates the proposed rule change operative upon filing.[30]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–CboeBZX–2019–055 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–CboeBZX–2019–055.This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CboeBZX–2019–055 and should be submitted on or before July 11, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[31]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13069 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[29] *See supra* note 6. In the approval order for proposed rule change SR–CboeBZX–2018–029, the Commission noted that the proposing exchange stated that ''SPX options are among the most liquid index options in the U.S. and derive their value from the actively traded S&P 500 components. SPX options are cash-settled with no delivery of stocks or ETFs, and trade in competitive auction markets with price and quote transparency. The Exchange believes that the highly regulated S&P 500 options markets, and the broad base and scope of the S&P 500 Index, make securities that derive their value from that index, including S&P 500 options, less susceptible to potential market manipulation in view of market capitalization and liquidity of the S&P 500 Index components, price and quote transparency, and arbitrage opportunities.'' *See* Securities Exchange Act Release No. 77045, *supra* note 6, 81 FR at 6917 n.15.

[30] For purposes only of waiving the operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[31] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE, Washington, DC 20549–2736.

Extension:

Rule 302, SEC File No. 270–453, OMB Control No. 3235–0510

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (''PRA'') (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') is soliciting comments on the existing collection of information provided for in Rule 302 (17 CFR 242.302) of Regulation ATS (17 CFR 242.300 *et seq.*) under the Securities and Exchange Act of 1934 (''Act'') (15 U.S.C. 78a *et seq.*). The Commission plans to submit this existing collection of information to the Office of Management and Budget (''OMB'') for extension and approval.

Regulation ATS sets forth a regulatory regime for ''alternative trading systems'' (''ATSs''). An entity that meets the definition of an exchange must register, pursuant to Section 5 of the Exchange Act, as a national securities exchange under Section 6 of the Exchange Act [1] or operate pursuant to an appropriate exemption.[2] One of the available exemptions is for ATSs.[3] Exchange Act Rule 3a1–1(a)(2) exempts from the definition of ''exchange'' under Section 3(a)(1) an organization, association, or group of persons that complies with Regulation ATS.[4] Regulation ATS requires an ATS to, among other things, register as a broker-dealer with the Securities and Exchange Commission (''SEC''), file a Form ATS with the Commission to notice its operations, and establish written safeguards and procedures to protect subscribers' confidential trading information. An ATS that complies with Regulation ATS and operates pursuant to the Rule 3a1–1(a)(2) exemption would not be required by Section 5 to register as a national securities exchange.

Rule 302 of Regulation ATS (17 CFR 242.302) describes the recordkeeping requirements for ATSs. Under Rule 302,

[1] *See* 15 U.S.C. 78e and 78f. A ''national securities exchange'' is an exchange registered as such under Section 6 of the Exchange Act.

[2] 15 U.S.C. 78a *et seq.*

[3] Rule 300(a) of Regulation ATS provides that an ATS is ''any organization, association, person, group of persons, or system: (1) [t]hat constitutes, maintains, or provides a market place or facilities for bringing together purchasers and sellers of securities or for otherwise performing with respect to securities the functions commonly performed by a stock exchange within the meaning of [Exchange Act Rule 3b-16]; and (2) [t]hat does not: (i) [s]et rules governing the conduct of subscribers other than the conduct of subscribers' trading on such [ATS]; or (ii) [d]iscipline subscribers other than by exclusion from trading.''

[4] *See* 17 CFR 240.3a1–1(a)(2).

ATSs are required to, among other things, make a record of subscribers to the ATS, daily summaries of trading in the ATS, and time-sequenced records of order information in the ATS.

The information required to be collected under Rule 302 should increase the abilities of the Commission, state securities regulatory authorities, and the self-regulatory organizations to ensure that ATSs are in compliance with Regulation ATS as well as other applicable rules and regulations. If the information is not collected or collected less frequently, the regulators would be limited in their ability to comply with their statutory obligations, provide for the protection of investors, and promote the maintenance of fair and orderly markets.

Respondents consist of ATSs that choose to operate pursuant to the exemption provided by Regulation ATS from registration as national securities exchanges. There are currently 83 respondents. These respondents will spend approximately 3,735 hours per year (83 respondents at 45 burden hours/respondent) to comply with the recordkeeping requirements of Rule 302. At an average cost per burden hour of $73, the resultant total related internal cost of compliance for these respondents is $272,655 per year (3,735 burden hours multiplied by $73/hour).

Written comments are invited on (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Please direct your written comments to: Charles Riddle, Acting Director/Chief Information Officer, Securities and Exchange Commission, c/o Candace Kenner, 100 F Street NE, Washington, DC 20549, or send an email to: *PRA_Mailbox@sec.gov.*

Dated: June 14, 2019.

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13056 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–86117; File No. SR–NYSE–2018–46]

Self-Regulatory Organizations; New York Stock Exchange LLC; Order Disapproving a Proposed Rule Change To Amend the Listed Company Manual for Special Purpose Acquisition Companies To Reduce the Continued Listing Standards for Public Holders From 300 to 100 and To Enable the Exchange To Exercise Discretion To Allow Special Purpose Acquisition Companies a Reasonable Time Period Following a Business Combination to Demonstrate Compliance With the Applicable Quantitative Listing Standards

June 14, 2019.

I. Introduction

On October 1, 2018, New York Stock Exchange LLC (''NYSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'' or ''Exchange Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend the NYSE Listed Company Manual (''Manual'') for Special Purpose Acquisition Companies (''SPACs'') [3] to reduce the minimum number of public holders required for continued listing from 300 to 100, and to enable the Exchange to exercise discretion to allow SPACs a reasonable time period following a business combination to demonstrate compliance with the applicable quantitative listing standards. The proposed rule change was published for comment in the **Federal Register** on October 18, 2018.[4] The Commission received one comment letter on the proposal.[5] On November 29, 2018, the Commission designated a longer period within which to approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to approve or disapprove the proposed rule change.[6] On January 15, 2019, the Commission issued an order instituting proceedings (''OIP'' or ''Order Instituting Proceedings'') under Section 19(b)(2)(B) of the Act to determine whether to approve or disapprove the proposed rule change.[7] The Commission received one additional comment letter, from the same commenter, on the OIP.[8] On April 15, 2019, the Commission designated a longer period within which to issue an order approving or disapproving the proposed rule change.[9] This order disapproves the proposed rule change.

II. Description of the Proposal

A. Background on SPACs

A SPAC is a special purpose acquisition company whose business plan is to raise capital in an initial public offering (''IPO'') and, within a specific period of time, engage in a merger or acquisition with one or more unidentified companies. Among other things, a SPAC must keep 90% of the gross proceeds of its IPO in an escrow account until the date of a business combination.[10] The SPAC must complete one or more business combinations, having an aggregate fair market value of at least 80% of the value of the escrow account, within 36 months of the effectiveness of the IPO registration statement.[11] Additionally, public shareholders who object to a business combination have the right to convert their common stock into a pro rata share of the funds held in escrow.[12] Following a business combination, the combined company must meet the Exchange's requirements for initial listing of an operating company.[13]

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The Commission notes that throughout this order we have used the term ''SPAC'' or ''SPACs.'' These terms have the same meaning as ''Acquisition Company'' which is the term used by the Exchange in the Manual.

[4] *See* Securities Exchange Act Release No. 84420 (October 12, 2018), 83 FR 52854 (October 18, 2018) (''Notice'').

[5] *See* Letter to Secretary, Commission, from Jeffrey P. Mahoney, General Counsel, Council of Institutional Investors, dated November 8, 2018 (''CII Letter'').

[6] *See* Securities Exchange Act Release No. 84680 (November 29, 2018), 83 FR 62942 (December 8, 2018).

[7] *See* Securities Exchange Act Release No. 84984 (January 15, 2019), 84 FR 0855 (January 31, 2019).

[8] *See* Letter to Secretary, Commission, from Jeffrey P. Mahoney, General Counsel, Council of Institutional Investors, dated February 11, 2019 (''CII Letter II'').

[9] *See* Securities Exchange Act Release No. 85644 (April 15, 2019), 84 FR 16299 (April 18, 2019). The date was extended until June 15, 2019.

[10] *See* Section 102.06 of the Manual. Section 102.06 also contains additional quantitative requirements to list a SPAC.

[11] *See id.*

[12] *See* Section 102.06(b) of the Manual.

[13] This includes the requirement to maintain a minimum of 400 round lot holders. *See* Sections 102.01A and 802.01B of the Manual.

B. Description of the Proposed Changes to SPAC Listing Standards

The Exchange has proposed two changes to its SPAC listing requirements. First, the Exchange has proposed to reduce the number of public stockholders required for continued listing of a SPAC, prior to consummation of a business combination, from 300 to 100.[14] According to the Exchange, SPACs have difficulty demonstrating compliance with the 300 public stockholders continued listing requirement because there is limited retail investor interest in SPACs, and those who do invest in SPACs tend to hold their shares until a transaction is announced. The Exchange also stated its belief that the number of stockholders is less relevant for SPACs than for operating companies, because ''the price of [a SPAC] is based primarily on the value of the funds it holds in trust, and the [SPAC]'s shareholders have the right to redeem their shares for a pro rata share of that trust in conjunction with a Business Combination.'' For these reasons, NYSE asserted that SPACs, historically ''trade close to the value in the trust, even when they have had few shareholders,'' and that these ''trading patterns suggest that the low number of shareholders has not resulted in distorted prices.'' [15]

Second, the Exchange has proposed to give itself discretion to allow SPACs a reasonable time period following a business combination to demonstrate compliance with the applicable quantitative listing standards for an operating company, rather than requiring SPACs to immediately comply with such standards. These listing standards include: (1) A price per share of at least $4.00; (2) a global market capitalization of at least $150,000,000; (3) an aggregate market value of publicly held shares of at least $40,000,000; and (4) other quantitative requirements set forth in Section 102.01A of the Manual, including the requirement to maintain a minimum of 400 round lot holders and 1,100,000 publicly held shares.[16] The Exchange has proposed to delete the language in Section 802.01B of the Manual requiring the combined entity to meet these listing standards ''immediately upon consummation of the Business Combination.'' According to the Exchange, it can be difficult for a company, once listed, to obtain evidence demonstrating the number of its shareholders, because many accounts are held in street name, so companies must seek this information from broker-dealers or their third-party agents. The Exchange stated that the process of identifying shareholders is especially burdensome for SPACs at the time of the business combination, because SPAC shareholders have the right to request redemption of their securities until immediately before consummation of the business combination.

III. Summary of Comments

The Commission received one comment letter on the proposal and an additional comment letter, from the same commenter, in response to the OIP.[17] The commenter stated that it could not support the proposal as submitted ''because it does not provide sufficient information for us to make a determination as to whether our members and the capital markets would benefit from the proposed changes.'' [18] The commenter referenced its prior comments on similar proposals from the Exchange and Nasdaq, both of which were subsequently withdrawn.[19] The commenter noted that the proposed reduction in the minimum number of holders from 300 to 100 is far more modest than eliminating it outright, as was proposed in the prior proposals, but believed that additional information would be helpful in determining whether the proposal would benefit investors.

In response to the OIP, the commenter expressed concerns broadly that competition between the Exchange and Nasdaq was weakening listing standards, ''lower[ing] the bar for what goes in the world of SPACs,'' [20] and is in conflict with the Exchange Act requirement that exchange rules be designed to protect investors and the public interest. With respect to the Exchange's proposal, the commenter stated that it did not believe the Exchange provided sufficient information to determine whether the commenter's members and the capital markets would benefit from the proposed changes.

IV. Discussion and Commission Findings

Under Section 19(b)(2)(B) of the Act,[21] the Commission shall approve a proposed rule change by a self-regulatory organization if the Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder that are applicable to such organization.[22] The Commission shall disapprove a proposed rule change if the Commission does not make such a finding.[23] Under the Commission's Rules of Practice, the ''burden to demonstrate that a proposed rule change is consistent with the Exchange Act and the rules and regulations issued thereunder . . . is on the self-regulatory organization that proposed the rule change,'' and a ''mere assertion that the proposed rule change is consistent with those requirements . . . is not sufficient.'' [24]

The description of a proposed rule change, its purpose and operation, its effect, and a legal analysis of its consistency with applicable requirements must all be sufficiently detailed and specific to support an affirmative Commission finding, and any failure of a self-regulatory organization to provide this information may result in the Commission not having a sufficient basis to make an affirmative finding that a proposed rule change is consistent with the Act and the applicable rules and regulations.[25]

For the reasons discussed below, the Commission is disapproving the proposed rule change because the information before the Commission is insufficient to support a finding that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities

[14] Public stockholders exclude holders that are directors, officers, or their immediate families and holders of other concentrated holdings of 10% or more. *See* Section 802.01B ''Criteria for Acquisition Companies'' of the Manual.

[15] The Exchange also articulated other arguments, including that Exchange Traded Funds are ''somewhat similar'' and do not have as high of a continued listing shareholder requirement as SPACs. *See* Notice, *supra,* note 4.

[16] *See* Section 802.01B of the Manual.

[17] *See supra* notes 5 and 8.

[18] *See supra* note 5.

[19] *See* SR–NYSE–2017–53 (proposal to, among other things, lower the initial holders requirement from 300 to 150 round lot holders and to eliminate the continued holders requirement from 300 public stockholders to zero, and to impose a 30-day deadline to demonstrate compliance with certain initial requirements following a business combination). The proposal was withdrawn on June 21, 2018 after the Commission institute proceedings to determine whether to approve or disapprove the proposal. *See* Notice of Withdrawal, Securities Exchange Act Release No. 83570 (June 29, 2018), 83 FR 31628 (July 6, 2018). *See* also SR–Nasdaq–2017–87 (proposal to reduce round lot holders on Nasdaq Capital Market for initial listing From 300 to 150 and eliminate public holders for continued listing from 300 to zero, and impose a deadline to demonstrate compliance with initial listing requirements within 30 Days following each business combination). The proposal was withdrawn on June 1, 2018 after the Commission instituted proceedings to determine whether to approve or disapprove the proposal. *See* Notice of Withdrawal, Securities Exchange Act Release No. 83383 (June 5, 2018), 83 FR 27055 (June 11, 2018).

[20] *See supra* note 8.

[21] *See* 15 U.S.C. 78s(b)(2)(C).

[22] *See* 15 U.S.C. 78s(b)(2)(C)(i).

[23] *See* 15 U.S.C. 78s(b)(2)(C)(ii).

[24] 17 CFR 201.700(b)(3).

[25] *See id.*

exchange.[26] Specifically, the Commission concludes that it does not have sufficient information to determine that the proposed rule change is consistent with Section 6(b)(5) of the Act, and in particular the requirements that a national securities exchange's rules be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest.[27]

The Commission has consistently recognized the importance of the minimum number of holders and other similar requirements in exchange listing standards. For example, the Commission has repeatedly stated in approving exchange listing requirements, including NYSE's original SPAC listing standards, that the development and enforcement of adequate standards governing the listing of securities on an exchange is an activity of critical importance to financial markets and the investing public.[28] Among other things, such listing standards help ensure that exchange listed securities have sufficient public float, investor base, and trading interest to provide the depth and liquidity necessary to promote fair and orderly markets.[29]

NYSE has proposed to lower the minimum number of holders required for continued listing of a SPAC, in the period prior to consummation of a business combination, from 300 public holders to 100 public holders. In support of its proposal, NYSE asserts, among other things, that SPACs often have difficulty demonstrating compliance with the minimum number of holders requirements because there is limited retail investor interest in them, and that this requirement is less relevant for SPACs because they historically trade close to the value of the funds held in trust, and without distorted prices, even when they have few shareholders. NYSE, however, has provided no evidence (such as, for example, information about the number of SPAC delisting proceedings as compared to the number of delisting proceedings for other types of listed companies) that SPACs in fact have difficulty complying with the existing minimum number of holders requirements. In addition, to support its position that the minimum number of holders requirements are less relevant for SPACs, NYSE made certain representations about the current trading characteristics of SPACs when they have few shareholders. The Commission notes, however, that NYSE's observations were made when the current minimum number of holders requirements were in place, and NYSE has provided no evidence that the same observations would be repeated if these requirements were substantially reduced, as proposed. In the OIP, the Commission asked several questions relating to this aspect of the proposal, including whether it would ensure a sufficient liquid market for NYSE-listed SPACs, whether SPACs would still trade close to their redemption value or be more prone to manipulation (both before and after the business combination announcement), and whether there was any data to support NYSE's assertions about the nature of SPAC trading or the difficulties faced by SPACs in meeting existing listing standards. NYSE offered no additional response, arguments or data in response to these questions or in support of its proposal, nor did any other commenter.

NYSE also has proposed to provide itself discretion to allow SPACs a reasonable time period following a business combination to demonstrate compliance with the minimum number of holders and other applicable quantitative listing standards for an operating company, rather than requiring SPACs to immediately comply with such standards. NYSE, however, has provided no supporting evidence (such as, for example, information about the number of SPAC delisting proceedings as compared to the number of delisting proceedings for other types of listed companies) that SPACs have particular difficulties demonstrating compliance with these important requirements. In addition, the Commission notes that, while NYSE's current listing standards require a SPAC to have at least 300 public holders prior to the business combination, NYSE's proposal would reduce that requirement to as few as 100 public holders. Following consummation of the business combination, the SPAC would be required to have at least 400 round lot holders. In the OIP, the Commission questioned whether such a structure would be workable, and how a listed SPAC would ensure it is in a position to sufficiently increase its number of holders from the proposed 100 public holder threshold (as opposed to the current 300 threshold), even within the ''reasonable time period'' contemplated by NYSE. The Commission further noted that the Exchange offered no explanation as to why SPACs require additional time, following the consummation of a business combination, to meet all of the other applicable quantitative listing standards for operating companies, including those relating to share price, global market capitalization, and the market value of the publicly-held shares. However, as with the other concerns raised by the Commission in the OIP, NYSE offered no additional response, arguments or data in response to these concerns or in support of its proposal, nor did any other commenter.

For the reasons discussed above, the Commission concludes that the record before it does not provide a basis to conclude that the Exchange has met its burden under the Act and the Commission's Rules of Practice to demonstrate that its proposed rules change is consistent with Section 6(b)(5) of the Act.[30]

V. Conclusion

For the reasons set forth above, the Commission does not find, pursuant to Section 19(b)(2) of the Act,[31] that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange, and in particular, with Section 6(b)(5) of the Act.[32]

It is therefore ordered that, pursuant to Section 19(b)(2) of the Act,[33] the proposed rule change (SR–NYSE–2018–46) be, and it hereby is, *disapproved.*

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[34]

Vanessa A. Countryman,

Acting Secretary.

[FR Doc. 2019–13075 Filed 6–19–19; 8:45 am]

BILLING CODE 8011–01–P

[26] In disapproving the proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[27] *See* 15 U.S.C. 78f(b)(5).

[28] *See, e.g.,* Securities Exchange Act Release No. 57785 (May 6, 2008), 73 FR 27597 (May 13, 2008) (stating that the distribution standards, which include exchange holders requirements ''. . . should help to ensure that the [SPACs'] securities have sufficient public float, investor base, and liquidity to promote fair and orderly markets''). *See also* Securities Exchange Act Release No. 58228, (July 25, 2008) 73 FR 44794 (July 31, 2008) (approving Nasdaq initial and continued listing standards for SPACs).

[29] *Id.*

[30] *See* 15 U.S.C. 78f(b)(5).

[31] *See* 15 U.S.C. 78s(b)(2).

[32] *See* 15 U.S.C. 78f(b)(5).

[33] *See* 15 U.S.C. 78s(b)(2).

[34] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #15986 and #15987; INDIANA Disaster Number IN–00064]

Administrative Declaration of a Disaster for the State of INDIANA

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of INDIANA dated 06/12/2019.

Incident: Tornadoes, High Winds and Severe Storms.

Incident Period: 05/27/2019.

DATES: Issued on 06/12/2019.

Physical Loan Application Deadline Date: 08/12/2019.

Economic Injury (EIDL) Loan Application Deadline Date: 03/12/2020.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Madison

Contiguous Counties:

Indiana: Delaware, Grant, Hamilton, Hancock, Henry, Tipton.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	3.875
Homeowners without Credit Available Elsewhere	1.938
Businesses with Credit Available Elsewhere	8.000
Businesses without Credit Available Elsewhere	4.000
Non-Profit Organizations with Credit Available Elsewhere	2.750
Non-Profit Organizations without Credit Available Elsewhere	2.750
For Economic Injury:	
Businesses & Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Non-Profit Organizations without Credit Available Elsewhere	2.750

The number assigned to this disaster for physical damage is 15986 C and for economic injury is 15987 0.

The State which received an EIDL Declaration # is Indiana.

(Catalog of Federal Domestic Assistance Number 59008)

Dated: June 12, 2019.

Christopher M. Pilkerton,

Acting Administrator.

[FR Doc. 2019–13094 Filed 6–19–19; 8:45 am]

BILLING CODE 8206–03–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2019–0108]

Agency Information Collection Activities; Renewal and Revision of an Approved Information Collection: Commercial Driver's License Drug and Alcohol Clearinghouse

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), Department of Transportation (DOT).

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FMCSA announces its plan to submit the Information Collection Request (ICR) described below to the Office of Management and Budget for its review and approval and invites public comment. The FMCSA requests to renew an ICR titled, ''Commercial Driver's License Drug and Alcohol Clearinghouse.'' The Agency's final rule, published December 5, 2016, titled ''Commercial Driver's License Drug and Alcohol Clearinghouse'' (81 FR 87686) (Clearinghouse) established the regulatory requirements for the Clearinghouse. The compliance date of the final rule is January 6, 2020. Since the original ICR was approved, no data has yet been collected. With the upcoming compliance date, this ICR is needed to ensure that querying and reporting requirements are met to diminish the problem of Commercial Driver's License (CDL) and Commercial Learner's Permit (CLP) holders who test positive for drugs or alcohol and then continue to perform safety sensitive functions, including driving a commercial motor vehicle (CMV), without participating in the required return-to-duty process.

DATES: We must receive your comments on or before August 19, 2019.

ADDRESSES: You may submit comments identified by Federal Docket Management System (FDMS) Docket Number FMCSA–2019–0108 using any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Operations; U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building, Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building, Ground Floor, Room W12–140, Washington, DC, 20590–0001 between 9 a.m. and 5 p.m. E.T., Monday through Friday, except Federal holidays.

Instructions: All submissions must include the Agency name and docket number. For detailed instructions on submitting comments, see the Public Participation heading below. Note that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. Please see the Privacy Act heading below.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov,* and follow the online instructions for accessing the dockets, or go to the street address listed above.

Privacy Act: In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *www.dot.gov/privacy.*

Public Participation: The Federal eRulemaking Portal is available 24 hours each day, 365 days each year. You can obtain electronic submission and retrieval help and guidelines under the ''help'' section of the Federal eRulemaking Portal website. If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard, or print the acknowledgement page that appears after submitting comments online. Comments received after the comment closing date will be included in the docket and will be considered to the extent practicable.

FOR FURTHER INFORMATION CONTACT: Juan Moya, Compliance Division, Federal Motor Carrier Safety Administration, Department of Transportation, West Building 6th Floor, 1200 New Jersey Avenue SE, Washington, DC 20590.

Telephone: 202–366–4844; email *clearinghouse@dot.gov*.

SUPPLEMENTARY INFORMATION:

Background

Agency regulations at 49 CFR part 382 apply to persons and employers of such persons who operate CMVs in commerce in the United States and who are subject to the CDL requirements in 49 CFR part 383 or the equivalent CDL requirements for Canadian and Mexican drivers (49 CFR 382.103(a)). Part 382 requires that employers conduct pre-employment drug testing, post-accident testing, random drug and alcohol testing, and reasonable suspicion testing, as well as return-to-duty (RTD) testing and follow-up testing for those drivers who test positive or otherwise violate DOT drug and alcohol program requirements. Motor carrier employers are prohibited from allowing an employee to perform safety-sensitive functions, which include operating a CMV, if the employee tests positive on a DOT drug or alcohol test, refuses to take a required test, or otherwise violates the DOT or FMCSA drug and alcohol testing regulations.

Section 32402 of the Moving Ahead for Progress in the 21st Century Act (MAP–21) requires that the Secretary of Transportation establish, operate, and maintain a national clearinghouse for records relating to alcohol and controlled substances testing of CMV operators to improve compliance with the Department of Transportation's (DOT) alcohol and controlled substances testing program and to enhance the safety of our roadways by reducing crashes and injuries involving the misuse of alcohol or use of controlled substances by operators of CMVs. As noted above, FMCSA published a final rule on December 5, 2016, with an effective date of January 4, 2017, and a compliance date of January 6, 2020 to implement the requirements of the Clearinghouse. No information is currently being collected.

The Clearinghouse will function as a repository for records relating to the positive test results and test refusals of CMV operators and violations by such operators of prohibitions set forth in part 382, subpart B, of title 49, Code of Federal Regulations. An employer will utilize the Clearinghouse to determine whether current and prospective employees have incurred a drug or alcohol violation that would prohibit them from performing safety-sensitive functions, including operating a CMV.

The Clearinghouse will provide FMCSA and employers the necessary tools to identify drivers who are prohibited from operating a CMV and ensure that such drivers receive the required evaluation and treatment before resuming safety-sensitive functions. Specifically, information maintained in the Clearinghouse will ensure that drivers who commit a drug or alcohol violation while working for one employer and attempt to find work with another employer, can no longer conceal their drug and alcohol violations merely by moving on to the next job or the next state. Drug and alcohol violation records maintained in the Clearinghouse will follow the driver regardless of how many times he or she changes employers, seeks employment or applies for a CDL in a different State.

The information in the Clearinghouse will be used by FMCSA and its State partners for enforcement purposes:

- Ensure employers are meeting their pre-employment investigation and reporting requirements.
- Place drivers out of service if drivers are found to be operating a CMV without completing the RTD process.
- Ensure Medical Review Officers (MROs) and Substance Abuse Professionals (SAPs) meet their reporting requirements.

Only authorized users, including employers and their service agents, and Federal Enforcement personnel and State Driver Licensing Agencies (SDLAs) will be able to register and access the Clearinghouse for designated purposes. State enforcement personnel will receive the driver's eligibility status to operate a CMV, based on Clearinghouse information, when they check Query Central or NLets for driver information. FMCSA will share a driver's drug and alcohol violation information with the National Transportation Safety Board when it is investigating a crash involving that driver.

Drivers will be able to access their own information, but not information of other drivers. The Clearinghouse will meet all relevant federal security standards and FMCSA will continuously monitor compliance with applicable security regulations.

Title: Commercial Driver's License Drug and Alcohol Clearinghouse.

OMB Control Number: 2126–0057.

Type of Request: Renewal and revision of a currently approved information collection.

Respondents: Motor carriers (employers), drivers, medical review officers, substance abuse professionals, consortia/third-party administrators (C/TPAs), and State Driver's Licensing Agencies.

Estimated Number of Respondents: 11,038,986.

Estimated Time per Response: Varies; 10 to 20 minutes.

Expiration Date: January 31, 2020.

Frequency of Response: On occasion.

A user's role will determine the frequency of the response in the Clearinghouse.

- Employers, or C/TPAs acting on behalf of an employer: At a minimum, employers are required to query the Clearinghouse for each driver they currently employ at least once a year. Employers must query the Clearinghouse for all prospective employees, as needed. In addition, employers report to the Clearinghouse alcohol confirmation tests with a concentration of 0.04 or higher, refusal to test (alcohol), refusal to test (drug) that is not determined by an MRO, actual knowledge, negative RTD testing, and completion of follow-up testing. Employer reporting must be completed by the close of the third business day following the date they obtained the information on a driver.
- MROs: Verified positive, adulterated or substituted drug test result and refusals to tests (drug) must be entered to the Clearinghouse on occasion, but no later than two business days after making a determination or verification.
- SAPs: Must enter the initial assessment date and the date the driver successfully complied with RTD requirements. SAPs are required to enter this information on occasion by the close of business day following the date of the initial assessment or completion of the RTD process.
- SDLAs may query the Clearinghouse prior to specified licensing transactions to determine if there are existing drug or alcohol violations.
- Drivers must provide their specific consent to pre-employment queries electronically through the Clearinghouse.

Estimated Total Annual Burden: 1,864,251.

Estimated Total Number Respondents: 11,038,986.

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) Whether the proposed collection is necessary for the performance of FMCSA's functions; (2) the accuracy of the estimated burden; (3) ways for FMCSA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized without reducing the quality of the collected information. The agency will summarize or include your comments in the request

for OMB's clearance of this information collection.

Issued under the authority of 49 CFR 1.87 on: June 13, 2019.

Kenneth Riddle,

Director for Office of Registration and Safety Information.

[FR Doc. 2019–13086 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2019–0044]

Notice of Application for Approval of Discontinuance or Modification of a Railroad Signal System

Under part 235 of Title 49 of the Code of Federal Regulations (CFR) and 49 U.S.C. 20502(a), this document provides the public notice that by a document dated May 30, 2019, the Belt Railway Company of Chicago (BRC) petitioned the Federal Railroad Administration (FRA) seeking approval to discontinue or modify a signal system. FRA assigned the petition Docket Number FRA–2019–0044.

Applicant: The Belt Railway Company of Chicago, Mr. Harold T. Kirman, Director Strategic Planning & Compliance, 6900 South Central Avenue, Bedford Park, IL 60638–6397.

Specifically, BRC requests permission to permanently remove signals 8R and 24RC within the interlocking at Lemoyne, Chicago, IL, located on BRC's Kenton Line at milepost 6.7. Signals 8R and 24RC share a common mast and are a legacy configuration from the Canadian National Railway adopting centralized traffic control on the Joliet Subdivision.

BRC states the removal of these signals will eliminate superfluous signals with a commensurate reduction in the cost of maintaining the signals. The balance of the interlocking functionality will remain the same.

A copy of the petition, as well as any written communications concerning the petition, is available for review online at *http://www.regulations.gov* and in person at the U.S. Department of Transportation's (DOT) Docket Operations Facility, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590. The Docket Operations Facility is open from 9 a.m. to 5 p.m., Monday through Friday, except Federal Holidays.

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested parties desire an opportunity for oral comment and a public hearing, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number and may be submitted by any of the following methods:

- *Website: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* Docket Operations Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590.
- *Hand Delivery:* 1200 New Jersey Avenue SE, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Communications received by August 5, 2019 will be considered by FRA before final action is taken. Comments received after that date will be considered if practicable.

Anyone can search the electronic form of any written communications and comments received into any of our dockets by the name of the individual submitting the comment (or signing the document, if submitted on behalf of an association, business, labor union, etc.). Under 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its processes. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *http://www.dot.gov/privacy.* See also *http://www.regulations.gov/#!privacyNotice* for the privacy notice of *regulations.gov*.

Issued in Washington, DC.

John Karl Alexy,

Acting Associate Administrator, Office of Railroad Safety.

[FR Doc. 2019–13067 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2009–0078]

Petition for Waiver of Compliance

Under part 211 of Title 49 Code of Federal Regulations (CFR), this document provides the public notice that on June 10, 2019, the American Short Line and Regional Railroad Association (ASLRRA) petitioned the Federal Railroad Administration (FRA) for an amended waiver of compliance from certain provisions of the Federal hours of service laws contained at 49 U.S.C. 21103(a)(4), which, in part, require a train employee to receive 48 hours off duty after initiating an on-duty period for 6 consecutive days. FRA assigned the petition Docket Number FRA–2009–0078.

Specifically, ASLRRA seeks to amend its existing waiver to add four member railroads that did not participate in the original waiver, but in the second quarter of 2019 determined that they now wish to participate. ASLRRA states the following railroads expressed a desire to participate in the waiver, and maintain at their headquarters supporting documentation of employee support as required:

- Black River & Western
- Belvidere and Delaware River Railroad
- Dover and Delaware River Railroad
- Dover and Rockaway River Railroad

A copy of the petition, as well as any written communications concerning the petition, is available for review online at *www.regulations.gov* and in person at the U.S. Department of Transportation's (DOT) Docket Operations Facility, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590. The Docket Operations Facility is open from 9 a.m. to 5 p.m., Monday through Friday, except Federal Holidays.

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested parties desire an opportunity for oral comment and a public hearing, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number and may be submitted by any of the following methods:

- *Website: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* Docket Operations Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590.
- *Hand Delivery:* 1200 New Jersey Avenue SE, Room W12–140,

Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Communications received by August 5, 2019 will be considered by FRA before final action is taken. Comments received after the comment period ends will be considered if practicable.

Anyone can search the electronic form of any written communications and comments received into any of our dockets by the name of the individual submitting the comment (or signing the document, if submitted on behalf of an association, business, labor union, etc.). Under 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its processes. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *https://www.transportation.gov/privacy.* See also *https://www.regulations.gov/privacyNotice* for the privacy notice of *regulations.gov.*

Issued in Washington, DC.

John Karl Alexy,

Deputy Associate Administrator, Office of Railroad Safety.

[FR Doc. 2019–13077 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2019–0045]

Notice of Application for Approval of Discontinuance or Modification of a Railroad Signal System

Under part 235 of Title 49 of the Code of Federal Regulations (CFR) and 49 U.S.C. 20502(a), this document provides the public notice that by a document dated May 28, 2019, the Consolidated Rail Corporation (Conrail) petitioned the Federal Railroad Administration (FRA) seeking approval to discontinue or modify a signal system. FRA assigned the petition Docket Number FRA–2019–0045.

Applicant: Consolidated Rail Corporation, Mr. Steven J. Vant, Signal Engineer, 1000 Howard Boulevard, Mt. Laurel, NJ 08054.

Specifically, Conrail requests permission to discontinue cab signals within control point (CP) John at milepost (MP) 4.7; discontinue cab signals between CP MY at MP 0.5 and CP John; remove circuit controllers between CP MY and CP John, and change method of operation from NORAC Rule 261 to NORAC Rule 97, Running Track Rule, which allows for operation at Restricted Speed, on the Morrisville Line, South Jersey District.

CP John is controlled and maintained by Conrail. CP MY is controlled and maintained by Amtrak. Trackage between CP MY and CP John is controlled and maintained by Conrail. The signal system consists of wayside signals at CP MY and CP John governing movement into a single block between the two interlockings. There are no wayside signals between CP MY and CP John. There are cab signals, which would be removed. Conrail states the majority of the track has poor shunting due to rusty rail which has forced Conrail to disable the signal system.

A copy of the petition, as well as any written communications concerning the petition, is available for review online at *http://www.regulations.gov* and in person at the U.S. Department of Transportation's (DOT) Docket Operations Facility, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590. The Docket Operations Facility is open from 9 a.m. to 5 p.m., Monday through Friday, except Federal Holidays.

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested parties desire an opportunity for oral comment and a public hearing, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number and may be submitted by any of the following methods:

- *Website: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* Docket Operations Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE, W12–140, Washington, DC 20590.
- *Hand Delivery:* 1200 New Jersey Avenue SE, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Communications received by August 5, 2019 will be considered by FRA before final action is taken. Comments received after that date will be considered if practicable.

Anyone can search the electronic form of any written communications and comments received into any of our dockets by the name of the individual submitting the comment (or signing the document, if submitted on behalf of an association, business, labor union, etc.). Under 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its processes. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *http://www.dot.gov/privacy.* See also *http://www.regulations.gov/#!privacyNotice* for the privacy notice of *regulations.gov*.

Issued in Washington, DC.

John Karl Alexy,

Acting Associate Administrator, Office of Railroad Safety.

[FR Doc. 2019–13068 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2019–0057]

Federal Advisory Committee National Emergency Medical Services Advisory Council (NEMSAC); Notice of Meeting

AGENCY: National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation (DOT).

ACTION: Meeting Notice—National Emergency Medical Services Advisory Council

SUMMARY: NHTSA announces a meeting of NEMSAC to be held at DOT Headquarters in Washington, DC. This notice announces the date, time, and location of the meeting, which will be open to the public, as well as provide opportunities for public input to the NEMSAC. The purpose of NEMSAC, a nationally recognized council of emergency medical services representatives and consumers, is to advise and consult with DOT and the Federal Interagency Committee on Emergency Medical Services (FICEMS) on matters relating to emergency medical services (EMS).

DATES: The NEMSAC meeting will be held on July 9, 2019, from 9 a.m. to 4:30 p.m. EDT, on July 10, 2019, from 9 a.m. to 4:30 p.m. EDT and on July 11, 2019 form 9 a.m. to 4:00 p.m. EDT. A public comment period will take place on July 9, 2019, between 11 a.m. and 11:30 a.m. EDT and July 10, 2019, between 10:45 a.m. and 11:15 a.m. EDT. Written comments for the NEMSAC from the

public must be received no later than July 1, 2019.

ADDRESSES: The meetings will be held at the DOT Headquarters, 1200 New Jersey Avenue SE, Washington, DC 20590. Attendees should plan to arrive 10–15 minutes early.

FOR FURTHER INFORMATION CONTACT: Eric Chaney, DOT, Office of Emergency Medical Services, 1200 New Jersey Avenue SE, NPD–400, Washington, DC 20590, *EricChaney@dot.gov* or 202–366–0257.

SUPPLEMENTARY INFORMATION: Notice of the NEMSAC meeting is given under the Federal Advisory Committee Act, Public Law 92–463, as amended (5 U.S.C. App. 2). The NEMSAC is authorized under Section 31108 of the Moving Ahead with Progress in the 21st Century Act of 2012.

Tentative Agenda of the National EMS Advisory Council Meeting

The tentative NEMSAC agenda includes the following:

Tuesday, July 9, 2019 (9 a.m. to 4:30 p.m. EDT)

(1) Call to Order, Introductions, and Opening Remarks (9 a.m. to 9:30 a.m. EDT)
(2) Approval of October 2018 NEMSAC Meeting Minutes (9:30 a.m. to 9:45 a.m. EDT)
(3) Federal Liaison Update
(4) Prehospital Pediatric Emergency Care Coordinator Project (10 a.m. to 10:30 a.m. EDT)
(5) Critical Crossroads Project (10:30 a.m. to 10:45 a.m. EDT)
(6) Break (10:45 a.m. to 11 a.m. EDT)
(7) Public Comment (11 a.m. to 11:30 a.m. EDT)
(8) FICEMS Strategic Plan Update/Revision (11:30 a.m. to 12:00 p.m. EDT)
(9) Lunch (12 p.m. to 1 p.m. EDT)
(10) CMS Emergency Triage, Treat and Transport (ET3) Model (1 p.m. to 1:30 p.m. EDT)
(11) Review and Discussion of Previously Approved NEMSAC Recommendations (1:30 p.m. to 2 p.m. EDT)
(12) Review of Ongoing NHTSA Projects (2 p.m. to 2:30 p.m. EDT)
(13) Break (2:30 p.m. to 3 p.m. EDT)
(14) Ad Hoc Committee Reports (3 p.m. to 3:30 p.m. EDT)
(15) NEMSIS Update (3:30 p.m. to 4 p.m. EDT)
(16) Review of Action Items (4:00 p.m. to 4:30 p.m. EDT)

Wednesday, July 10, 2019 (9:00 a.m. to 4:30 p.m. EDT)

(1) Reconvene and Introductions (9 a.m. to 9:15 a.m. EDT)
(2) Committee Reports (9:15 a.m. to 10:45 a.m. EDT)
(3) Public Comment (10:45 a.m. to 11:15 a.m. EDT)
(4) Continue Discussion of NEMSAC Focus Areas for 2019—2020 (11:15 a.m. to 11:30 a.m. EDT)
(5) Committee Break Out Sessions (12:00 p.m. to 4:00 p.m. EDT)

Thursday, July 11, 2019 (9:00 a.m. to 4:00 p.m. EDT)

(1) Reconvene and Introductions (9 a.m. to 9:15 p.m. EDT)
(2) Committee Break Out Sessions (9:15 a.m. to 12:00 a.m. EDT)
(3) Lunch (12:00 a.m. to 1:00 p.m. EDT)
(4) Committee Reports (1:15 a.m. to 4 p.m.)

Registration Information: This meeting will be open to the public; however, pre-registration is requested no later than June 28, 2019. For assistance with NEMSAC registration, please contact Eric Chaney at *Eric.Chaney@dot.gov* or 202–366–0257. There will not be a teleconference option for this meeting.

Public Comment: Members of the public are encouraged to comment directly to the NEMSAC during designated public comment periods. In order to allow as many people as possible to speak, speakers are requested to limit their remarks to 5 minutes. Written comments from members of the public will be distributed to NEMSAC at the meeting and should reach the NHTSA Office of EMS no later than July 1, 2019. Written comments may be submitted by either one of the following methods: (1) You may submit comments by email: *nemsac@dot.gov* or (2) you may submit comments by fax: 202–366–7149.

NHTSA is committed to providing equal access to this meeting for all participants. If you need alternative formats or services because of a disability, please contact the Eric Chaney at the email or phone number listed in the ''Registration Information'' section with your request by close of business on July 1, 2019.

A final agenda as well as meeting materials will be available to the public online through *www.EMS.gov* on or before July 1, 2019.

Authority: 44 U.S.C. Section 3506(c)(2)(A)

Issued in Washington, DC.

Jon Krohmer,

Acting Associate Administrator, Office of Research and Program Development.

[FR Doc. 2019–12934 Filed 6–19–19; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF THE TREASURY

United States Mint

Establish Pricing and Pricing Changes for 2019 United States Mint Numismatic Products

AGENCY: United States Mint, Department of the Treasury.

ACTION: Notice.

SUMMARY: The United States Mint is establishing a price for a new United States Mint numismatic product in accordance with the table below:

Product	2019 retail price
2019 United States Mint Native American $1 Coin & Currency Set	$15.95

FOR FURTHER INFORMATION CONTACT: Kara Murphy Haire, Marketing Specialist, Sales and Marketing Directorate; United States Mint; 801 9th Street NW; Washington, DC 20220; or call 202–354–7871.

Authority: 31 U.S.C. 5111, 5112, 5132 & 9701.

Dated: June 13, 2019.

David J. Ryder,

Director, United States Mint.

[FR Doc. 2019–13096 Filed 6–19–19; 8:45 am]

BILLING CODE P

FEDERAL REGISTER

Vol. 84 Thursday,

No. 119 June 20, 2019

Part II

Department of the Treasury

Internal Revenue Service

26 CFR Parts 1 and 54

Department of Labor

Employee Benefits Security Administration

29 CFR Parts 2510 and 2590

Department of Health and Human Services

45 CFR Parts 144, 146, 147, and 155

Health Reimbursement Arrangements and Other Account-Based Group Health Plans; Final Rule

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 54

[TD 9867]

RIN 1545–BO46

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Parts 2510 and 2590

RIN 1210–AB87

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, and 155

[CMS–9918–F]

RIN 0938–AT90

Health Reimbursement Arrangements and Other Account-Based Group Health Plans

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: This document sets forth final rules to expand opportunities for working men and women and their families to access affordable, quality healthcare through changes to rules under various provisions of the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (Code) regarding health reimbursement arrangements (HRAs) and other account-based group health plans. Specifically, the final rules allow integrating HRAs and other account-based group health plans with individual health insurance coverage or Medicare, if certain conditions are satisfied (an individual coverage HRA). The final rules also set forth conditions under which certain HRAs and other account-based group health plans will be recognized as limited excepted benefits. Also, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) are finalizing rules regarding premium tax credit (PTC) eligibility for individuals offered an individual coverage HRA. In addition, the Department of Labor (DOL) is finalizing a clarification to provide assurance that the individual health insurance coverage for which premiums are reimbursed by an individual coverage HRA or a qualified small employer health reimbursement arrangement (QSEHRA) does not become part of an ERISA plan, provided certain safe harbor conditions are satisfied. Finally, the Department of Health and Human Services (HHS) is finalizing provisions to provide a special enrollment period (SEP) in the individual market for individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA. The goal of the final rules is to expand the flexibility and use of HRAs and other account-based group health plans to provide more Americans with additional options to obtain quality, affordable healthcare. The final rules affect employees and their family members; employers, employee organizations, and other plan sponsors; group health plans; health insurance issuers; and purchasers of individual health insurance coverage.

DATES:

Effective date: These final rules are effective on August 19, 2019.

Applicability dates: The final rules generally apply for plan years beginning on or after January 1, 2020. However, the final rules under Code section 36B apply for taxable years beginning on or after January 1, 2020, and the final rules providing a new special enrollment period in the individual market apply January 1, 2020. See Section VI of the **SUPPLEMENTARY INFORMATION** section for more information on the applicability dates.

FOR FURTHER INFORMATION CONTACT: Christopher Dellana, Internal Revenue Service, Department of the Treasury, at (202) 317–5500; Matthew Litton or David Sydlik, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; David Mlawsky, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786–1565.

Customer Service Information: Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (*www.dol.gov/ebsa*). In addition, information from HHS on private health insurance coverage and coverage provided by non-federal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (*www.cms.gov/cciio*), and information on healthcare reform can be found at *www.HealthCare.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Executive Order

On October 12, 2017, President Trump issued Executive Order 13813,[1] ''Promoting Healthcare Choice and Competition Across the United States,'' stating, in part, that the ''Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).'' With regard to HRAs, the Executive Order directs the Secretaries of the Treasury, Labor, and HHS to ''consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.'' The Executive Order further provides that expanding ''the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.''

B. HRAs and Other Account-Based Group Health Plans

1. In General

An account-based group health plan is an employer-provided group health plan that provides for reimbursement of expenses for medical care (as defined under Code section 213(d)) (medical care expenses), subject to a maximum fixed-dollar amount of reimbursements for a period (for example, a calendar year). An HRA is a type of account-based group health plan funded solely by employer contributions (with no salary reduction contributions or other contributions by employees) that reimburses an employee solely for medical care expenses incurred by the employee, or the employee's spouse, dependents, and children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period.[2] The reimbursements under these types of arrangements are excludable from the employee's income and wages for federal income tax and employment tax purposes. Amounts that remain in the HRA at the end of the year often may

[1] 82 FR 48385 (Oct. 17, 2017). The executive order was issued on October 12, 2017 and was published in the **Federal Register** on October 17, 2017.

[2] *See* IRS Notice 2002–45, 2002–2 CB 93; Revenue Ruling 2002–41, 2002–2 CB 75; and IRS Notice 2013–54, 2013–40 IRB 287.

be used to reimburse medical care expenses incurred in later years, depending on the terms of the HRA.

HRAs are not the only type of account-based group health plan. For example, an employer payment plan is also an account-based group health plan. An employer payment plan is an arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for individual health insurance coverage, or other non-employer sponsored hospital or medical insurance. This includes a reimbursement arrangement described in Revenue Ruling 61–146, 1961–2 CB 25, or an arrangement under which the employer uses its funds directly to pay the premium for individual health insurance coverage or other non-employer sponsored hospital or medical insurance covering the employee.[3] Other examples of account-based group health plans include health flexible spending arrangements (health FSAs) and certain other employer-provided medical reimbursement plans that are not HRAs.[4]

2. Application of the Patient Protection and Affordable Care Act to HRAs and Other Account-Based Group Health Plans

The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, was enacted on March 30, 2010 (collectively, PPACA). PPACA reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to health coverage requirements for group health plans and health insurance issuers in the group and individual markets. The term ''group health plan'' includes both insured and self-insured group health plans.

PPACA also added section 715 to ERISA and section 9815 to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, PHS Act sections 2701 through 2728 (the market requirements), into ERISA and the Code, making them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. In accordance with Code section 9831(b) and (c), ERISA section 732(b) and (c), and PHS Act sections 2722(b) and (c) and 2763, the market requirements do not apply to a group health plan or a health insurance issuer in the group or individual market in relation to the provision of excepted benefits described in Code section 9832(c), ERISA section 733(c), and PHS Act section 2791(c).[5] See the discussion later in this preamble for additional background on excepted benefits. In addition, in accordance with Code section 9831(a)(2) and ERISA section 732(a), the market requirements do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year.[6]

PHS Act section 2711, as added by PPACA, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage[7] from establishing for any individual any lifetime or annual limits on the dollar value of essential health benefits (EHBs), as defined in PPACA section 1302(b). PHS Act section 2711, however, does not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing an annual or lifetime dollar limit for any individual on specific covered benefits that are not EHBs, to the extent these limits are otherwise permitted under applicable law.[8]

HRAs are subject to PHS Act section 2711. An HRA generally will fail to comply with PHS Act section 2711 because the arrangement is a group health plan that imposes an annual dollar limit on EHBs that the HRA will reimburse for an individual.[9]

[3] For more information about employer payment plans, see IRS Notice 2013–54, Q&A–1 and Q&A–3, and IRS Notice 2015–17, Q&A–4 and Q&A–5, 2015–14 IRB 845.

[4] For simplicity, the preamble generally refers only to HRAs, but references to HRAs should also be considered to include other account-based group health plans as defined in the final rules, unless otherwise specified. This term does not include QSEHRAs, under Code section 9831(d); medical savings accounts (MSAs), under Code section 220; or health savings accounts (HSAs), under Code section 223. In addition, for purposes of the final rules, the term ''HRA or other account-based group health plan'' does not include an employer arrangement that reimburses the cost of individual health insurance coverage through a cafeteria plan under Code section 125 (cafeteria plan premium arrangements); however see later in this preamble for a clarification that plan sponsors may offer such an arrangement in addition to an individual coverage HRA. A QSEHRA is not a group health plan for purposes of the market requirements of the Code (except as provided in Code section 4980I(f)(4)), parts 6 and 7 of ERISA, and titles XXII and XXVII of the PHS Act, and is not included in the definition of HRAs and other account-based group health plans for purposes of the final rules or this preamble. A QSEHRA is, however, considered a group health plan under the PHS Act for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d *et seq.*). *See* PHS Act section 2791(a)(1), as amended by the 21st Century Cures Act (Cures Act), Public Law 114–255, section 18001(c).

[5] While the PPACA amendments to PHS Act section 2722(b) and (c) (formerly PHS Act section 2721(c) and (d)) could be read as restricting the exemption for excepted benefits so it applies only with respect to subpart 2 of part A of title XXVII of the PHS Act, HHS does not intend to use its resources to enforce the market requirements with respect to excepted benefits offered by non-federal governmental plan sponsors and encourages states to adopt a similar approach with respect to issuers of excepted benefits. *See* 75 FR 34537, 34539–34540 (June 17, 2010).

[6] While the PPACA amendments to title XXVII of the PHS Act removed the parallel provision at section 2722(a) (formerly PHS Act section 2721(a)), HHS follows a similar approach for retiree-only non-federal governmental plans and encourages states to adopt a similar approach with respect to health insurance issuers of retiree-only plans. *See* 75 FR 34537, 34539–34540 (June 17, 2010).

[7] PHS Act section 2711 applies to grandfathered health plans, except that the annual dollar limit prohibition does not apply to grandfathered individual health insurance coverage. Grandfathered health plans are health plans that were in existence as of March 23, 2010, and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules. *See* 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140.

[8] For information regarding EHBs, see HHS's February 25, 2013 final rules addressing EHBs under PPACA section 1302 (78 FR 12834 (Feb. 25, 2013)); *see also* HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10871 (Feb. 27, 2015)). In addition, HHS issued final rules providing states with additional flexibility to define EHBs, starting with plan years beginning on or after January 1, 2020. *See* 45 CFR 156.111 (83 FR 16930 (April 17, 2018)). The current rules under PHS Act section 2711 include a definition of EHBs that applies for plans that are not required to cover EHBs. *See* 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), and 45 CFR 147.126(c). As explained later in this preamble, the rules set forth in this document include amendments to the definition of EHBs under the PHS Act section 2711 rules to reflect the updated final EHB rules.

[9] As explained in prior guidance, the Departments of Labor, the Treasury and HHS (the Departments) have determined that the annual dollar limit prohibition is not applicable to certain account-based group health plans that are subject to other statutory provisions limiting the benefits available under those plans. *See* 80 FR 72192, 72201 (Nov. 18, 2015). Specifically, the Departments have explained that the annual dollar limit prohibition does not apply to health FSAs that are offered through a cafeteria plan under Code section 125 (cafeteria plan) because PPACA section 9005 specifically limits salary reduction contributions to health FSAs to $2,500 (indexed for inflation) per year. Notwithstanding this exclusion for certain health FSAs from the application of the annual dollar limit prohibition, rules under Code section 125 provide that health FSAs are not permitted to reimburse employees for premiums for health insurance coverage. *See* Code section 125(d)(2)(A) and proposed 26 CFR 1.125–5(k)(4) (72 FR 43938, 43959 (Aug. 6, 2007)). Similarly, although MSAs and HSAs generally are not treated as group health plans subject to the market requirements, the Departments have concluded that the annual dollar limit prohibition would not apply to an MSA or HSA even if a particular arrangement did satisfy the criteria to be a group health plan because both types of arrangements are subject to specific statutory provisions that limit the contributions. *See* 75 FR 37188, 37190 (June 28, 2010); see also IRS Notice 2004–2, Q&A–1 and Q&A–3, 2004–2 IRB 269, which defines an HSA as a tax-exempt trust or custodial account and a high-deductible health plan as a health plan; *see also* DOL Field Assistance Bulletin No. 2004–01, available at *https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2004-01* and DOL Field Assistance Bulletin No. 2006–02,

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PHS Act section 2713, as added by PPACA, generally requires non-grandfathered group health plans, and health insurance issuers offering non-grandfathered group or individual health insurance coverage, to provide coverage for certain preventive services without imposing any cost-sharing requirements for these services.[10] Non-grandfathered HRAs are subject to and fail to comply with PHS Act section 2713 because, while HRAs may be used to reimburse the costs of preventive services, HRAs do not reimburse such costs after the HRAs have reimbursed the maximum dollar amount for a coverage period, and therefore HRAs fail to provide the required coverage, and violate the prohibition on imposing cost sharing for preventive services.[11]

3. Prior Rules and Guidance on Integration of HRAs and Other Account-Based Group Health Plans

The Departments previously issued rules and subregulatory guidance regarding the application of PHS Act sections 2711 and 2713 to HRAs.[12] The rules and guidance generally provide that, if an HRA is ''integrated'' with other group health plan coverage that complies with PHS Act sections 2711 and 2713, the HRA is considered to be in compliance with those sections because the combined arrangement complies with them. The rules and guidance also provide that HRAs may be integrated with Medicare and TRICARE coverage if certain conditions are satisfied, but may not be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713.[13]

More specifically, in the preamble to the 2010 interim final rules under PHS Act section 2711, the Departments provided that HRAs may be integrated with ''other coverage as part of a group health plan'' that complies with PHS Act section 2711 in order for the HRAs to be considered to satisfy PHS Act section 2711.[14] The interim final rules did not, however, set forth rules for implementing integration; the integration methods were set forth in later subregulatory guidance and subsequently included in the final rules under PHS Act section 2711 issued in 2015.

On September 13, 2013, the Treasury Department and the IRS issued Notice 2013–54, the DOL issued Technical Release 2013–03, and HHS issued contemporaneous guidance explaining that HHS concurred with the DOL and Treasury Department guidance.[15] This guidance stated that an HRA may not be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713, but described methods for integrating an HRA with another group health plan.[16] The Departments later incorporated the provisions of this guidance into the final rules issued in 2015 under PHS Act section 2711 [17], which are summarized later in this section of the preamble.

On November 6, 2014, the Departments issued FAQs about Affordable Care Act Implementation (Part XXII).[18] Q&A–1 reiterated and clarified prior subregulatory guidance by explaining that if an employer offers its employees cash to reimburse the purchase of individual health insurance coverage, the payment arrangement is a group health plan, without regard to whether the employer treats the money as a pre-tax or post-tax benefit to the employee, and it may not be integrated with individual health insurance coverage, and, therefore, will fail to comply with PHS Act sections 2711 and 2713.[19]

On February 18, 2015, the Treasury Department and the IRS issued Notice 2015–17. Q&A–3 provided that an arrangement under which an employer reimburses (or pays directly) some or all of the medical care expenses for employees covered by TRICARE constitutes an HRA and may not be integrated with TRICARE to comply with PHS Act sections 2711 and 2713 because TRICARE is not a group health

available at *https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2006-02,* which provide guidance regarding HSAs not constituting ''employee welfare benefit plans'' covered by ERISA Title I where employer involvement with the HSA is limited. Therefore, the final rules do not apply to MSAs, HSAs, or, in certain circumstances, health FSAs.

[10] *See also* 26 CFR 54.9815–2713, 29 CFR 2590.715–2713, and 45 CFR 147.130.

[11] Because MSAs and HSAs generally are not treated as group health plans, these arrangements are not subject to PHS Act section 2713. Health FSAs are group health plans and, unless they are excepted benefits, will fail to satisfy the requirements of PHS Act section 2713 unless they are integrated with other coverage that satisfies these requirements. For more information about the application of PHS Act section 2713 to health FSAs, see IRS Notice 2013–54, Q&A–7; DOL Technical Release No. 2013–03, Q&A–7, issued on September 13, 2013, available at *https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/13-03;* and CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.*

[12] Rules and subregulatory guidance issued on this topic include: (1) 75 FR 37188 (June 28, 2010); (2) FAQs about Affordable Care Act Implementation (Part XI), available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf* or *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html;* (3) IRS Notice 2013–54 and DOL Technical Release No. 2013–03 and CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements; (4) IRS FAQ on Employer Healthcare Arrangements, available at *https://www.irs.gov/affordable-care-act/employer-health-care-arrangements;* (5) FAQs about Affordable Care Act Implementation (Part XXII), available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf;* (6) IRS Notice 2015–17, issued on February 18, 2015; (7) 80 FR 72192 (Nov. 18, 2015); (8) IRS Notice 2015–87, 2015–52 IRB 889, issued on December 16, 2015; (9) IRS Notice 2016–17, 2016–9 IRB 358, issued on February 5, 2015; DOL Technical Release No. 2016–01, issued on February 5, 2016, available at *https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/16-01;* and CMS Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, issued on February 5, 2016, available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/student-health-bulletin.pdf;* (10) FAQs about Affordable Care Act Implementation Part 33, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-33.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA–FAQ-Set-33-Final.pdf;* (11) FAQs about Affordable Care Act Implementation Part 37, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf;* (12) 83 FR 54420 (Oct. 29, 2018); and (13) IRS Notice 2018–88, 2018–49 IRB 817, issued on November 19, 2018.

[13] 26 CFR 54.9815–2711(d)(4), 29 CFR 2590.715–2711(d)(4), and 45 CFR 147.126(d)(4).

[14] *See* 75 FR 37187, 37190–37191 (June 28, 2010).

[15] *See* CMS Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements.

[16] In addition to describing the integration methods, IRS Notice 2013–54 and DOL Technical Release No. 2013–03, in Q&A–5, provided that, whether or not an HRA is integrated with other group health plan coverage, unused amounts that are credited to the HRA while the HRA is integrated with other group health plan coverage may be used to reimburse medical care expenses in accordance with the terms of the HRA after an employee ceases to be covered by the integrated group health plan coverage without causing the HRA to fail to comply with PHS Act sections 2711 and 2713. In IRS Notice 2015–87, Q&A–2, however, the Departments clarified that an HRA that includes terms permitting the purchase of individual health insurance coverage, even if reimbursement is only allowed after the employee ceases to be covered by other integrated group health plan coverage, fails to be integrated with other group health plan coverage and therefore fails to comply with PHS Act sections 2711 and 2713.

[17] *See* 80 FR 72192 (Nov. 18, 2015).

[18] *See* FAQs about Affordable Care Act Implementation (Part XXII), available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf.*

[19] The Treasury Department and the IRS note that the information included in this preamble is not intended to be guidance regarding the proper federal tax treatment or consequences of any particular arrangement, except to the extent the preamble addresses the application of Code sections 36B, 9801, 9802, 9815, 9831, and 9832 and PHS Act sections 2711 and 2713.

plan for integration purposes. However, Q&A–3 stated that an HRA that pays for or reimburses medical care expenses for employees covered by TRICARE may be integrated with another group health plan offered by the employer for purposes of PHS Act sections 2711 and 2713 if: (1) The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and that provides minimum value (MV); (2) the employee participating in the HRA is enrolled in TRICARE; (3) the HRA is available only to employees who are enrolled in TRICARE; and (4) the HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums.

Q&A–3 of Notice 2015–17 also provided that an employer payment plan through which an employer reimburses (or pays directly) all or a portion of Medicare Part B or D premiums for employees may not be integrated with Medicare coverage to comply with PHS Act sections 2711 and 2713 because Medicare coverage is not a group health plan. However, under the notice, this type of employer payment plan may be integrated with another group health plan offered by the employer for purposes of PHS Act sections 2711 and 2713 if: (1) The employer offers a group health plan (other than the employer payment plan) to the employee that does not consist solely of excepted benefits and that provides MV; (2) the employee participating in the employer payment plan is actually enrolled in Medicare Part A and B; (3) the employer payment plan is available only to employees who are enrolled in Medicare Part A and Part B or D; and (4) the employer payment plan is limited to reimbursement of Medicare Part B or D premiums and excepted benefits, including Medigap premiums. Notice 2015–17 also includes a general reminder that, to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer (MSP) provisions.[20] See later in this preamble for a discussion of the rules provided in the 2015 rules under PHS Act section 2711 allowing Medicare Part B and D reimbursement arrangements to be integrated with Medicare in certain limited circumstances (that is, generally, for HRAs sponsored by employers with fewer than 20 employees).

On November 18, 2015, the Departments finalized the proposed and interim final rules under PHS Act section 2711, incorporating certain subregulatory guidance regarding HRA integration, and making various additional clarifications (the 2015 rules).[21] The 2015 rules incorporate prior subregulatory guidance that HRAs may not be integrated with individual health insurance coverage for purposes of complying with PHS Act sections 2711 and 2713. Consistent with the initial subregulatory guidance, the 2015 rules provide two methods for integration of HRAs with other group health plan coverage.[22] The first method applies to HRAs integrated with other group health plan coverage that provides MV (the MV Integration Method).[23] The second method applies to HRAs integrated with other group health plan coverage that does not provide MV (the Non-MV Integration Method).[24]

Both the MV Integration Method and the Non-MV Integration Method require that: (1) The HRA plan sponsor offer the employee a group health plan other than the HRA (non-HRA group coverage); (2) the employee receiving the HRA be enrolled in non-HRA group coverage, even if the non-HRA group coverage is not offered by the HRA plan sponsor, such as a group health plan maintained by an employer of the employee's spouse;[25] and (3) the HRA be made available only to employees who are enrolled in non-HRA group coverage, regardless of whether such coverage is provided by the HRA plan sponsor. For both integration methods, the non-HRA group coverage may not consist solely of excepted benefits and, for the MV Integration Method, the non-HRA group coverage offered by the employer and in which the employee enrolls must provide MV.

In addition, both the MV Integration Method and the Non-MV Integration Method require that, under the terms of the HRA, an employee (or former employee) be permitted to permanently opt out of and waive future reimbursements at least annually from the HRA. Both integration methods also require that, upon termination of employment, either the funds remaining in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements under the HRA. For this purpose, forfeiture of the funds remaining in the HRA, or waiver of future reimbursements under the HRA, occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, the participant's death, or the earlier of the two events.

The two methods differ with respect to the expenses that the HRA may reimburse. Under the MV Integration Method, the HRA may reimburse any medical care expenses, but under the Non-MV Integration Method, the HRA may reimburse only co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute EHBs.[26]

The 2015 rules also include a special integration method for certain arrangements offered by employers that are not required to offer, and do not offer, non-HRA group coverage to employees who are eligible for Medicare coverage (generally, employers with fewer than 20 employees), but that offer non-HRA group coverage that does not consist solely of excepted benefits to employees who are not eligible for Medicare.[27] For these employers, an

[20] See later in this preamble for a clarification of the meaning of this statement included in IRS Notice 2015–17, regarding the MSP provisions.

[21] *See* 80 FR 72192 (Nov. 18, 2015). To the extent the 2015 rules did not incorporate or modify the prior subregulatory guidance, that guidance remains in effect.

[22] These two methods of integration were originally discussed in IRS Notice 2013–54, Q&A–4, and DOL Technical Release No. 2013–03.

[23] *See* 26 CFR 54.9815–2711(d)(2)(ii), 29 CFR 2590.715–2711(d)(2)(ii), and 45 CFR 147.126(d)(2)(ii).

[24] *See* 26 CFR 54.9815–2711(d)(2)(i), 29 CFR 2590.715–2711(d)(2)(i), and 45 CFR 147.126(d)(2)(i).

[25] In IRS Notice 2015–87, Q&A–4, the Departments clarified that an HRA that may be used to reimburse the medical care expenses of an employee's spouse or dependents (a family HRA) may not be integrated with self-only coverage of the employee under the employer's non-HRA group health plan. On January 12, 2017, the Departments issued guidance to clarify that a family HRA is permitted to be integrated with a combination of coverage under qualifying non-HRA group health plan coverage for purposes of complying with PHS Act sections 2711 and 2713, provided that all of the individuals who are covered under the family HRA are also covered under qualifying non-HRA group coverage. *See* FAQs about Affordable Care Act Implementation Part 37, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-37.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf.*

[26] Although, in general, an HRA integrated with non-HRA group coverage fails to comply with PHS Act section 2711 if the non-HRA group coverage with which the HRA is integrated does not cover a category of EHB and the HRA is available to cover that category of EHB and limits the coverage to the HRA's maximum benefit, the Departments have provided that if the non-HRA group coverage satisfies the MV Integration Method, an HRA will not be treated as failing to comply with PHS Act section 2711, even if the non-HRA group coverage with which the HRA is integrated does not cover a category of EHB and the HRA is available to cover that category of EHB and limits the coverage to the HRA's maximum benefit. *See* IRS Notice 2013–54, Q&A–6.

[27] *See* 26 CFR 54.9815–2711(d)(5), 29 CFR 2590.715–2711(d)(5), and 45 CFR 147.126(d)(5). The 2015 rules did not address the Medicare integration rules that apply to employers who are required to offer non-HRA group coverage to employees who are eligible for Medicare (generally, employers with 20 or more employees). For a discussion of those rules, see IRS Notice 2015–17 and the discussion in this preamble.

HRA that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the employees who are offered the HRA are enrolled in Medicare Part B or D, the HRA is available only to employees who are enrolled in Medicare Part B or D, and the HRA complies with the opt-out and forfeiture rules under the MV Integration Method and Non-MV Integration Method. These employers may use either of the non-Medicare-specific integration methods, as applicable, for HRAs offered to employees who are ineligible for Medicare.

C. HIPAA Nondiscrimination Provisions

Prior to the enactment of PPACA, titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, added Code section 9802, ERISA section 702, and PHS Act section 2702 (HIPAA nondiscrimination provisions). The Departments published final rules implementing the HIPAA nondiscrimination provisions on December 13, 2006 (the 2006 rules).[28] PPACA section 1201 reorganized and amended the HIPAA nondiscrimination provisions of the PHS Act. Although Code section 9802 and ERISA section 702 were not amended, the requirements of PHS Act section 2705 were incorporated by reference into Code section 9815 and ERISA section 715.[29] As amended by PPACA, the nondiscrimination provisions of PHS Act section 2705 largely reflect the 2006 rules and extend the HIPAA nondiscrimination protections (but not the wellness program exception) to the individual market. These provisions generally prohibit group health plans and health insurance issuers in the group and individual markets from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor.[30]

Q&A–2 of FAQs about Affordable Care Act Implementation (Part XXII)[31] provided that, if an employer offers only employees with high claims risk a choice between enrollment in a traditional group health plan or cash, the arrangement would not comply with the market requirements, citing PHS Act section 2705 (which is incorporated by reference into Code section 9815 and ERISA section 715), as well as the HIPAA nondiscrimination provisions of Code section 9802 and ERISA section 702. The Q&A explained that these arrangements violate the nondiscrimination provisions regardless of whether: (1) The cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance coverage. The Departments explained that offering cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the traditional group health plan, in contravention of the HIPAA nondiscrimination provisions.

D. Excepted Benefits

Code section 9831, ERISA section 732, and PHS Act sections 2722 and 2763 provide that the requirements of chapter 100 of the Code, part 7 of ERISA, and title XXVII of the PHS Act do not apply to excepted benefits. Excepted benefits are described in Code section 9832, ERISA section 733, and PHS Act section 2791.

There are four statutory categories of excepted benefits, including limited excepted benefits. Under the statutory provisions, limited excepted benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home healthcare, or community-based care, or any combination thereof, and ''such other similar, limited benefits as are specified in regulations'' by the Departments.[32] To be excepted benefits under this category, the benefits must either: (1) Be insured and provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of the plan.[33] The Departments previously exercised the authority to specify additional types of limited excepted benefits with respect to certain health FSAs, certain employee assistance programs, and certain limited wraparound coverage.[34]

Coverage that consists of excepted benefits is not minimum essential coverage (MEC).[35] Therefore, an individual offered or covered by an excepted benefit is not deemed ineligible for the PTC by virtue of the excepted benefit offer or coverage.[36] Further, the offer of an excepted benefit by an employer is not considered to be an offer of MEC under an eligible employer-sponsored plan for purposes of Code section 4980H, the employer shared responsibility provisions. Thus, an employer does not avoid a payment under Code section 4980H by virtue of an offer of an excepted benefit.[37]

E. Premium Tax Credit

1. In General

Code section 36B allows for the PTC to be available to applicable taxpayers to help with the cost of individual health insurance coverage obtained through an Exchange.[38] Under Code section 36B(a) and (b)(1) and 26 CFR 1.36B–3(d), a taxpayer's PTC is the sum of the premium assistance amounts for all coverage months during the taxable year for individuals in the taxpayer's family.

Under Code section 36B(c)(2), a month is not a coverage month for an individual if either: (1) The individual is eligible for coverage under an eligible employer-sponsored plan and the coverage is affordable and provides MV; or (2) the individual is enrolled in an eligible employer-sponsored plan, even if the coverage is not affordable or does not provide MV.[39] An eligible employer-sponsored plan includes coverage under a self-insured (as well as an insured) group health plan[40] and is MEC unless it consists solely of excepted benefits.[41]

[28] 71 FR 75013 (Feb. 12, 2007).

[29] PPACA section 1201 moved the HIPAA nondiscrimination provisions from PHS Act section 2702 to PHS Act section 2705, with some modifications.

[30] The HIPAA nondiscrimination provisions set forth eight health status related factors. The eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. These terms are largely overlapping and, in combination, include any factor related to an individual's health. 66 FR 1377, 1379 (Jan. 8, 2001).

[31] *See* FAQs about Affordable Care Act Implementation (Part XXII), available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxii.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf.*

[32] *See* Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2).

[33] *See* Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1) and 2763(b). *See also* 79 FR 59130, 59131–59134 (Oct. 1, 2014) discussing the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs.

[34] *See* 26 CFR 54.9831–1(c)(3)(v), (vi), and (vii); 29 CFR 2590.732(c)(3)(v), (vi), and (vii); and 45 CFR 146.145(b)(3)(v), (vi), and (vii).

[35] *See* Code section 5000A(f)(3).

[36] *See* Code section 36B(c)(2)(B).

[37] *See* Code section 4980H(a)(1) and (b)(1). *See also* 26 CFR 54.4980H–1(a)(14).

[38] Exchanges are entities established under PPACA section 1311 through which qualified individuals and qualified employers can purchase health insurance coverage.

[39] *See* Code section 36B(c)(2)(C)(iii) and 26 CFR 1.36B–2(c)(3)(vii)(A) and 1.36B–3(c).

[40] *See* 26 CFR 1.5000A–2(c).

[41] *See* Code section 5000A(f)(3) and 26 CFR 1.5000A–2(g).

An HRA is a self-insured group health plan and, therefore, is an eligible employer-sponsored plan. Accordingly, under existing rules, an individual is ineligible for the PTC for the individual's Exchange coverage for a month if the individual is covered by an HRA or is eligible for an HRA that is affordable and provides MV for the month.

2. Affordability and Minimum Value

Under Code section 36B(c)(2)(C) and 26 CFR 1.36B–2(c)(3)(v)(A)(*1*) and (*2*), an eligible employer-sponsored plan is affordable for an employee, or for an individual who may enroll in the coverage because of a relationship to the employee, if the amount the employee must pay for self-only coverage whether by salary reduction or otherwise (the employee's required contribution) does not exceed a specified percentage of the employee's household income. The percentage is adjusted annually. However, 26 CFR 1.36B–2(c)(3)(v)(A)(*3*) provides an employee safe harbor under which an eligible employer-sponsored plan is not considered affordable for the entire plan year of the eligible employer-sponsored plan if, at the time an individual enrolls in a qualified health plan (QHP) offered through an Exchange, the Exchange determines that the eligible employer-sponsored plan is not affordable.[42] Thus, the employee safe harbor locks in the Exchange's determination of unaffordability, which is based on estimated household income, even if the eligible employer-sponsored plan ultimately proves to be affordable based on actual household income for the tax year.

Under Code section 36B(c)(2)(C)(ii), an eligible employer-sponsored plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of the costs. PPACA section 1302(d)(2)(C) provides that, in determining the percentage of the total allowed costs of benefits provided under a group health plan, the rules promulgated by HHS under that paragraph of PPACA apply. In general, HHS rules provide that an eligible employer-sponsored plan provides MV only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.[43]

F. QSEHRAs

1. In General

The 21st Century Cures Act (Cures Act) Public Law 114–255 was enacted on December 13, 2016. Cures Act section 18001 amended the Code, ERISA, and the PHS Act to permit an eligible employer to provide a QSEHRA to its eligible employees. The Cures Act provides that a QSEHRA is not a group health plan for purposes of the market requirements, and, as a result, QSEHRAs are not subject to PHS Act sections 2711 and 2713.[44] For purposes of these rules, the term ''HRA or other account-based group health plans'' does not include QSEHRAs, unless otherwise specified.

Pursuant to Code section 9831(d), a QSEHRA is an arrangement that generally must be provided on the same terms, subject to certain exceptions, and cannot exceed a prescribed maximum amount.[45] For the purpose of identifying who can provide a QSEHRA, the statute provides that an eligible employer is an employer that is not an applicable large employer (ALE), as defined in Code section 4980H(c)(2), and that does not offer a group health plan to any of its employees. The statute also requires that an employer providing a QSEHRA satisfies certain notice requirements including a statement that the employee should provide the information about the permitted benefit to the applicable Exchange if the employee applies for advance payments of the premium tax credit (APTC).

On October 31, 2017, the Treasury Department and the IRS issued Notice 2017–67[46] to provide guidance on the requirements for providing a QSEHRA. If an eligible employer complies with the guidance provided in Code section 9831(d) and Notice 2017–67, it may provide a QSEHRA to its eligible employees and the QSEHRA is not required to comply with PHS Act sections 2711 and 2713 because it is not subject to those requirements.

2. QSEHRAs and the PTC

The Cures Act also added provisions to Code section 36B relating to how participation in a QSEHRA affects a taxpayer's eligibility for the PTC and how participation in a QSEHRA affects a taxpayer's computation of the PTC. Under Code section 36B(c)(4)(A), if an employee is provided a QSEHRA that constitutes affordable coverage for a month, the month is not a coverage month for the employee or the employee's spouse or dependents, meaning that the PTC is not allowed for that month. Code section 36B(c)(4)(C) provides that a QSEHRA constitutes affordable coverage for a month if the excess of the monthly premium for the self-only second lowest cost silver plan in the employee's individual market over 1/12 of the employee's permitted benefit, as defined in Code section 9831(d)(3)(C), does not exceed 1/12 of a specified percentage of the employee's household income.

Code section 36B(c)(4)(B) provides that if an employee is provided a QSEHRA that does not constitute affordable coverage for a coverage month, the PTC otherwise allowable for the month is reduced by 1/12 of the employee's annual permitted benefit under the QSEHRA.

G. Individual Market Special Enrollment Periods

Generally, individuals may enroll in or change to different individual health insurance coverage only during the annual open enrollment period described in 45 CFR 155.410. An individual may qualify for an SEP to enroll in or change to a different Exchange plan outside of the annual open enrollment period under a variety of circumstances prescribed by PPACA section 1311(c)(6)(C) and (D) and as described in 45 CFR 155.420. These SEPs are under the jurisdiction of HHS, and apply to persons seeking individual health insurance coverage through a State Exchange or Federally-facilitated

[42] This employee safe harbor does not apply if the individual does not respond to a redetermination notice or, with reckless disregard for the facts, provides incorrect information to the Exchange. *See* 26 CFR 1.36B–2(c)(3)(v)(A)(*3*).

[43] *See* 45 CFR 156.145. *See also* 80 FR 52678 (Sept. 1, 2015).

[44] *See* Code section 9831(d)(1), ERISA section 733(a)(1), and PHS Act section 2791(a)(1). However, QSEHRAs are group health plans under the PHS Act definition for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d *et seq.*). *See* PHS Act section 2791(a)(1), as amended by Cures Act section 18001(c). In addition, QSEHRAs were not excluded from ERISA's definition of employee welfare benefit plan under ERISA section 3(1) and, therefore, remain subject to the requirements for employee welfare benefit plans under ERISA. *See* H. Rept. 114–634—Small Business Health Care Relief Act of 2016 (the relevant provisions of this bill were passed into law by the Cures Act). Moreover, because QSEHRAs are employee welfare benefit plans, individual health insurance coverage that is reimbursed by a QSEHRA would not become part of an ERISA plan if the conditions of the DOL safe harbor described later in this preamble are satisfied.

[45] See Code section 9831(d) and IRS Notice 2017–67, 2017–47 IRB 517, for additional detail.

[46] See IRS Notice 2017–20, 2017–11 IRB 1010, which extended the period for an employer to furnish an initial written notice to its eligible employees regarding a QSEHRA, and see FAQs About Affordable Care Act Implementation Part 35, Q&A–3, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-35_12-20-16.pdf*.

Exchange (FFE) and, in most cases, to individuals seeking individual health insurance coverage outside an Exchange.[47]

Paragraph (d) of 45 CFR 155.420 describes the triggering events that qualify individuals, enrollees, and in some cases, their dependents for SEPs on the Exchanges through which they can enroll in a QHP or change from one QHP to another. Paragraph (b) of 45 CFR 155.420 describes the coverage effective dates available in connection with each SEP. Paragraph (c) describes the availability of each SEP relative to its triggering event—that is, whether applicants may select a plan after the event or also before the event. That paragraph also describes the length of time applicants have to select a plan based on their SEP. Paragraph (a)(4) of 45 CFR 155.420 describes the plan changes that current Exchange enrollees and their dependents may make upon qualifying for an SEP. Generally, current Exchange enrollees who qualify for most SEPs may change to another QHP within the same metal level, or ''plan category,'' as their current QHP. Current enrollees whose dependent(s) qualify for most SEPs may add their dependent(s) to their current QHP, or enroll them in a separate QHP.[48] In combination, the rules at 45 CFR 155.420(a)(4) are generally referred to as ''plan category limitations.''

With regard to individual health insurance coverage sold outside of an Exchange, 45 CFR 147.104(b)(2) provides that health insurance issuers must provide SEPs (referred to in the regulation as limited open enrollment periods) for the triggering events described in 45 CFR 155.420(d), except for certain triggering events listed under 45 CFR 147.104(b)(2). Additionally, 45 CFR 147.104(b)(4)(ii) and (b)(5) apply the SEP availability and coverage effective dates at 45 CFR 155.420 to SEPs available off-Exchange. However, the plan category limitations do not apply outside the Exchanges.

H. Proposed Rules

In response to Executive Order 13813, the Departments published a notice of proposed rulemaking entitled ''Health Reimbursement Arrangements and Other Account-Based Group Health Plans'' on October 29, 2018 (83 FR 54420) (the proposed rules), which would expand the flexibility and use of HRAs.

The proposed rules would expand the use of HRAs in several ways. First, the proposed rules included a proposal to remove the current prohibition against integrating an HRA with individual health insurance coverage[49] under the PHS Act section 2711 rules (the proposed integration rules). The proposed integration rules included a proposal to permit an HRA to be integrated with individual health insurance coverage and, therefore, to satisfy PHS Act sections 2711 and 2713, if the provisions of the proposed rules under 26 CFR 54.9802–4, 29 CFR 2590.702–2, and 45 CFR 146.123 were satisfied. These final rules refer to this type of HRA as an individual coverage HRA.

Second, the proposed rules provided an expanded definition of limited excepted benefits, under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2)(C), to include certain HRAs that are limited in amount and with regard to the types of coverage for which premiums may be reimbursed, if certain other conditions are satisfied (an excepted benefit HRA) (the proposed excepted benefit HRA rules).

The Treasury Department and the IRS also proposed rules under Code section 36B for PTC eligibility for individuals who are offered an individual coverage HRA[50] (the proposed PTC rules). DOL proposed a clarification to provide HRA and QSEHRA plan sponsors with assurance that the individual health insurance coverage the premiums of which are reimbursed by the HRA or QSEHRA does not become part of an ERISA plan when certain conditions are satisfied. Finally, HHS proposed changes to rules regarding SEPs in the individual market that would provide an SEP for individuals who gain access to individual coverage HRAs or who are provided QSEHRAs (the proposed SEP rules).[51]

The Departments requested comments on all aspects of the proposed rules, as well as requesting comments on a number of specific issues. The Departments received over 500 comments in response to the proposed rules from a range of stakeholders, including employers, health insurance issuers, State Exchanges, state regulators, unions, and individuals. No requests for a public hearing were received. After careful consideration of all of the comments, the Departments are finalizing the proposed rules with certain modifications made in response to comments. These modifications are discussed later in this preamble.

II. Overview of the Final Rules on Individual Coverage HRAs and Excepted Benefit HRAs—the Departments of the Treasury, Labor, and Health and Human Services

A. Integration Rules

1. Integration—In General

Consistent with the objectives in Executive Order 13813 to consider proposing rules to expand and facilitate access to HRAs, the proposed rules included a proposal to remove the prohibition on integration of an HRA with individual health insurance coverage, if certain conditions were satisfied. More specifically, in order to ensure compliance with PHS Act sections 2711 and 2713, the proposed rules provided that to be integrated with individual health insurance coverage, the HRA must require participants[52]

[47] Group health plans and group health insurance issuers must provide SEPs under certain circumstances and the Departments have jurisdiction over those provisions. *See* Code section 9801(f), ERISA section 701(f), and PHS Act section 2704(f); *see also* 26 CFR 54.9801–6, 29 CFR 2590.701–6, and 45 CFR 146.117. The final rules do not affect the group health plan and group health insurance issuer SEPs, which continue to apply to group health plans, including HRAs, and group health insurance issuers.

[48] If an enrollee wants to add their dependent(s) to their current QHP, but the plan's business rules do not allow the dependent(s) to enroll, then the Exchange must allow the enrollee and his or her dependent(s) to change to another QHP within the same level of coverage, or one metal level higher or lower, if no such QHP is available.

[49] For purposes of this preamble and the final rules, ''individual health insurance coverage'' means health insurance coverage offered to individuals in the individual market, but does not include STLDI. *See* PHS Act section 2791(b)(5). *See also* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. Individual health insurance coverage can include dependent coverage and therefore can be self-only coverage or other-than-self-only coverage. ''Individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan. *See* PHS Act section 2791(e)(1). *See also* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103. As discussed later in this preamble, ''group health insurance coverage'' means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) (which is finalized in this rule) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied. *See* ERISA section 733(b)(4) and PHS Act section 2791(b)(4). *See also* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

[50] References in the preamble to ''an offer of an individual coverage HRA'' or to similar phrases mean an offer of an HRA designed to be integrated with individual health insurance coverage under the final rules that will be considered integrated with that individual health insurance coverage for an individual who enrolls in that coverage.

[51] On November 19, 2018, the Treasury Department and the IRS issued Notice 2018–88. IRS Notice 2018–88 described a number of proposals related to the application of Code sections 4980H and 105(h) to individual coverage HRAs. For additional discussion of IRS Notice 2018–88, see elsewhere in this preamble.

[52] For this purpose, the definition of participant under 26 CFR 54.9801–2, 29 CFR 2590.701–2, and

and any dependents [53] covered by the HRA [54] to be enrolled in individual health insurance coverage and to substantiate compliance with this requirement.

Further, in order to prevent a plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from the plan sponsor's traditional group health plan and into the individual market, the proposed rules prohibited a plan sponsor from offering employees within a class of employees a choice between a traditional group health plan and an individual coverage HRA. The proposed rules also required that an individual coverage HRA be offered on the same terms to all employees within a class of employees, subject to certain exceptions, and the proposed rules included proposed classes of employees that employers could use for this purpose.

The proposed rules also required individual coverage HRAs to allow employees to opt out of and waive future reimbursements under the HRA at certain times, and to provide a notice to eligible participants regarding how the offer of the HRA, or enrollment in the HRA, affects the ability to claim the PTC. This was proposed because an offer of an HRA may affect an individual's eligibility for the PTC, and enrollment in an HRA does affect an individual's eligibility for the PTC.

Each of these conditions, and the related comments received, are discussed in the following sections of this preamble. This section of the preamble addresses the more general comments on allowing HRAs to be integrated with individual health insurance coverage.

Many commenters supported the proposed rules. Some of these commenters expressed general support for the Departments' efforts to expand the availability and use of HRAs and the priority the Departments have placed on HRAs. Some commenters stated that the proposed rules would enable employers to offer more affordable health coverage alternatives to employees and could expand health insurance coverage, including for lower-wage and part-time and other particular groups of employees. Some commenters focused on the potential benefits for small employers, commenting that the proposed HRA expansion would create new options for small employers that have otherwise been unable to offer health insurance coverage due to PPACA-related requirements. These commenters asserted that the proposed HRA expansion would help small employers provide meaningful benefits, attract talent, and keep their workforce healthy. Some commenters expressed general support for allowing employers to move to a defined contribution approach for health insurance coverage, including because this likely permits greater employee choice.

Some commenters noted that allowing individual coverage HRAs could expand and stabilize the individual health insurance market while providing greater administrative simplicity and reducing administrative costs for employers. In particular, some commenters expressed the view that the proposed rules would strengthen the individual market due to an increased number of individuals in the individual market and because working individuals who would be added to the individual market tend to be of lower health risk than those currently comprising the individual market risk pool. Some commenters also stated that employers may not necessarily be incentivized to segment their risk and, therefore, concerns about adverse selection may be overstated.

Some commenters who generally supported the proposed rules emphasized that their support was contingent on any final rules retaining the conditions intended to prevent adverse selection. And some commenters opposed allowing individual coverage HRAs. These commenters stated that the safeguards in the proposed rules were insufficient to prevent market segmentation and destabilization of the individual market. Several of these commenters argued that market segmentation could occur if employers that choose to offer an individual coverage HRA have higher-risk employees than those employers that choose not to offer an individual coverage HRA and that employers may still be able to segment risk based on the proposed classes of employees. Some of these commenters asked that the rules be withdrawn, or at least delayed, until the potential effects on the individual and group markets could be better understood.

More generally, commenters expressed a number of concerns regarding adverse selection and risk-pool effects of the proposed rules, including that the proposed rules would change the composition of the risk pools for the individual and small group markets, making coverage more expensive and less accessible overall. Some commenters were concerned that the proposed rules would be particularly harmful to self-employed individuals and small business employees because those individuals generally rely on coverage in the individual market and, according to the commenters, the proposed rules would increase premiums in the individual market. Some commenters were also concerned that employers may substantially alter traditional group health plans to the detriment of all employees who rely on that coverage and that there could be negative implications in the small group market for states that have merged their individual and small group market risk pools. One commenter stated that the negative effects of the proposed rules, particularly the increase in individual market premiums and the attendant fiscal cost that the commenter expects to occur, are likely to outweigh the benefits to employers and their employees. Another commenter asserted that the proposed rules would increase premiums due to both adverse selection and issuers' increased uncertainty regarding the effect of individual coverage HRAs on the individual market.

The Departments agree with the commenters who asserted that allowing individual coverage HRAs will expand flexibility and use of HRAs to provide additional options for employers and employees to offer and obtain quality, affordable healthcare. The Departments also agree that individual coverage HRAs would expand coverage and may provide greater administrative

45 CFR 144.103 applies, which is defined as a participant within the meaning of ERISA section 3(7). Under ERISA section 3(7), ''the term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.''

[53] For this purpose, the definition of dependent under 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103 applies, which is defined as ''any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.''

[54] The final rules use several terms interchangeably regarding an individual's individual coverage HRA status. These terms generally parallel those used when referring to group or individual health insurance coverage. Specifically, ''enrolled in'' and ''covered by,'' both refer to the status of an individual who is participating in an individual coverage HRA and can request reimbursements for medical care expenses reimbursable under the HRA. The date on which an individual coverage HRA ''takes effect'' or ''begins'' refers to the first date on which reimbursable medical care expenses may be incurred. For example, an employee whose individual coverage HRA takes effect on June 1 may request reimbursements for medical care expenses incurred on or after that date, if the individual is enrolled in individual health insurance coverage or Medicare on or before June 1.

simplicity and reduce administrative costs for employers.

The Departments acknowledge the concerns expressed by commenters that allowing individual coverage HRAs could cause adverse selection in the individual market. As explained in the preamble to the proposed rules, allowing individual coverage HRAs could theoretically result in opportunities for employers to encourage higher-risk employees (that is, employees with high expected medical claims or employees with family members with high expected medical claims) to obtain coverage in the individual market, external to the traditional group health plan sponsored by the employer, in order to reduce the cost of traditional group health plan coverage provided by the employer to lower-risk employees. This could happen in a number of ways. For example, if employees were permitted to choose between participating in an employer's traditional group health plan or an individual coverage HRA, some higher-risk employees might have an incentive to select the HRA and enroll in individual health insurance coverage, depending on the relative generosity of the individual coverage HRA and the individual health insurance coverage as compared to the traditional group health plan. There could be significant differences between these coverage options because individual health insurance coverage generally is required to cover all categories of EHBs, and large group market and self-insured group health plans are not required to do so. An employer could also deliberately attempt to steer employees with certain medical conditions away from the employer's traditional group health plan. In either case, if disproportionately higher-risk employees enrolled in individual coverage HRAs, this adverse selection could raise premiums in the individual market.

Both in promulgating the proposed rules and again in response to comments provided on the proposed rules, the Departments considered the possibility that the individual market could instead be positively impacted. Lower-risk employees might choose individual coverage HRAs, while higher-risk employees might elect to remain in their employer's traditional group health plan. Such an outcome could result for a host of reasons, including because higher-risk employees may be more risk averse to changing health benefits. Additionally, individual health insurance coverage might have more restrictive provider networks than traditional group health plans and higher-risk employees are generally more sensitive to the make-up of the provider network than lower-risk employees. In addition, lower-risk employees might prefer an individual coverage HRA because it could allow them to spend less on premiums—reducing or potentially eliminating out-of-pocket premiums and potentially leaving more funds to cover cost sharing. Further, employers might be discouraged by the legal risk involved with attempting to steer higher-risk employees away from the traditional group health plan.

However, employers also would face strong countervailing incentives to maintain (or improve) the average health risk of participants in their traditional group health plans. Therefore, the Departments have determined that there is a risk of some market segmentation and health factor discrimination that could result from allowing individual coverage HRAs, but the Departments also have determined that the risk can be sufficiently mitigated with conditions of the type provided in the proposed rules (and in the final rules) designed to limit adverse selection. Moreover, as discussed in more detail later in this preamble, the Departments considered the comments requesting that the Departments strengthen the conditions intended to limit adverse selection, and the Departments are finalizing those proposed conditions with some changes in response to comments, including adding a minimum class size requirement that will apply to certain classes of employees in certain instances. Regarding the concern raised by commenters that the proposed conditions would not prevent adverse selection if employers with higher-risk employees chose to offer individual coverage HRAs, the Departments took that possibility into account in the regulatory impact analysis.

Therefore, taking all of these considerations into account, the Departments have determined that allowing individual coverage HRAs will produce significant benefits, including increased options and coverage, and is not likely to create a material risk of adverse selection in the individual market due to the sufficiency of, and changes to strengthen, the integration conditions intended to mitigate that risk that are finalized in this rulemaking. Accordingly, the Departments are finalizing the proposed rules, including each of the conditions included in the proposed rules, but with various changes and clarifications, as explained later in this preamble.

A number of commenters expressed concern about the impact on employees shifting from traditional group health plans to the individual market. Some commenters emphasized that in order to achieve the goals of expanding coverage and increasing choice and flexibility for employers, it is vital that the individual market be stable and well-functioning; otherwise, employers will be unwilling to utilize the expanded flexibility. Some commenters recommended that the Departments delay issuing the final integration rules until insurance in the individual market is more affordable or until clearer information is available regarding the long-term stability of the individual market, including the impacts of other recent changes such as the expansion of STLDI and changes to the PPACA section 1332 waiver program. Some commenters asked the Departments to withdraw the proposed integration rules and, instead, take other actions to stabilize the individual market. One commenter requested that HRA integration with individual health insurance coverage be allowed only if each employee is provided at least three choices for coverage in the individual market.

The Departments acknowledge that the extent to which the goals of expanding coverage and options through individual coverage HRAs will be achieved depends on the existence of a stable individual market. Accordingly, the Departments are finalizing the proposed rules with conditions on individual coverage HRAs intended to prevent a negative impact on the individual market. The Departments expect individual coverage HRAs, with the safeguards in the final rules, will substantially increase the size of the individual market and will not result in significant changes in the average health risk of the individual market risk pool. The Departments also understand that currently the stability of the individual market varies a great deal across the country, and that in some places improvement will likely be needed before employers elect to offer individual coverage HRAs. The Departments considered these issues in developing the proposed and final rules and incorporated significant flexibility, including geographic flexibility, to address these issues so that each employer may choose what is best for its workforce. However, the final rules do not require that a minimum number of individual health insurance plans be available to employees in order for the employer to offer an individual coverage HRA. There is no compelling justification for such a requirement, and

it is not necessary to ensure compliance with PHS Act sections 2711 and 2713. Employees often have limited choices with respect to the traditional group health plans they are offered, if any, and adopting this type of requirement would unnecessarily prevent certain employers from offering an individual coverage HRA. Further, suggestions regarding changes to the other rules that affect the individual market, in order to improve the individual market, are outside the scope of this rulemaking.

Some commenters stated that the proposed rules failed to adequately take into account the differences between traditional group health plans and individual health insurance coverage, the increased burden on employees in choosing and enrolling in a plan in the individual market relative to the burden on employees under a traditional group health plan, and the significance of the change, from the employee's perspective. Other commenters stated that individuals in the individual market could face more expensive plans, lower employer contributions, narrower networks, and higher cost sharing. Some commenters stated that these individuals could also face more confusion and be provided less assistance, in part due to decreased federal funding for outreach and assistance in the individual market. Some of these commenters asserted what they believed to be the comparative advantages of traditional group health plans, including that those plans are more robust, cost-effective, and consumer-friendly. One commenter expressed general concern about the shifting of employees from a defined benefit health plan system to a defined contribution health plan system, because, according to the commenter, it may result in less comprehensive coverage.

The Departments considered, and are aware, that an employee's experience enrolling in and having coverage under an individual coverage HRA may be different than the experience of enrolling in and having coverage under a traditional group health plan. The Departments took this into account in developing the proposed and final rules, including by requiring the individual coverage HRA to provide a notice to eligible participants explaining the individual coverage HRA and the possible consequences of the HRA being offered and accepted. The Departments understand that employers tend to act in the best interest of their workers in order to recruit and retain talent. Therefore, an employer offering an individual coverage HRA generally will do so because it is a better alternative for a substantial share of their employees than a traditional group health plan or no offer of employer-sponsored coverage. Further, as described later in this preamble, DOL is also clarifying the extent to which employers may assist employees with regard to enrollment in individual health insurance coverage without resulting in the individual health insurance coverage becoming part of an ERISA plan. In addition, the Departments are continuing to consider ways to assist employees offered an individual coverage HRA, including through clear instructions in the Exchange application process and other possible methods of outreach and assistance. As to the more general comments asserting that traditional group health plans have advantages as compared to individual health insurance coverage, the Departments acknowledge that there are differences. The Departments intend with the final rules to expand the choices available to employers and employees and to make an additional option available for employers, including those that have not previously offered traditional group health plan coverage.

Some commenters questioned the Departments' legal authority with regard to certain aspects of the proposed rules. A few commenters questioned whether the Departments have the authority to allow HRAs to satisfy PHS Act sections 2711 and 2713 by virtue of integration with other coverage, and a few stated that the Departments failed to justify the removal of the regulatory prohibition on integration of an HRA with individual health insurance coverage. Further, a few commenters asserted that the Departments do not have the authority to allow individual coverage HRAs because Congress enacted the Cures Act, which provided a limited exception to the prohibition on HRAs provided in conjunction with individual health insurance coverage in the form of QSEHRAs, and the commenters believe this indicates that Congress did not intend to allow the Departments to otherwise remove the regulatory prohibition on integration of an HRA with individual health insurance coverage.

The Departments disagree with these commenters and, instead, have determined that the final rules are justified and within the Departments' authority. While HRAs are group health plans subject to PHS Act sections 2711 and 2713 and would fail to comply with those provisions if they were offered on their own, PHS Act sections 2711 and 2713 do not speak directly to situations in which an HRA is integrated with other coverage that satisfies those statutory requirements. The Departments have determined that it is reasonable, and consistent with the statutory scheme, to apply PHS Act sections 2711 and 2713 to the integrated arrangement rather than to each of its component parts.

As explained earlier in this preamble, the Departments previously determined that it was reasonable to consider an HRA to be compliant with PHS Act sections 2711 and 2713 as long as individuals covered by the HRA had other employer-provided group health plan coverage (including coverage offered by a different employer, such as a spouse's employer) that satisfied the conditions in PHS Act sections 2711 and 2713, subject to certain other conditions.[55] In that case, under the combined arrangement, individuals have the protections intended by PPACA, in addition to the HRA that they generally may use to pay for premiums or other medical care expenses not covered by the group health plan. The Departments now extend this same approach to integration with individual health insurance coverage, which the Departments have determined is similarly justified and appropriate, as individual health insurance coverage is generally subject to and compliant with PHS Act sections 2711 and 2713.[56]

In developing the proposed and final rules, the Departments considered that the Cures Act provided for QSEHRAs. However, in creating QSEHRAs, Congress did not enact a general prohibition on integrating an HRA with individual health insurance coverage. Instead, Congress allowed a limited HRA that certain small employers may provide that is not a group health plan subject to the market requirements and, thus, need not be integrated with any

[55] The Departments note that under IRS Notice 2015–17, HRAs that reimburse certain Medicare premiums and TRICARE expenses may be considered integrated with the group health plan coverage offered to the employee by the employer although the employee is not enrolled in that group coverage and is instead enrolled in Medicare or TRICARE, subject to certain conditions. Further, under 26 CFR 54.9815–2711(d)(5), 29 CFR 2590.715–2711(d)(5), and 45 CFR 147.126(d)(5), an employer payment plan for Medicare premiums offered by certain employers may be considered integrated with Medicare (and considered to be compliant with PHS Act sections 2711 and 2713), subject to certain conditions.

[56] Further, for the reasons discussed later in this preamble, the Departments have determined that permitting integration of individual coverage HRAs with Medicare is also justified and appropriate, subject to certain conditions. References in this preamble to an individual coverage HRA integrated with Medicare refer to an individual coverage HRA integrated with Medicare Part A and B or Medicare Part C.

other health coverage to satisfy PHS Act sections 2711 and 2713. The fact that Congress provided some flexibility for certain employers by creating QSEHRAs does not preclude the Departments from providing additional flexibility through rulemaking to allow individual coverage HRAs.[57] The final rules do not change the ability of eligible employers to provide QSEHRAs. Rather, the final rules provide an opportunity for all employers, including those who may or may not qualify to sponsor a QSEHRA, to sponsor an individual coverage HRA.[58] Moreover, by virtue of providing for QSEHRAs, Congress acknowledged and left intact the Departments' regulations allowing for integration of HRAs with other group health plan coverage. In so doing, Congress recognized the Departments' authority to allow HRAs to be integrated with other group health plan coverage, which is the same authority the Departments now extend to allow integration of HRAs with individual health insurance coverage.

The Departments acknowledge that the final rules, in allowing individual coverage HRAs, remove the prohibition on an HRA being integrated with individual health insurance coverage that the Departments had previously imposed. As noted earlier in this section of the preamble, in the 2015 rules and the guidance that preceded those rules, the Departments determined that HRAs should not be allowed to be integrated with individual health insurance coverage, even though that insurance coverage is generally subject to and compliant with PHS Act sections 2711 and 2713. The Departments at that time declined to allow integration with individual health insurance coverage because of concerns about adverse selection in the individual market. Since that time, the Departments have observed that many employers, especially small employers, continue to struggle to offer health insurance coverage to their employees.[59] Further, the Departments have had additional time to consider whether, and what type of, conditions would be sufficient to mitigate the risk of adverse selection and health factor discrimination that might otherwise result from allowing HRAs to be integrated with individual health insurance coverage.

The Departments have determined that the advantages to employers and employees of individual coverage HRAs warrant allowing them to be offered,[60] notwithstanding the concerns regarding potential adverse selection risk to the individual market. This is because the Departments expect that the conditions adopted in the final rules will significantly mitigate the risk of adverse selection. As to the benefits, the final rules will increase flexibility and choices of health coverage options for employers and employees. The increased use of individual coverage HRAs could potentially reduce healthcare spending, particularly less efficient spending, and ultimately result in increased taxable wages for workers in firms that currently offer traditional group health plans. The final rules are also expected to increase the number of low- and moderate-wage workers (and their family members) with health insurance coverage.

Accordingly, the Departments disagree with commenters who asserted that the Departments are precluded from allowing individual coverage HRAs because those arrangements were not previously allowed and that such a change is not sufficiently justified. The Departments have considered whether to allow HRAs to be integrated with individual health insurance coverage, and have determined that a change allowing that integration is warranted, subject to a number of significant conditions intended to protect against the risk of adverse selection and health factor discrimination. This change comes after the Departments' consideration of various factors, including the need to provide employers and employees additional choices with respect to healthcare coverage, the ability of the conditions in the final rules to mitigate against adverse selection and health factor discrimination, and the anticipated effect of the final rules to increase choice and competition and decrease the number of uninsured individuals.

One commenter stated that allowing individual coverage HRAs is contrary to PPACA's intent to create a stable individual market. The Departments acknowledge that allowing individual coverage HRAs in a way that could lead to large-scale destabilization of the individual market could undermine one purpose of PPACA. However, the Departments have carefully designed the final rules to be consistent with Congress's intent in enacting both PPACA and HIPAA.[61] In developing the proposed and final rules, the Departments considered how to avoid permitting discrimination based on health status or similar practices with respect to offering individual coverage HRAs to employees that might have destabilizing effects on the individual market or lead to higher premiums in that market. The Departments have determined that the risk of market segmentation and health factor discrimination is sufficiently significant to justify including conditions in the final rules intended to mitigate those risks, including strengthening certain conditions provided for in the proposed rules. Additionally, the Departments have determined that the strengthened conditions in the final rules, which are described at length later in this preamble, are both sufficient to mitigate those risks and consistent with HIPAA and PPACA.

One commenter stated that it would make little sense to expect individual coverage HRAs to comply with PHS Act sections 2711 and 2713 because HRAs function more like bank accounts than health insurance policies. The Departments recognize that HRAs and health insurance policies can function

[57] Congress has granted the Departments the authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act that were added as a result of HIPAA and PPACA. *See* Code section 9833, ERISA section 734, and PHS Act section 2792.

[58] The Departments note that an employer may not both offer an individual coverage HRA and provide a QSEHRA, as a result of the QSEHRA rules under Code section 9831(d) and as a result of the conditions that apply to individual coverage HRAs.

[59] In 2018, 57 percent of firms offered health benefits to at least some of their workers; 47 percent of employers with three to nine workers offered coverage, while virtually all firms with 1,000 or more workers offered coverage. *See* Kaiser Family Foundation, ''Employer Health Benefits 2018 Annual Survey'', Figure 2.2 at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

[60] HRA expansion is an Administration priority. In October 2017, the President issued Executive Order 13813, directing the Departments ''to consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.'' The Executive Order further provides that expanding ''the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.''

[61] In 1996, Congress enacted the HIPAA nondiscrimination provisions, which now generally prohibit group health plans and health insurance issuers in the group and individual markets from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. In 2010, Congress enacted PPACA, in part, because individual health insurance coverage was not a viable option for many individuals who lacked access to group health plan coverage, given that individual market issuers in many states could deny coverage, charge higher premiums based on an individual's health risk, or impose preexisting condition exclusions based on an individual's health risk. To address these issues, PPACA included numerous provisions that were intended to create a competitive individual market that would make affordable coverage available to individuals who do not have access to other health coverage, as set forth in detail in the preamble to the proposed rules. *See* 83 FR 54420, 54428–54429 (Oct. 29, 2018).

differently. However, HRAs are group health plans and, therefore, generally are subject to the market requirements under the PHS Act, except to the extent that they are excepted benefits or are retiree-only HRAs. The Departments lack the statutory authority to exempt HRAs that are otherwise subject to the market requirements from the category of group health plans subject to the market requirements. The final rules allow individual coverage HRAs to comply with the requirements of PHS Act sections 2711 and 2713 in a manner that preserves the protections of those sections.

2. Requirement That All Individuals Covered by an Individual Coverage HRA Be Enrolled in Individual Health Insurance Coverage

a. In General

The proposed rules provided that an HRA may be integrated with individual health insurance coverage, and would be considered compliant with PHS Act sections 2711 and 2713, if the HRA requires the participant and any dependent(s) to be enrolled in individual health insurance coverage (other than coverage that consists solely of excepted benefits) [62] for each month each individual is covered by the HRA. Under the proposed rules, if the participants and dependents merely have the ability to obtain individual health insurance coverage, but do not actually have that coverage, the HRA would fail to comply with PHS Act sections 2711 and 2713.

Many commenters supported this condition and strongly recommended it be included in the final rules. Commenters that supported the condition stated that it would reduce or prevent the risk of adverse selection and would ensure that employees directed out of the group market have access to a stable individual market. The Departments agree that the requirement to have individual health insurance coverage in order to be covered by an individual coverage HRA is essential and, in order to ensure compliance with PHS Act sections 2711 and 2713, the final rules adopt this requirement, generally as set forth in the proposed integration rules, but with some clarifications as explained later in this section of the preamble.[63]

One commenter suggested that the final rules should allow an individual coverage HRA to provide benefits to dependents who are not enrolled in individual health insurance coverage so long as the employee-participant is enrolled in individual health insurance coverage. The Departments decline to adopt this suggestion because the requirements of PHS Act sections 2711 and 2713 apply to group health plans with respect to both participants and dependents.[64]

b. Individual Health Insurance Coverage With Which an Individual Coverage HRA May Be Integrated

Commenters generally supported the rule that individual coverage HRAs must be integrated with individual health insurance coverage as defined in the PHS Act. As discussed in this section of the preamble, several commenters requested clarification regarding whether integration with various types of individual health insurance coverage would be allowed under the proposed rules.

Some commenters requested that the final rules only permit integration with individual health insurance coverage that covers all EHBs or that provides comprehensive mental health and substance use disorder benefits. The Departments decline to make revisions in response to these comments because under PPACA, individual health insurance coverage generally is required to cover all EHBs, including mental health and substance use disorder services.[65]

Commenters also requested that the final rules clarify whether an individual coverage HRA may be integrated with individual health insurance coverage sold in a state that has a waiver under PPACA section 1332.[66] Some commenters stated that integration with that coverage should be permitted so long as the waiver does not allow coverage to impose annual or lifetime dollar limits or exclude benefits for preventive services. Other commenters argued that integration with that coverage should not be permitted because it might not satisfy all of the PPACA requirements.

The Departments note that although PPACA section 1332 allows states to waive certain provisions of PPACA, it does not allow states to waive PHS Act sections 2711 and 2713. Therefore, the final rules do not prohibit integration of an HRA with individual health insurance coverage obtained in a state with a PPACA section 1332 waiver because individual health insurance coverage obtained in that state will be subject to PHS Act sections 2711 and 2713.[67] Other issues with regard to PPACA section 1332 are beyond the scope of this rulemaking.

One commenter requested confirmation that HRAs may be integrated with catastrophic plans in the individual market. Another commenter requested that the final rules not allow integration of HRAs with catastrophic plans because of the limited nature of those plans. The Departments note that catastrophic plans, as set forth in PPACA section 1302(e), are a type of individual health insurance coverage available to only certain individuals and that provide only limited benefits until the individual has incurred expenses

[62] Throughout this preamble, references to individual health insurance coverage in the context of the integration rules do not include coverage that consists solely of excepted benefits unless otherwise specified. Also, see later in this preamble for a discussion of the conditions that apply if an individual coverage HRA is integrated with Medicare, in which case references to individual health insurance coverage generally are considered to also refer to Medicare.

[63] The Departments note that when an individual enrolls in individual health insurance coverage, the coverage generally will have an effective date that is the first day of a calendar month. Other than for mid-month enrollment of a new child, individual health insurance plans generally are not made available for coverage to start mid-month. Therefore, individual coverage HRA plan sponsors will need to take this into account in designing plan terms for eligibility for individual coverage HRAs, both with respect to employees offered the HRA for the full plan year and for those who become covered by the HRA subsequent to the first day of the plan year, to ensure compliance with the enrollment requirement under the final rules.

[64] In addition, the commenter expressed confusion as to how this integration requirement applies to a dependent who is not covered by the individual coverage HRA, including a dependent covered by another type of coverage or a dependent the employee does not want to identify to the employer. While under the final rules an individual coverage HRA must require that each individual covered by the HRA be enrolled in individual health insurance coverage, the final rules do not include a requirement that the HRA cover any particular dependent(s), provided the HRA complies with PHS Act section 2714 and 26 CFR 54.9815–2714, 29 CFR 2590.715–2714, and 45 CFR 147.120 (relating to dependent coverage of children to age 26), nor is there a prohibition on allowing the participant to exclude certain dependents from coverage under the HRA.

[65] *See* PPACA section 1302 and PHS Act section 2707(a). However, the Departments note that grandfathered individual health insurance coverage and ''grandmothered'' individual health insurance coverage subject to the HHS non-enforcement policy might not cover all EHBs. See later in this preamble for a discussion of ''grandmothered'' individual health insurance coverage.

[66] Under PPACA section 1332, a state can apply for a state innovation waiver from HHS and the Treasury Department, which allows the state, if approved, to implement innovative programs to provide access to quality healthcare. States seeking approval for a state innovation waiver must demonstrate that the waiver will provide access to health insurance coverage that is at least as comprehensive and affordable as would be provided under PPACA without the waiver, will provide coverage to at least a comparable number of residents of the state as would be provided without a waiver, and will not increase the federal deficit.

[67] HHS and the Treasury Department evaluate state PPACA section 1332 waiver applications on a case-by-case basis and will include a determination of the interaction with the final rules (if any).

sufficient to reach the maximum out-of-pocket limit under PPACA.[68] However, catastrophic plans are subject to the market requirements, including PHS Act sections 2711 and 2713. Therefore, the final rules do not prohibit integration of an individual coverage HRA with catastrophic plans.

One commenter asked that the Departments prohibit integration with ''grandmothered'' individual health insurance coverage, as it is not compliant with PPACA. Grandmothered individual health insurance coverage refers to certain non-grandfathered health insurance coverage with respect to which CMS has announced it will not take enforcement action even though the coverage is out of compliance with certain specified market requirements. To date, the CMS non-enforcement policy has been extended to apply to renewals of such coverage through policy years beginning on or before October 1, 2020, provided that all such coverage comes into compliance with the specified requirements by January 1, 2021.[69] The Departments note that although grandmothered individual health insurance coverage is subject to a non-enforcement policy for some market requirements, the non-enforcement policy does not extend to compliance with PHS Act sections 2711 and 2713. Accordingly, grandmothered plans are subject to PHS Act sections 2711 and 2713, and under the final rules, an individual coverage HRA may be integrated with grandmothered individual health insurance coverage.

One commenter requested clarification as to whether individual health insurance coverage sold through a private exchange model qualifies as coverage that may be integrated with an HRA. To the extent coverage sold through a private exchange model is individual health insurance coverage, within the meaning of the PHS Act,[70] an HRA may be integrated with that coverage. However, the Departments note that as part of the final rules DOL is issuing a safe harbor to clarify to stakeholders when individual health insurance coverage obtained by a participant in an individual coverage HRA would not be part of an employee welfare benefit plan under ERISA, which would avoid the individual health insurance coverage effectively becoming group coverage. See later in this preamble for discussion of how this safe harbor would apply with respect to individual health insurance coverage offered through web-based platforms, such as private exchanges.

One commenter supported the proposal to prohibit integration with individual health insurance coverage that consists solely of excepted benefits, noting that this aspect of the rule is consistent with the limited nature of excepted benefits. The Departments agree. Because coverage consisting solely of excepted benefits is not subject to or generally compliant with PHS Act sections 2711 and 2713, the final rules provide that individual coverage HRAs may not be integrated with individual health insurance coverage that consists solely of excepted benefits. However, as discussed later in this preamble, an HRA that reimburses only excepted benefits is not subject to the market requirements or the final rules.

See later in this preamble for a discussion of comments received regarding integration of HRAs with student health insurance coverage, as well as types of coverage other than individual health insurance coverage. Also, see later in this preamble for a discussion of the conditions under which an individual coverage HRA may be integrated with Medicare.

c. Proxy Approach To Verify Compliance

Under the proposed rules, all individual health insurance coverage (except for coverage that consists solely of excepted benefits) would be treated as being subject to and compliant with PHS Act sections 2711 and 2713. The Departments explained that requiring a participant or an individual coverage HRA to substantiate compliance with PHS Act sections 2711 and 2713 separately for each individual health insurance policy in which a participant or dependent is enrolled would be an unwieldy and overly burdensome task.

The Departments acknowledged that this approach would allow integration with grandfathered individual health insurance coverage, which is not subject to, and might not be compliant with, PHS Act sections 2711 and 2713. However, the Departments reasoned that requiring participants or HRAs to substantiate compliance with PHS Act sections 2711 and 2713 separately for each individual health insurance policy in which a participant or dependent is enrolled would be impracticable. An independent assessment of compliance could require the participant or the HRA to identify for each individual health insurance policy in which a participant or dependent is enrolled: (1) Which benefits are considered EHBs for purposes of PHS Act section 2711, and (2) whether all recommended preventive services are covered without cost sharing as required under PHS Act section 2713.

The Departments also noted that only a small number of individuals currently are enrolled in grandfathered individual health insurance coverage, and that grandfathered individual health insurance coverage may not be sold to new enrollees and may be renewed by current enrollees only so long as the coverage satisfies strict conditions. Additionally, the Departments noted that the number of individuals with grandfathered individual health insurance coverage has declined each year since PPACA was enacted, and the already small number of individuals who have retained grandfathered coverage is expected to continue to decline each year. Further, the Departments stated that because there are few individuals covered by grandfathered individual health insurance coverage, the Departments anticipate that there will only be extremely limited instances in which these individuals will be offered and accept an individual coverage HRA. Moreover, because new enrollees cannot enroll in grandfathered individual health insurance coverage, employers offering traditional group health plans would not be able to shift workers into this coverage. The Departments also explained that although plans are required to disclose grandfathered status in any summary of benefits provided under the plan, the Departments were concerned that the frequency of this disclosure to participants may be insufficient to substantiate compliance if integration with these policies were prohibited.

For these reasons, the Departments preliminarily determined that deeming a policy to be compliant with PHS Act sections 2711 and 2713 for purposes of the proposed rules if it is sold in the individual market, referred to as the proxy approach, strikes an appropriate balance. The Departments also solicited comments on methods by which an HRA could substantiate whether individual health insurance coverage is subject to and complies with PHS Act sections 2711 and 2713, including how an HRA might identify which benefits

[68] To be eligible for a catastrophic plan, an individual must either be under the age of 30 or qualify for a hardship or affordability exemption under Code section 5000A. *See* PPACA section 1302(e) and 45 CFR 156.155. One commenter suggested that the Departments change the definition of catastrophic plan so that it is available to individuals other than those who are eligible under PPACA section 1302(e). That change is outside the scope of this rulemaking.

[69] *See* CMS Insurance Standards Bulletin Series—INFORMATION—Extension of Limited Non-Enforcement Policy through 2020 (March 25, 2019), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Limited-Non-Enforcement-Policy-Extension-Through-CY2020.pdf.*

[70] *See* PHS Act section 2791(b)(5).

under the individual health insurance coverage are considered EHBs for purposes of PHS Act section 2711 and whether all recommended preventive services are covered without cost sharing. The Departments solicited comments on whether an alternative approach, such as a requirement that an issuer make a representation about compliance and/or grandfathered status upon request, would be practical, or whether any other methods might be appropriate as an alternative to the proposed proxy approach.

Some commenters expressed support for the proxy approach, stating that it would be unreasonable to require employers or participants to substantiate that individual health insurance coverage is compliant with PHS Act sections 2711 and 2713. They stated that the proxy approach is reasonable with respect to grandfathered individual health insurance coverage because the number of individuals with that coverage is declining and consumers may not newly purchase grandfathered individual health insurance coverage.[71]

However, some commenters encouraged the Departments to prohibit integration with grandfathered coverage because it is not required to comply with the annual dollar limit prohibition or the preventive services requirement.[72] Some of these commenters questioned whether the Departments had the legal authority to deem such coverage to be in compliance with PHS Act sections 2711 and 2713. One commenter disagreed with the Departments' assumption that employers and employees would be unable to determine if the individual health insurance coverage was compliant with PHS Act sections 2711 and 2713. Another commenter noted that if only a small number of individuals currently are enrolled in grandfathered individual health insurance coverage, prohibiting integration with that coverage should impact very few individuals. One commenter suggested, as an alternative to the proxy approach, that issuers could be required to provide a list of enrolled individuals to the individual coverage HRA.

The Departments considered these comments and have determined that requiring a participant or an HRA to substantiate each individual health insurance policy's compliance with PHS Act sections 2711 and 2713 would be an unwieldy and burdensome task. Further, state and federal regulators review policy forms of issuers in the individual market for compliance with the federal requirements before the products can be offered for sale in the states and undertake market conduct examinations to ensure compliance with federal requirements. Thus, it is reasonable to assume, as a general matter, that a policy sold in the individual market complies with PHS Act sections 2711 and 2713 for purposes of the final rules.[73]

With respect to grandfathered individual health insurance coverage, the Departments have concluded that it is appropriate to adopt the proxy approach as proposed because the number of individuals with grandfathered individual health insurance coverage is low and expected to decrease; individual coverage HRAs and participants may have difficulty confirming which benefits under the grandfathered plan are considered EHBs for purposes of PHS Act section 2711, whether all recommended preventive services are covered without cost sharing, and whether a particular policy is grandfathered; and grandfathered coverage may not be sold to new enrollees.[74]

d. Forfeiture

The proposed rules provided that the requirement that each individual covered by an individual coverage HRA must be enrolled in individual health insurance coverage would apply for each month that the individual is covered by the HRA. The proposed rules further provided that if an individual covered by the HRA fails to have individual health insurance coverage for any month, the HRA would fail to comply with PHS Act sections 2711 and 2713 for that month. Accordingly, the proposed rules required that an individual coverage HRA provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the individual may not seek reimbursement under the HRA for claims that are incurred after the individual health insurance coverage ceases, subject to any applicable continuation-of-coverage requirements. Further, under the proposed rules, if all individuals in a given family who are covered by the individual coverage HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA, in accordance with applicable laws (including COBRA and other continuation-of-coverage requirements).

One commenter requested that the Departments clarify how the COBRA rules apply when an individual loses access to an individual coverage HRA due to failing to maintain individual health insurance coverage. Other commenters generally requested guidance on the interaction between COBRA and individual coverage HRAs.

Generally, HRAs are group health plans subject to COBRA continuation coverage requirements under Code section 4980B and ERISA sections 601 through 608 (COBRA continuation coverage), unless an exception applies.[75] Under the COBRA continuation coverage rules, certain individuals who lose employer-sponsored coverage may elect to continue the coverage by paying a premium.[76] In order to qualify for

[71] A few commenters expressed concern with what they understood to be a proposed requirement that the employer verify that each individual health insurance policy in which an employee enrolls complies with PHS Act sections 2711 and 2713. Due to this concern, they suggested safe harbors to avoid imposing this burden on employers, such as only allowing integration with QHPs or plans of a certain metal level, and one commenter suggested implementing a plan compliance certification system. However, the proposed rules did not impose a requirement on the employer to verify the compliance of each individual health insurance policy in which an employee enrolls with PHS Act sections 2711 and 2713. Furthermore, the Departments are not imposing such a requirement in the final rules, and are finalizing the proxy approach.

[72] One commenter objected to the Departments' assertion in the preamble to the proposed rules that only a small number of individuals are currently enrolled in grandfathered individual health insurance coverage. However, the study the commenter cited to support the assertion that there is a substantial amount of grandfathered individual health insurance coverage remaining relates to grandfathered group coverage (not grandfathered individual health insurance coverage). *See* Kaiser Family Foundation, ''Employer Health Benefits 2018 Annual Survey'', *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

[73] With respect to the suggested alternative approach to the proxy approach that the Departments could require issuers to provide employers who sponsor individual coverage HRAs with a list of individuals covered by individual health insurance coverage, that alternative approach appears to also include an assumption that the policies sold are in compliance with PHS Act sections 2711 and 2713 (to avoid requiring confirmation of the compliance of each policy enrolled in), while adding burdens on the issuers to track and communicate with employers with whom they would not otherwise interact. For these reasons, the final rules do not adopt this alternative approach.

[74] See later in this preamble for a discussion of the conditions that apply to an individual coverage HRA integrated with Medicare, including that the combined arrangement is considered to comply with PHS Act sections 2711 and 2713.

[75] Plans sponsored by certain small employers, churches, or governments are not subject to Code section 4980B. *See* Code section 4980B(d).

[76] *See* Code section 4980B and ERISA sections 601–608. *See also* 26 CFR 54.4980B–1 *et seq.* and 29 CFR 2590.606–1, 2590.606–2, 2590.606–3, and 2590.606–4. Non-federal governmental group health

Continued

COBRA continuation coverage, the loss of coverage must be the result of a ''qualifying event.'' The Departments clarify that failure by an individual to satisfy the integration requirement of maintaining individual health insurance coverage is not a qualifying event for purposes of COBRA or other continuation of coverage rules. Thus, the loss of eligibility to participate in an individual coverage HRA due to the failure of the individual to maintain individual health insurance coverage does not create a right to COBRA or other group continuation coverage in the individual coverage HRA.

However, a loss of coverage due to a termination of employment or a reduction in the number of hours of employment generally is a loss of coverage due to a qualifying event. Thus, for example, an employee covered by an individual coverage HRA who, due to a reduction in hours, is moved to a class of employees who are not offered any group health coverage would have a right to COBRA or other group continuation coverage in the HRA, as would an individual who loses coverage under the HRA due to termination of employment. That HRA COBRA or other group continuation coverage would be conditioned on a timely election of COBRA or other group continuation coverage and payment of COBRA or other group continuation coverage premiums, as well as maintaining (or enrolling in) individual health insurance coverage.[77] Alternatively, an employee who loses coverage under an individual coverage HRA for these reasons may qualify for an SEP to change his or her individual coverage either on- or off-Exchange.[78]

One commenter requested clarification regarding whether a failure to maintain individual health insurance coverage causes retroactive forfeiture of the individual coverage HRA. Under the final rules, the required forfeiture applies prospectively. The individual coverage HRA must allow an employee who loses coverage under the HRA due to failure to maintain individual health insurance coverage to seek reimbursement for substantiated medical care expenses that were incurred during the coverage period prior to the failure to maintain individual health insurance coverage. However, the individual coverage HRA may limit the time to submit expenses to a reasonable specified period. The final rules include some modifications to clarify these rules. The final rules also clarify that the prohibition on reimbursing amounts for expenses incurred after an individual's individual health insurance coverage ceases applies to the individual coverage HRA, rather than to the individual seeking reimbursement.

One commenter requested clarification regarding whether an individual with individual health insurance coverage who is in an Exchange grace period[79] is considered to be enrolled in individual health insurance coverage for purposes of this integration requirement. Under the final rules, in the event an individual initially enrolled in individual health insurance coverage fails to pay premiums for the individual health insurance coverage timely and is, therefore, in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of the enrollment requirement, and the HRA must reimburse the individual for expenses incurred during that time period according to the terms of the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and individual health insurance coverage is cancelled or terminated, including retroactively, the HRA must require the individual to notify the HRA that the individual health insurance coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse expenses incurred on and after the date of cancellation or termination of the individual health insurance coverage, which is considered to be the date of termination of coverage under the HRA. Although the commenter specifically asked about grace periods, the final rules have also been revised to address other situations in which coverage is cancelled or terminated retroactively, including rescissions,[80] and in those cases, the same rules regarding notification, reimbursement, and date of termination of coverage would apply.[81]

One commenter requested that, following separation from service, amounts should remain in a former employee's individual coverage HRA for out-of-pocket costs and should remain available after the individual has access to other coverage. Under the final rules, a plan sponsor may permit a former employee to have continued access to an individual coverage HRA, and in some circumstances a former employee may be able to elect to continue the HRA under the applicable continuation of coverage requirements. However, the final rules do not include an exception for former employees to the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage. This is because PHS Act sections 2711 and 2713 apply with respect to each individual covered by a group health plan, including any former employee. Therefore, a former employee with an individual coverage HRA is required to be enrolled in individual health insurance coverage to ensure that the former employee has a combined arrangement that is in compliance with PHS Act sections 2711 and 2713.[82]

3. Prohibition Against Offering a Choice Between an Individual Coverage HRA and a Traditional Group Health Plan to the Same Class of Employees

a. In General

To address the previously described concerns about potential adverse selection and health factor discrimination, the proposed rules provided that a plan sponsor may offer an individual coverage HRA to a class of employees only if the plan sponsor

plans offered by state or local governments to their respective employees are subject to parallel continuation of coverage requirements under the PHS Act. *See* 42 U.S.C. 300bb–1 *et seq.*

[77] See IRS Notice 2002–45 for more information on providing COBRA continuation coverage under an HRA.

[78] *See* 45 CFR 147.104(b)(2) and 155.420(d)(1)(i).

[79] The Departments note that while 45 CFR 156.270 provides a specific grace period for individuals enrolled in the Exchange who are receiving APTC, this grace period would not be applicable for an individual covered by an individual coverage HRA because the individual will be ineligible for the PTC and APTC. Outside of the context of Exchange coverage for which APTC is being provided, grace periods are determined by state law.

[80] See 45 CFR 147.128 for rules regarding rescissions of individual health insurance coverage.

[81] The Departments note that in considering whether to attempt to recoup reimbursements paid for medical care expenses under an individual coverage HRA, including expenses incurred during a period in which an individual did not have individual health insurance coverage due to a retroactive cancellation or termination of coverage, the individual coverage HRA must consider PHS Act section 2712, which limits a plan's ability to rescind coverage to instances in which an individual has committed fraud or intentionally misrepresented a material fact. *See* 26 CFR 54.9815–2712, 29 CFR 2590.715–2712, and 45 CFR 147.128. *See also* DOL Advisory Opinion 77–08A (advising a health plan that depending on the facts and circumstances, the hardship to the participant or beneficiary resulting from such recovery or the cost to the fund of collection efforts may be such that it would be prudent, within the meaning of ERISA section 404(a)(1)(B), for the fund not to seek recovery from the participant or beneficiary).

[82] However, as explained earlier in this preamble, a retiree-only HRA is not subject to the market requirements. Therefore, a retiree-only HRA need not comply with the final integration rules, including the requirement that individuals receiving the HRA enroll in individual health insurance coverage.

does not also offer a traditional group health plan to the same class of employees. Therefore, a plan sponsor would not be permitted to offer any employee a choice between a traditional group health plan and an individual coverage HRA.

Many commenters expressed support for the prohibition against allowing a plan sponsor to offer a class of employees a choice between an individual coverage HRA and a traditional group health plan. These commenters generally stated that this prohibition is essential to prevent market segmentation and health status discrimination. They noted that, while on its face allowing a choice between the two types of coverage may seem appealing, in practice it would lead employers to encourage higher-risk employees to go into the individual market, by making plan design changes to traditional group health plans to make them less attractive to higher-risk employees. This, in turn, could have significant detrimental effects on the individual market due to the small size of the individual market compared to the size of the group market. One commenter noted that the prohibition against offering employees a choice between a traditional group health plan and an individual coverage HRA would protect employers from baseless claims of discrimination. Another commenter stated that permitting employers to offer a choice between an individual coverage HRA and a traditional group health plan could raise practical and administrative issues for employers and issuers, including in estimating participation in the traditional group health plan.

A few commenters opposed the prohibition on offering employees a choice between a traditional group health plan and an individual coverage HRA, asserting that such a rule would restrict choice for employees and flexibility for employers. Some of these commenters asserted that the other conditions in the proposed rules, such as the same terms requirement and the prohibition on integration with STLDI, each described later in this preamble, were sufficient to prevent adverse selection.

A few commenters acknowledged the risk of market segmentation by employers in the large group market or that offer self-insured plans, but requested that small employers generally, or small employers offering plans in the fully insured small group market, be allowed to offer their employees a choice between an individual coverage HRA and a traditional group health plan. They noted that small employers would not have an incentive to send their higher-risk employees to the individual market because insured traditional group health plans in the small group market are part of a community rated single risk pool. A few commenters also noted that allowing small employers to offer employees a choice would be consistent with Executive Order 13813, which one commenter noted specifically referred to small employers. One commenter indicated that the prohibition on choice might dissuade employers from offering individual coverage HRAs to their employees. The commenter also noted that if given the choice, lower-risk employees, rather than higher-risk employees, may leave the employer's traditional group health plan and purchase individual health insurance coverage.[83]

The Departments generally agree with commenters that stated that permitting employers to offer an employee a choice between an individual coverage HRA and a traditional group health plan could lead to market segmentation.[84] Although some lower-risk employees may choose to enroll in individual health insurance coverage if offered a choice, many employers would have strong economic incentives to encourage lower-risk employees to retain traditional group health plan coverage and higher-risk employees to enroll in individual health insurance coverage.

With respect to the suggestion that the Departments allow employers in the small group market to offer a choice to employees, the Departments acknowledge that the incentives for these employers to segment risk are substantially lower than for other employers offering experience-rated coverage or self-insured plans. However, the Departments would not expect many small employers to offer this choice because the coverage in the small group market and individual market is quite similar and because, as the commenters note, small employers that purchase health insurance would not have an incentive to segment their risk pool. Although allowing small employers to offer a choice would not provide small employers much benefit, it would increase the complexity of the final rules for entities involved in implementation, such as the Exchanges. Additionally, it could cause some uncertainty for issuers, and, therefore, increased premiums, in both the individual and small group markets. Accordingly, in the final rules, the Departments decline to provide an exception for small employers to the condition that a plan sponsor may not offer an employee a choice between a traditional group health plan and an individual coverage HRA. While the Departments are finalizing the proposal to prohibit choice between an individual coverage HRA and a traditional group health plan, the Departments are generally supportive of maximizing employee choice and employer flexibility and so may revisit this issue in future rulemaking once the Departments have had the opportunity to gauge the results of the initial implementation of individual coverage HRAs.

b. Definition of Traditional Group Health Plan

For purposes of the condition that a plan sponsor may not offer any employee a choice between an individual coverage HRA and a traditional group health plan, under the proposed rules, the term ''traditional group health plan'' was defined as any group health plan other than: (1) An account-based group health plan, or (2) a group health plan that consists solely of excepted benefits.

Several commenters supported the proposed definition, which provided that a ''traditional group health plan'' excludes a group health plan that consists solely of excepted benefits, so that a plan sponsor may offer an employee both an individual coverage HRA and a group health plan that consists solely of excepted benefits.[85]

[83] One commenter requested that the prohibition against choice not apply to spouses and dependents, noting that many employers do not contribute to family premiums under group health plans. Although the Departments anticipate that employers will generally not offer dependents an independent benefit package, for the sake of clarity, and in response to this comment, the Departments note that the prohibition is intended to apply to both participants and dependents, and the final rules are revised to clarify this intent.

[84] Although this condition generally is finalized as proposed, the text of the final rules is updated to include a reference to the special rule for new hires, explained later in this preamble. In general, under the special rule for new hires, a plan sponsor may continue to offer some employees in a class of employees a traditional group health plan (that is, current employees), while offering new employees in that class an individual coverage HRA, and, therefore, in that limited case, a plan sponsor may offer a traditional group health plan to some employees in a class of employees and an individual coverage HRA to other employees in the same class of employees. However, the special rule for new hires does not provide an exception to the rule that no participant may be given a choice between a traditional group health plan and an individual coverage HRA.

[85] One commenter asked that the Departments confirm that a traditional group health plan means a major medical plan and not a group health plan that consists solely of excepted benefits. The Departments confirm the definition of traditional group health plan does not include a group health plan that consists solely of excepted benefits. The

Continued

After considering these comments, the Departments finalize the definition of ''traditional group health plan'' in the proposed rules without change. Notwithstanding different QSEHRA rules,[86] under the final rules, a traditional group health plan does not include a group health plan that consists solely of excepted benefits and, therefore, a plan sponsor generally may offer an employee both an individual coverage HRA and a group health plan that consists solely of excepted benefits.[87]

One commenter requested that the Departments clarify that the final rules would not preclude an employer that offers an individual coverage HRA from offering a separate HRA under which only premiums for excepted benefits may be reimbursed. The Departments agree that such an arrangement is not precluded by these final rules. An HRA under which only excepted benefit premiums may be reimbursed is an account-based group health plan (and, therefore, not considered a traditional group health plan). Further, the HRA under which only excepted benefit premiums may be reimbursed is a group health plan that provides only excepted benefits (and, therefore, not considered a traditional group health plan). See later in this preamble for a discussion of the interaction of an excepted benefit HRA and an individual coverage HRA, and the difference between an excepted benefit HRA and an HRA that only provides excepted benefits.

c. Salary Reduction Arrangements

The preamble to the proposed rules noted that the Departments were aware that some employers may want to allow employees to pay the portion of the premium for individual health insurance coverage that is not covered by an individual coverage HRA, if any, through a salary reduction arrangement under a cafeteria plan. Pursuant to Code section 125(f)(3), an employer generally may not provide a QHP offered through an Exchange as a benefit under its cafeteria plan.[88] Therefore, an employer generally may not permit employees to make salary reduction contributions to a cafeteria plan to purchase a QHP offered through an Exchange.

However, Code section 125(f)(3) does not apply to individual health insurance coverage that is not purchased on an Exchange. Therefore, for an employee covered by an individual coverage HRA who purchases individual health insurance coverage outside of an Exchange, the employer may permit the employee to pay the balance of the premium for the coverage through its cafeteria plan, subject to all applicable cafeteria plan guidance. Such an arrangement would not be considered to be a traditional group health plan for purposes of the final rules.

Some commenters supported allowing a salary reduction arrangement under a cafeteria plan alongside an individual coverage HRA, with one commenter noting that this flexibility is essential to ensuring successful take-up of individual coverage HRAs. One commenter recommended against allowing a salary reduction arrangement alongside an individual coverage HRA unless further guidance is issued on cafeteria plans addressing nondiscrimination rules and penalties. One commenter requested that the Departments work with Congress to eliminate the prohibition, under Code section 125(f)(3), against purchasing Exchange coverage under a cafeteria plan.

Under the final rules, as under the proposed rules, an employer may permit an employee covered by an individual coverage HRA who purchases individual health insurance coverage outside of an Exchange to pay the balance of the premium for the coverage through its cafeteria plan, subject to all applicable cafeteria plan guidance. This arrangement would not be considered to be a traditional group health plan for purposes of the final rules. Changes to the statutory prohibition regarding the use of cafeteria plans to purchase Exchange coverage are outside of the scope of this rulemaking.

Commenters also raised various other issues related to the interaction between individual coverage HRAs and cafeteria plans under Code section 125. A few commenters expressed support for the ability to integrate a stand-alone cafeteria plan with individual health insurance coverage.[89] And some commenters requested that the Departments provide answers to hypothetical scenarios involving the intersection of cafeteria plans, HSAs, and HRAs. Neither the proposed rules nor the final rules make any changes to the rules under Code section 125. Thus, any issues arising under Code section 125, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however, appreciate the comments and will consider whether to address some of these issues in future guidance.

4. Same Terms Requirement

a. In General

To address concerns about health status discrimination leading to adverse selection in the individual market, the proposed rules generally required that a plan sponsor that offers an individual coverage HRA to a class of employees must offer the HRA on the same terms (that is, both in the same amount and otherwise on the same terms and conditions) to all employees within the class of employees.[90] As part of this proposed condition, the Departments made clear that offering a more generous HRA to individuals based on an adverse health factor would violate the integration rules.

Commenters generally supported the same terms requirement as a condition essential to protecting against market segmentation and recommended that it be retained in the final rules. Some commenters specifically supported the ability under the proposed rules to vary the HRA terms and amounts between different classes of employees. Because the Departments have concluded that the same terms requirement is critical to protecting against adverse selection in the individual market, the final rules retain this requirement, but with some revisions and clarifications in response to comments as explained later in this section of the preamble.

One commenter stated that the same terms requirement prohibits discrimination that could occur either by offering less generous benefits to only certain employees in a class of employees or by offering more generous benefits to only certain employees in a class of employees. The commenter stated that it is critical that this prohibition against ''benign'' discrimination be retained in the final rules. The Departments agree, and this aspect of the rule is being adopted as proposed.

b. Exceptions to the Same Terms Requirement

The Departments recognize that premiums for individual health

commenter also noted that an employer may not provide both a QSEHRA and a group health plan that consists solely of excepted benefits.

[86] *See* Code section 9831(d)(3)(B)(ii) and IRS Notice 2017–67.

[87] But see later in this preamble for a discussion of the interaction between excepted benefit HRAs and individual coverage HRAs.

[88] *But see* Code section 125(f)(3)(B).

[89] As noted earlier in this preamble, for purposes of the final rules, the term ''HRA or other account-based group health plan'' does not include an employer arrangement that reimburses the cost of individual health insurance coverage through a cafeteria plan under Code section 125.

[90] The Departments note that if an employer chooses not to distinguish its employees based on the classes of employees permitted under the final rules and offers an individual coverage HRA to all of its employees, the same terms requirement would apply to all of the employer's employees.

insurance coverage obtained by individual coverage HRA participants and their dependents may vary and, thus, some variation in amounts made available under an individual coverage HRA, even within a class of employees, may be appropriate. Therefore, the proposed rules provided that it would be permissible to increase the maximum dollar amount made available under an individual coverage HRA for participants within a class of employees as the age of the participant increases, so long as the same maximum dollar amount attributable to that increase in age was made available to all participants of the same age within the same class of employees.

Commenters generally supported the provision allowing increases in individual coverage HRA amounts based on the participant's age, as premiums in the individual market generally increase based on age. However, some commenters expressed concern that an unlimited ability to increase amounts made available under an individual coverage HRA based on age could be used to shift older, higher cost workers to the individual market. Therefore, these commenters recommended that, to avoid adverse selection, the ability to increase amounts by age be tied to actual variance in premiums for individual health insurance coverage, such as the 3:1 age rating rule in PPACA [91] or through some other reasonable relationship to the cost of individual coverage.

The Departments agree that imposing an outer bound on the ability of a plan sponsor to vary the maximum amounts made available under an individual coverage HRA based on a participant's age could further protect against adverse selection in the individual market, while not hampering the ability of a plan sponsor to provide benefits that account for increased costs for older workers in the individual market. Therefore, in response to these comments, the same terms requirement is revised under the final rules to provide that an individual coverage HRA does not fail to be provided on the same terms to a class of employees solely because the maximum dollar amount made available under the terms of the HRA increases as the age of the participant increases, so long as the maximum dollar amount made available under the terms of the HRA to the oldest participant(s) is not more than three times the maximum dollar amount made available under the terms of the HRA to the youngest participant(s). The final rules retain the rule that the same maximum dollar amount attributable to the increase in age must be made available to all participants in a class of employees who are the same age.

The Departments considered a number of different ways to design the limitation on age variation, including by incorporating the federal and state age curves, tying the variation to a specific premium for a specific policy that a participant in the class of employees could purchase, and basing the maximum dollar amount made available by the individual coverage HRA on the degree of age variation in individual market premiums in the rating area where each employee resides. However, the Departments determined that these options would be unduly complex and that imposing the 3:1 limit, which is generally based on the degree of age variation allowed in individual market premiums under PHS Act section 2701, sufficiently limits the potential for abuse.[92]

One commenter expressed concern that permitting, rather than requiring, increases in the maximum amount available under an individual coverage HRA based on age could invite age discrimination. Thus, the commenter argued that the final rules should require employers to vary individual coverage HRA amounts based on age to account for increases in costs for older workers. The Departments note that other federal laws and rules address age discrimination and are the more appropriate area of regulation in which to address these concerns. Accordingly, the Departments decline to require, but will permit, employers to increase individual coverage HRA amounts based on participants' ages under the final rules. However, individual coverage HRAs may be subject to restrictions imposed under other laws, such as those that protect against age discrimination.

One commenter requested that the Departments clarify the date as of which the age of the participant may be determined for this purpose and suggested the first day of the HRA plan year. The final rules clarify that a participant's age, for purposes of the same terms requirement, may be determined by the plan sponsor using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for this purpose using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year. For example, as the commenter suggests, the plan sponsor may determine each participant's age based on their age on the first day of the individual coverage HRA plan year.

Additionally, the proposed rules included a proposal to permit the maximum dollar amount made available under an individual coverage HRA within a class of employees to increase as the number of the participant's dependents covered under the HRA increased, so long as the same maximum dollar amount attributable to that increase in the number of dependents is made available to all participants in that class of employees with the same number of dependents covered by the HRA. Commenters generally supported this provision, as the cost of individual health insurance coverage generally increases with an increase in the number of dependents covered. Some commenters asked for clarification on the extent to which employers may increase amounts made available under an individual coverage HRA based on an increase in the number of the participant's dependents. One commenter recommended that any permitted increase be tied to individual market premium variance in order to prevent employers from varying HRA amounts to encourage higher-risk employees to shift to the individual market. Another commenter recommended that employers be required to vary individual coverage HRA amounts based on the number of dependents covered by the HRA in order to put employees on equal footing with other individuals and allow them to purchase insurance based on their relevant circumstances.

The Departments considered these comments, but have determined that providing employers flexibility as to if and how they vary HRA amounts based on family size does not raise a significant risk of adverse selection or health factor discrimination and,

[91] *See* PHS Act section 2701(a)(1)(A)(iii).

[92] Relatedly, on November 19, 2018, the Treasury Department and the IRS issued Notice 2018–88, which addressed the application of the rules under Code section 105(h) to individual coverage HRAs. HRAs generally are subject to the rules under Code section 105(h) and its related rules because they are self-insured medical reimbursement plans. However, HRAs that reimburse employees only for premiums paid to purchase health insurance policies, including individual health insurance policies, are not subject to the rules under Code section 105(h) and its related rules. *See* 26 CFR 1.105–11(b)(2). Notice 2018–88 described an anticipated safe harbor that would apply to individual coverage HRAs that are subject to Code section 105(h) to address the fact that under the Code section 105(h) rules, variation in employer contributions based on age is not allowed. The Treasury Department and the IRS intend to propose rules under Code section 105(h) in the near term that set forth an age variation standard that is consistent with the rule included in these final integration rules, and the proposed rules under Code section 105(h) will be subject to notice and comment.

instead, avoids unnecessary complexity. Therefore, under the final rules, it remains permissible to vary HRA amounts based on the number of a participant's dependents covered by the individual coverage HRA as proposed. Moreover, there is no specific limit on an employer's ability to increase HRA amounts based on the number of a participant's dependents covered by the HRA, so long as the same maximum dollar amount attributable to that increase in the number of dependents is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

Commenters also suggested additional factors for which employers should be allowed to vary amounts provided under an individual coverage HRA within a class of employees, including earnings or salary, role/title, and geographic region. The Departments note that the suggestions that individual coverage HRA amounts be allowed to vary within a class of employees based on earnings, salary, or role/title raise adverse selection and health factor discrimination concerns, as these classes are more susceptible to manipulation by an employer. Accordingly, the Departments decline to adopt any of these suggestions. Regarding geographic region, the Departments acknowledge that individual health insurance costs vary based on geography, but the Departments decline to adopt this suggestion because the issue is already addressed under the final rules through the ability to classify employees based on the rating area of their primary site of employment.

A few commenters recommended that the Departments consider an employer that contributes the same percentage of an employee's individual health insurance premium (for example, 80 percent) to an individual coverage HRA to be considered to be providing the individual coverage HRA on the same terms to the employees in the class. The Departments decline to adopt this suggestion because this type of rule would add significant complexity to the same terms requirement, particularly with respect to determining how to coordinate the ability to vary based on age and family size, and would also raise adverse selection concerns, as well as more general concerns about the inherent incentives of a percentage-based standard and its effect on healthcare spending.

See later in this preamble for a discussion of the same terms requirement as applied to an employer that offers both an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible to the same class of employees and for a discussion of how the same terms requirement applies if an individual coverage HRA makes amounts available based on amounts remaining in another HRA by which the participant was previously covered.

c. Former Employees

The proposed rules generally would apply to an individual coverage HRA that includes participants who are former employees in the same way that they would apply if the HRA only provided benefits to current employees. However, the Departments recognized that eligibility for post-employment group health plan coverage, if any, varies widely and may be subject to age, service, or other conditions. To avoid undue disruption of employers' practices relating to the provision of post-employment health coverage, the proposed rules provided that an individual coverage HRA may be treated as provided on the same terms even if the plan sponsor offers the individual coverage HRA to some, but not all, former employees within a class of employees (for example, to all former employees with a minimum tenure of employment). But, under the proposed rules, if a plan sponsor offers the individual coverage HRA to one or more former employee(s) within a class of employees, the HRA must be offered to those former employee(s) on the same terms as all other employees within the class.

One commenter expressed concern that allowing employers to offer some retirees an individual coverage HRA, but not all retirees, creates the potential for health status discrimination. The Departments note, however, that many nondiscriminatory reasons may influence an employer's decisions whether to offer retiree health coverage. For example, it is not uncommon for employers to offer retiree health coverage only to workers that have been with the company at least 5 years prior to retirement.[93] Moreover, the HIPAA nondiscrimination rules (as well as other applicable federal and state laws) address discrimination based on a health factor.

One commenter supported treating former employees under the same terms as all members of the class of employees. Another commenter requested confirmation that employers providing retirees and current employees with different amounts in individual coverage HRAs would satisfy the same terms requirement and requested confirmation that contributing different amounts to former employees based on years of service would satisfy the same terms requirement. The final rules provide that former employees within a class of employees offered an individual coverage HRA need not be offered an individual coverage HRA, but if they are, the HRA must be provided to them on the same terms as other employees in that class of employees (based on the class in which the former employee was included immediately prior to separation from service). Therefore, a plan sponsor would not comply with the same terms requirement if it provided some employees in a class of employees larger or smaller HRA amounts based on years of service or status as a former employee.[94]

The Departments received a number of comments on retiree-only HRAs in response to the proposed rules. Although the final rules do not modify the rules for retiree-only HRAs, the Departments note that the market requirements do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year.[95] Therefore, a retiree-only HRA need not satisfy the requirements of any integration test, including the same terms requirement.

d. New Employees or New Dependents

One commenter asked for clarification regarding the application of the same terms requirement in the case of coverage changes during the plan year, including in cases in which an employee gains a dependent. In response to this comment, in the final rules, the Departments clarify the application of the same terms requirement both for new employees and new dependents. Therefore, in the final rules, the Departments clarify that, under the same terms requirement, in the case of a participant who becomes covered by an individual coverage HRA after the first day of the plan year, the individual coverage HRA may make the full annual amount available or adopt a reasonable proration methodology. The Departments also clarify in the final rules how the same terms requirement

[93] *See e.g.,* 5 U.S.C. 8905(b).

[94] Also, eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days under PHS Act section 2708. *See* 26 CFR 54.9815–2708, 29 CFR 2590.715–2708, and 45 CFR 147.116.

[95] *See* Code section 9831(a)(2) and ERISA section 732(a). HHS follows a similar approach for non-federal governmental retiree-only plans and encourages states to adopt a similar approach with respect to issuers of retiree-only plans. *See* 75 FR 34537, 34539 (June 17, 2010).

applies if the individual coverage HRA varies the maximum amount available based on the number of a participant's dependents covered by the HRA and the number of the participant's dependents covered by the HRA either increases or decreases during the plan year. In that case, the individual coverage HRA may make available the same amount made available to participants in the class who had the same number of dependents covered by the HRA on the first day of the plan year or may adopt a reasonable proration methodology of that amount for the remainder of the plan year. The method the individual coverage HRA uses to determine amounts made available for participants who enroll during the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees, and the method must be determined prior to the beginning of the plan year.

5. Classes of Employees

a. In General

The proposed and final rules require a plan sponsor that offers an individual coverage HRA to a class of employees to offer the individual coverage HRA on the same terms to each participant within the class of employees, subject to certain exceptions. Also, the proposed and final rules provide that a plan sponsor may offer individual coverage HRAs on different terms to different classes of employees, and may offer either an individual coverage HRA or a traditional group health plan to different classes of employees. However, within a class of employees, a plan sponsor generally may not offer some employees a traditional group health plan and others an individual coverage HRA [96] (or offer any employee a choice between a traditional group health plan or an individual coverage HRA). The proposed rules enumerated the classes of employees that would apply for these purposes. As discussed in more detail in this section of the preamble, the final rules make a number of changes to the list of permissible classes of employees in response to comments.

Many commenters supported the general ability of a plan sponsor to offer individual coverage HRAs on different terms to different classes of employees and to offer either a traditional group health plan or an individual coverage HRA to different classes of employees. These commenters applauded the flexibility provided by this aspect of the proposed rules, emphasizing that such flexibility is critical for plan sponsors that want to offer individual coverage HRAs.

However, some commenters objected to this aspect of the proposed rules, expressing concerns about the ability of plan sponsors to use the classes of employees to segment risk. These commenters suggested that a plan sponsor that wants to offer an individual coverage HRA should not be allowed to offer a traditional group health plan to any of its employees and, instead, should be required to offer the HRA, on the same terms, to all of its employees and, therefore, fully replace the traditional group health plan(s) it may have offered. One commenter requested that the Departments disallow the use of different classes of employees in applying the final rules as a transitional measure, so that plan sponsors would not be allowed to offer some classes of employees a traditional group health plan and other classes of employees an individual coverage HRA for some transitional period of time. A number of commenters, including some of those who generally supported the ability to vary benefits on a class-by-class basis, expressed concerns about the possibility of adverse selection and, therefore, recommended that additional safeguards be provided, or, at a minimum, no further flexibility be provided.

The Departments considered these comments and have determined that permitting plan sponsors to offer different benefits to certain classes of employees is essential to providing the flexibility needed to achieve increased HRA usability and to maximize employee welfare. The Departments understand that employers commonly use certain job-based classifications for employee benefits and other purposes and that failing to provide flexibility to offer different benefits to different classes of employees, even for a transitional period of time, could reduce the use and availability of individual coverage HRAs. However, the Departments acknowledge the concerns regarding the potential for adverse selection and health factor discrimination and, therefore, have concluded that additional parameters in certain circumstances are needed for employers to offer different benefits to different classes of employees in order to address the potential for adverse selection and health factor discrimination. Accordingly, the final rules permit employers to apply the integration rules on a class-by-class basis, as was allowed under the proposed rules. However, as explained later in this section of the preamble, the final rules make a number of changes, including revisions to the list of permissible classes of employees, the addition of a minimum class size requirement that applies in certain instances, and clarifications of a number of other related issues in response to comments.

b. Proposed and Final Classes

The proposed rules included the following proposed classes of employees: (1) Full-time employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (2) part-time employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (3) seasonal employees (using either the definition that applies for purposes of Code section 105(h) or 4980H, as determined by the plan sponsor); (4) employees who are included in a unit of employees covered by a collective bargaining agreement (CBA) in which the plan sponsor participates (as described in 26 CFR 1.105–11(c)(2)(iii)(D)) (the CBA class of employees); (5) employees who have not satisfied a waiting period for coverage (if the waiting period complies with the waiting period rules in PHS Act section 2708 and its implementing rules) (the waiting period class); (6) employees who have not attained age 25 prior to the beginning of the plan year (as described in 26 CFR 1.105–11(c)(2)(iii)(B)) (the under-age-25 class); (7) employees who are non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105–11(c)(2)(iii)(E)) (generally, foreign employees who work abroad) (the non-resident alien class); and (8) employees whose primary site of employment is in the same rating area, as defined in 45 CFR 147.102(b) (the rating area class). In addition, the proposed rules permitted, as additional classes of employees, groups of employees described as a combination of two or more of the enumerated classes.

As explained in the preamble to the proposed rules, the Departments took a number of considerations into account in determining the proposed classes of employees. First, the proposed classes were ones that, based on the Departments' experience, employers historically have used for employee benefit purposes other than inducing higher-risk employees to leave the plan sponsor's traditional group health plan.

[96] The one exception to this general rule, described later in this preamble, is the special rule for new hires. However, even under the special rule for new hires, no employee may be offered a choice between an individual coverage HRA and a traditional group health plan.

Second, the proposed classes of employees were not ones that could be easily manipulated in order to transfer higher-risk individuals (and perceived higher costs) from the employer's traditional group health plan to the individual market, as it would be burdensome for employers to shift employees from one of these classes of employees to another merely for the purpose of offering different types of health benefits to employees based on a health factor. Therefore, the Departments determined that these proposed classes of employees would balance employers' reasonable need to make distinctions among employees with respect to offering health benefits with the need to protect against adverse selection and health factor discrimination. The Departments requested comments on the proposed classes of employees, including whether additional classes of employees should be provided and whether the proposed classes of employees and any potential additional classes are sufficient to mitigate adverse selection concerns.

Several commenters supported the proposed classes of employees, with some insisting that no additional classes be added because of the increased likelihood of risk pool manipulation. Several commenters expressed support for the proposed list of specific enumerated classes, as opposed to an open-ended standard, as a way to mitigate adverse selection.

Some commenters objected to the proposed classes, expressing general concern that the rules would provide employers too much flexibility, which would lead to manipulation of classes and risk segmentation. Some commenters requested that specific classes be eliminated or modified. In particular, several commenters expressed concern that the under-age-25 class of employees would lead to adverse selection. These commenters stated that this class is not justified based on a bona fide relationship to employment or the need to provide employers flexibility because employers do not typically structure benefits based on whether an employee has attained age 25. Some commenters raised administrative complexity concerns in their objections to this proposed class because employees under age 25 may be eligible for coverage under their parents' group health plans. One commenter, however, supported this class, stating that it may lead to healthier risk entering the individual market. The Departments agree with the commenters who raised concerns about the under-age-25 class of employees, both as to the potential for adverse selection and the fact that employers do not typically structure benefits based on this classification and, therefore, do not need the flexibility the proposed rules provided.[97] Therefore, the final rules do not include the under-age-25 class of employees as a permitted class of employees.

With regard to the proposed part-time employee class, several commenters supported including the class because of the additional flexibility it would provide to employers when determining whether to offer any benefits to part-time employees. One commenter highlighted that some large employers (who would not be able to provide a QSEHRA) may want to offer their part-time employees some level of tax-preferred health benefits but have no options today other than offering a traditional group health plan. Some commenters also argued that providing additional flexibility for employers to offer individual coverage HRAs to part-time employees who might otherwise not have been offered any benefits could lead to increased enrollment in individual health insurance coverage, thereby stabilizing the individual market risk pool and reducing premiums. One commenter suggested that the Departments should allow multiple gradations of part-time employees (for example, employees who work 10 to 20 hours per week, employees who work 20 to 30 hours per week, etc.). However, one commenter expressed concern that a part-time employee class could be a proxy for higher-risk employees, and could, therefore, lead to adverse selection, as the commenter asserted that many employees who work part-time do so due to health issues.

The Departments agree with those commenters who asserted that a part-time employee class should be included in the final rules, as it could provide necessary flexibility to allow some employers to offer an individual coverage HRA to part-time employees who might otherwise not be offered any group health plan benefits. While the Departments do not dispute that some employees may change from full-time employee status to part-time employee status due to health issues, the Departments have determined that allowing full-time employees and part-time employees as separate classes of employees is essential for employer flexibility, increasing HRA usability, and maximizing employee welfare. Further, the Departments have concluded that the requirements of the final rules, including these employee classifications, are sufficiently robust to mitigate market segmentation. Therefore, the final rules include full-time employees and part-time employees as separate permitted classes for individual coverage HRAs. However, see the discussion later in this preamble regarding the definitions of these terms and the application of a minimum class size requirement to these classes in certain circumstances.

With regard to a class of employees based on a geographic area, some commenters expressed concern that basing the class on the rating area of the work site could be too granular risking increased adverse selection. Thus, the commenters asserted that a class based on geography should instead be determined at the state level. While the Departments understand and considered the concern raised by commenters, the Departments have determined, based on information regarding the significant differences in individual market premiums between rating areas within some states and significant differences in the number of individual health insurance plans available between rating areas within some states, that it would be an unreasonable limitation on employer flexibility to prohibit employers from offering different benefits based on different work-site rating areas. The Departments concluded that a rule that would prohibit employers from differentiating between these particular classes of employees for purposes of offering individual coverage HRAs would pose significant costs that might undermine the willingness of employers to offer an individual coverage HRA. Therefore, the final rules allow a class of employees to be based on the rating area of the employees' primary work site. However, in response to concerns raised by commenters regarding the potential for adverse selection and health factor discrimination with this class of employees in particular, see the discussion later in this preamble regarding the application of a minimum class size requirement to this class in certain circumstances.

With regard to the waiting period class of employees, one commenter recommended that this class of employees be limited to a 30-day waiting period maximum to provide an additional market segmentation safeguard. Another commenter specifically supported this class. The final rules include the waiting period

[97] The Departments note that the under-age-25 class of employees was included in the proposed rules because it is a class of employees that may be excluded for certain purposes under Code section 105(h) and under the QSEHRA rules. *See* earlier in this preamble for a discussion of the application of Code section 105(h) to individual coverage HRAs.

class of employees, which aligns with the waiting periods allowed under PHS Act section 2708 and its implementing rules, because this avoids unneeded complexity and burden and the Departments do not consider this class of employees to raise significant adverse selection concerns.

Several commenters requested clarification regarding the CBA class of employees, which under the proposed rules was defined as ''employees included in a unit of employees covered by a collective bargaining agreement in which the plan sponsor participates (as described in 26 CFR 1.105–11(c)(2)(iii)(D)).'' Commenters sought clarification as to whether employers may establish separate classes for employees subject to different CBAs or whether all employees subject to various CBAs entered into by the employer would be aggregated and considered one class of employees for purposes of offering individual coverage HRAs. One commenter requested that the Departments clarify whether a class of employees based on a CBA would include all the employees subject to that CBA or could be based on distinctions within the CBA. Under the final rules, employers may establish separate classes of employees for employees covered by separate CBAs. However, under the final rules, an employer is not specifically permitted to create its own classes of employees based on any distinctions relating to employees within one CBA. However, an employer is permitted to combine a CBA classification with other permitted classes of employees (for example, combining the CBA class with the full-time employee and part-time employee classes to create full-time and part-time CBA subclasses), thereby allowing the employer to make certain further distinctions within the group of employees subject to the CBA. The Departments have revised the definition of this class of employees in the text of the rules and added an example to the text to clarify its meaning in response to comments. Further, to account for, and to avoid disruption of, the way in which multiemployer plan coverage is sometimes offered, the final rules also clarify that the CBA class may include employees covered by a CBA and employees covered by an appropriate related participation agreement.[98]

[98] A participation agreement allows non-collectively bargained employees to participate in a multiemployer plan. Non-collectively bargained employees can only participate in a multiemployer plan if the plan specifically allows it, and a participation agreement will set forth who is eligible and the benefits for which they are eligible.

With regard to the proposed ability to combine classes of employees more generally to create subclasses, some commenters supported the flexibility, but others expressed concern with the potential for risk segmentation. Some commenters recommended that the final rules not permit combinations of classes of employees or that, if permitted, the final rules apply certain additional safeguards, including a minimum class size requirement. Several commenters recommended not allowing combinations of classes of employees for small employers but permitting combinations of classes of employees for large employers, as long as the number of employees in a combined class satisfies a minimum. The Departments determined that it is important to provide employers with the flexibility to combine classes of employees but, as discussed later in this preamble, it is also appropriate to apply a minimum class size requirement in certain circumstances to mitigate adverse selection and health factor discrimination concerns. Therefore, the final rules continue to allow for the combination of classes of employees as proposed but, in certain circumstances, apply a minimum class size requirement. The final rules also include additional examples to illustrate the ability of plan sponsors to combine classes of employees.

c. Additional Classes

Some commenters recommended against adding any classes to the list of proposed permitted classes of employees, stating that the proposed classes of employees were sufficient and that additional classes of employees could lead to an increased risk of adverse selection. However, as discussed in this section of the preamble, several other commenters requested that certain additional classes of employees be added to the final rules.

In the proposed rules, the Departments acknowledged that permitting plan sponsors to treat salaried and hourly employees as different classes of employees was considered, but not proposed. The Departments noted that employers might easily be able to change an employee's status from salaried to hourly (and in certain circumstances, from hourly to salaried) with seemingly minimal economic or other consequences for either the employer or the employees. Some commenters agreed and strongly opposed adding hourly and salaried employees as classes of employees, expressing concern that classes of employees based on pay status could facilitate health status discrimination and be easily manipulated.

However, several commenters requested that salaried and hourly employees be added as separate classes of employees. These commenters disagreed with the Departments' assertion that employers might be able to easily change employee status from salaried to hourly and vice versa. The commenters noted that changing status from salaried to hourly in particular has substantial economic and other consequences for both employers and employees and that doing so on the basis of the health of an employee could violate ERISA section 510. One commenter noted that employers historically have provided different benefits to hourly and salaried workers and that adding these as permitted classes of employees could facilitate increased use of individual coverage HRAs for employers that might otherwise decline to offer an individual coverage HRA. The Departments considered the issues raised in these comments. The Departments have concluded that the benefits of employer flexibility, increased utilization of individual coverage HRAs, and maximizing employee welfare outweigh the potential risk of adverse selection and health factor discrimination, due to a reconsideration of the extent to which these categories could be manipulated and because of the application of a minimum class size requirement, as described later in this preamble. Therefore, the final rules include salaried and non-salaried employees as permitted classes of employees.

One commenter requested that employees employed by a staffing firm for temporary placement at entities unrelated to the staffing firm (temporary workers) be treated as a separate class. The commenter stated that this rule would facilitate offering of individual coverage HRAs by staffing firms to full-time temporary workers (while it is likely that regular full-time employees of the staffing firm would continue to receive an offer of a traditional group health plan). The commenter further stated that staffing firms historically have offered temporary workers different benefits than regular full-time employees for reasons other than to segment risk. The commenter further stated that it would be burdensome for staffing firms to shift workers between the temporary worker and regular employee classes merely to shift risk. The Departments agree that adding this class could increase the usability of HRAs for staffing firms and benefit their employees, that this class would be difficult to manipulate, and, that,

therefore, this class does not raise a substantial risk of adverse selection or health factor discrimination. Therefore, the final rules include as a permitted class of employees individuals who, under all the facts and circumstances, are the employees of an entity that hired the employees for temporary placement at an unrelated entity (that is, another entity that is not the common law employer of the employees and that is not treated as a single employer under Code section 414(b), (c), (m), or (o) with the entity that hired the employees for temporary placement).

One commenter requested that independent contractors be permitted as a separate class of employees, and one commenter requested that the Departments allow self-employed business owners to participate in an individual coverage HRA. HRAs were established [99] as a means for employers to provide tax-favored benefits to employees, but the exclusion from federal income tax for reimbursements of medical expenses by HRAs is set forth in Code sections 105 and 106, both of which generally are restricted to employer-provided coverage to employees. Moreover, Code section 105(g) specifically provides that the exclusion under Code section 105(b) is not available to an individual who is an employee within the meaning of Code section 401(c)(1) (relating to self-employed individuals). For these reasons, businesses that utilize the services of independent contractors cannot provide those self-employed individuals with a tax-favored individual coverage HRA nor may a self-employed business owner be provided a tax-favored individual coverage HRA. Therefore, the final rules do not adopt the suggestion to add independent contractors, or self-employed individuals more generally, as a permitted class of employees because these individuals cannot be provided tax-favored HRAs.

One commenter requested that employees eligible for Medicare and employees enrolled in Medicare be treated as two separate classes. The Departments decline to adopt this suggestion. Sections 1862(b)(1)(A), (B), and (C) of the Social Security Act (SSA) generally provide that an employer that is subject to its provisions may not take into account an employee's (or employee spouse's) eligibility for Medicare in the design or offering of its group health plan.[100] Section 1862(b)(1)(A)(i)(II) provides that a group health plan must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under age 65, regardless of whether the individual or spouse age 65 or older is entitled to Medicare. Because Medicare is also generally available to people with end-stage renal disease (ESRD) regardless of their age, SSA section 1862(b)(1)(C) further provides that a group health plan may not differentiate in the benefits it provides between individuals having ESRD and other individuals on the basis of the existence of ESRD, the need for dialysis, or in any other manner (except during a 30-month coordination period). Because these SSA provisions generally prohibit an employer that is subject to them from discriminating on the basis of an employee's (or the employee's spouse's) Medicare eligibility and treating Medicare employees (other than retirees) differently for benefits under the plan, the Departments decline to establish separate classes of employees for employees who are eligible for or enrolled in Medicare. However, see later in this preamble for a discussion of the conditions under which an individual coverage HRA may be integrated with Medicare.

Commenters also requested a number of other classes of employees, with different commenters suggesting different classes of employees, such as classes based on status as a field worker (such as craft workers and laborers), role or job title, employee tenure, being subject to the Davis Bacon Act and Related Acts or the Service Contract Act, exempt or non-exempt status under the Fair Labor Standards Act, and religion or status as a minister. The Departments considered each of these suggestions and have determined that these suggested classes of employees raise various issues including ease of manipulation and potential for adverse selection and health factor discrimination, industry-specificity, and administrability and definitional challenges. The Departments also took into account that, in general, the more classes that are permitted, the greater the risk of adverse selection and health factor discrimination. With respect to the requested class based on employee tenure, the Departments determined that such a class could be inconsistent with the prohibition on waiting periods that exceed 90 days under PHS Act section 2708, in addition to raising concerns regarding ease of manipulation and potential for adverse selection and health factor discrimination. Therefore, the Departments have determined that, on balance, for these suggested additional classes, the potential risks posed outweigh the potential benefits, and the Departments decline to add these suggested classes of employees to the final rules. However, see the discussion later in this preamble regarding the special rule for new hires, which is related in part to the comments suggesting a new class based on employee tenure.

d. Additional Safeguards

In the preamble to the proposed rules, the Departments stated that to minimize burden and complexity, the Departments had not proposed a minimum employer size or employee class size. The Departments identified a concern that very small employers could manipulate the classes of employees, but noted that other economic incentives related to attracting and retaining talented workers would discourage employers from doing so. Accordingly, the Departments invited comments on whether employer size or employee class size should be considered in determining permissible classes of employees.

With regard to employer size, some commenters stated that the risk of health factor discrimination is higher with small employers and that the final rules should prohibit small employers from using, or combining, classes of employees to make health coverage distinctions. However, other commenters asserted that the concern that small employers may discriminate based on health status is invalid, arguing that small employers are less likely to discriminate because of both the complexity required to design discriminatory programs and the minimal incentives that small employers have to remove risk from their small group market traditional group health plans that are part of a community rated single risk pool. For these reasons, one commenter requested that the final rules include less restrictive guardrails for small employers. The commenter also requested that large employers offering only an individual coverage HRA be permitted additional flexibility to structure their classes of employees because the risk of discrimination would be mitigated as the employer is not offering a traditional group health

[99] *See* IRS Notice 2002–45.

[100] The applicability of the Medicare nondiscrimination rules depends on the size of the employer and the type of Medicare beneficiary. For working aged beneficiaries, the rules apply to employers with 20 or more employees. For disabled beneficiaries, the rules apply to employers with at least 100 employees. For ESRD beneficiaries, they rules apply to employers of any size. *See* 42 CFR 411.100 *et seq.*

plan and, therefore, would not have incentives to remove risk from its plan.

With regard to minimum class size, a number of commenters requested that individual coverage HRAs only be available to classes of employees that include a minimum number of employees or are a minimum percentage of an employer's workforce. A few commenters noted that although a minimum class size requirement would be restrictive, and perhaps inhibit the use of individual coverage HRAs, it would be necessary to prevent risk segmentation. Some commenters supported applying a minimum class size requirement in all cases and some supported applying such a requirement only when separate classes of employees are combined to make smaller subclasses of employees. Some commenters made general requests for a minimum class size requirement (for example, requests for a meaningful threshold) and others included specific suggestions, such as requiring a minimum class size of 10 percent of employees, at least 10 percent of the employer's workforce or 100 workers, at least 20 employees, or prohibiting employers with fewer than 10 employees from being able to create classes. One commenter requested that there be no minimum class size requirement, in particular to provide flexibility to small employers.

In response to these comments, the Departments have concluded that it is appropriate to apply a minimum class size requirement under the final rules in certain circumstances. The Departments sought to develop a rule that is narrowly tailored both to mitigate the risk of adverse selection and health factor discrimination while also avoiding overly burdening employers or unnecessarily hampering the use and flexibility of HRAs to maximize employee welfare.

In order to balance these various considerations, the final rules include a minimum class size requirement that varies based on employer size and that applies only to certain classes of employees in certain circumstances in which the potential for adverse selection is greatest. If a class of employees is subject to the minimum class size requirement, the class must include a minimum number of employees for the individual coverage HRA to be offered to that class. The final rules explain the circumstances in which the minimum class size requirement applies, how to determine the applicable class size minimum, and how an individual coverage HRA determines if a particular class of employees satisfies the applicable class size minimum. The final rules also provide a number of examples to illustrate each aspect of the minimum class size requirement.

As to the circumstances in which the minimum class size requirement applies, it applies only if the plan sponsor offers a traditional group health plan to at least one other class of employees and offers an individual coverage HRA to at least one class of employees. To the extent the minimum class size requirement applies, it applies only to certain classes that are offered an individual coverage HRA. The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or to a class of employees that is not offered any group health plan.

Under the final rules, the minimum class size requirement generally applies to the following classes of employees offered an individual coverage HRA: (1) Salaried employees, (2) non-salaried employees, (3) full-time employees, (4) part-time employees, and (5) employees whose primary site of employment is in the same rating area (although the minimum class size requirement does not apply if the geographic area defining the class is a state or a combination of two or more entire states) (these classes are referred to collectively as the applicable classes). However, in the case of full-time employees and part-time employees, the minimum class size requirement applies only to those classes if the employees in either the part-time or full-time class are offered a traditional group health plan while the employees in the other class are offered an individual coverage HRA. The Departments considered each of the classes of employees permitted under the final rules to determine which classes, if any, present a risk of adverse selection sufficiently significant to justify the imposition of the minimum class size requirement. The Departments determined that classes composed of salaried employees, non-salaried employees, full-time employees, part-time employees, and employees whose primary site of employment is in the same rating area (except if the geographic area defining the class is a state or a combination of two or more entire states) present a substantial risk that employers could apply each of these classes in a way that targets certain higher-risk employees and, therefore, could lead to health factor discrimination and adverse selection. However, the Departments determined that the other permitted classes of employees (that is, the seasonal employee class, the CBA class, the waiting period class, the class based on non-resident aliens with no U.S.-based income, and the class of employees for temporary workers employed by a staffing firm) are unlikely to be manipulated by employers in a way that would lead to health factor discrimination or adverse selection.

Under the final rules, the minimum class size requirement applies to a class of employees created by combining any of the applicable classes with any other class of employees, except that the minimum class size requirement does not apply to a class that is the result of any combination of an applicable class and the waiting period class. Waiting periods are most typically applied to new hires, and it is not uncommon for employers to hire new employees in small numbers, to respond to attrition and as workflow increases. Further, the Departments are of the view that combinations of classes that include the waiting period class do not raise a significant risk of manipulation that could lead to adverse selection or health factor discrimination. Therefore, taking these factors into account, the Departments have determined that applying the minimum class size requirement to a class comprised of an applicable class and a waiting period class is not warranted.

Consistent with the comments received on this topic, the minimum number of employees that must be included in a class of employees subject to the minimum class size requirement (the applicable class size minimum) depends on the number of employees employed by the employer. The plan sponsor must determine the applicable class size minimum for each plan year of the individual coverage HRA. The applicable class size minimum is: (a) 10, for an employer with fewer than 100 employees; (b) a number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and (c) 20, for an employer that has more than 200 employees. In selecting these thresholds, the Departments considered the suggestions made by commenters and sought to strike a balance between providing employers with flexibility to offer different healthcare packages as part of their compensation framework and design, and limiting employers' ability to use the classes in ways that would create adverse selection in the individual market. The Departments agree with commenters that small employers may not have significant incentives to establish classes in a way that would result in adverse selection or health discrimination, but also are of the view that it could be easier for smaller

employers to manipulate the classes of employees. Further, the Departments selected thresholds for larger employers taking into account that, despite their total size, the classes of employees could also be manipulated by larger employers in ways that could lead to adverse selection and health factor discrimination. Therefore, the minimum class size requirement applies to small employers and large employers, but at lower thresholds for smaller employers than for large employers. For the purpose of applying the minimum class size requirement, an employer must determine the number of its employees based on its reasonable expectation of the number of employees it expects to employ on the first day of the plan year of the individual coverage HRA.

The annual determination of whether a class of employees satisfies the applicable class size minimum is based on the number of employees in the class who are offered the individual coverage HRA as of the first day of the plan year.[101] Therefore, the determination of whether a class of employees satisfies the minimum class size requirement is not based on the number of employees who enroll in the individual coverage HRA and is not affected by changes that occur during the plan year.

Some commenters requested that, in addition to, or instead of, a minimum class size requirement, the Departments should add an anti-abuse rule that would give the Departments the discretion to determine whether an individual coverage HRA is offered in a manner that is intended to segment sicker workers based on all the facts and circumstances. Therefore, even if an employer followed the other rules set forth in the final rules, this additional rule would nevertheless permit the Departments to address instances of discrimination based on a health factor. The Departments decline to add a facts and circumstances test to the final rules because the Departments have concluded that the minimum class size requirement, as set forth in the final rules, adequately balances the need to prevent health factor discrimination with the need to provide employers with certainty in order to encourage expansion and use of individual coverage HRAs. Moreover, other applicable nondiscrimination laws continue to apply. Under the HIPAA nondiscrimination provisions, for example, a group health plan (including an individual coverage HRA) may not discriminate in eligibility for benefits, or in premiums or contributions, based on one or more health factors.[102] In addition, for ERISA-covered plans, it is unlawful for any person to discriminate against a participant or beneficiary for the purpose of interfering with the attainment of any right to which the participant may become entitled under a health plan or ERISA.[103] Further, under the SSA, an employer generally may not take into account that an individual is entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD, and may not differentiate in the benefits it provides between individuals who have ESRD and other individuals covered under the plan.[104] In addition, other nondiscrimination laws (such as the Americans with Disabilities Act) may also apply, and the Departments note that compliance with the final rules is not determinative of compliance with any other applicable law. A new facts and circumstances test would add significant uncertainty for employers while adding little additional protection mitigating adverse selection and health factor discrimination.

e. Former Employees

Under the proposed rules, if an individual coverage HRA were offered to former employees, former employees would be considered to be in the same class of employees in which they were included immediately before separation from service. While the plan sponsor would not be required to offer the individual coverage HRA to all former employees (or to all former employees in the applicable class of employees), if it did offer the HRA to a former employee, it would have to do so on the same terms as for the other employees in that class.

A few commenters requested that employers be permitted to treat former employees as a separate class of employees, stating that the rule under the proposed rules treating former employees as part of the class of employees in which they would have been included immediately prior to separation from service will impose a barrier to offering individual coverage HRAs. These commenters stated that such a new class of employees would not raise manipulation concerns because whether to terminate employment generally is an independent decision made by the employee. Commenters further suggested that if a class of employees were created for former employees, the final rules should also permit subclasses within the class of former employees based on years of service.

Some commenters supported the proposed treatment of former employees and commented that former employees should not be permitted as a separate class of employees under the final rules because the general age and health status of former employees would present adverse selection concerns. One commenter included a number of requests regarding retiree-only HRAs in the context of rehired employees.

Notwithstanding that employers may continue to offer retiree-only HRAs that are not subject to the market requirements (and, therefore, are not subject to any integration requirements), the Departments understand the commenters' concern regarding adverse selection and are not aware of a compelling need to treat former employees as a separate class of employees under the final rules in light of the continued allowance of retiree-only HRAs that are not subject to any integration requirements. All of the rules and eligibility criteria related to retiree-only HRAs continue to apply without change.[105] Therefore, the final rules provide that a former employee is considered to be a member of the same class of employees the former employee was in immediately before separation from service, as proposed.

Several commenters raised other classification and administration issues related to retirees. One commenter requested clarification that the final rules would not affect the status of former employees who participate in their employer's traditional group health plan through COBRA. The Departments note that the impact of the final rules on any former employee participating in an employer's traditional group health plan through COBRA continuation coverage depends on the facts and circumstances. For example, COBRA continuation coverage ends on the date the employer ceases to provide any group health plan (including successor plans). If a former employee is participating in a

[101] The Departments reiterate that under the same terms requirement, an employer offering an individual coverage HRA to any employee in a class of employees must offer the HRA, generally on the same terms and conditions, to all employees in the class.

[102] Code section 9802, ERISA section 702, and PHS Act section 2705. *See also* 26 CFR 54.9802–1, 29 CFR 2590.702, and 45 CFR 146.121.

[103] ERISA section 510.

[104] SSA section 1862(b)(1)(A), (B), and (C) and 42 CFR 411.102, 411.161, and 411.170.

[105] *See* Code section 9831(a)(2) and ERISA section 732(a). While title XXVII of the PHS Act, as amended by PPACA, no longer contains a parallel provision at PHS Act section 2721(a), HHS has explained that it will not enforce the requirements of title XXVII of the PHS Act with respect to non-federal governmental retiree-only plans and encourages states to adopt a similar approach with respect to retiree-only plans offered by health insurance issuers. *See* 75 FR 34537, 34540 (June 17, 2010).

traditional group health plan that is replaced by an individual coverage HRA, the former employee would have a right to elect to participate in the successor plan, the individual coverage HRA (conditioned on the payment of premiums and enrollment in individual health insurance coverage), but would generally not have a right to continue coverage in the traditional group health plan. One commenter requested that the final rules define ''former employee.'' The final rules provide that for purposes of this rule a former employee is an employee who is no longer performing services for the employer.

f. Controlled Group

Commenters requested clarification as to whether the classes of employees are identified based on the employees of the common law employer or, rather, whether the determination is made at the controlled group level (generally referring to a group of employers treated as a single employer with the common law employer under Code section 414(b), (c), (m), or (o)), such that all employees of a controlled group of employers would be combined to create the classes of employees. Some commenters recommended that the Departments confirm that the controlled group rules do not apply for this purpose, and some recommended that the controlled group rules be used to determine the classes of employees as a way to reduce the number of small classes and prevent adverse selection.

After consideration of these comments, the Departments have concluded that determining the classes of employees at the common law employer level will avoid complexity for employers and that applying the minimum class size requirement (to the extent applicable), as described earlier in this preamble, at the common law employer level, is a more straightforward way of addressing the adverse selection concerns raised by some commenters. Accordingly, the final rules clarify that the classes of employees are determined based on the employees of a common law employer, rather than the employees of a controlled group of employers.

g. Movement Among Classes

A few commenters requested clarification regarding the application of the final rules in the situation in which an employee moves out of a class of employees that is offered an individual coverage HRA and into a different class of employees that is offered either a traditional group health plan, a different individual coverage HRA, or no coverage. As discussed earlier in this preamble, the Departments note that as group health plans, HRAs generally are subject to the COBRA or other group continuation of coverage rules. However, if the change in the employee's classification is not the result of termination of employment or reduction in hours, there generally is not a qualifying event resulting in a COBRA or other group continuation of coverage right.

Even if an employee who ceases enrollment in an individual coverage HRA does not have a right to continuation of coverage, the HRA must allow the individual to submit for reimbursement substantiated medical care expenses that were incurred during the coverage period prior to the termination date of the individual coverage HRA. In this case, the individual coverage HRA may limit the period of time to submit expenses to a reasonable specified time period after termination of coverage under the individual coverage HRA during which the participant may submit those claims. Additionally, an employee who loses coverage under an individual coverage HRA may qualify for an SEP for loss of MEC to change his or her individual health insurance coverage either on or off an Exchange.

One commenter asked whether an employee who changes classes of employees and loses coverage under an individual coverage HRA may convert unused amounts to another type of HRA. The Departments note that under existing rules, employers generally may provide employees enrolled in a traditional group health plan an HRA that is integrated with that traditional group health plan and in some circumstances may provide an HRA that can be integrated with TRICARE or Medicare. Nothing in the final rules or current guidance would prevent employers from basing the amount in these types of HRAs on unused amounts in an individual coverage HRA in which the individual was previously enrolled, nor are employers precluded from basing the amount of an individual coverage HRA on unused amounts in these types of HRAs in which the individual was previously enrolled. Also, if an employee moves from a class of employees offered an individual coverage HRA to a class of employees offered a different individual coverage HRA, nothing in the final rules would prevent the employer from permitting the unused amounts in the first individual coverage HRA to be considered transferred to the second. Therefore, the final rules are revised to clarify that amounts made available in an individual coverage HRA based on amounts remaining in another HRA under which the participant was previously covered are disregarded for purposes of determining whether the individual coverage HRA is offered on the same terms, provided that if the HRA takes these amounts into account, it does so on the same terms for all participants in the class of employees.[106]

Further, with regard to amounts remaining in an individual coverage HRA after the individual is no longer covered by the HRA, the HRA must allow a participant (and the participant on behalf of dependents) to submit claims to the HRA for reimbursement of substantiated expenses that were incurred during the coverage period prior to the termination of the individual's coverage under the individual coverage HRA, even if the claim is submitted after the individual is no longer covered by the individual coverage HRA. However, the HRA may limit the period to submit expenses to a reasonable specified time period.

One commenter requested guidance on situations in which employees are currently receiving treatment for health conditions when an employer switches from a traditional group health plan to an individual coverage HRA. The Departments note that a similar issue arises under existing rules when an employer switches from one group health plan to another group health plan with a different network of providers, so that providers participating under the first plan are no longer in network. The final rules do not address this issue because it is not specific to this rulemaking. To the extent an employee or dependent is switching from an insured traditional group health plan to individual health insurance coverage purchased with an individual coverage HRA, state ''succeeding carrier'' or ''extension of benefit'' laws may regulate the obligations of the prior or succeeding issuer to cover an individual's ongoing health conditions at the time of the coverage switch.

[106] However, employers may not permit unused amounts in an individual coverage HRA, or any other type of HRA, to be considered transferred to an excepted benefit HRA because amounts made available under an excepted benefit HRA are necessarily limited in order for the HRA to constitute an excepted benefit. Allowing amounts remaining in other types of HRAs to be transferred to an excepted benefit HRA could lead to significant circumvention of that limit. Also, note that under the final excepted benefit HRA rules, if the plan sponsor offers more than one HRA to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

h. Definition of Full-Time Employee, Part-Time Employee, and Seasonal Employee

For purposes of identifying classes of employees, the proposed rules provided that a plan sponsor may define full-time employees, part-time employees, and seasonal employees in accordance with either the applicable definitions under Code section 105(h) or those under Code section 4980H to avoid overlapping classes of employees. The proposed rules included a proposal that a plan sponsor's choice of which statutory definitions to apply must be consistent across these three classes of employees, to the extent the plan sponsor differentiates based on these classes.

A few commenters requested that only one definition for each term be permitted and requested that the final rules adopt the definitions in Code section 4980H. One commenter recommended that only the definition of full-time employee under Code section 4980H (which is based on 30 hours per week) should be permitted. This commenter asserted that use of the definition under Code section 105(h) (which is based on 35 hours per week) could lead to adverse selection, because many plans currently offer traditional group health plan coverage to employees based on the Code section 4980H definition, and use of another definition could lead to subdivision of full-time employees. A few commenters supported the proposed ability to choose either set of definitions, including the requirement to use either the definitions under Code section 4980H or those under Code section 105(h) consistently across these classes of employees.

The Departments considered these comments and have determined that the final rules should adopt the definitions provided in the proposed rules. This approach provides employers with flexibility, while limiting opportunities for risk segmentation. The Departments understand that, to avoid the inclusion of amounts in income, plan sponsors of self-insured plans subject to Code section 105(h) (in particular small employers not subject to Code section 4980H) may want to design their health plans to offer a traditional group health plan and individual coverage HRAs (or individual coverage HRAs in different amounts or under different terms and conditions) to different classes of employees that are identified in a manner that complies with the requirements of Code section 105(h). The Departments also acknowledge that certain larger employers have already determined how to apply the definitions under Code section 4980H to their workforces and using those same definitions for purposes of applying the integration rules may reduce burden for those employers. Therefore, the final rules include flexibility for each employer to determine which set of definitions is appropriate for its workforce, provided the employer uses the same set of definitions for classifying its full-time, part-time, and seasonal employees to the extent it uses one or more of these classes of employees.

The proposed rules further provided that the HRA plan document must set forth the applicable definitions of full-time employee, part-time employee, and seasonal employee prior to the beginning of the plan year in which the definitions will apply and that nothing would prevent an employer from changing the definitions for a subsequent plan year. Some commenters supported that provision, asserting that it minimizes the potential for adverse selection, with one requesting clarification whether it is permissible to change the definitions of the classes of employees during the plan year. One commenter stated that plan sponsors should not be allowed to change the definitions each plan year, asserting that this flexibility could allow small employers in particular to segment risk.

The Departments have determined that in order to mitigate the risk of market segmentation and minimize disruption to employees with respect to a coverage period, it is important for plan sponsors to determine prior to the plan year which definitions will apply and to apply them consistently throughout the plan year. The Departments also have concluded that limiting an employer's ability to revise the definitions it applies from one plan year to the next would be unnecessarily restrictive. Accordingly, the final rules generally retain the rules in the proposed rules. However, the final rules clarify that adjustments during the plan year to the definitions used to identify the classes of employees are not permitted.

6. Special Rule for New Hires

As explained earlier in this preamble, some commenters expressed concerns about the challenges employees may experience in transitioning from a traditional group health plan to individual health insurance coverage, with some stating that the proposed rules failed to adequately take into account the differences between the coverage types and the significance of the change from the employee's perspective. The Departments are aware that the transition from coverage under a traditional group health plan to coverage under an individual coverage HRA could represent a substantial change from an employee perspective, and, as a result, employers may want to phase in individual coverage HRAs. By allowing plan sponsors to offer traditional group health plans to some classes of employees while offering other classes of employees an individual coverage HRA, the final rules provide plan sponsors with some flexibility to manage the transition to individual coverage HRAs. However, in response to comments, including those expressing concern about the transition from traditional group health plans to individual coverage HRAs and those expressing interest in being able to provide different benefits based on employee tenure, the Departments have determined that it is appropriate to provide additional flexibility to plan sponsors, in particular for employers that offer traditional group health plans that would like to continue to offer that type of coverage to current employees who are accustomed to that coverage, but offer individual coverage HRAs to newly hired employees.

Therefore, notwithstanding the general rule that a plan sponsor may only offer either a traditional group health plan or an individual coverage HRA to a class of employees, the final rules provide that a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer employees in that class hired on or after a certain date in the future (the new hire date) an individual coverage HRA (the new hire subclass), while continuing to offer employees in the class hired before the new hire date a traditional group health plan (the special rule for new hires). A plan sponsor may set the new hire date prospectively for a class of employees as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

Although this special rule provides additional flexibility, it is still the case that for the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the new hire subclass, in accordance with the generally applicable rules under the same terms requirement. Further, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant, whether a current employee or a newly hired employee in the new hire subclass.

A plan sponsor may discontinue the special rule for new hires at any time for a class of employees. In that case, the new hire subclass would no longer be treated as a separate subclass of employees, and each employee that was previously treated as part of the new hire subclass would then be treated as an employee in the class of which he or she would have otherwise belonged for purposes of the final rules. In that case, if the plan sponsor wanted to offer an individual coverage HRA, it would need to do so for all the employees in the class and generally on the same terms, as explained earlier in this preamble. It could also choose instead to offer a traditional group health plan to some or all of the employees [107] in the class or to offer no coverage.

In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues using the rule for the class of employees, the plan sponsor may apply the special rule for new hires to the class of employees again, at a later time, under the same rules as the initial application of the rule. For example, as under the basic requirements for the application of the special rule for new hires, the plan sponsor would only be allowed to apply the rule to a class to which it is offering a traditional group health plan. If a plan sponsor applies the special rule for new hires again, in accordance with the general rules under the special rule for new hires, the plan sponsor would choose a prospective new hire date. In no circumstances may the special rule for new hires be applied to a class of employees (including a new hire subclass) already being offered an individual coverage HRA, in an attempt to offer different HRA amounts or other different terms within a class of employees based on different hire dates.

The minimum class size requirement described earlier in this preamble does not apply to a new hire subclass. This is because the Departments recognize that many employers hire only a few employees, or even only one employee, at a time and a subclass based on a new hire date does not present a high risk of manipulation that could lead to adverse selection. However, if a plan sponsor subdivides the new hire subclass based on a permissible class of employees subsequent to creating the new hire subclass, the minimum class size requirement applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies. The text of the final rules includes examples to illustrate these rules.

7. Opt-Out Provision

If an individual is covered by an HRA, including an individual coverage HRA, for a month, regardless of the amount of reimbursement available under the HRA, the individual is not eligible for the PTC for that month. Because in some circumstances an individual may benefit more from claiming the PTC than from having funds in an HRA available for reimbursement, the Departments' existing rules regarding integration with non-HRA group coverage and with Medicare require a plan sponsor that offers an HRA to allow participants to opt out of and waive future reimbursements from the HRA at least annually.[108] The proposed rules also included this requirement with respect to the individual coverage HRA, so that employees would be allowed the PTC, if they are otherwise eligible, if they opt out of and waive future reimbursements from the HRA and the HRA is either unaffordable or does not provide MV.[109] The Departments have concluded that this condition is important as a result of the PTC consequences of HRA coverage, and, therefore, the final rules retain this condition, with some clarifications.

Furthermore, consistent with the current rules for integration with a group health plan and with Medicare, the proposed rules required that upon termination of employment, either the remaining amounts in the HRA must be forfeited or the participant must be allowed to permanently opt out of and waive future reimbursements from the HRA. This requirement ensures that the HRA participant may choose whether to claim the PTC, if otherwise eligible, or to continue to participate in the HRA after the participant's separation from service.[110]

Commenters generally supported these opt-out requirements as necessary to protect PTC eligibility for employees. Some commenters expressed concern that due to the complexity of the PTC affordability rules, employees are likely to have difficulty understanding whether or not they should opt out of an individual coverage HRA. Similarly, some commenters expressed concern that some low- and moderate-income employees may opt into the individual coverage HRA although they may have been better off opting out of the HRA and receiving the PTC, while others expressed concern that some employees may opt out of the HRA based on the misimpression that they will receive the PTC, when actually they are ineligible for the PTC.

The Departments appreciate the concerns expressed regarding the burden on employees to properly determine whether the individual coverage HRA they have been offered is affordable and provides MV and to determine whether they will be better off with the HRA or, if otherwise eligible, the PTC. These concerns are the primary reason that the Departments proposed and are finalizing the requirement for individual coverage HRAs to provide a written notice to each participant. Further, the Departments will work with the FFEs and State Exchanges to ensure that their applications and other relevant materials are updated to accommodate individuals who are offered an individual coverage HRA and are applying for individual health insurance coverage with APTC.

Some commenters requested clarification regarding the timing of the annual opt-out condition. One commenter asked the Departments to clarify how the annual opt-out condition applies in the case of an HRA with a non-calendar year plan year. In response, the final rules clarify that an HRA may establish timeframes for enrollment in (and opting out of) the HRA, but participants generally [111] must be provided an opportunity to opt out of the individual coverage HRA once for each plan year, which must occur in advance of, and with respect to, the plan year. That is, individual coverage HRAs must provide participants with one advance opportunity to accept, or opt out of, the individual coverage HRA for each plan year, but the individual coverage HRA may not provide participants with multiple opportunities

[107] To the extent such an arrangement is available to active employees it may be subject to restrictions under other laws, such as the MSP provisions.

[108] *See* 26 CFR 54.9815–2711(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv); 29 CFR 2590.715–2711(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv); and 45 CFR 147.126(d)(2)(i)(E), (d)(2)(ii)(D), and (d)(5)(iv).

[109] See later in this preamble for a discussion of the final rules regarding the circumstances in which an offer of an individual coverage HRA is affordable and provides MV for purposes of Code section 36B.

[110] Note that a former employee is only rendered ineligible for the PTC if the former employee enrolls in employer-sponsored coverage; an offer of coverage (even if it is affordable and provides MV) does not preclude a former employee from claiming the PTC. *See* 26 CFR 1.36B–2(c)(3)(iv).

[111] The final rules also clarify that for participants or dependents who become eligible for the individual coverage HRA on a date other than the first day of the plan year (or participants who are not required to be provided the HRA notice at least 90 days in advance of the plan year (that is, employees who become eligible less than 90 days prior to the plan year and employees of newly established employers)), the option to opt out must be provided during the HRA enrollment period established by the HRA for these individuals and then subsequently on an annual basis in advance of the plan year.

to opt into, or out of, the individual coverage HRA over the course of the plan year, except that the final rules require HRAs to provide an opt out opportunity upon termination of employment. This is generally consistent with employees' ability to decline traditional group health plan coverage that is not affordable or does not provide MV in order to claim the PTC, if otherwise eligible. See later in this preamble for a discussion of comments received on the proposed PTC rules and an explanation of the final PTC rules, including for additional discussion of the application of the PTC rules to an employee opting out of, or accepting, an individual coverage HRA with a non-calendar year plan year.

One commenter requested clarification as to whether a former employee offered an individual coverage HRA must be provided the annual opportunity to opt out of the individual coverage HRA. The Departments clarify that the annual opt-out condition applies for all participants eligible to enroll in an individual coverage HRA, including former employees. Another commenter requested clarification whether an employee's choice to opt out of an individual coverage HRA also applies to the employee's dependents who are otherwise eligible for the individual coverage HRA. The Departments intend for the opt-out opportunity to extend to dependents, but expect that an employer would provide an individual coverage HRA to an employee's dependent only if the employee participates in the individual coverage HRA. Therefore, the final rules clarify that if an employee opts out of an individual coverage HRA, the individual coverage HRA is considered waived for the employee's eligible dependents as well.[112] See later in this preamble for a discussion of the circumstance in which the offer of an individual coverage HRA to an employee's dependents will render the dependents ineligible for the PTC.

One commenter requested clarification as to whether, instead of permanently forfeiting an individual coverage HRA upon termination of employment, an individual coverage HRA may be suspended for a period of time, allowing the individual to receive the PTC during that period of time if otherwise eligible, and then have the HRA amounts reinstated in the individual coverage HRA years in the future. Although the current rules for integration of an HRA with other group coverage allow certain HRA amounts that would otherwise be permanently forfeited to be reinstated in the future upon a fixed date, a participant's death, or the earlier of the two events, the final rules do not include a similar provision for individual coverage HRAs. The final rules do not include such a provision due to the Departments' concerns about complexity and burden on employers in needing to establish procedures for substantiation of enrollment in individual health insurance coverage upon reinstatement, and on an ongoing basis, possibly many years in the future; the lack of demand for such a rule from employers; and potential complexities related to the interaction with the PTC.[113] However, as explained earlier in this section of the preamble, the final rules require an individual coverage HRA to provide an annual opportunity for participants to opt out of the HRA, which may, depending on the individual coverage HRA offered, allow the participant, if otherwise eligible, to claim the PTC.

8. Substantiation of Coverage Under Individual Health Insurance Coverage

a. In General

The proposed rules required that individuals whose medical care expenses may be reimbursed under an individual coverage HRA must be enrolled in individual health insurance coverage. To facilitate the administration of this requirement, under the proposed rules, an individual coverage HRA would be required to implement, and comply with, reasonable procedures to verify that individuals whose medical care expenses are reimbursable by the individual coverage HRA are, or will be,[114] enrolled in individual health insurance coverage during the plan year (annual coverage substantiation requirement).

Commenters generally supported the annual coverage substantiation requirement, asserting that it is necessary to ensure the effectiveness of the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage. The Departments agree; therefore, the final rules adopt the annual coverage substantiation requirement, with minor clarifications described in this section of the preamble.[115]

Some commenters asked the Departments to clarify the timeframe within which the substantiation must be provided, including requests for clarification as to whether it would be acceptable for the substantiation to occur during the individual coverage HRA enrollment period or prior to the first request for reimbursement under the individual coverage HRA, which commenters stated would be consistent with typical administrative procedures for HRAs. For individuals who seek enrollment in an individual coverage HRA for the entire HRA plan year, the Departments intend for the annual coverage substantiation requirement to provide verification of an individual's enrollment in individual health insurance coverage for the entire HRA plan year (and, therefore, that coverage is in effect as of the first day of the HRA plan year). Accordingly, the final rules clarify that the HRA may establish the date by which the annual coverage substantiation requirement must be satisfied, but, in general, the date may be no later than the first day of the HRA plan year. Nothing in the final rules prevents an HRA from setting reasonable parameters for when the substantiation must be provided to the HRA (for example, by the end of the individual coverage HRA open enrollment period).[116]

[112] The Departments note that this provision addresses the right of participants to opt out of the HRA generally, including for their dependents, and is not intended to preclude an HRA from allowing a participant who enrolls in the HRA from enrolling some, but not all, dependents (including new dependents added during the year). The Departments also clarify that in the event a participant gains a dependent during the year, the HRA must provide the participant the right to decline to enroll that dependent, if the participant had enrolled for the plan year.

[113] *See* 26 CFR 54.9815–2711(d)(3), 29 CFR 2590.715–2711(d)(3), and 45 CFR 147.126(d)(3).

[114] The Departments clarify that the reference to ''will be'' applies for participants who provide the substantiation in advance of when their individual coverage HRA coverage begins.

[115] One commenter asserted that the substantiation requirements in the proposed rules are not sufficient but the commenter appears to have understood that the annual coverage substantiation requirement is the sole substantiation requirement. The Departments note that the final rules, like the proposed rules, also require that the HRA satisfy the ongoing substantiation requirement. The Departments determined that both the annual coverage substantiation requirement and the ongoing substantiation requirement are necessary to ensure that individuals covered by an individual coverage HRA have individual health insurance coverage. Also, this commenter asserted that in the proposed rules the Departments acknowledged that employees may fail to obtain coverage, and cited to 83 FR 54445 (Oct. 29, 2018), where, in the regulatory impact analysis the Departments stated that loss of coverage could occur as a result of the integration rules ''if some previously covered employees do not accept the HRA and fail to obtain their own coverage.'' The Departments clarify that this statement related to individuals who opt out of the HRA and did not address the circumstance in which an individual with an individual coverage HRA does not have individual health insurance coverage.

[116] The Departments note that in establishing the enrollment period for an individual coverage HRA,

However, for individuals who become eligible for the HRA during the HRA plan year, including dependents, or who otherwise are not required to be provided the HRA notice described later in this preamble 90 days prior to the plan year (that is, employees who become eligible fewer than 90 days prior to the plan year or employees of newly established employers), the HRA may establish the date by which the substantiation must be provided, but the date may be no later than the date the HRA coverage begins. These individuals may not have sufficient time to enroll in individual health insurance coverage that is effective on or before the first day of the HRA plan year. Thus, the final rules provide a timing requirement that is consistent with the annual coverage substantiation requirement to provide verification of an individual's enrollment in individual health insurance coverage for the portion of the HRA plan year during which the individual is covered by the HRA. The final rules also clarify that, for these individuals, whether the individual is a participant or a dependent, the annual coverage substantiation requirement requires substantiation that the individual will have individual health insurance coverage for the portion of the HRA plan year during which the individual is covered by the HRA (rather than requiring substantiation of coverage for the entire plan year). The final rules also clarify that to the extent a new dependent's coverage is effective retroactively, the HRA may establish any reasonable timeframe for the annual coverage substantiation but must require it be provided before the HRA will reimburse medical care expenses for the newly added dependent.

In addition to the annual coverage substantiation requirement, the proposed rules provided that an individual coverage HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation that the participant and, if applicable, any dependent(s) whose medical care expenses are requested to be reimbursed, continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred (ongoing substantiation requirement).

Several commenters expressed support for the ongoing substantiation requirement, as necessary to ensure the effectiveness of the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage. Several commenters, however, were concerned about what they characterized as the complexity, burdens, and liabilities associated with the ongoing substantiation requirement, in particular for smaller employers, and noted that those burdens could deter employers from adopting individual coverage HRAs. Some commenters asserted that the annual coverage substantiation requirement would be sufficient to verify enrollment in individual health insurance coverage and, therefore, ongoing substantiation would be unnecessary.

The Departments note that currently, separate from the market requirements or integration rules, HRAs are subject to substantiation requirements with respect to each request for reimbursement. This is because in order to provide a benefit excludable from income for federal tax purposes, employer-provided accident or health plans, including HRAs, may only reimburse medical care expenses that have been substantiated as an expense for medical care.[117] Consequently, each reimbursement for medical care expenses by an HRA may only be paid after the expense has been substantiated as being for medical care.[118] Each claim for reimbursement also generally must include the employee's certification that the expense has not otherwise been reimbursed and that the employee will not seek reimbursement for the expense from any other plan.[119]

The Departments have determined that requiring ongoing substantiation of an individual's continued enrollment in individual health insurance coverage for the month in which the expense was incurred is not unduly burdensome because of these existing substantiation requirements. Further, the Departments have determined that the ongoing substantiation requirement is essential to ensure compliance with the requirement that an individual covered by an individual coverage HRA be enrolled in individual health insurance coverage and, as explained later in this section of the preamble, will impose minimal burden because it can be satisfied by collecting a written attestation from the participant on the same form used for requesting reimbursement. Thus, the final rules retain the ongoing substantiation requirement.[120]

Commenters requested that the Departments confirm the entity to which the substantiation requirements apply. Under the final rules, the substantiation requirements (both the annual coverage substantiation requirement and the ongoing substantiation requirement) apply to the individual coverage HRA, rather than to any other entity or individual, such as an issuer or employee, because the requirements relate to compliance of the individual coverage HRA with PHS Act sections 2711 and 2713. The substantiation requirements do not impose any new requirements on issuers, although individual coverage HRAs may accept certain documentation provided by issuers in the normal course of business to verify individual health insurance coverage enrollment.

b. Methods of Substantiation

The proposed rules included a proposal that the reasonable procedures an individual coverage HRA may use to verify enrollment in individual health insurance coverage for purposes of the annual coverage substantiation requirement include the individual coverage HRA requiring the participant to provide either: (1) A document from a third party (for example, the issuer or Exchange) showing that the participant and any dependent(s) covered by the individual coverage HRA are, or will be, enrolled in individual health insurance coverage during the plan year (for example, an insurance card or an explanation of benefits pertaining to the plan year or relevant month, as applicable);[121] or (2) an attestation by the participant stating that the participant and any dependent(s) are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage. For the ongoing substantiation requirement, the

plan sponsors should consider the timeframes for the relevant individual market enrollment periods.

[117] *See* Code section 105(b), 26 CFR 1.105–2, and IRS Notice 2002–45.

[118] See Prop. Treas. Reg. 1.125–6(d) for rules regarding reimbursement of medical care expenses through electronic methods, including some debit cards that satisfy certain requirements.

[119] *See* IRS Notice 2006–69, 2006–31 IRB 107; Revenue Ruling 2003–43, 2003–1 CB 935; and Prop. Treas. Reg. 1.125–6(b)(3)(ii), (d)(i).

[120] The Departments note that the final rules clarify that the ongoing substantiation requirement applies with respect to the individual on whose behalf reimbursement is being sought.

[121] The Departments are aware that in the case of an individual coverage HRA with a non-calendar year plan year, the individual may not have documentation showing an individual health insurance policy that spans the entire plan year as individual health insurance policy years are based on the calendar year. However, such an HRA may establish reasonable procedures to implement the annual coverage substantiation requirement, including documentation showing coverage for the first part of the plan year combined with an attestation that the participant intends to obtain individual health insurance coverage for the second part of the plan year or an attestation with respect to the full plan year.

proposed rules permitted that substantiation could be in the form of a written attestation by the participant, which could be part of the form used for requesting reimbursement.

Commenters generally supported that the proposed rules provided that attestation by a participant would be sufficient to satisfy both the annual coverage substantiation requirement and the ongoing substantiation requirement. However, one commenter stated that allowing attestation to be used to satisfy the annual coverage substantiation requirement is not sufficient to ensure that individuals covered by an individual coverage HRA have individual health insurance coverage. The Departments acknowledge the importance of the requirement under the final rules that individuals with an individual coverage HRA be enrolled in individual health insurance coverage and, therefore, the need for related substantiation requirements that ensure that requirement is satisfied. The Departments note that attestation is permitted to be used to satisfy similar requirements in related contexts and that the Departments generally are not aware of issues with regard to the accuracy of attestations used to satisfy those rules.[122] Further, in setting out one type of attestation that is sufficient to satisfy the annual coverage substantiation requirement, the final rules state that, in addition to providing that the individual is (or will be) enrolled in individual health insurance coverage, the attestation would also provide the date coverage began or will begin and the name of the provider of the coverage. Moreover, HRAs can use other reasonable methods to satisfy the substantiation requirements and, in fact, the Departments generally expect that employees will use individual coverage HRAs to reimburse premiums for the individual health insurance coverage in which they are enrolled and, therefore, employers will be able to confirm enrollment in individual health insurance coverage by virtue of reimbursing the premiums for such coverage (or paying the premiums for such coverage directly). Taking these factors into consideration, the Departments have determined that allowing participant attestation, among other options, to satisfy the substantiation requirements strikes the appropriate balance between ensuring individuals with individual coverage HRAs are enrolled in individual health insurance coverage and minimizing burdens on employers and employees. Accordingly, the final rules retain this provision and permit substantiation by participant attestation.

Some commenters requested that the final rules provide a model attestation. In response, to reduce burden on individual coverage HRAs and their participants, the Departments are providing model attestation language contemporaneously with, but separate from, the final rules. However, the Departments note that individual coverage HRAs will not be required to use the model attestation.

Some commenters requested clarification as to whether other substantiation methods, in addition to collection of an attestation, would satisfy the substantiation requirements. One commenter suggested that a list of covered individuals provided by the insurance carrier should be sufficient. The Departments agree that this would generally be a type of third-party document that could be used to verify enrollment, assuming the individual coverage HRA timely receives the substantiation. However, the Departments note that the final rules do not require issuers to provide individual coverage HRAs with lists of covered individuals nor are individual coverage HRAs required to contact issuers to substantiate an individual's enrollment in individual health insurance coverage. In addition, the final rules clarify that a document from an Exchange showing that the individual has completed the application and plan selection would be sufficient to satisfy the annual coverage substantiation requirement. This clarification is intended to address the situation in which, due to the SEP verification process, an individual is not yet enrolled in individual health insurance coverage but will be enrolled with a retroactive start date upon successful completion of the SEP verification.[123] See later in this preamble for a discussion of SEPs, including a new SEP for individuals who newly gain access to an individual coverage HRA.

One commenter requested that the final rules adopt a requirement for issuers similar to the creditable coverage certification requirement created by HIPAA, under which, as suggested by the commenter, issuers would be required to generate a letter for all individuals covered by individual health insurance coverage for each month showing payment was made and that the individual had the coverage for the month.[124] The Departments decline to impose such a requirement because it would increase burden and other reasonable substantiation methods are available. One commenter suggested that the ongoing substantiation requirement should be considered satisfied so long as the employer sends a notice to employees advising them to contact the employer if they no longer are enrolled in individual health insurance coverage. The Departments decline to adopt this suggestion because this method of substantiation would be insufficient to ensure with reasonable accuracy that a participant had continued enrollment in individual health insurance coverage.

Several commenters requested that individual coverage HRAs be permitted to comply with the substantiation requirements electronically, such as through debit card technology.[125] Some commenters noted this would provide consistency with current rules that allow HRAs to satisfy the current requirement to substantiate that an expense is for medical care using debit cards and other electronic means.[126] Nothing in the final rules would prohibit an individual coverage HRA from establishing procedures to comply with the substantiation requirements through electronic means, so long as the procedures are reasonable to verify enrollment.[127] See also the discussion

[122] *See* IRS Notice 2013–54, Q&A–4 (providing that attestation is sufficient to show that an individual is enrolled in group coverage, as required by the rules allowing HRA integration with a traditional group health plan) and IRS Notice 2017–67, Q&A–41 (providing that attestation is sufficient to satisfy the QSEHRA requirement that individuals provide proof that they are covered by MEC).

[123] The Departments note that a document from an Exchange showing that the individual has completed the application and plan selection would not be sufficient to satisfy the ongoing substantiation requirement; to satisfy that requirement the individual on whose behalf reimbursement is sought must be enrolled in individual health insurance coverage. Therefore, individual health insurance coverage must become effective, including retroactively in the case of delayed SEP verification, in which case reimbursement can then be sought for expenses incurred during the coverage period (including during the period to which the individual health insurance coverage applies retroactively, assuming the individual was covered by the HRA during that time).

[124] Code section 9801(e), ERISA section 701(e), and PHS Act section 2704(e).

[125] A couple of commenters requested clarification that funds in an individual coverage HRA could be accessed via debit cards. The final rules do not change the methods currently allowed for facilitating reimbursements of HRA amounts, electronic or otherwise.

[126] *See* IRS Notice 2006–69 and Revenue Ruling 2003–43, 2003–1 CB 935.

[127] For purposes of the Code provisions affected by the final rules, the otherwise generally applicable substantiation and recordkeeping requirements under Code section 6001 apply, including the requirements specified in Revenue Procedure 98–25, 1998–1 CB 689, for records maintained within an Automated Data Processing system.

later in this preamble regarding the interaction of these rules with the safe harbor that DOL is finalizing, to clarify that individual health insurance coverage will not be treated as part of an ERISA-covered group health plan so long as certain conditions (including the prohibition on endorsement) are satisfied.

c. Reliance on Documentation or Attestation

The proposed rules provided that, for both the annual coverage substantiation requirement and the ongoing substantiation requirement, an individual coverage HRA may rely on the documentation or attestation provided by the participant unless the individual coverage HRA has actual knowledge that any participant or dependent covered by the individual coverage HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year or the month, as applicable.

Despite this provision in the proposed rules, some commenters expressed concern, and requested clarification, regarding liability of an individual coverage HRA if it relies on a participant's misrepresentation regarding enrollment in individual health insurance coverage. In response to these comments, the final rules provide that an individual coverage HRA may rely on the documentation or attestation provided by the participant unless the HRA has actual knowledge that any participant or dependent covered by the individual coverage HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or the applicable portion of the plan year) or the month, as applicable. Therefore, the final rules provide that an inaccurate attestation or document will not cause an individual coverage HRA to fail to be considered integrated with individual health insurance coverage unless the HRA has actual knowledge that the attestation or document is inaccurate. The Departments clarify that in the event an individual coverage HRA subsequently gains actual knowledge that the attestation or document was inaccurate, the HRA may not provide further reimbursement on behalf of the individual for expenses incurred during the period to which the inaccurate attestation relates.

One commenter requested that the final rules clarify whose knowledge can be imputed to the individual coverage HRA for purposes of liability and one commenter requested clarification that vendors contracted by the HRA could rely on coverage information provided by the HRA. The individual coverage HRA will be considered to have actual knowledge that a participant or dependent is not, or will not be, enrolled in individual health insurance coverage for the plan year or the month, as applicable, if the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has such actual knowledge.

One commenter suggested that the final rules apply penalties to individual participants for an inaccurate attestation. The final rules do not impose penalties on participants. Instead, the final rules, like the proposed rules, provide conditions under which an HRA will be considered integrated with individual health insurance coverage and, therefore, in compliance with PHS Act sections 2711 and 2713. Failing to properly integrate will cause an HRA to run afoul of PHS Act sections 2711 and 2713. Therefore, the responsibility to have reasonable procedures in place to ensure coverage is integrated falls on the HRA, not the participants.

One commenter asked that individual coverage HRA amounts made available for a month be treated as taxable income for individuals who do not have individual health insurance coverage for the month and that the attestation requirement and required notice include a related warning. The Departments decline to adopt this suggestion. Whether an individual is enrolled in individual health insurance coverage for a month relates to whether the individual coverage HRA satisfies the conditions for integration for the month and does not affect the tax treatment of reimbursements provided to a participant under the individual coverage HRA.[128]

One commenter suggested that the final rules address substantiation requirements relative to a private exchange. The Departments note that the substantiation requirements set forth in the final rules apply to all individual coverage HRAs, regardless of the manner in which the individual health insurance coverage is purchased. See later in this preamble for a discussion of private exchanges and the DOL clarification regarding the application of ERISA to individual health insurance coverage purchased through an individual coverage HRA.

To mitigate discrimination concerns, one commenter requested that the substantiation requirements be consistent across all classes of employees. The Departments note that the substantiation requirements set forth in the final rules apply to all individual coverage HRAs, including different individual coverage HRAs offered to different classes of employees. The Departments generally expect plan sponsors to establish similar procedures to satisfy the substantiation requirements for different individual coverage HRAs they may offer. However, the Departments decline to adopt the commenter's specific recommendation in order to allow plan sponsors the flexibility to establish reasonable procedures to satisfy the substantiation requirements, which presumably could differ across the employer's workforce, depending on the characteristics of the workforce or for other legitimate business reasons.

One commenter requested that employers offering an individual coverage HRA to employees or former employees who are either eligible for or enrolled in Medicare should be exempt from the substantiation requirement. However, as discussed in more detail later in this preamble, the final rules permit integration of an individual coverage HRA with Medicare, and the substantiation requirements apply to enrollment in Medicare in the same manner as they apply to enrollment in individual health insurance coverage. Therefore, the final rules do not adopt this suggestion.

9. Notice Requirement

Because HRAs are different from traditional group health plans in many respects, in the preamble to the proposed rules, the Departments expressed a concern that individuals eligible for individual coverage HRAs might not recognize that the offer or acceptance of the individual coverage HRA may have consequences for APTC and PTC eligibility, as described elsewhere in this preamble. In order to ensure that employees who are eligible to participate in an individual coverage HRA understand the potential effect that the offer of and enrollment in the HRA might have on their ability to receive the benefit of APTC and claim the PTC, the proposed rules included a requirement that an individual coverage HRA provide written notice to eligible participants.

Commenters generally supported the notice requirement, sharing the Departments' determination that many individuals will need the information to understand the PTC consequences of the individual coverage HRA. However, a number of commenters expressed concerns about the potential for consumer confusion, notwithstanding

[128] However, see Code section 106(g) regarding the taxation of QSEHRA reimbursements if an individual fails to have MEC.

the notice requirement, and some suggested ways to strengthen the notice. Other commenters expressed concern that the notice requirement could burden employers, with one noting in particular the burden of providing notices to former employees.

The Departments have considered these comments and agree with the commenters that assert that the notice is necessary and appropriate for individuals offered an individual coverage HRA to understand the consequences of the offer. Although the Departments also considered the burden on employers identified by commenters, the Departments have determined that the notice requirement is essential to implementation of the final rules. Along with updates to Exchanges' application processes, the notice, which will include information that individuals will be instructed to provide to Exchanges during the application process, is key to ensuring that APTC and PTC are properly allowed and that improper APTC payments are prevented. The notice will also aid implementation of the new individual market SEP, as explained later in this preamble. Therefore, the final rules retain this requirement, with a number of revisions made in response to comments, including that the Departments are providing model notice language, separate from, but contemporaneously with the final rules, in order to address commenters' concerns about burden on employers. The comments received and changes made in the final rules are described in the remainder of this section of the preamble.

a. Notice Content

As proposed, the notice was required to include certain relevant information, including a description of the terms of the individual coverage HRA (including the self-only maximum dollar amount made available, which is used in the affordability determination under the proposed PTC rules); a statement of the right of the participant to opt out of and waive future reimbursement under the HRA; a description of the potential availability of the PTC if the participant opts out of and waives the HRA and the HRA is not affordable under the proposed PTC rules; a description of the PTC eligibility consequences for a participant who accepts the HRA; a statement that the participant must inform any Exchange to which they apply for APTC of certain relevant information; and a statement that the individual coverage HRA is not a QSEHRA.

Commenters generally supported the notice content elements, and the final rules include each of the proposed notice content elements, some with clarifications. Some commenters requested that the notice be required to include additional content, as explained in this section of the preamble, and some commenters requested that the notice be as simple as possible. Some commenters requested that the notice explain the differences between an employer's traditional group health plan and alternative health insurance products. And one commenter requested that the specific dollar amount made available be included in the notice. The Departments note that under the final rules, the notice is required to provide the amount(s) made available under the individual coverage HRA. As to the suggestion that the notice explain common differences between traditional group health plans and individual coverage HRAs and other insurance products, the Departments decline to adopt the suggestion due to concerns that it would cause confusion for participants, as participants are prohibited from being offered both a traditional group health plan and an individual coverage HRA under the final rules. The intent of the notice is to explain the individual coverage HRA that the employee is being offered to avoid consumer confusion. Adding information about other types of coverage would undermine that goal. Further, traditional group health plans differ in cost-sharing structures, network rules, and benefits covered, and any standardized language in the notice would have to be general and would not capture these elements, as standardized language about traditional group health plans would not be describing any particular plan. Moreover, the individual coverage HRA must provide a summary of benefits and coverage (SBC), which will include a description of the coverage, including cost sharing; the exceptions, reductions and limitations on coverage; and other information.[129]

One commenter requested that the notice be required to contain contact information for a specific person that participants can contact with questions. The Departments agree that this could be useful information for participants, without imposing significant additional burden on employers, and therefore the final rules add a requirement that the notice include contact information of an individual or a group of individuals who participants may contact with questions regarding their individual coverage HRA. For purposes of this new requirement, the plan sponsor may determine which individual or group of individuals is in the best position to answer these questions. The final rules provide that the contact information provided in the notice must, at least, include a telephone number.

The final rules also newly require that the notice include a statement of availability of an SEP for employees and dependents who newly gain access to the HRA. This is in part in response to a commenter who suggested that the notice could be used to improve Exchange program integrity by making it easier for Exchanges that require pre-enrollment verification to use the notice to confirm enrollees' SEP eligibility. Separate from, but contemporaneously with the final rules, HHS is providing model language that will be relevant to employees purchasing coverage through or outside an Exchange, including a State Exchange, which HRAs may use to satisfy this requirement. The final rules also clarify that, to facilitate participants' timely enrollment in individual health insurance coverage using the new SEP described later in this preamble, the notice must also indicate the date as of which coverage under the HRA may first become effective and the date on which the HRA plan year begins and ends. The notice must also include information on when amounts will be made available (for example, monthly or annually).

Commenters also requested that the notice explain the extent to which individuals enrolled in Medicare may use an individual coverage HRA. In response to these comments, and to reflect the content of the final rules, the notice content requirements have been updated to reflect that individual coverage HRAs may be integrated with Medicare and to require inclusion of a statement in that notice that Medicare beneficiaries are ineligible for the PTC, without regard to whether the individual coverage HRA the individual is offered is affordable or provides MV or whether the individual accepts the HRA.

Further, the Departments note that, as under the proposed rules, while the written notice must include the information required by the final rules, it may include other information, as long as the additional content does not conflict with the required information.

b. Notice Individualization

The proposed rules did not include a requirement that the notice be

[129] *See* PHS Act section 2715(b)(3) (incorporated in Code section 9815 and ERISA section 715). *See also* 26 CFR 54.9815–2715, 29 CFR 2590.715–2715, and 45 CFR 147.200.

individualized for each participant. Although the notice would have been required to include a description of the potential availability of the PTC for a participant who opts out of and waives an unaffordable individual coverage HRA, and the individual coverage HRA amount that is relevant for determining affordability, the proposed rules did not require that the HRA include in the notice a determination of whether the HRA is considered affordable for the specific participant.

Some commenters agreed that the notice should not be required to be tailored to each participant. However, others stated that the notice would be insufficient if not individualized and requested that the final rules require that the notice provide information specific to each participant, including the premium for the relevant lowest cost silver plan, or, at a minimum, detailed instructions for where to find information on the lowest cost silver plan, while others requested that the notice include a completed affordability and MV calculation specific to each participant.

While the Departments understand the concerns about consumer confusion, under the final rules, the notice is not required to include a determination of whether the offer of an individual coverage HRA is affordable for a particular participant. Plan sponsors are not in a position to make this determination for, or provide it to, each participant because it would require information that plan sponsors do not possess (for example, the participant's household income). In addition, requiring a plan sponsor to determine the cost of the lowest cost silver plan that will apply for a specific participant to determine affordability under the PTC rules would be burdensome, and the information is available to the participant through other means. Specifically, by November 1, 2019, HHS will provide resources to assist individuals offered an individual coverage HRA and using the Federal *HealthCare.gov* platform with determining their PTC eligibility based on whether the individual coverage HRA is considered affordable, and with understanding when they must enroll in individual health insurance coverage based on their individual coverage HRA effective date, including whether they may qualify for an SEP. HHS will also begin working with State Exchanges immediately to assist with the development of resources for individuals using State Exchanges' applications for coverage. Further, although some plan sponsors will need to determine whether the offer of the individual coverage HRA is affordable for purposes of the employer shared responsibility provisions under Code section 4980H, smaller employers are not subject to Code section 4980H. Moreover, the Treasury Department and the IRS intend to issue guidance in the near term providing safe harbors or other methods intended to reduce burdens and provide more predictability regarding the application of Code section 4980H to these arrangements.[130]

The Departments acknowledge that it is critical that participants have the information that they need to determine the affordability of their individual coverage HRA under the PTC rules, and, accordingly, the final rules add a requirement that the notice include a statement about how the participant may find assistance for determining their individual coverage HRA affordability. The model language that the Departments are providing contemporaneously with the final rules includes language that can be used to satisfy this requirement.

One commenter requested that the notice be required to be tailored for each class of employees offered the individual coverage HRA, in cases in which different classes are provided different HRA amounts, rather than allowing an employer to provide one notice for several or all classes. The final rules do not adopt this suggestion because the Departments have concluded any marginal advantages would be outweighed by the additional employer burdens of creating and distributing multiple versions of the notice. However, the Departments note that the final rules do not prohibit an employer from providing more individualized notices, such as different notices for different classes of employees, if the employer so chooses.

c. Model Notice

Many commenters requested that the Departments provide a model notice or model language for certain parts of the notice, such as model language to describe the consequences of opting into or out of the individual coverage HRA and language describing the related PTC consequences. One commenter suggested that the Departments provide translations of the model notice into languages other than English.

In response to these requests, and published separately from the final rules, the Departments are providing model language contemporaneously on certain aspects of the notice that are not employer-specific, including model language describing the PTC consequences of being offered and accepting an individual coverage HRA. In addition, HHS is providing, contemporaneously, model language that relates to all Exchanges that can be used to satisfy the SEP-related notice content requirement and model language that can be used to satisfy the requirement that the notice include a statement describing how the participant may find assistance with determining affordability. While the Departments hope it will be useful, plan sponsors are not required to use the model language.

For individual coverage HRAs, including ERISA-covered plans, other disclosure requirements may require participants to be provided with a reasonable opportunity to become informed as to their rights and obligations under the individual coverage HRA.[131] Those requirements are of general applicability, and the Departments decline to adopt a special requirement, or model non-English translation, here.[132]

d. Notice Timing and Delivery

Under the proposed rules, the individual coverage HRA generally would be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. The proposed rules also provided that for participants not eligible to participate at the beginning of the plan year (or not eligible when the notice is otherwise provided to plan participants), the individual coverage HRA would be required to provide the notice no later than the date on which the participant is first eligible to participate in the HRA.

Some commenters supported the notice timing as proposed and others indicated that small employers will not be able to provide notices 90 days prior to the plan year because they do not make benefit decisions that far in

[130] *See* IRS Notice 2018–88. Further, lowest cost silver plan data will be made available by HHS for employers in all states that use the Federal *HealthCare.gov* platform to determine whether the individual coverage HRA offer is affordable for purposes of the employer shared responsibility provisions under Code section 4980H.

[131] *See, e.g.,* ERISA sections 102, 104(b), and 503 and PHS Act sections 2715 and 2719 (incorporated in Code section 9815 and ERISA section 715). *See also* 26 CFR 54.9815–2715 and 54.9815–2719; 29 CFR 2520.102–3, 2520.104b–1, 2560.503–1, 2590.715–2715, and 2590.715–2719; and 45 CFR 147.136 and 147.200.

[132] *But see* 29 CFR 2520.102–2(c) (requiring that plans where either 500 participants or at least 10 percent of all participants (or for plans with fewer than 100 participants, 25 percent of participants) are literate in the same non-English language provide those literate only in a non-English language a reasonable opportunity to become informed as to their rights and obligations under the plan).

advance. Several commenters requested that the notice delivery coincide with the annual Exchange open enrollment period, others requested it coincide with each employer's annual open enrollment period, and others requested that plan sponsors have the flexibility to provide the required notice at any time prior to the plan year, including upon initial enrollment in an individual coverage HRA. One commenter requested the notice be required to be provided within 60 days, instead of 90 days, prior to the start of the plan year. One commenter requested that the Departments apply the distribution requirements that apply for purposes of SBCs and the uniform glossary. One commenter also asked the Departments to clarify the notice timing requirement as applied to individual coverage HRAs that do not have a calendar year plan year.

The Departments considered these comments, but have determined that, with the addition of a rule for newly established employers and certain other clarifications, the final rules should adopt the notice timing requirement as proposed, because, for a calendar year plan year, it ensures that participants who are current employees will receive the notice prior to the individual market annual open enrollment period, and for employers offering an individual coverage HRA on a non-calendar year plan year, it ensures participants who are current employees will receive the notice prior to the applicable individual market SEP. The Departments also clarify that the notice timing requirement applies in the same way to an individual coverage HRA with a calendar year plan year or with a non-calendar year plan year. The notice's primary purpose is to provide necessary information to participants that Exchanges will need in order to accurately determine eligibility for APTC. With that purpose in mind, the Departments have determined that a shorter timing requirement, including one mirroring the requirement for the SBC, or a timing requirement tied to the employer's open enrollment period, would not be sufficient.

As previously noted, the proposed rules provided an exception to the 90 day notice requirement for participants who are not eligible to participate either at the beginning of the plan year or at the time the notice is provided at least 90 days prior to the plan year. For those participants, the proposed rules would allow the individual coverage HRA to provide the notice no later than the date on which the participants are first eligible to participate in the HRA. The final rules adopt this rule generally as proposed, but clarify the language to provide that the date by which the notice must be provided is the date on which the HRA may first take effect for the participant. Further, the Departments have determined that individual coverage HRAs sponsored by employers that are first established within a short period of time prior to the first plan year of the HRA may not have an adequate amount of time to provide a notice to participants at least 90 days prior to beginning of the first plan year. Therefore, the final rules provide that in the case of an individual coverage HRA sponsored by an employer that is established less than 120 days prior to the beginning of the first plan year of the HRA, the notice may be provided no later than the date on which the HRA may first take effect for the participant, for that first plan year of the HRA.

Moreover, although the final rules provide that for participants not eligible to participate in the individual coverage HRA at the beginning of the plan year (or not eligible when the notice is otherwise provided) and for participants of newly established employers, the HRA is not required to provide the notice until the date on which the HRA may first take effect for the participant, the Departments encourage HRAs to provide the notice as soon as practicable. As explained later in this preamble, individuals who newly gain access to an individual coverage HRA will have an individual market SEP that provides the chance to select an individual health insurance plan in advance of the date when the HRA may first take effect, so that individual health insurance coverage can be effective on the first date the individual is eligible to be covered by the HRA. If the notice is not provided until the day the HRA may first take effect for the participant, individuals may not be aware of the HRA offer and will not be able to enroll in individual health insurance coverage that has an effective date on the earliest effective date of their HRA coverage. However, the Departments are aware that in some circumstances it would not be reasonable to require HRAs to provide the notice well in advance of the date the HRA may first take effect for new employees. Therefore, the final rules continue to require that the notice be provided in these circumstances no later than the date on which the HRA may first take effect, but if possible, HRAs should provide the notice sooner. This will allow new employees to begin coverage in the HRA as soon as possible.

With regard to delivery methods, the proposed rules provided that the notice must be a written notice but did not further address delivery or format. Several commenters requested that the final rules clarify the notice delivery procedures and requirements, including allowing for electronic delivery (through email delivery, internet/intranet posting, or any other electronic means) if participants are provided the appropriate opportunity to opt out of electronic delivery. One commenter asked specifically if the notice delivery would be subject to ERISA's delivery rules.

Under the final rules, individual coverage HRAs that are subject to ERISA, and individual coverage HRAs sponsored by nonfederal governmental plan sponsors, must provide the notice in a manner reasonably calculated to ensure actual receipt of the material by plan participants covered by the HRA. Additionally, individual coverage HRAs that are subject to ERISA must provide the notice in a manner that complies with the DOL's rules.[133] For ERISA plans using electronic disclosure, the DOL has provided a safe harbor at 29 CFR 2520.104b–1(c). This safe harbor is not intended to represent the exclusive means by which the requirements of 29 CFR 2520.104b–1 may be satisfied using electronic media.[134] As to individual coverage HRAs sponsored by nonfederal governmental plan sponsors, HHS is revising the final rule to provide that the notice must be provided in a manner reasonably calculated to ensure actual receipt of the material by plan participants covered by the HRA, which HHS has determined is sufficient to ensure that participants receive the required notice.

Commenters also requested that the Departments confirm that the notice may be delivered along with other plan materials, including, but not limited to, annual enrollment materials or new hire benefit packages. The Departments confirm that the individual coverage HRA notice may be delivered with other plan materials, so long as it satisfies the content and timing requirements specific to the individual coverage HRA notice.

e. Other Notice Requirements and Consumer Assistance

Some commenters suggested that all types of HRAs (including excepted benefit HRAs and HRAs integrated with traditional group health plans) should include notice requirements so that individuals understand which type of arrangement they have and the consequences of the arrangement. The Departments acknowledge the potential for consumer confusion as a result of the

[133] 29 CFR 2520.104b–1.

[134] 67 FR 17263, 17264 (April 9, 2002).

existence of various types of health coverage, including various types of HRAs. However, the Departments generally decline the suggestion to impose new notice requirements under the final rules across all types of HRAs. The Departments note that this type of consumer information notice requirement is typically only imposed in situations in which there is a specific justification for it. For example, individual coverage HRAs are unique in that specific PTC rules apply, and for QSEHRAs, which also have specific PTC rules, notices are already required under the law.[135]

Further, the Departments note that the proposed rules would have required the notice to include a statement that the individual coverage HRA is not a QSEHRA, and the final rules revise the statement in response to comments to clarify further that there are multiple types of HRAs and the type the participant is being offered is an individual coverage HRA (rather than a QSEHRA or any other type).

Moreover, HRAs that are ERISA-covered plans must provide a summary plan description (SPD), summaries of material modifications, and summaries of material reductions in covered services or benefits.[136] The SPD must be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. It must also include, for example, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits, the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits and the procedures governing claims for benefits under the plan. HRAs that are ERISA-covered plans are also required to provide the instruments under which the plan is established or operated and information relevant to a participant's adverse benefit determination upon request.[137] This information should be adequate to enable individuals to understand which type of arrangement they have and the consequences of the arrangement.[138]

One commenter requested that the Departments clarify the interaction between the notice requirements associated with the Fair Labor Standards Act (FLSA) and the notice requirement for individual coverage HRAs. The Departments note that under FLSA section 18B, an applicable employer is required to provide notice to inform employees of coverage options, including the existence of an Exchange, and the availability of the PTC if the employer's plan does not provide MV. This notice is provided at the time of hiring. The FLSA section 18B requirement to provide a notice to employees of coverage options applies to employers to which the FLSA applies. An employer sponsoring an individual coverage HRA that provides the required notice under the final rules must also provide a notice that satisfies the FLSA notice requirement if the FLSA applies to the employer. However, nothing in the final rules prohibits an employer from combining the notices for employees eligible for the individual coverage HRA, provided that both notice requirements are satisfied.

Commenters also urged the Departments more generally to create tools and resources for employees and employers that are easily accessible to help determine PTC eligibility and to dedicate additional funding to the State Exchanges for increased administration and assistance to individuals trying to determine APTC eligibility. A few commenters suggested that more education for consumers, enrollment assisters, and agents and brokers would be necessary. The Departments acknowledge the crucial role that the Exchanges have in implementation and operationalization of individual coverage HRAs, and the Departments will work closely with the Exchanges on the implementation of the final rules. The Departments note that language will be added to the HealthCare.gov application to help consumers understand that if they are eligible for an individual coverage HRA, this offer may affect their APTC eligibility. As discussed elsewhere in this preamble, HHS also intends to provide technical assistance materials for consumers in HealthCare.gov states, as well as for enrollment assisters and agents and brokers participating in Exchanges that use HealthCare.gov, so they may help consumers understand the implications of their individual coverage HRA offer. The Departments are also continuing to consider other ways to provide outreach and assistance to stakeholders regarding individual coverage HRAs.

10. Student Health Insurance Coverage

Federal rules under PPACA define student health insurance coverage as a type of individual health insurance coverage.[139] Although those rules exempt student health insurance coverage from certain provisions of PPACA and HIPAA,[140] they do not exempt this coverage from PHS Act sections 2711 and 2713. Therefore, given that student health insurance coverage is a type of individual health insurance coverage, and is subject to PHS Act sections 2711 and 2713, in the preamble to the proposed rules, the Departments clarified that an HRA may be integrated with student health insurance coverage that satisfies the requirements in 45 CFR 147.145.

One commenter expressed support for allowing integration of HRAs with student health insurance coverage. Another commenter requested that integration with student health insurance coverage not be permitted due to concerns that HRA plan sponsors would be required to confirm that the student health insurance coverage complies with the market requirements. The final rules permit HRA integration with student health insurance coverage because student health insurance coverage is individual health insurance coverage that is subject to PHS Act sections 2711 and 2713. In response to concerns about the difficulty of determining the compliance of individual health insurance coverage policies with the market requirements generally for all individual health insurance coverage, under the final rules, all individual health insurance coverage is treated as compliant with PHS Act sections 2711 and 2713. Therefore, plan sponsors are not required to confirm that any particular student health insurance policy (or any other individual health insurance policy) complies with PHS Act sections 2711 and 2713.

Further, in the preamble to the proposed rules, the Departments noted that self-insured student health plans

[135] Code section 9831(d)(4) and IRS Notice 2017–67.

[136] *See* 29 CFR 2520.104b–2 and 29 CFR 2520.104b–3(a), (d)(3).

[137] *See, e.g.,* ERISA sections 104(b), 502(c), and 503. *See also* 29 CFR 2520.104b–1 and 29 CFR 2560.503–1.

[138] The final excepted benefit HRA rules specifically note the ERISA disclosure obligations, and HHS intends to propose similar disclosure requirements for non-federal governmental plan excepted benefit HRAs.

[139] Under this definition, student health insurance coverage must be provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution and their dependents, and does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution, does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in 45 CFR 146.121(a)) relating to a student (or a dependent of a student), and satisfies any additional requirements that may be imposed under state law. *See* 45 CFR 147.145(a).

[140] *See* 45 CFR 147.145(b).

are not a form of individual health insurance coverage.[141] Therefore, the proposed rules did not provide for HRA integration with self-insured student health plans. One commenter expressed concern that it may be difficult for employers to verify whether an individual with student health plan coverage has insured or self-insured coverage. The Departments appreciate the comment and recognize that employers and employees may not know whether a student health plan is insured or self-insured, but expect that employers will take reasonable steps to ensure compliance with the final rules. This includes making reasonable efforts to ensure that, when employees substantiate enrollment in student health coverage, they are correctly substantiating enrollment in a student health plan provided through insurance by a licensed issuer. If a student enrolled in an institution of higher education has questions about the type of student health coverage that is offered by the institution, this information should be available in the governing plan document or by contacting the plan administrator for the student health plan.

The Departments also confirmed in the preamble to the proposed rules that prior guidance,[142] which provided enforcement relief to institutions of higher education for certain healthcare premium reduction arrangements offered to student employees in connection with insured or self-insured student health coverage (student premium reduction arrangements) remains in effect, pending any further guidance. One commenter expressed support for keeping the current enforcement relief in effect.

The Departments reiterate that the previously provided enforcement relief remains in effect for institutions of higher education, pending any future guidance, and the final rules clarify that a student employee who is offered a student premium reduction arrangement is not considered part of the class of employees of which the employee would otherwise be a part for purposes of the final integration rules. This provision applies only for plan sponsors that are institutions of higher education. For this purpose, a student premium reduction arrangement is defined as any program offered by an institution of higher education where the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement.[143] Therefore, the offer of that type of arrangement to student employees will not affect the compliance of an individual coverage HRA that the institution of higher education may offer to other employees. The final rules also clarify that a student employee offered a student premium reduction arrangement is not counted for purposes of determining whether the minimum class size requirement is satisfied. The text of the final rules includes examples.

However, if a student employee is not offered a student premium reduction arrangement (including if, instead, the student employee is offered an individual coverage HRA), the student employee is considered to be part of the class of employees to which he or she otherwise belongs, and the student employee is counted in determining whether the minimum class size requirement is satisfied. Further, if an individual coverage HRA is offered to student employees, the final integration rules apply to such an arrangement as they would any other individual coverage HRA.

11. Integration With Certain Other Types of Coverage

a. Short-Term, Limited-Duration Insurance

The Departments considered whether to propose a rule to permit individual coverage HRAs to be integrated with types of non-group coverage other than individual health insurance coverage, such as STLDI.[144] The Departments declined to do so in the proposed rules because STLDI is not subject to PHS Act sections 2711 and 2713 and, therefore, might not be compliant with these market requirements. However, the Departments requested comments on whether integration with STLDI should be permitted and, if so, what potential advantages and problems might arise.

Most commenters strongly opposed allowing integration with STLDI, expressing concerns that it would cause significant adverse selection in the individual market, which would lead to increased premiums and increased federal spending (through increased PTCs). Some of these commenters asserted that prohibiting integration with STLDI is necessary to ensure the integrity and sustainability of the individual market and that to allow integration with STLDI would run counter to, and negate, the various other provisions in the proposed rules intended to prevent adverse selection. Some commenters expressed concern that STLDI provides insufficient coverage and consumer protections, that individuals would unknowingly enroll, and that brokers would have incentives to encourage STLDI enrollment. Some commenters raised legal concerns with allowing integration of HRAs with STLDI, noting that STLDI is not subject to, or generally compliant with, PHS Act sections 2711 and 2713 and, therefore, would not be sufficient to ensure that an individual with an HRA integrated with STLDI had coverage that was compliant with these market requirements. One commenter asserted that an HRA integrated with STLDI would fail to comply with the health nondiscrimination rules under HIPAA because STLDI is allowed to discriminate based on health status.

A few commenters supported allowing integration of an individual coverage HRA with STLDI, noting that STLDI is an option that could provide relief to individuals unable to afford individual health insurance coverage and, for some lower-income individuals, such as those in states that did not expand Medicaid under PPACA, may be the only affordable alternative. One commenter supported integration with STLDI as long as additional guardrails were established and another requested additional notice requirements if integration of individual coverage HRAs were to be permitted with STLDI.

The Departments note that STLDI can be a useful option for certain individuals otherwise unable to afford or obtain PPACA-compliant health insurance. The final rules, however, do not allow integration with STLDI because of the concerns raised by commenters, including that the combined arrangement would not necessarily satisfy PHS Act sections 2711 and 2713 and that adverse selection could result. The Departments note that the new excepted benefit HRA finalized elsewhere in the final rules, which is not subject to PHS Act sections 2711 and 2713, generally may be used to reimburse premiums for STLDI. See later in this preamble for a discussion of the excepted benefit HRA, including a discussion of the limited circumstance in which an excepted benefit HRA may not be used to reimburse STLDI premiums.

[141] *See* 77 FR 16453, 16455 (March 21, 2012).

[142] *See* FAQs About Affordable Care Act Implementation Part 33, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-33.pdf* or *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Set-33-Final.pdf. See also* IRS Notice 2016–17; DOL Technical Release 2016–1; and CMS Insurance Standards Bulletin, Application of the Market Reforms and Other Provisions of the Affordable Care Act to Student Health Coverage, February 5, 2016.

[143] *Id.*

[144] See 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103 for the definition of STLDI.

b. Spousal Coverage

In developing the proposed rules, the Departments considered whether to allow individual coverage HRAs to be integrated with group health plan coverage, such as a group health plan maintained by the employer of the participant's spouse, in addition to individual health insurance coverage. Like individual health insurance coverage, group health plan coverage generally is subject to and compliant with PHS Act sections 2711 and 2713. The Departments indicated they did not propose such a rule because to do so would add significant complexity to the individual health insurance coverage integration test.[145] However, the Departments requested comments, including on the demand for such a rule, and any problems such a rule may raise.

Several commenters requested that integration with spousal coverage be permitted under the individual health insurance coverage integration test, with one stating that most group coverage is likely to cover all EHBs and therefore the issue of an HRA that covers all EHBs being integrated with coverage that does not cover all EHBs is unlikely to arise. One commenter suggested that the Departments allow an employee to be covered by a group health plan and also have access to an HRA that can be used to purchase individual health insurance coverage for a spouse. Other commenters requested that integration of an individual coverage HRA with spousal coverage be prohibited, expressing skepticism that employers would take advantage of this option and noting that the arrangement would add little value. In light of the Departments' continued concern with the added complexity that would be required and the response from commenters, the final rules do not allow an individual coverage HRA to also be integrated with other group health plan coverage, such as spousal coverage. This is an area that the Departments may explore in future rulemaking. The Departments reiterate that the current rules under PHS Act section 2711 allow HRAs to be integrated with other non-HRA group health plan coverage, including spousal coverage, subject to certain conditions.[146] However, amounts made available under such an HRA may not be used to purchase individual health insurance coverage.[147]

Commenters also requested clarification as to whether two spouses, each offered an individual coverage HRA from their respective employers, may use the separate individual coverage HRAs to buy a single individual health insurance policy that covers both spouses (and any dependents). Nothing in the final rules would prohibit this, if the separate individual coverage HRAs are each in compliance with the final rules. However, under the generally applicable rules for HRAs under the Code, each individual may only seek reimbursement for the portion of a medical care expense that has not already been reimbursed by some other means, including from one of the individual coverage HRAs.

c. Health Care Sharing Ministries

Several commenters requested that integration of HRAs with health care sharing ministries be permitted, in part to provide an alternative option that alleviates conscience issues faced by employers and employees with respect to individual health insurance coverage, and in part due to the success of health care sharing ministries in providing affordable, flexible choices.

The Departments are of the view that HRAs cannot be integrated with health care sharing ministries, consistent with PHS Act sections 2711 and 2713. Under current law, health care sharing ministries are not subject to those provisions, nor are they required to comply with other market requirements that apply to individual health insurance coverage. Health care sharing ministry arrangements are also not MEC.[148] Therefore, the integration of an individual coverage HRA with these arrangements would not result in a combined arrangement sufficient to satisfy PHS Act sections 2711 and 2713, which means that such a combined arrangement would not provide the protections afforded by those provisions.

One commenter asserted that the proposed rules would impermissibly burden the exercise of religion for purposes of the Religious Freedom Restoration Act of 1993 (RFRA)[149] because they would not allow individual coverage HRAs to be integrated with health care sharing ministries and thus would make participation in health care sharing ministries more expensive relative to individual coverage HRAs. Specifically, the commenter asserted that the proposed rules would impermissibly burden the free exercise of religion because, by not allowing HRAs to be integrated with health care sharing ministries, the rules would extend certain tax advantages to individual coverage HRAs that are not extended to participants in health care sharing ministries. However, although the RFRA provides a claim to persons whose religious exercise is substantially burdened by government, the Supreme Court has held that ''a generally applicable tax [that] merely decreases the amount of money [an individual or entity] has to spend on its religious activities'' does not impose a substantial burden on the exercise of religion.[150] Consequently, the final rules do not allow individual coverage HRAs to be integrated with health care sharing ministries.

d. Multiple Employer Welfare Arrangements (Including Association Health Plans)

One commenter requested that integration of HRAs be permitted with association health plans (AHPs)[151] and another commenter opposed allowing integration with AHPs, because coverage offered by an AHP is not required to cover all EHBs, to the extent

[145] PHS Act section 2711 applies with respect to the coverage of EHBs. Because large group market and self-insured group health plans are not required to cover EHBs, unlike individual health insurance coverage which generally is required to cover all EHBs, in the group health plan integration context, situations may arise where non-HRA group coverage with which the HRA is integrated does not cover every category of EHBs that the HRA covers. In that case, the HRA applies an annual dollar limit to a category of EHBs and the non-HRA group coverage with which it is integrated does not cure that limit by providing unlimited coverage of that category of EHBs. In the 2015 rules under PHS Act section 2711, and in subregulatory guidance that preceded the 2015 rules, the Departments addressed this issue by providing two tests. Specifically, if the non-HRA group coverage with which an HRA is integrated provides MV, the HRA will not be considered to fail to comply with PHS Act section 2711, even though the HRA might provide reimbursement of an EHB that the plan with which the HRA is integrated does not. If an HRA is integrated with non-HRA group coverage that does not provide MV, the 2015 rules limit the types of expenses that an HRA may reimburse to reimbursement of co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute an EHB. For additional discussion of the current rules under PHS Act section 2711, see the discussion earlier in this preamble.

[146] 26 CFR 54.9815–2711(d)(2), 29 CFR 2590.715–2711(d)(2), and 45 CFR 147.126(d)(2).

[147] IRS Notice 2015–87, Q&A–2.

[148] *See* Code section 5000A(d)(2)(B) and 5000A(f).

[149] 42 U.S.C. 2000bb(b).

[150] *Jimmy Swaggart Ministries* v. *Bd. of Equalization of California,* 493 U.S. 378, 391 (1990).

[151] On June 21, 2018, DOL published a final rule establishing a new test as an alternative to that described in prior DOL sub-regulatory guidance for determining who can sponsor an ERISA-covered AHP as an ''employer.'' *See* 83 FR 28912 (June 21, 2018). The AHP rule was intended to expand access to affordable, high-quality healthcare options, particularly for employees of small employers and some self-employed individuals. On March 28, 2019, in *State of New York* v. *United States Department of Labor,* the United States District Court for the District of Columbia vacated most of the DOL rule. On April 26, 2019, the Department of Justice filed a notice of appeal.

the coverage is offered through a large group market or self-insured group health plan. AHPs are a type of Multiple Employer Welfare Arrangement (MEWA) that are group health plans. The Departments current, final regulations at 26 CFR 54.9815–2711(d)(2), 29 CFR 2590.715–2711(d)(2), and 45 CFR 147.126(d)(2) set forth criteria for HRAs to be integrated with other group health plan coverage (including MEWAs).

e. TRICARE

The Departments note that, under the final rules, individual coverage HRAs may not be integrated with TRICARE.[152] However, for the sake of clarity, the Departments note that nothing in the final rules prevents an employer from offering an individual coverage HRA to an individual covered by TRICARE, subject to the provisions of the final rules, including that if an individual coverage HRA is offered to an employee in a class of employees, the HRA must generally be offered on the same terms to all the employees in the class. Further, nothing in the final rules prevents an individual covered by TRICARE from enrolling in an individual coverage HRA, if offered, subject to the conditions in the final rules, including that all individuals covered by an individual coverage HRA must be enrolled in either individual health insurance coverage or Medicare.[153] Consequently, an individual covered by TRICARE who is offered an individual coverage HRA will be enrolled in TRICARE and must also be enrolled in an individual health insurance policy (or Medicare, if applicable) in order to be enrolled in the individual coverage HRA. The individual may not enroll in the individual coverage HRA and only TRICARE without enrolling in an individual health insurance policy (or Medicare). Further, as explained later in this preamble, HRAs may reimburse medical care expenses and the HRA plan sponsor determines which medical care expenses a particular HRA may reimburse, consistent with the discussion later in this preamble. It may be the case that an HRA will be available to pay both the premiums and cost-sharing for individual health insurance coverage as well as any medical care expenses related to TRICARE, subject to the terms of the HRA.

12. Expenses Eligible for Reimbursement by an Individual Coverage HRA

A number of commenters requested clarification of the expenses that may be reimbursed under an individual coverage HRA, such as whether expenses for premiums for excepted benefit coverage, cost sharing under excepted benefit coverage, and cost sharing under individual health insurance coverage may be reimbursed. One commenter recommended that the final rules require individual coverage HRAs to provide reimbursement for cost sharing in addition to premiums, and another asked for clarification that an individual coverage HRA is not required to be used to reimburse premiums for individual health insurance coverage, so long as the individual coverage HRA otherwise satisfies the requirements under the final rules.

An HRA may provide for reimbursement of expenses for medical care, as defined under Code section 213(d). Consistent with the current rules that apply to HRAs generally, under the final rules, a plan sponsor has discretion to specify which medical care expenses are eligible for reimbursement from an individual coverage HRA it establishes. A plan sponsor may allow an HRA to reimburse all medical care expenses, may limit an HRA to allow reimbursements only for premiums, may limit an HRA to allow reimbursements only for non-premium medical care expenses (such as cost sharing), or may decide which particular medical care expenses will be reimbursable and which will not be reimbursable. However, in the latter case, the designation of the reimbursable expenses must not violate other rules applicable to group health plans, such as the HIPAA nondiscrimination rules or the MSP provisions. The final rules do not require that an individual coverage HRA be used (or be allowed to be used) for reimbursement of premiums for individual health insurance coverage (or Medicare). However, as detailed earlier in this preamble, the final rules require that individuals covered by an individual coverage HRA be enrolled in individual health insurance coverage (or Medicare). Thus, the Departments generally anticipate that employers will allow individual coverage HRAs to reimburse premiums for such coverage.

Some commenters requested that the Departments confirm that certain excepted benefits, including standalone dental coverage, hospital indemnity or other fixed indemnity coverage, and coverage for a specific disease or illness, provide medical care within the meaning of Code section 213(d) and, therefore, that expenses for these types of coverage are reimbursable by an individual coverage HRA. Some commenters requested that expenses paid with regard to direct primary care arrangements be recognized as expenses for medical care under Code section 213(d). In addition, one commenter requested clarification of whether payments for participation in health care sharing ministries qualify as medical care expenses under Code section 213(d).

An HRA, including an individual coverage HRA, generally may reimburse expenses for medical care, as defined under Code section 213(d), of an employee and certain members of the employee's family. Under Code section 213(d), medical care expenses generally include amounts paid (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure of function of the body; (2) for transportation primarily for and essential to medical care; (3) for certain qualified long-term care services; and (4) for insurance covering medical care. Neither the proposed rules nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however, appreciate the comments and plan to address some of these issues in future rulemaking or guidance.

13. Interaction of Individual Coverage HRAs and HSAs

Commenters raised various issues related to the interaction between individual coverage HRAs and HSAs. Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, added section 223 to the Code to allow eligible individuals to establish HSAs. Among the requirements for an individual to qualify as an eligible individual under Code section 223(c)(1) is that the individual must be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. If an individual fails to satisfy the requirements to be an eligible individual, contributions to an HSA are disallowed.

Several commenters asked that the Treasury Department and the IRS clarify

[152] *See* chapter 55 of title 10, United States Code.

[153] IRS Notice 2015–17, Q&A–3, provides that an arrangement under which an employer reimburses certain medical care expenses for employees covered by TRICARE may be considered integrated with a traditional group health plan offered by the employer (even though the employee is not enrolled in the traditional group health plan), subject to certain conditions. The final rules do not affect this guidance provided under Notice 2015–17.

whether an individual covered by an individual coverage HRA may contribute to an HSA. Some commenters specifically asked the Treasury Department and the IRS to address the application of prior guidance under the Code, which provides that certain types of HRAs do not render an individual ineligible to contribute to an HSA. Several commenters expressed support for HSAs and emphasized the importance of allowing individuals who have individual coverage HRAs to contribute to HSAs.

In Revenue Ruling 2004–45,[154] the Treasury Department and the IRS clarified that an otherwise eligible individual (that is, an individual with coverage under an HDHP and no other disqualifying coverage) remains an eligible individual for purposes of making contributions to an HSA for periods during which the individual is covered by, among other things, a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements.[155] Subsequently, Q&A–1 of IRS Notice 2008–59 [156] stated that a limited-purpose HRA that is also available to pay premiums for health coverage does not disqualify an otherwise eligible individual from contributing to an HSA, provided the individual does not use the HRA to, or otherwise, obtain coverage that is not HSA-compatible. This prior guidance applies to all HRAs, including individual coverage HRAs. Therefore, for example, an individual coverage HRA that solely makes available reimbursements of individual health insurance coverage premiums does not disqualify an otherwise eligible individual covered under an HDHP and no other disqualifying coverage from making contributions to an HSA. However, an individual coverage HRA that is not limited in accordance with the relevant guidance under the Code would not be HSA-compatible (for example, an HRA that can reimburse first dollar cost sharing).

One commenter asked whether employers are allowed, or required, to offer both an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible to a class of employees. The Departments recognize that some employees offered an individual coverage HRA may choose individual health insurance coverage that is an HDHP and other employees may choose non-HDHP individual health insurance coverage that is not HSA compatible. While some employers may offer all employees in a class of employees an HSA-compatible individual coverage HRA, some employers may want to offer employees in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible. In response to this comment, the final rules clarify that an employer that offers employees in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible does not fail to satisfy the same terms requirement provided both types of individual coverage HRAs are offered to all employees in the class on the same terms.[157] The final rules have been revised to reflect this rule.

With respect to the post-deductible feature of certain HSA-compatible HRAs, one commenter suggested that the final rules provide that employees may self-administer the post-deductible restriction by tracking medical expenses incurred during the year and refraining from submitting medical expenses to the post-deductible HRA until the minimum deductible is satisfied. The Treasury Department and the IRS decline to adopt this approach because it would be inconsistent with the rules for the administration of HDHPs.[158] If a plan sponsor chooses to offer an HSA-compatible individual coverage HRA that reimburses medical care expenses after the minimum deductible under Code section 223(c)(2)(A)(i) is satisfied, it is the employer's responsibility to track medical care expenses incurred during the year and ensure that the individual coverage HRA does not reimburse medical care expenses (other than premiums or expenses allowed as limited purpose) incurred prior to the satisfaction of the minimum deductible.[159]

The commenter further requested clarification as to whether unused amounts in an individual coverage HRA at the end of the plan year may be transferred to the employee's HSA. The Treasury Department and the IRS note that amounts available under an HRA, whether an individual coverage HRA or another type of HRA, may not be funded by salary reduction amounts. Moreover, the amounts are available only to reimburse Code section 213(d) medical care expenses and may not be cashed out.[160] However, amounts in an HSA may be withdrawn for non-medical purposes, subject to inclusion in income and an additional tax.[161] In addition, Congress previously provided for one-time distributions from HRAs to HSAs, in certain circumstances, subject to the annual HSA contribution limits, but this special rule was only made available on a temporary basis, and the rule sunset at the end of 2011.[162] Therefore, allowing unused amounts in an individual coverage HRA to be transferred to an HSA would be inconsistent with the relevant provisions of the Code and is not permitted.

Finally, some commenters requested that direct primary care arrangements not be treated as a health plan or coverage under Code section 223, so that an individual may have a direct primary care arrangement without becoming ineligible for HSA contributions. Similar to the discussion of Code section 213 in the preceding section of this preamble, neither the proposed rules nor the final rules make any changes to the rules under Code section 223. Thus, any issues arising under Code section 223, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking.

[154] Revenue Ruling 2004–45, 2004–1 IRB 971.

[155] *See* Revenue Ruling 2004–45, which defines a limited-purpose HRA as an HRA that pays or reimburses benefits for ''permitted insurance'' (for a specific disease or illness or that provides a fixed amount per day (or other period) of hospitalization) or ''permitted coverage'' (for example, vision or dental coverage), but not for long-term care services. In addition, the limited-purpose HRA may pay or reimburse preventive care benefits. The ruling also defines a post-deductible HRA as an HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied.

[156] IRS Notice 2008–59, 2008–29 IRB 123.

[157] The Departments note that under the opt out requirement, described later in this preamble, each participant must be given the chance to opt out of (or into) an individual coverage HRA once, and only once, with respect to a plan year and to the extent a participant is offered a choice between an HSA-compatible HRA and a non-HSA-compatible HRA, the participant will opt into either one or the other, for the plan year (or for the portion of the plan year during which the participant is covered by the HRA). (Note that participants are also generally given the chance to waive the HRA upon termination of employment).

[158] *See* Revenue Ruling 2004–45.

[159] Another commenter inquired about the interaction of individual coverage HRAs and HSAs and the rules for cafeteria plans under Code section 125. These issues are outside the scope of this rulemaking, and the Treasury Department and the IRS are continuing to consider whether future guidance is needed.

[160] *See* IRS Notice 2002–45.

[161] *See* Code section 223(f). Notwithstanding that HSA amounts may be withdrawn for non-medical purposes, subject to inclusion in income and additional tax, Code section 106(d) provides that in the case of amounts contributed by an employer to the HSA of an eligible individual, those amounts are treated as employer-provided coverage for medical care expenses under an accident or health plan to the extent the amounts do not exceed the annual limits on contributions to an HSA.

[162] *See* Code section 106(e).

14. Interaction of Individual Coverage HRAs and Medicare

Commenters raised various issues related to the interaction between individual coverage HRAs and Medicare. The comments focused on the interaction with the Medicare anti-duplication provision under SSA section 1882(d)(3)(A)(i)(I) and the MSP provisions under SSA section 1862(b). In response to these comments, the final rules have been revised to provide that an individual coverage HRA may be integrated with either individual health insurance coverage or Medicare Part A and B or Part C. Also, the Departments clarify that an individual coverage HRA may be used to reimburse premiums for Medicare and Medicare supplemental health insurance (Medigap), as well as other medical care expenses, as discussed in more detail in this section of the preamble.

a. Background

Comments regarding the interaction between individual coverage HRAs and Medicare addressed a number of federal laws and rules governing the relationship between group health plans and the Medicare program. This section of the preamble briefly summarizes these laws to provide context for comments received on the proposed rules and the provisions of the final rules related to integration of an individual coverage HRA with Medicare.

Under SSA section 1882(d)(3)(A)(i)(I), it is unlawful for any person to issue or sell to an individual entitled to benefits under Medicare Part A or enrolled in Medicare Part B (including an individual electing a Medicare Part C plan) an individual health insurance policy with the knowledge that the policy duplicates [163] health benefits to which the individual is otherwise entitled under Medicare or Medicaid.[164] Persons who violate SSA section 1882(d)(3)(A)(i)(I) are subject to criminal fines and imprisonment, as well as civil monetary penalties.[165]

The MSP provisions in SSA section 1862(b) make Medicare the secondary payer to certain other health plans and coverage, including group health plans. These provisions protect the Medicare trust funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. In general, the MSP provisions describe when Medicare is secondary in relation to other health plans or coverage and prohibit Medicare from making payment for an item or service if payment has been made, or can reasonably be expected to be made, by a primary plan when certain conditions are satisfied.[166]

SSA section 1862(b) and 42 CFR 411.20 *et seq.* provide, in part, that Medicare is the secondary payer, under specified conditions, for services covered under any of the following:

- Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status [167] with an employer or the current employment status of a spouse of any age.[168]
- Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in 42 CFR 411.163, group health plans are always primary payers throughout the first 30 months of ESRD-based Medicare eligibility or entitlement.[169]
- Large group health plans, as defined by Code section 5000(b)(2) without regard to Code section 5000(d) (that is, plans of employers that employ at least 100 employees), that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer.[170]

Generally, under SSA section 1862(b)(1)(A), (B), and (C), a group health plan may not take into account that individuals are entitled to Medicare on the basis of age or disability, or that individuals are eligible for or entitled to Medicare on the basis of ESRD, in the design or offering of the plan. The provisions at SSA section 1862(b)(1)(A), (B), and (C) (including subsections (b)(1)(A)(i)(II) and (b)(1)(C)(ii)) are collectively referred to as the Medicare nondiscrimination provisions. Examples of actions that constitute taking into account Medicare entitlement are listed in 42 CFR 411.108.

SSA section 1862(b)(1)(A)(i)(II) and (ii) provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that the plan provides to those individuals under age 65 (equal benefit rule). For example, a group health plan of an employer with 20 or more employees may not provide lesser benefits to individuals age 65 or over, or charge higher premiums for individuals age 65 or over, because these actions would take into account employees' entitlement to Medicare on the basis of age and would provide different benefits based on whether an employee is under or over age 65. This requirement applies regardless of whether the individual or spouse age 65 or older is entitled to Medicare.

SSA section 1862(b)(1)(C)(ii) provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute ''differentiating'' are listed in 42 CFR 411.161(b).

SSA section 1862(b)(3)(C) and 42 CFR 411.103 provide that it is unlawful for an employer or other entity (for example, an issuer) to offer any financial or other benefits as incentives for an individual entitled to Medicare not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. For example, employers may not offer benefits to Medicare beneficiaries that are available only as alternatives to the employer's primary group health plan (for example, prescription drug benefits) unless the beneficiary has primary coverage other than Medicare (for example, primary plan coverage through his or her spouse's employer).

b. Integration of Individual Coverage HRAs With Medicare

Several commenters requested clarification generally about how employees who are enrolled in Medicare may use amounts in an individual coverage HRA. Some commenters explained that because of the Medicare anti-duplication provision applicable to individual health insurance coverage, employees who are Medicare beneficiaries may not be able to purchase individual health insurance

[163] If benefits under an individual health insurance policy are payable without regard to other health benefit coverage of such individual, the policy is not considered to ''duplicate'' any health benefits to which the individual is otherwise entitled under Medicare or Medicaid, and therefore, the statutory prohibition on the sale of such coverage does not apply. *See* SSA section 1882(d)(3)(A)(iv).

[164] Group health plans, including HRAs, are generally exempt from this Medicare anti-duplication provision. *See* SSA section 1882(d)(3)(C).

[165] SSA section 1882(d)(3)(A)(ii).

[166] *See* CMS Publication #100–05, Medicare Secondary Payer Manual, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS019017.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.*

[167] An individual has current employment status if the individual is actively working as an employee or is otherwise described in 42 CFR 411.104.

[168] SSA section 1862(b)(1)(A), 42 CFR 411.20(a)(1)(ii), and 42 CFR 411.100(a)(1)(i).

[169] SSA section 1862(b)(1)(C).

[170] SSA section 1862(b)(1)(B).

coverage and, therefore, would be unable to enroll in an individual coverage HRA. One commenter suggested that issuers should have to make their individual health insurance policies available to employees eligible for or enrolled in Medicare, if they are offered an individual coverage HRA.

Some commenters sought clarification about the relationship between the Medicare anti-duplication provision and the Medicare nondiscrimination provisions as they relate to individual coverage HRAs. Specifically, some commenters asked HHS to clarify that the inability of employees who are Medicare beneficiaries to obtain individual health insurance coverage due to the Medicare anti-duplication provision will not cause the individual coverage HRA or its plan sponsor to violate rules prohibiting discrimination based on Medicare status, age, disability, or other factors. One commenter suggested that employers that otherwise comply with the proposed rules should not be precluded from offering an individual coverage HRA because a class of employees includes a Medicare beneficiary who cannot obtain individual health insurance coverage. Another commenter asked whether employers would be required to offer Medicare-eligible employees the same HRA contribution as non-Medicare-eligible employees in the same class even though Medicare beneficiaries may not be able to purchase individual health insurance coverage.

In response to these comments, HHS notes that there is no exception to the Medicare anti-duplication provision under SSA section 1882(d)(3)(A)(i)(I) for individual health insurance coverage purchased with an HRA. Therefore, neither the proposed rules nor the final rules make any changes related to the application of the Medicare anti-duplication provision. Thus, the statutory prohibition against selling an individual health insurance policy to a Medicare beneficiary with knowledge that the policy duplicates benefits under Medicare continues to apply, regardless of whether the individual is offered an individual coverage HRA. However, the Departments have considered commenters' concerns about individual coverage HRAs and the potential effects of the Medicare anti-duplication provision, as well as those related to the interaction of the MSP provisions, and have determined that revisions to the final rules are warranted.

HHS recognizes that, for an individual coverage HRA, it is necessary to address how the Medicare anti-duplication provision interacts with the rules under SSA section 1862(b)(1) that generally provide that group health plans may not take into account entitlement to Medicare and must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that the group health plan provides to individuals under age 65. If an employer offers an individual coverage HRA, some employees who are Medicare beneficiaries may not be able to obtain individual health insurance coverage due to the anti-duplication provision at SSA section 1882(d)(3)(A)(i)(I). This might cause such employees to be unable to enroll in the individual coverage HRA, effectively treating them differently in violation of the SSA's equal benefit rule.

To address these comments, the final rules permit an individual coverage HRA to be integrated with either individual health insurance coverage or Medicare for a participant or dependent who is enrolled in Medicare Part A and B or Part C (and the HRA will be deemed to comply with PHS Act sections 2711 and 2713), if certain conditions are satisfied. Under the final rules, an individual coverage HRA may be integrated with Medicare regardless of whether the HRA is subject to the MSP provisions, because the Medicare anti-duplication provision applies without regard to whether the HRA plan sponsor is subject to the MSP provisions.[171]

The Departments are adopting this approach due to the challenges presented by the intersection of the requirements that apply to individual coverage HRAs, the MSP requirements applicable to group health plans, and the Medicare anti-duplication provision applicable to individual health insurance coverage. The Departments have determined that it is appropriate to permit an individual coverage HRA to integrate with Medicare coverage, and therefore, be considered compliant with PHS Act sections 2711 and 2713, because individuals enrolled in Medicare Part A and B or Part C have the comprehensive benefit packages established by Congress, generally with no annual dollar limits and with coverage of preventive services without cost sharing.[172] An individual coverage HRA that helps pay premiums for, or supplements, the Medicare benefit package established by Congress will not be considered by the Departments to fail to satisfy PHS Act sections 2711 and 2713. Further, the Departments determined in the 2015 rules under PHS Act 2711 that allowing Medicare Part B and D reimbursement arrangements to be integrated with Medicare was sufficient to constitute compliance with PHS Act sections 2711 and 2713 in the circumstances described in that guidance, as discussed earlier in this preamble.

The final integration rules generally apply in the same manner to Medicare coverage as they apply to individual health insurance coverage. Thus, under the final rules, an individual coverage HRA must require individuals whose medical care expenses may be reimbursed under the HRA to be enrolled in either individual health insurance coverage or Medicare Part A and B or Part C for each month such individuals are covered by the HRA. The individual coverage HRA also must implement, and comply with, reasonable procedures to substantiate enrollment in either individual health insurance coverage or Medicare Part A and B or Part C for the HRA plan year (or for the portion of the plan year the individual is covered by the individual coverage HRA) and with each new request for reimbursement of an incurred medical care expense. The Departments clarify that the final rules do not require that a participant and his or her dependents all have the same type of coverage (that is, either individual health insurance coverage or Medicare). Therefore, an individual coverage HRA may be integrated with Medicare for some individuals in a family or household and with individual health insurance coverage for others in the same family or household.

In addition, under the final rules, an individual coverage HRA must be offered on the same terms to all employees within a class of employees, regardless of Medicare eligibility or entitlement, including that the individual coverage HRA must make the same amount available to all employees in the class, subject to the exceptions provided in the final rules under the same terms requirement.[173] Moreover,

[171] For group health plans not subject to the MSP provisions, the existing integration rules permit integration with Medicare Part B and D if certain conditions are satisfied, including that the employer offer traditional group health plan coverage to its non-Medicare employees. *See* 26 CFR 54.9815–2711(d)(5), 29 CFR 2590.715–2711(d)(5), and 45 CFR 147.126(d)(5).

[172] *See, e.g.,* SSA sections 1861 and 1833, as added by PPACA sections 4103 and 4104.

[173] The Departments note that although there is an exception to the same terms requirement that allows a plan sponsor to offer both an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, Code section 223(b)(7) provides that an individual ceases to be an eligible individual for HSA purposes starting with the month he or she is entitled to benefits under Medicare. IRS Notice 2004–50, 2004–33 IRB 196, Q&A–2, clarifies that

Continued

no employee may be offered a choice between an individual coverage HRA and a traditional group health plan, including an employee enrolled in or eligible for Medicare. The individual coverage HRA must also allow participants, whether or not covered by Medicare, to opt-out of and waive future reimbursements from the individual coverage HRA annually and upon termination of employment. Finally, the individual coverage HRA must provide the notice required by the final rules to all individuals eligible for the HRA, including those for whom the HRA would be integrated with Medicare. Relatedly, in the final rules, the Departments clarify the notice content requirements to reflect that an individual coverage HRA may be integrated with Medicare and to include a statement regarding PTC eligibility for Medicare beneficiaries.[174] The final rules also clarify that some of the notice content elements relate only to individual health insurance coverage and not to Medicare.

c. Reimbursement of Expenses Under Individual Coverage HRAs for Medicare Beneficiaries

One commenter requested clarification that offering an individual coverage HRA to Medicare-eligible employees will not be considered an improper financial incentive for those individuals to select Medicare as their primary payer. The commenter also suggested that employees be able to use amounts in an individual coverage HRA to pay for medical care expenses not covered by Medicare, such as dental, vision, and other out-of-pocket expenses, including Medicare Part D premiums, as well as premiums for Medigap, without it being viewed as offering an improper incentive.

For group health plans subject to the MSP provisions, offering an HRA to reimburse Medicare premiums is impermissible if it provides a financial incentive for Medicare beneficiaries to decline enrollment in the employer's group health plan and make Medicare the primary payer. Under the final rules, the employer would not be offering Medicare beneficiaries a financial incentive as an inducement to decline group health plan coverage. Rather, the individual coverage HRA would be the group health plan coverage offered to a class of employees that includes Medicare beneficiaries. Under these circumstances, unless the employer could offer an individual coverage HRA that may be integrated with Medicare, the employer would risk running afoul of the equal benefit rule under SSA section 1862(b)(1)(A)(i). This is because employees who are Medicare beneficiaries who are unable to purchase individual health insurance coverage would be ineligible for the employer's group health plan (that is, the individual coverage HRA) as a result of the Medicare anti-duplication provision.

HHS recognizes that in other circumstances, offering an HRA to reimburse Medicare premiums might be viewed as impermissible because it would have the effect of making Medicare the primary payer in relation to a group health plan.[175] Nevertheless, for purposes of the final rules, HHS has concluded that employers need the flexibility to offer individual coverage HRAs that may be integrated with Medicare, and that may provide for reimbursement of Medicare premiums. This flexibility does not violate the prohibition against financial incentives under SSA section 1862(b)(3)(C). Where a group health plan is an individual coverage HRA that can be used to pay Medicare premiums or other medical care expenses,[176] there is no incentive for a Medicare beneficiary to decline or terminate enrollment under the group health plan (that is, the individual coverage HRA). Thus, there is no violation of the SSA's financial incentive prohibition.

Therefore, under the final rules, an individual coverage HRA that is integrated with Medicare may reimburse premiums for Medicare Part A, B, C, or D, as well as premiums for Medigap policies. The individual coverage HRA may also reimburse other medical care expenses as defined under Code section 213(d) (subject to the exception discussed later in this section of the preamble regarding taking Medicare entitlement into account). Thus, an individual coverage HRA will not be considered to provide unequal benefits to participants who are eligible for Medicare because those participants will be able to receive the same benefits under the HRA regardless of whether they are able to purchase individual health insurance coverage.[177] However, as explained earlier in this preamble, the plan sponsor generally has discretion to specify which medical care expenses (premiums, cost sharing, or otherwise) are eligible for reimbursement under the terms of an individual coverage HRA, as long as the HRA offers the same benefits, on the same terms and conditions, to a class of employees, subject to the exceptions under the same terms requirement in the final rules. In addition, as discussed earlier in this preamble, the designation of the reimbursable expenses must not violate other rules applicable to group health plans, such as the HIPAA nondiscrimination rules or the MSP provisions.

To ensure that an individual coverage HRA that is subject to the MSP provisions does not violate those rules, an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare, as HHS has determined this could amount to a group health plan taking into account entitlement to Medicare in violation of the MSP provisions. However, an individual coverage HRA may limit reimbursement to only premiums or non-premium medical care expenses (such as cost sharing), or may decide which particular medical care expenses will be reimbursable and which will not be reimbursable under the terms of the HRA.

d. Other Medicare Issues

Some commenters sought assurance that a health insurance issuer providing individual health insurance coverage purchased with an individual coverage HRA would not be required to comply with MSP reporting requirements or pay for benefits primary to Medicare where MSP provisions might apply to the

mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, the term ''entitled to benefits under Medicare,'' for purposes of an HSA, means both eligibility for, and enrollment in, Medicare.

[174] Although individuals enrolled in Medicare may not be able to purchase individual health insurance coverage for themselves through the Exchange, individuals who do so are not eligible for the PTC for their Exchange coverage in any event. *See* Code section 36B(c)(2)(B) and 26 CFR 1.36B–2(a)(2).

[175] Under IRS Notice 2015–17, an arrangement under which an employer reimburses (or pays directly) Medicare Part B or D premiums may be considered integrated with the group health plan coverage offered to the employee by the employer although the employee is not enrolled in that group coverage and is instead enrolled in Medicare, subject to certain conditions. IRS Notice 2015–17 also states that to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws, such as the Medicare secondary payer provisions. For clarity, the Departments confirm that reimbursement of Medicare Part B and D premiums under IRS Notice 2015–17 is permitted only for such arrangements not subject to the MSP provisions.

[176] However, as discussed later in this section of the preamble, an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare.

[177] The fact that a participant or dependent in a class of employees may not be able to enroll in individual health insurance coverage or Medicare due to the operation of federal law does not mean the individual coverage HRA that is offered to that class of employees violates the same terms requirement under the final rules or the equal benefit rule under the SSA.

individual's HRA. These commenters recommended clarifying that an HRA plan sponsor's failure to satisfy the conditions of the ERISA safe harbor described later in this preamble will have no effect on the MSP status of the individual health insurance coverage.

HHS notes that individual health insurance coverage is not subject to the MSP provisions, including the reporting, nondiscrimination, and ''primary plan'' requirements described earlier in this section of the preamble.[178] Nothing in the final rules changes the application of the MSP provisions. This is true even where individual health insurance coverage is integrated with an HRA as allowed under the final rules.[179] However, an individual coverage HRA will generally pay primary to Medicare, consistent with the MSP provisions applicable to group health plans. HHS intends to issue further guidance clarifying the primary versus secondary payer responsibility of individual coverage HRAs for plan sponsors subject to the MSP provisions.

One commenter requested guidance about the MSP reporting requirements that apply to individual coverage HRAs. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Public Law 110–173, established mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation.[180] The purpose of this reporting is to ensure that Medicare correctly pays for covered services provided to Medicare beneficiaries consistent with Medicare payment rules. HRAs (including individual coverage HRAs) are group health plans and, therefore, generally trigger the MMSEA section 111 reporting requirements.[181] HHS will provide future guidance regarding MMSEA section 111 reporting requirements and individual coverage HRAs. HHS notes that entities that currently do not offer a group health plan and therefore do not have reporting obligations may be required to report if they elect to offer individual coverage HRAs, similar to if they elected to offer other group health plan coverage.

15. Other Integration Issues

Some comments were received regarding dollar limits on individual coverage HRAs. One commenter supported that the proposed rules did not impose any specific dollar limit on the amount that an employer may contribute to an individual coverage HRA. The commenter noted that this is a welcome difference from QSEHRAs, to which a statutory dollar limit applies, and stated that this flexibility will help encourage employers to offer individual coverage HRAs. One commenter requested that the Departments place a limit on contributions to an individual coverage HRA to prevent adverse selection. A few commenters asked that the Departments require employers to make certain minimum amounts available under an individual coverage HRA to approximate the amount the employer generally would contribute to a traditional group health plan as a way to maintain availability and generosity of coverage.

In previous guidance on HRAs, including on integration of HRAs with other coverage, the Departments provided no minimum or maximum contribution amount. Similarly, the Departments decline to impose a minimum or maximum contribution amount on individual coverage HRAs under the final rules, in order to provide employers with flexibility and because the Departments have imposed other conditions to address the potential for adverse selection. However, the Treasury Department and the IRS note that employers subject to the employer shared responsibility provisions under Code section 4980H may want to make sufficient amounts available to employees in order to avoid a potential employer shared responsibility payment. The Treasury Department and the IRS intend to propose separate rules regarding the interaction of individual coverage HRAs and Code section 4980H that will be available for public comment.

Some commenters addressed which employers should be permitted to offer an individual coverage HRA. One commenter applauded the proposed rules for allowing employers of all sizes to offer an individual coverage HRA. One commenter requested that the Departments only permit individual coverage HRAs to be offered by small employers, because, the commenter asserted, small employers have less incentive to segment risk and are less likely to create classes of employees leading to adverse selection. One commenter asked that the Departments only permit large employers to offer an individual coverage HRA, asserting that small employers would be able to manipulate the rules to create small classes and segment risk. Another commenter requested that only employers that do not currently offer coverage be allowed to offer an individual coverage HRA.

The Departments considered these suggestions and determined that limiting the ability of one or more categories of employers to offer an individual coverage HRA in these ways would unnecessarily restrict the rules and could decrease the usability of individual coverage HRAs and harm employee welfare without a compelling reason for these limitations. Therefore, under the final rules, any employer may offer an individual coverage HRA, subject to compliance with the conditions in the final rules. However, the Departments note that the final rules include a minimum class size requirement which applies in certain instances, to address the issue identified regarding the ability to create small classes and segment risk.

One commenter urged HHS to allow for wellness program demonstration projects in the individual market under PHS Act section 2705(l) because the commenter asserted wellness programs are a popular aspect of traditional employer coverage. Because this comment is outside the scope of this rulemaking, it is not addressed in the final rules. However, HHS appreciates the comment and may consider addressing this issue in future guidance.

Several commenters emphasized the importance of strong enforcement of the conditions in the final rules and requested that the Departments issue guidance detailing how the Departments would enforce the final rules. DOL has enforcement jurisdiction over private sector employer-sponsored group health plans, and HHS has enforcement jurisdiction over public sector group health plans, such as those sponsored by state and local governments. Individual coverage HRAs are group health plans, and DOL and HHS will monitor individual coverage HRAs' compliance with applicable requirements, consistent with the general approach to enforcement with respect to other group health plans. The

[178] *See* SSA section 1862(b)(1) and (2) (MSP rules apply only to certain group health plans).

[179] The term ''group health plan'' for purposes of the MSP provisions is not defined by reference to ERISA; therefore, this section of the preamble does not address the application of the ERISA safe harbor described later in this preamble.

[180] *See also* SSA section 1862(b)(7) and (8).

[181] For information about mandatory MMSEA section 111 reporting for group health plans, see *https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html* and *https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/GHP-Training-Material/Downloads/Health-Reimbursement-Arrangement-HRA.pdf.*

Departments believe that it is unnecessary to include specific enforcement guidance for individual coverage HRAs in the final rules. The Departments may provide additional guidance if the Departments become aware of arrangements that are inconsistent with the final rules.

One commenter requested that employers be permitted to pay issuers directly for individual health insurance coverage in which individual coverage HRA participants are enrolled. The Departments note that existing guidance for health plans generally allows employers to pay health insurance premiums to issuers directly,[182] so this is already permitted. Also, see the discussion later in this preamble regarding a safe harbor for determining whether an individual health insurance policy purchased with funds from an individual coverage HRA will be treated as part of an ERISA-covered employee welfare benefit plan.

One commenter requested that the Departments clarify that a plan sponsor may make amounts in an individual coverage HRA available either monthly or annually at the beginning of the plan year. The Departments clarify that the final rules do not change existing rules for HRAs, which do not require the entire annual amount to be available at the beginning of the year and would allow the HRA to only make amounts available pro rata over the 12 months of the year.[183] However, the Departments note that the amounts made available under an individual coverage HRA, including when they will be made available, must be described in the notice that is required under the final rules.[184] The Departments also note that within a class of employees, the terms and conditions of an individual coverage HRA generally must be the same, including the timing of how amounts are made available.

One commenter requested that the Departments interpret ''employer'' to include non-employer plan sponsors such as boards of trustees for multiemployer plans. The final rules allow plan sponsors to offer an individual coverage HRA, and plan sponsors include, but are not limited to, employers and could include a board of trustees for a multiemployer plan.

Various commenters requested additional reporting requirements or other types of mandatory data collection regarding individual coverage HRAs. The Departments have not identified a compelling need for this information that would justify the significant additional burden this would place on each employer offering this type of coverage. Accordingly, the final rules do not adopt these suggestions. However, to the extent an individual coverage HRA is otherwise subject to reporting requirements under other rules, including PPACA, the Code, the SSA, or ERISA, the final rules do not affect the application of those reporting requirements.[185]

One commenter requested additional time to comment on the proposal. The Administrative Procedure Act grants Executive Agencies discretion to set the timeframe during which public comments will be received and considered. Interested stakeholders were given 60 days from the publication of the proposed rules to submit comments for consideration. Many comments were received and considered by the Departments. This solicitation for public comments allowed the Departments to gather sufficient information from interested stakeholders. The Departments, therefore, declined to extend the timeframe to comment on the proposed rules.

One commenter requested that the final rules consider enrollment in an individual coverage HRA as other group coverage for purposes of determining whether employers satisfy minimum participation thresholds for guaranteed availability. In the large group market, issuers may not apply minimum participation rules to deny guaranteed availability of coverage. In the small group market, issuers may apply minimum participation rules, as allowed under applicable state law. However, failure to satisfy an issuer's minimum participation rules may not be used to deny guaranteed availability of coverage between November 15 and December 15 of each year. The Departments clarify that in both the large and small group markets, issuers may apply minimum participation rules, pursuant to applicable state law, as an exception to guaranteed renewability of coverage requirements.[186] State law may determine which individuals to include in the minimum participation calculation, including whether issuers are allowed to include individuals who have other coverage within the total number of eligible individuals and which types of coverage may be counted as other coverage.[187] Neither the proposed rules nor the final rules make changes to these existing, separate requirements.

One commenter requested that the Departments provide information about how an employer would transition from offering a QSEHRA to offering an individual coverage HRA. The Departments note that IRS Notice 2017–67 provides guidance on the requirements for providing a QSEHRA. The guidance in Notice 2017–67 remains unaffected by the final rules. Additional QSEHRA guidance generally is outside of the scope of these final rules, and to the extent an employer wants to transition from offering a QSEHRA to offering an individual coverage HRA, the individual coverage HRA must comply with the requirements set forth in the final rules.

One commenter asked the Departments to clarify that individual coverage HRA participants may contribute to a health FSA even if their employer does not offer traditional group health plan coverage. The Departments note that employers generally may provide excepted benefits (other than an excepted benefit HRA [188]) to employees in a class offered an individual coverage HRA. In addition, the Departments clarify that the individual coverage HRA would qualify as ''other group health plan coverage not limited to excepted benefits'' under the requirements for the health FSA to qualify as an excepted benefit.[189] Thus, nothing in the final rules prohibits employees in a class of employees offered an individual coverage HRA from participating in a health FSA through salary reduction in a cafeteria plan.

Other comments not responsive to the provisions and topics addressed by the proposed rules, or otherwise beyond the

[182] *See* Revenue Ruling 61–146, 1961–2 CB 25.

[183] *See* IRS Notice 2002–45.

[184] Also see the discussion later in the preamble regarding the final PTC rules, under which amounts newly made available for an HRA plan year must be determinable within a reasonable time before the beginning of the plan year in order to be considered in determining affordability of the offer of the individual coverage HRA.

[185] *See e.g.,* ERISA sections 101, 103, and 104 and PHS Act section 2715 (incorporated in Code section 9815 and ERISA section 715).

[186] *See* 78 FR 13406, 13416 (Feb. 27, 2013).

[187] *See* Health Care Financing Administration Insurance Standards Bulletin 00–05, Guaranteed Availability Under Title XXVII of the Public Health Service Act—Applicability of Group Participation Rules (Nov. 2000), available at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_00_05_508.pdf.* However, for purposes of participation in a Federally-facilitated Small Business Health Options Program (FF–SHOP), see the methodology for calculating a minimum participation rate specified in 45 CFR 155.706(b)(10)(i).

[188] See later in this preamble for a discussion of the interaction of individual coverage HRAs and excepted benefit HRAs.

[189] 26 CFR 54.9831–1(c)(3)(v)(A), 29 CFR 2590.732(c)(3)(v)(A), and 45 CFR 146.145(b)(3)(v)(A).

scope of the proposed and final rules, are not summarized or addressed.

16. Revisions to Current PHS Act Section 2711 Rules Regarding Integration With Other Group Health Plan Coverage and Medicare

The 2015 rules under PHS Act section 2711 provide methods for integrating HRAs with coverage under another group health plan, and, in certain circumstances, with Medicare Part B and D. The proposed rules did not include a proposal to substantively change the current group health plan or Medicare integration tests under the existing PHS Act section 2711 rules. However, the proposed rules included minor proposed revisions to those rules, including changing the term ''account-based plan'' to ''account-based group health plan'' and moving defined terms to a definitions section. The proposed rules also proposed to amend the rules under PHS Act section 2711 to reflect that HRAs may be integrated with individual health insurance coverage subject to the requirements of 26 CFR 54.9802–4, 29 CFR 2590.702–2, and 45 CFR 146.123. The final rules adopt these changes as proposed, except that the final rules have been updated to reflect that individual coverage HRAs may be integrated with Medicare, for purposes of compliance with PHS Act sections 2711 and 2713, if certain conditions are satisfied.[190]

In addition, the proposed rules included a proposal to update the definition of EHBs set forth in paragraph (c) of the rules under PHS Act section 2711, which applies for a group health plan or health insurance issuer not required to cover EHBs. The update in the proposed rules reflected the revision to the EHB-benchmark plan selection process that was promulgated in the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) and that applies for plan years beginning on or after January 1, 2020.[191] The 2019 Payment Notice revisions provide states with additional choices with respect to the selection of benefits and promote affordable coverage through offering states additional flexibility in their selection of an EHB-benchmark plan for plan years beginning on or after January 1, 2020. The state's existing EHB-benchmark plan will continue to apply for any year for which a state does not select a new EHB-benchmark plan from the available EHB-benchmark plan selection options finalized in the 2019 Payment Notice.[192] The Departments are finalizing as proposed the update to the definition of EHB under the PHS Act section 2711 rules.

One commenter expressed concern with the change made by HHS to the definition of EHB in the 2019 Payment Notice and requested that the Departments decline to update the rules under PHS Act section 2711 to reflect the revised EHB definition. The Departments clarify that PHS Act section 2711 defines EHB by reference to PPACA section 1302(b), under which HHS has the authority to define EHB. The update to the definition of EHB in the PHS Act section 2711 rules is a technical update made to avoid applying an out-of-date definition and is the result of the change HHS finalized in the 2019 Payment Notice. Issues regarding EHBs more generally, as well as the specific changes made in the 2019 Payment Notice, are outside of the scope of this rulemaking.

B. Excepted Benefit HRAs

1. In General

As the Departments noted in the preamble to the proposed rules, there may be scenarios in which an employer wants to offer an HRA that might not be integrated with individual health insurance coverage, non-HRA group coverage, Medicare, or TRICARE. For example, some employers may want to offer an HRA without regard to whether their employees have other coverage at all, or without regard to whether their employees have coverage that is subject to and satisfies the market requirements. Therefore, the proposed rules utilized the Departments' discretion under Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C), and included an amendment to the prior rules that would recognize certain limited HRAs as excepted benefits (excepted benefit HRAs), if specific conditions were satisfied.[193]

As explained earlier in this preamble, the Departments have the authority and discretion to specify in rules additional limited excepted benefits that are similar to the limited benefits specified in the statutes and that either are insured under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan. The proposed rules included a proposal for an excepted benefit HRA that is consistent with both this statutory framework and the Departments' objective of expanding the availability and usability of HRAs to maximize employee welfare. Specifically, the proposed rules provided that, to be recognized as an excepted benefit, the HRA: (1) Must not be an integral part of the plan, (2) must provide benefits that are limited in amount, (3) cannot provide reimbursement for premiums for certain health insurance coverage, and (4) must be made available under the same terms to all similarly situated individuals.

A number of commenters generally expressed support for the proposed excepted benefit HRA rule as a way to expand the availability and use of HRAs. Some of the commenters who supported the proposed excepted benefit HRA rule opposed allowing the purchase of STLDI. Also, a number of commenters opposed the proposed excepted benefit HRA rule, expressing concerns that the excepted benefit HRA could incentivize individuals to obtain STLDI, cause adverse selection in the small group and individual market risk pools, and increase complexity and the potential for confusion.

The Departments considered these comments and agree that the excepted benefit HRA is a way to expand the availability and use of HRAs, thereby providing increased options for healthcare coverage to employers and employees. Therefore, the final rules recognize certain HRAs as limited excepted benefits, with some changes from the proposed rule, which are intended to address concerns raised by commenters regarding the potential for adverse selection and confusion.

A few commenters questioned the Departments' legal authority for establishing the excepted benefit HRA, with one requesting that the proposed excepted benefit HRA rules be withdrawn. These commenters stated that the excepted benefit HRA is not similar to the other limited excepted benefits because it does not provide insurance that is limited in scope for a particular medical condition. The Departments disagree. As stated earlier in this section of the preamble, Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C) authorize the Secretaries of the Treasury, Labor, and HHS to issue rules establishing other, similar limited benefits as excepted benefits. Similar to

[190] The Departments further note that, unless the final rules conflict with the subregulatory guidance that has been issued under PHS Act section 2711, that guidance remains in effect.

[191] *See* 83 FR 16930 (April 17, 2018). The definition of EHB that applies under the PHS Act section 2711 rules for plan years beginning before January 1, 2020 is not substantively changed by the final rules.

[192] For more information on the revised EHB standard, refer to the preamble to the 2019 Payment Notice (83 FR 16930, 17007 (April 17, 2018)).

[193] The proposed rules, and the final rules, do not apply to health FSAs. For a health FSA to qualify as an excepted benefit, the rules at 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v) continue to apply.

the exercise of authority with respect to certain health FSAs, limited wraparound coverage,[194] and employee assistance programs, the Departments utilized this authority to propose rules to permit HRAs as limited excepted benefits, if certain conditions are satisfied. The Departments have determined that the conditions that apply to excepted benefit HRAs under the final rules result in such an arrangement being sufficiently limited and sufficiently similar to other limited excepted benefits. The Departments are now adopting these final rules on excepted benefit HRAs, subject to clarifications, described later in this section of the preamble.

As a general matter, some commenters expressed confusion and asked for clarification regarding the difference, if any, between the proposed excepted benefit HRA and an HRA that only reimburses expenses for excepted benefits. In IRS Notice 2015–87, Q&A–5, the Treasury Department and the IRS explained that an HRA or employer payment plan that, by its terms, reimburses (including paying directly for) premiums for individual health insurance coverage solely to the extent that the individual health insurance coverage covers excepted benefits would not fail to satisfy the market requirements because those requirements do not apply to a group health plan that is designed to provide only excepted benefits, either through reimbursement of premiums or cost sharing (referred to in this preamble as an HRA that provides only excepted benefits). Excepted benefit HRAs, on the other hand, can provide reimbursement for costs incurred related to coverage that is not limited to excepted benefits (for example, cost sharing for individual health insurance coverage). Several commenters asked the Departments to confirm that an HRA that provides only excepted benefits is not subject to the conditions that apply to an excepted benefit HRA. One commenter was concerned that if an HRA that provides only excepted benefits must satisfy the conditions that apply to an excepted benefit HRA, the proposed rules would inadvertently reduce employers' ability to fund excepted benefits.

The final rules establish a new excepted benefit HRA under Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C), which can be used to reimburse certain medical care expenses incurred with respect to coverage that is not limited to other types of excepted benefits. If a plan sponsor offers an HRA that only provides reimbursement for other types of excepted benefits (for example, limited-scope vision and limited-scope dental benefits), that arrangement is, itself, already an excepted benefit and need not satisfy the criteria of the final excepted benefit HRA rules. Instead, the final rules provide that an additional type of HRA, specifically, one that reimburses benefits not limited to other types of excepted benefits, can also qualify as an excepted benefit.[195] Excepted benefit HRAs may reimburse medical care expenses, such as cost sharing for individual health insurance coverage or group health plan coverage that would not otherwise qualify as excepted benefits, if the conditions of the final rules are satisfied.

2. Otherwise Not an Integral Part of the Plan

Among other things, to be a limited excepted benefit under Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1), benefits must: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of the plan.[196] HRAs are self-insured group health plans and, therefore, are not insurance coverage that can be provided under a separate policy, certificate, or contract of insurance. Accordingly, to satisfy the statutory requirement to be a limited excepted benefit, among other things, an HRA must not be an integral part of the plan.

To satisfy this condition, the proposed rules specified that other group health plan coverage (other than an account-based group health plan or coverage consisting solely of excepted benefits) must be made available by the same plan sponsor for the plan year to the participants offered the excepted benefit HRA. Only individuals eligible to participate in the traditional group health plan would be eligible to participate in the excepted benefit HRA. However, while the plan sponsor would be required to make an offer of a traditional group health plan, HRA participants (and their dependents) would not be required to enroll in the traditional group health plan for the HRA to be an excepted benefit HRA. In the preamble to the proposed rules, the Departments noted that this provision is similar to the requirement that applies under the limited excepted benefits rules for health FSAs at 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v).

Commenters generally supported this requirement and suggested that it be retained in the final rules. Some commenters suggested that the Departments should go further and permit employers to offer an excepted benefit HRA only to individuals who are actually enrolled in a traditional group health plan.[197] These commenters argued that without such a requirement, healthy employees would decline their employer's traditional group health plan and only participate in the excepted benefit HRA. These commenters speculated this might lead to a less stable small group market risk pool and higher premiums for employees who remain in the traditional group health plan. One commenter was concerned that if some employers offer traditional group health plans that are exorbitantly expensive, many employees would decline to enroll and rely on their excepted benefit HRA as their only source of coverage. One commenter disagreed with the Departments' assertion that the requirement to offer a traditional group health plan satisfies the requirement that limited excepted benefits not be an integral part of the plan. Another commenter stated that individuals could be without comprehensive coverage if they do not enroll in the employer's traditional

[194] The Departments note that limited wraparound coverage was permitted as an excepted benefit under a temporary pilot program. Specifically, limited wraparound coverage could be offered as excepted benefits if it was first offered no earlier than January 1, 2016, and no later than December 31, 2018, and would end no later than on the later of: (1) The date that is 3 years after the date limited wraparound coverage is first offered, or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered). *See* 26 CFR 54.9831–1(c)(3)(vii)(F), 29 CFR 2590.732(c)(3)(vii)(F), and 45 CFR 146.145(b)(3)(vii)(F).

[195] That is, the excepted benefit HRA may reimburse expenses for excepted benefits, as well as other types of medical expenses that do not qualify as excepted benefits.

[196] Code section 9831(c)(1), ERISA section 732(c)(1), and PHS Act section 2722(c)(1).

[197] One commenter opposed the requirement that traditional group health plan coverage be made available to the participants offered the excepted benefit HRA, but the comment was based on the misunderstanding that the proposed conditions that apply to the excepted benefit HRA apply to an HRA that provides only excepted benefits. The commenter was concerned that an employer that did not previously offer a traditional group health plan, but did previously offer an HRA that provides only excepted benefits, might discontinue offering that HRA if the final rules were to apply to the HRA that provides only excepted benefits. As explained earlier in this preamble, the final rules do not apply to HRAs that provide only excepted benefits. Therefore, if an employer offers an HRA that provides only excepted benefits, such an arrangement would not be subject to the requirements of the final rules, including the requirement that the plan sponsor must offer a traditional group health plan.

group health plan and rely instead on an excepted benefit HRA, or a combination of the excepted benefit HRA and other excepted benefits, without understanding the limited nature of excepted benefits. The commenter also represented that there is a long history of unscrupulous promoters cobbling together different types of excepted benefits and fraudulently marketing them as major medical insurance, leaving thousands of participants and beneficiaries with unpaid claims. One commenter urged the Departments to add a requirement that employers offering an excepted benefit HRA must maintain their traditional group health plan at an equivalent level of coverage, actuarial value, and premium affordability relative to the coverage offered prior to offering the excepted benefit HRA.

The final rules do not adopt a requirement that excepted benefit HRAs be limited to employees who are enrolled in the employer's traditional group health plan or impose a maintenance of effort requirement. First, the condition that employees must be offered (but not necessarily enrolled) in the employer's traditional group health plan is similar to that for excepted benefits health FSAs, pursuant to the same statutory authority.[198] Second, limiting eligibility to employees enrolled in their employer's traditional group health plan would make employees covered under other primary coverage, such as a spouse's plan, ineligible for the excepted benefit HRA. Applying such a restrictive requirement would unduly limit some employees' access to excepted benefit HRAs and reduce their welfare if they choose a different primary health coverage option to best meet their needs.[199] Third, other factors will likely prevent most employees from relying on an excepted benefit HRA as their primary form of coverage. For example, the dollar limit imposed on excepted benefit HRAs (discussed later in this preamble) will likely make it apparent that an excepted benefit HRA does not provide adequate financial protection against unexpected health costs, even for the healthiest individuals. Moreover, as discussed later in this preamble, in general, excepted benefit HRAs must provide notice of the dollar limits and other limitations on coverage under the plan. Finally, as to the concern that employers will offer traditional group health plans that are very expensive, thereby encouraging employees to enroll only in the excepted benefit HRA, the employer shared responsibility provisions of Code section 4980H (for ALEs), and employers' desire to offer affordable health coverage as a means to attract and retain talented workers, are strong incentives for employers to offer affordable, quality health coverage.

3. Limited in Amount

Under the Code, ERISA and the PHS Act, limited excepted benefits may include limited scope vision or dental benefits, benefits for long-term care, nursing home care, home healthcare, or community-based care, or any combination thereof and may include ''such other similar, limited benefits as are specified in regulations'' by the Departments.[200] Thus, in creating the excepted benefit HRA, the Departments had to determine what type of HRA would be sufficiently limited to qualify as a limited excepted benefit.

The Departments have applied limiting principles consistently in prior rulemakings under which discretion was exercised to establish additional types of limited excepted benefits.[201] For example, a health FSA is an excepted benefit only if the arrangement is structured so that the maximum benefit payable to any participant in the class for a year does not exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, $500 plus the amount of the participant's salary reduction election).[202] Additionally, limited wraparound coverage is a limited excepted benefit only if it is limited in amount, such that the cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the greater of the maximum permitted annual salary reduction contribution toward a health FSA or 15 percent of the cost of coverage under the primary plan.

The Departments recognize that limited excepted benefits that are not limited in scope by benefit type (such as limited-scope dental or limited-scope vision benefits) must be limited in amount to constitute the type of ancillary benefit contemplated by the statutes within the meaning of a ''similar, limited benefit'' under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2).[203]

Accordingly, the Departments proposed that amounts newly made available for a plan year in an excepted benefit HRA may not exceed $1,800, indexed for inflation for plan years beginning after December 31, 2020. For this purpose, inflation was defined in the proposed rules by reference to the Chained Consumer Price Index for All Urban Consumers, unadjusted (C–CPI–U), published by DOL. Also, the Departments stated that the adjusted limit for plan years beginning in a particular calendar year would be published early in the fall of the prior calendar year.

a. Dollar Limit on the Amount That May Be Made Newly Available During a Plan Year

Many commenters supported the proposed dollar limit as a reasonable mid-point of the different limits that would result in applying various methodologies. Several noted it was sufficient because excepted benefits are meant to provide ancillary coverage, and the proposed amount is comparable to the cost of other excepted benefits, such as stand-alone dental and vision plans. One commenter noted that $1,800 would be a generous level of reimbursement for excepted benefits, but only a modest support to participants and beneficiaries seeking reimbursement for COBRA premiums. Another commenter asserted that it was a reasonable middle ground relative to the various alternatives that the Departments considered and discussed in the preamble to the proposed rules.[204] A few commenters supported the proposed dollar limit due to their opposition to allowing excepted benefit HRAs to provide reimbursement for STLDI premiums, arguing that if the limit were any higher some participants could be more likely to rely on STLDI

[198] *See* 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v). *See also* 62 FR 67688 (Dec. 29, 1997).

[199] In the context of other HRA integration rules, the Departments have recognized and supported employee choice to enroll in primary coverage other than the employer's group health plan (such as a spouse's plan or Medicare), without these types of limitations. *See, e.g.,* 26 CFR 54.9815–2711(d)(2) and (d)(5), 29 CFR 2590.715–2711(d)(2) and (d)(5), and 45 CFR 147.126(d)(2) and (d)(5).

[200] Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C).

[201] See the discussion in the preamble to the proposed rules at 83 FR 54420, 54437 (Oct. 29, 2018).

[202] 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(b)(3)(v).

[203] *See also* 80 FR 13995, 13997 (March 18, 2015).

[204] The Departments stated in the preamble to the proposed rules that a range of options were considered, such as a limit that would mirror the cap on employer contributions for excepted benefit health FSAs, a fixed percentage of the cost of coverage under the plan sponsor's primary group health plan, and the cost of coverage under the second lowest cost silver plan in various markets. However, consistent with the principle of promoting HRA usability and availability, rather than proposing a complex test for the limit on amounts newly made available in the excepted benefit HRA, the Departments proposed a maximum of $1,800 because it approximated the midpoint amount yielded by the various methodologies considered. 83 FR 54420, 54437 (Oct. 29, 2018).

as their primary form of coverage. In expressing their support for the proposed dollar limit, a number of commenters stated that the limit should not be any higher, due to adverse selection concerns and concerns about disincentivizing comprehensive coverage.

Other commenters requested that excepted benefit HRAs not be subject to any dollar limit because a limit would restrict participants' ability to choose the types of treatment or coverage that is best suited to their needs. Some commenters argued that the proposed dollar limit should be higher. Some of these commenters favored a higher limit for excepted benefit HRAs based on age and number of dependents to reflect that participants who are older or have dependents are likely to have higher healthcare costs. Some commenters suggested specific higher limits that, in their view, would be appropriate, such as the maximum annual permitted benefit for QSEHRAs, the maximum out-of-pocket limit for HDHPs, the annual salary reduction contribution limit for health FSAs, the greater of 15 percent of the cost of coverage under the employer's primary group health plan or the health FSA salary reduction contribution limit (which is the threshold for limited wraparound coverage), [205] or 15 percent of the cost of coverage under the employer's primary group health plan (which is the threshold for certain supplemental excepted benefits). [206] The commenters asserted that the limit should be increased for various reasons, including to enable employees to pay for premiums and cost sharing for excepted benefit policies, to approximate the limits allowed for limited wraparound coverage, to reduce administrative complexity for plan sponsors by aligning the limit with a limit that already exists, to help employees bypass insurance and pay directly for medical care, and to enable employees to pay for more expensive STLDI plans that may, in some cases, provide comprehensive, high-quality coverage. Some commenters noted that setting the limit as a percentage of the cost of the employer's primary group health plan could partially account for regional differences for healthcare services.

One commenter stated that a dollar limit is not sufficient to cause the excepted benefit HRA to be a limited excepted benefit and also stated that the proposed dollar limit was too high, with the result that the excepted benefit HRA is not a limited excepted benefit because the dollar limit is significantly more than the premium value of the other limited excepted benefits; therefore, according to the commenter, the excepted benefit HRA is not similar to other limited excepted benefits.

The final rules do not remove or change the dollar limit for the excepted benefit HRA. The Departments agree that significantly increasing the dollar limit could encourage certain participants to rely solely on benefits reimbursed through the excepted benefit HRA and could lead to adverse selection. Also, as stated earlier in this preamble, if a benefit that is generally not otherwise limited in scope is too large, it would not constitute a ''similar, limited benefit'' under Code section 9832(c)(2), ERISA section 733(c)(2), and PHS Act section 2791(c)(2). These governing statutes require that these benefits be limited, which the Departments interpret to require a strict dollar limit because the excepted benefit HRA is not restricted to reimbursing specific, limited types of medical expenses.[207] Further, the Departments are cognizant that an excepted benefit HRA, like all excepted benefits, does not render an individual ineligible for the PTC and, therefore, a higher dollar limit on the excepted benefit HRA could result in individuals being eligible for both subsidized coverage through the Exchanges and a higher employer provided HRA benefit, which would increase the cost to the federal government. To the extent commenters advocated for a higher dollar limit in order to allow HRAs to be used to purchase excepted benefits, HRAs that provide only excepted benefits may be an alternative option because those HRAs are not subject to the excepted benefit HRA rules, including the dollar limit.

In determining the appropriate dollar limit for excepted benefit HRAs, the Departments considered other, similar limited excepted benefits. The Departments agree with commenters' assertions that the proposed limit was reasonable and rational, especially considering the relatively low cost of excepted benefits coverage, such as dental or vision coverage. While limited wraparound coverage and similar supplemental coverage may have higher overall dollar limits, they are also limited in additional ways. Limited wraparound coverage must provide meaningful benefits beyond coverage of cost sharing (such as coverage for expanded in-network medical clinics or providers, or provide benefits that are not EHBs and that are not covered by the eligible health insurance) and, in general, may only be offered to part-time employees and retirees (and their dependents), and only if the employer makes certain offers of coverage to full-time employees.[208] Further, similar supplemental coverage is restricted to coverage ''specifically designed to fill gaps in the primary coverage.'' [209] On the other hand, employee salary reduction contributions to health FSAs, which will vary by employee and cannot exceed $2,700 (adjusted for inflation), cannot be used to pay premiums, and generally may not be rolled over from year to year, except for a limited runout period or limited amount.[210] Excepted benefit HRAs are not subject to all the limitations that apply to these other limited excepted benefits; thus, a lower dollar amount is appropriate for excepted benefit HRAs.

Additionally, although the Departments recognize that healthcare expenses may be higher for participants who are older or have dependents, adopting a higher limit to account for a combination of factors like age and family size could allow an excepted benefit HRA to be too large and to resemble major medical coverage. Moreover, these factors were already considered and accounted for in developing the $1,800 limit. Accordingly, the final rules adopt, without change, the proposed maximum that can be newly made available for a plan year of $1,800.

b. Indexing for Inflation

Many commenters supported the proposed rule's approach to indexing for inflation the amount that may be made newly available to participants during a plan year, though some suggested alternative methods of indexing may be more appropriate.

[205] *See* 26 CFR 54.9831–1(c)(3)(vii)(B), 29 CFR 2590.732(c)(3)(vii)(B), and 45 CFR 146.145(b)(3)(vii)(B).

[206] *See* EBSA Field Assistance Bulletin No. 2007–04 (available at *https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2007–04*); CMS Insurance Standards Bulletin 08–01 (available at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf*); and IRS Notice 2008–23.

[207] The Departments note, however, that an excepted benefit HRA is also limited, to some extent, in scope of reimbursable expenses in that it may not reimburse premiums for individual health insurance coverage (other than excepted benefits); group health coverage (other than COBRA or other continuation coverage or excepted benefits); Medicare Part A, B, C, or D; and under certain circumstances, it cannot reimburse STLDI premiums.

[208] *See* 26 CFR 54.9831–1(c)(3)(vii)(A) and (D), 29 CFR 2590.732(c)(3)(vii)(A) and (D), and 45 CFR 146.145(b)(3)(vii)(A) and (D). *See also* 80 FR 13995, 13997 (March 18, 2015).

[209] *See* 26 CFR 54.9831–1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C).

[210] IRS Notice 2005–42, 2005–1 CB 1204 and IRS Notice 2013–71, 2013–47 IRB 532.

Several commenters suggested that the chained CPI–U does not accurately reflect the increases in the cost of medical care over time because healthcare prices consistently increase at a greater rate than prices in the economy as a whole. Several commenters suggested that the appropriate measure of inflation would be the Consumer Price Index overall medical care component because it focuses on consumers' out-of-pocket medical expenses, while another suggested unchained CPI–U. Another commenter, however, suggested that the measure selected in the proposed rules would be the most appropriate measure, as other types of excepted benefits, such as limited-scope dental, limited-scope vision, and fixed indemnity plans, do not typically have cost trends (that is, inflation) similar to products that provide comprehensive medical care. One commenter expressed support for the proposed adjustment because it is consistent with the adjustment of various other amounts under the Code.

The final excepted benefit HRA rules index the annual dollar limit of $1,800 to inflation for plan years beginning after December 31, 2020, and define inflation by reference to the C–CPI–U, as was proposed. This index strikes a reasonable balance among a number of factors, including balancing the decreasing real value of a static excepted benefit HRA annual maximum contribution amount and the ability of an employer to maintain a meaningful, yet limited, excepted benefit HRA that can carry over unused amounts and accumulate to higher account balances over time. Also, C–CPI–U is used to index most other amounts under the Code with which employers are familiar, such as the annual limit on employee salary reduction contributions to health FSAs, annual HSA contributions amounts, and annual HDHP minimum deductible amounts and maximum HDHP out-of-pocket amounts.[211] Therefore, this inflation adjustment should be familiar to plan sponsors. Using the same indexing method is less likely to result in confusion and will make implementation and compliance easier.

One commenter urged that the annual amount should be announced at the same time that other account-based plan limits, such as the limits for HSAs and HSA-eligible HDHPs, are announced, as employers and plan administrators need to know these amounts in advance to set their benefit levels and communicate them to employees. The Departments agree that it is essential that the annual adjustment be made available sufficiently in advance of the upcoming plan year to allow plan sponsors to make benefit determinations. Therefore, the Departments are revising the final rules to provide that the C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12 month period ending on March 31 of that calendar year and that the Treasury Department and the IRS will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year, which is the same timing rule that applies for HSAs and HSA-eligible HDHPs.

c. Roll-Overs and Aggregation Rules

The proposed rules provided that if a participant or beneficiary in an excepted benefit HRA does not use all of the amounts made available for a plan year, and the excepted benefit HRA allows for these amounts to be carried over to later plan years, then these carryover amounts would be disregarded for purposes of determining whether the $1,800 limit is exceeded.[212] One commenter specifically expressed support for this aspect of the proposed rules, and this feature is retained in the final rules.

In addition, the proposed rules provided that if the plan sponsor provides more than one HRA to a participant for the same time period, the amounts made available under all such plans would be aggregated to determine whether the $1,800 limit has been exceeded. One commenter opposed this aspect of the rule. However, the Departments retain this provision in the final rules in order to avoid circumvention of the $1,800 limit, which provides the statutory basis for recognizing this type of HRA as a limited excepted benefit. However, the final rules clarify that the aggregation rules do not take into account amounts made available under HRAs that reimburse only excepted benefits (including premiums for individual health insurance coverage that consists solely of excepted benefits). An HRA that reimburses only excepted benefits is exempt from the provisions of the final rules, including those provisions that apply to individual coverage HRAs and excepted benefit HRAs.

4. Prohibition on Reimbursement of Premiums for Certain Types of Coverage

a. In General

To be an excepted benefit HRA, the proposed rules provided that the HRA could not reimburse premiums for Medicare Part B or D, individual health insurance coverage, or coverage under a group health plan (other than COBRA or other group continuation coverage), except that the HRA could reimburse premiums for individual health insurance coverage or group health plan coverage that consists solely of excepted benefits. An excepted benefit HRA would be permitted to reimburse any other medical care expenses, including STLDI premiums.

Commenters generally supported the proposed requirement that an excepted benefit HRA would not be permitted to reimburse premiums for individual health insurance coverage (other than for such coverage consisting solely of excepted benefits). These commenters contended that to allow reimbursement of individual health insurance coverage premiums would undermine the basis for recognizing the HRAs as limited excepted benefits, and would enhance employers' ability to move their higher-risk employees into the individual market. The Departments agree that maintaining the prohibition on the use of the excepted benefit HRA for individual health insurance coverage premiums is one way in which the HRA is limited, in order to qualify as a limited excepted benefit, and that the prohibition mitigates the risk that excepted benefit HRAs could cause adverse selection in the individual market.

In addition, the Departments have concluded that the prohibition on the reimbursement of premiums for group health plan coverage (other than COBRA or other continuation coverage and excepted benefits) and individual health insurance coverage (other than excepted benefits), is appropriate because other final rules that are part of this rulemaking permit individual coverage HRAs and other rules allow HRAs to be integrated with non-HRA group health plan. Further, current guidance allows HRAs to reimburse premiums for Medicare Part B and D in certain circumstances and under the final rules, individual coverage HRAs that are integrated with Medicare may be allowed to reimburse premiums for Medicare Part A, B, C, or D. Therefore, an employer that wants to provide an HRA that reimburses premiums for individual health insurance coverage, Medicare Part A, B, C or D, or group health plan coverage, may do so under

[211] *See* Code sections 125(i) and 223(g).

[212] Transfers, however, from other HRAs are not permitted. *See* the discussion earlier in this preamble.

the applicable integration rules. Accordingly, the final rules retain the proposed prohibition on reimbursing premiums for individual health insurance coverage (other than for such coverage consisting solely of excepted benefits) and group health insurance coverage (other than for such coverage consisting solely of excepted benefits and COBRA or other continuation coverage). Moreover, because the excepted benefit HRA generally is not intended to reimburse premiums that may be reimbursed under the individual coverage HRA, the final rules also provide that the excepted benefit HRA may not reimburse premiums for Medicare Part A or C, in addition to Medicare Part B and D, as provided for in the proposed rules. This approach ensures that, similar to other limited excepted benefits, excepted benefit HRAs provide limited benefits different from those typically provided by a traditional group health plan.

Some commenters requested clarification regarding the medical care expenses an excepted benefit HRA may reimburse. In particular, a few commenters requested that the Departments clarify that an excepted benefit HRA can reimburse individuals for cost sharing under individual health insurance coverage or group health plans, although excepted benefit HRAs may not be used to reimburse premiums for that coverage. Some commenters inquired whether an employer could place limits on the medical care expenses it allows to be reimbursed by the excepted benefit HRA, in addition to those limits imposed by the excepted benefit HRA rules. In particular, a few commenters asked whether an employer could choose not to provide any reimbursement of certain premiums or medical care expenses otherwise allowed under Code section 213(d).

In general, an HRA may provide for reimbursement for medical care expenses. Consistent with the current rules that apply to HRAs generally, a plan sponsor has discretion to specify which medical care expenses are eligible for reimbursement from an excepted benefit HRA it establishes, in addition to the limits under the excepted benefit HRA rules. For example, a plan sponsor may permit an excepted benefit HRA to reimburse all medical care expenses not otherwise disallowed by the excepted benefit HRA rules, it may permit reimbursements for non-premium medical care expenses only (such as cost sharing), or it may otherwise decide which particular medical care expenses will be reimbursable and which will not be reimbursable. An excepted benefit HRA may allow for reimbursement of cost sharing under individual health insurance coverage or group health insurance coverage, although the excepted benefit HRA may not reimburse the premiums for that coverage. Further, a plan sponsor generally may, but need not, allow reimbursement of STLDI premiums or cost sharing under the excepted benefit HRA. Also, see later in this section of the preamble for a discussion of the special circumstance in which excepted benefit HRAs may not be used to reimburse STLDI premiums.

Several commenters inquired whether an excepted benefit HRA could reimburse expenses related to participation in a health care sharing ministry or a direct primary care arrangement. One commenter asked whether reimbursement could be provided for categories of excepted benefits other than ''limited excepted benefits,'' such as those in which benefits for medical care are secondary or incidental (for example, travel insurance). This commenter expressed concern that there could be potential conflicts under rules regarding taxable fringe benefits under the Code. Some commenters requested clarification more generally regarding whether an excepted benefit HRA may only reimburse excepted benefits that pay health benefits or all excepted benefits, with some advocating that excepted benefit HRAs be allowed to reimburse all expenses for all excepted benefits and some advocating that the excepted benefit HRA only be allowed to reimburse expenses for excepted benefits that are medical care. The Departments clarify that an HRA, including an excepted benefit HRA, generally may reimburse medical care expenses of an employee and certain of the employee's family members (subject to the prohibition on the reimbursement of certain premiums that apply for excepted benefit HRAs).[213] Neither the proposed nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking. The Treasury Department and the IRS, however, appreciate the comments and anticipate addressing some of these issues in future rulemaking or guidance.

One commenter stated that excepted benefit HRAs should not be permitted to reimburse COBRA premiums because COBRA generally is more expensive than other coverage options and the Departments should not incentivize individuals to elect COBRA when more affordable coverage options may be available. Another commenter opposed allowing reimbursement for COBRA premiums because COBRA generally provides comprehensive coverage and, to the extent an HRA can be used to reimburse such coverage, it should not be considered to be providing limited benefits within the meaning of the statutes.

The Departments decline to prohibit reimbursement for COBRA premiums under excepted benefit HRAs in the final rules. Excepted benefit HRA participants or beneficiaries may choose to elect COBRA or other group continuation coverage, even if other more affordable coverage options are available. For example, they may want to ensure they are still able to see their preferred doctors or maintain coverage for certain prescription drugs. Furthermore, nothing in the final rules requires an employer to make an excepted benefit HRA available for the reimbursement of COBRA (or other group continuation coverage) premiums. The Departments also do not agree that an HRA that provides reimbursement for COBRA (or other group continuation coverage) premiums would not be providing limited benefits, consistent with Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C). As explained earlier in this preamble, the restriction on annual contributions to the excepted benefit HRA ensures this HRA is limited.

b. Reimbursement of STLDI Premiums

Many commenters requested that excepted benefit HRAs not be permitted to provide reimbursement of STLDI premiums. These commenters expressed concern that some participants may use excepted benefit HRA funds to purchase STLDI policies without understanding that STLDI might not provide comprehensive coverage and is not subject to the same federal consumer protections that apply to PPACA-compliant coverage. Some commenters expressed concerns that individuals with STLDI could be exposed to serious financial risk and others expressed concerns about specific benefits or conditions not generally covered by STLDI. One commenter represented that

[213] *See* Notice 2002–45 which states ''[a]n HRA does not qualify for the exclusion under [Code section] 105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement other than the reimbursement of medical care expenses. If any person has such a right under an arrangement currently or for any future year, all distributions to all persons made from the arrangement in the current tax year are included in gross income, even amounts paid to reimburse medical care expenses.''

in some states, individuals with an excepted benefit HRA and STLDI coverage would not satisfy state law requirements to maintain comprehensive coverage and would, therefore, incur state income tax penalties. A few commenters stated that they believed that permitting reimbursement for STLDI premiums would mean that the excepted benefit HRA would not be providing a limited benefit because STLDI policies typically cover at least some of the same benefits as individual health insurance coverage and because Congress exempted STLDI from the market requirements by distinguishing it from individual health insurance coverage rather than making it an excepted benefit. Other commenters were concerned that this rule would incentivize small employers to offer an excepted benefit HRA to purchase STLDI, instead of a QSEHRA to purchase individual health insurance coverage.

Several commenters also claimed that permitting excepted benefit HRAs to reimburse STLDI premiums would lead to market segmentation, potentially negatively affecting the small group market. These commenters argued that healthier, lower-cost individuals who do not have preexisting conditions and who believe they do not need comprehensive benefits would enroll in STLDI, rather than in more comprehensive group or individual coverage. In the opinion of these commenters, this scenario is more likely to occur in the fully-insured small group market, where premiums do not vary based on an individual employer's claims experience.[214] In contrast, large employers whose plans are experience-rated, or employers that offer self-insured plans, likely would not offer an excepted benefit HRA that could be used to reimburse STLDI premiums because, according to these commenters, healthy employees foregoing coverage under the employer's traditional group health plan could result in direct negative financial consequences on the cost of maintaining that plan; thus, the employer would have strong incentives not to offer an excepted benefit HRA that could be used to purchase STLDI. One commenter noted that the benefit of allowing HRAs to be used for STLDI is outweighed by the risks to the individual and small group markets. Other commenters supported making STLDI more available generally to consumers, citing choice and flexibility, as well as affordability.

The final rules generally do not prohibit reimbursement of STLDI premiums by excepted benefit HRAs. Employees at small firms are increasingly turning down an offer of health coverage.[215] Low-wage workers at small firms are especially likely to turn down such coverage when offered, particularly as a given premium is a larger share of income for a low-wage employee.[216] Thus, low-wage workers at smaller firms who are turning down the employer offer of coverage are potentially likely to benefit from permitting the excepted benefit HRA to reimburse STLDI premiums. To the extent that people who would use the excepted benefit HRA to purchase STLDI would otherwise have been uninsured and, therefore, would not have been part of the small group single risk pool, the small group market is unaffected by the introduction of an excepted benefit HRA that may be used to purchase STLDI. Moreover, the impact of any adverse selection is likely to be small because the small group market is much larger than the STLDI market. Thus, any potential expansion of the number of healthier-than-average STLDI enrollees will have a smaller proportional impact on expected claims in the small group market.

While the final rules do not prohibit reimbursement of STLDI premiums by excepted benefit HRAs, the final rules include a special rule in response to commenters' concerns about the potential for adverse selection in the small group markets, as discussed later in this preamble.[217] Further, because individuals offered an excepted benefit HRA must be offered a traditional group health plan, individuals with an excepted benefit HRA who are considering STLDI will likely be deciding between STLDI and the traditional group health plan, rather than individual health insurance coverage, premiums for which may not be reimbursed by an excepted benefit HRA. Therefore, adverse selection in the individual market is mitigated.

STLDI may not be suitable coverage for all individuals in all circumstances and in many instances it might not provide coverage that is as comprehensive as individual health insurance coverage. However, STLDI can be a viable health insurance option for many people in many circumstances. Also, no individual is required to enroll in STLDI; rather, it is simply an additional (and in some circumstances, more affordable), option that may be available to them. With respect to concerns that some excepted benefit HRA participants may not understand the limited nature of STLDI, a notice is required to be prominently displayed in STLDI contracts and enrollment application materials advising consumers of the differences between STLDI and other health insurance coverage. Among other things, the notice must state that the coverage: (1) Is not required to comply with certain federal market requirements for health insurance; (2) may exclude or limit coverage for preexisting conditions; (3) may not include coverage for hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services; and (4) may have lifetime or annual dollar limits on health benefits.[218]

The Departments disagree with commenters' assertions that permitting excepted benefit HRAs to reimburse STLDI would not be providing limited excepted benefits because STLDI is not an excepted benefit and often covers some of the same benefits as individual health insurance coverage. Nothing in these final rules would designate STLDI as a limited excepted benefit. Rather, it is the HRAs that must satisfy certain conditions to be recognized as limited excepted benefits, and the HRAs must be limited as to amount and are substantially limited as to the types of premiums they may reimburse. Further, STLDI coverage often provides much more limited benefits than coverage that is subject to the market requirements. Taking all of this into account, the Departments have determined that excepted benefit HRAs are sufficiently limited to constitute a limited excepted benefit, notwithstanding that employers may generally elect to permit HRA reimbursement of STLDI premiums.

One commenter noted that the excepted benefit HRA rules do not preempt state regulation of STLDI and

[214] *See* PHS Act section 2701 and PPACA section 1312(c). *See also* 45 CFR 147.102 and 45 CFR 156.80.

[215] In 1999, 17 percent of workers eligible for employer coverage at small firms (those with 3 to 199 workers) turned down the offer of employer coverage. By 2011, this share had climbed to 22 percent, and in 2018 it was 27 percent. *See* Kaiser Family Foundation, ''Employer Health Benefits 2018 Annual Survey,'' Figure 3.1, available at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

[216] *Id.*

[217] To the extent an excepted benefit HRA reimburses premiums for STLDI, the insurance, which is not individual health insurance coverage, will not be eligible for the safe harbor under 29 CFR 2510.3–1(l). Accordingly, to the extent offered in connection with a group health plan, the benefits could be subject to those provisions of ERISA that apply to excepted benefits (for example, ERISA parts 1, 4, and 5).

[218] *See* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

so do not inhibit a state from prohibiting the sale of STLDI. The Departments agree with the commenter that nothing in the final rules affects state regulation of STLDI.

5. Uniform Availability

To prevent an excepted benefit HRA from intentionally or unintentionally, directly or indirectly, steering participants or dependents with adverse health factors away from the sponsor's traditional group health plan, the proposed rules provided that an excepted benefit HRA must be made available under the same terms to all similarly situated individuals, regardless of any health factor.[219] The Departments proposed and are finalizing this condition to prevent discrimination based on health status and to preclude opportunities for an employer to offer a more generous excepted benefit HRA to individuals with an adverse health factor, such as an illness or a disability, as an incentive not to enroll in the plan sponsor's traditional group health plan.[220] Consistent with the approach outlined in the proposed rules, under the final rules, an excepted benefit HRA may not, for example, be offered only to employees who have cancer or fail a physical examination, just as the excepted benefit HRA may not be offered only to employees who are cancer-free or who pass a physical examination. Similarly, an employer may not make greater amounts available in an excepted benefit HRA for employees who have cancer or who fail a physical examination, just as an employer may not make greater amounts available in an excepted benefit HRA for employees who are cancer-free or who pass a physical examination.

Commenters generally supported this requirement and asserted that it is necessary to prevent discrimination based on health status. Two commenters sought confirmation that an excepted benefit HRA would not violate the uniform availability requirement if it were made available to only certain individuals, such as pre-Medicare eligible retirees who decline coverage under the former employer's traditional group health plan and purchase coverage through the individual market, so long as those eligibility conditions are not based on a health factor. In the Departments' view, a plan design that permits enrollment in an excepted benefit HRA only if coverage is declined under the traditional group health plan is inconsistent with the uniform availability requirement and with the basic premise that an excepted benefit HRA must be ancillary to the employer's traditional group health plan. HHS further notes that structuring the offering or design of a group health plan based on pre-Medicare status would generally run afoul of the Medicare nondiscrimination provisions described earlier in this preamble.[221] Therefore, an employer may not condition enrollment in an excepted benefit HRA on declining to enroll in the traditional group health plan.

As noted earlier in this preamble, Code section 9831(a) and ERISA section 732(a) generally provide that chapter 100 of the Code and part 7 of ERISA, respectively, do not apply to plans, including HRAs, with fewer than two participants who are current employees on the first day of the plan year (including retiree-only plans that cover fewer than two participants who are current employees).[222] Therefore, a retiree-only HRA is not subject to the market requirements and would not need to qualify as an excepted benefit in order to avoid the application of PHS Act sections 2711 and 2713. However, a retiree-only HRA that does not qualify as an excepted benefit would qualify as MEC,[223] and, therefore, a retiree who accepted such an HRA could not claim the PTC.[224]

One commenter suggested that the Departments should issue additional guidance and resources about the definition of similarly situated individuals to ensure that this requirement is properly implemented. In response to these comments, the final rules define similarly situated individuals by reference to the definition found in the HIPAA nondiscrimination rules, as was proposed.[225] Those rules generally provide that group health plans may, subject to an anti-abuse provision for discrimination directed at individuals, treat groups of participants as distinct groups if the distinction is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined based on all the relevant facts and circumstances, including whether the employer uses the classification for purposes independent of qualification for health coverage (such as, determining eligibility for other employee benefits or determining other terms of employment). Examples in the HIPAA nondiscrimination rules of classifications that may be bona fide, based on all the relevant facts and circumstances, include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, current employee versus former employee status, and different occupations. Under the anti-abuse provision, however, a distinction between groups of individuals is not permitted if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may, subject to certain anti-abuse provisions for discrimination directed at individuals, treat beneficiaries as distinct groups based on the bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage; the relationship to the participant; marital status; with respect to children of a participant, age or student status; and other factors if the factor is not a health factor. Finally, the HIPAA nondiscrimination rules generally allow group health plans to treat participants and beneficiaries as distinct groups. Additional guidance on similarly situated individuals is available on DOL's website.[226] The final rules define similarly situated individuals by reference to the definition in the HIPAA

[219] *See* Code section 9802(a)(1), ERISA section 702(a)(1) and PHS Act 2705(a)(1). *See also* 26 CFR 54.9802–1(a)(1) and (d), 29 CFR 2590.702(a)(1) and (d), and 45 CFR 146.121(a)(1) and (d).

[220] *See* 83 FR 54420, 54438 (Oct. 29, 2018).

[221] SSA sections 1862(b)(1)(A)(i)(I), (b)(1)(B)(i), and (b)(1)(C)(i).

[222] While title XXVII of the PHS Act, as amended by PPACA, no longer contains a parallel provision at PHS Act section 2721(a), HHS has explained that it will not enforce the requirements of title XXVII of the PHS Act with respect to nonfederal governmental retiree-only plans and generally encourages states to adopt a similar approach with respect to retiree-only plans offered by issuers. *See* 75 FR 34538, 34540 (June 17, 2010).

[223] 26 CFR 1.5000A–2(c).

[224] 26 CFR 1.36B–2(c)(3). Note that a former employee is only rendered ineligible for the PTC if the former employee enrolls in employer-sponsored coverage; an offer of coverage (even if it is affordable and provides MV) does not preclude a former employee from claiming the PTC. *See* 26 CFR 1.36B–2(c)(3)(iv).

[225] *See* 26 CFR 54.9802–1(d), 29 CFR 2590.702(d), and 45 CFR 146.121(d).

[226] *See* Compliance Assistance Guide—Health Benefits Coverage Under Federal Law, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf*; Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a.pdf*; and FAQs on HIPAA Portability and Nondiscrimination Requirements for Employers and Advisers, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.pdf*.

nondiscrimination rules, which are also designed to prevent discrimination in group health plans based on health status. These standards are already familiar to stakeholders and therefore use of the existing definition will reduce complexity and the potential burden of having to use a different definition.

6. Coordination With HSAs

Commenters asked for clarification regarding the circumstances in which participation in an excepted benefit HRA might preclude an individual from being eligible for an HSA. These commenters expressed concern that, because HSA eligibility is restricted if an individual has certain other types of health coverage, a loss of HSA eligibility could occur for some individuals enrolled in excepted benefit HRAs.

As explained earlier in this preamble, among the requirements for an individual to qualify as an eligible individual under Code section 223(c)(1) for purposes of HSA eligibility is that the individual must be covered under an HDHP and have no disqualifying health coverage. If an individual fails to satisfy the requirements to be an eligible individual, then contributions to an HSA are disallowed. The Treasury Department and the IRS have provided some guidance on the interaction between HRAs and the requirements of Code section 223 in Revenue Ruling 2004–45 and IRS Notice 2008–59. More specifically, as explained earlier in this preamble, in Revenue Ruling 2004–45, the Treasury Department and the IRS clarified that an otherwise eligible individual (that is, an individual with coverage under an HDHP and no disqualifying coverage) remains an eligible individual for purposes of making contributions to an HSA for periods during which the individual is covered by a limited-purpose HRA, a post-deductible HRA, or combinations of these arrangements. Subsequently, Q&A–1 of IRS Notice 2008–59 stated that a limited-purpose HRA that is also available to pay premiums for health coverage does not disqualify an eligible individual from contributing to an HSA, provided the individual does not use the HRA to, or otherwise, obtain coverage that is not HSA-compatible.

This prior guidance applies to all HRAs, including excepted benefit HRAs.[227] Therefore, for example, an individual covered by an excepted benefit HRA that is available to pay premiums for STLDI is an eligible individual for purposes of making contributions to an HSA, assuming the HRA is used to purchase STLDI that qualifies as an HDHP (and so, for example, the STLDI does not pay benefits prior to satisfying the minimum required deductible),[228] and the individual has no disqualifying coverage.

7. Notice Requirements

Several commenters suggested that the Departments impose certain notice requirements for excepted benefit HRAs in the final rules. Commenters stated that the required notice should be similar to the notice required for individual coverage HRAs, or should, at a minimum, inform participants and beneficiaries of the annual dollar limit for benefits under the excepted benefit HRA, other terms and conditions of the excepted benefit HRA, and participants' and beneficiaries' rights under the excepted benefit HRA.

However, the Departments note that for private-sector, employment-based plans, other long-standing notice requirements under Part 1 of ERISA already apply. ERISA-covered plans, including excepted benefit HRAs, must provide an SPD, summaries of material modifications, and summaries of material reductions in covered services or benefits.[229] Under ERISA sections 102 and 104 and their implementing regulations, an excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Excepted benefit HRAs that are ERISA-covered plans are subject to additional disclosure requirements to provide instruments under which the excepted benefit HRA is established or operated and information relevant to a participant's adverse benefit determination upon request.[230]

Under these disclosure provisions, excepted benefit HRAs that are ERISA-covered plans should generally provide information on eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits. Accordingly, for excepted benefit HRAs that are subject to ERISA, the final rules include a cross reference to existing ERISA notice provisions in order to ensure that excepted benefit HRA plan sponsors are aware of their obligations under those provisions. However, the final rules do not include any additional notice requirements for ERISA-covered plans.

In response to commenters' concerns, HHS intends to propose in future rulemaking a notice requirement with respect to non-federal governmental plan excepted benefit HRAs. HHS anticipates proposing that a non-federal governmental plan excepted benefit HRA would be required to provide a notice that states conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of, or summary of, the benefits consistent with the requirements of 29 CFR 2520.102–3(j)(2) and (3). HHS anticipates that, under the proposal, this notice would be required to be provided in a time and manner consistent with the requirements of 29 CFR 2520.104b–2(a).

8. Special Rule To Address the Potential Impact on the Small Group Market of the Reimbursement of STLDI Premiums Through Excepted Benefit HRAs

As discussed earlier in this preamble, the final rules include a special rule in response to comments regarding the potential for adverse selection in the small group market if small, insured employers also sponsor excepted benefit HRAs that reimburse STLDI premiums. Specifically, the final rules provide that the Departments may restrict excepted benefit HRAs from reimbursing STLDI premiums, for certain employers in a state, if five criteria are satisfied.

First, the restriction applies only to excepted benefit HRAs offered by small employers, as defined in PHS Act section 2791(e)(4), to respond to concerns by commenters about adverse selection in the small group market. Second, the restriction applies only in situations in which the other group health plan coverage offered by the

[227] To be an eligible individual under Code section 223(c)(1), an individual may not be covered by a health plan that is not an HDHP, except for certain coverage which is disregarded, as enumerated in Code section 223(c)(1)(B). Code section 223(c)(1)(B) does not disregard all excepted benefits, and an excepted benefit HRA is not disregarded coverage. Therefore, an excepted benefit HRA must be HSA-compatible under the relevant Code section 223 guidance in order to allow an otherwise eligible individual to remain an eligible individual under Code section 223.

[228] *See* Code section 223(c)(2). *See also* Notice 2008–59, Q&A–14, which provides that to be an HDHP a plan must provide significant benefits, and if a plan only provides benefits for hospitalization or in-patient care, the plan would not qualify as an HDHP.

[229] *See* ERISA sections 102 and 104. *See also* 29 CFR 2520.104b–2 and 2520.104b–3(a) and (d)(3).

[230] *See, e.g.,* ERISA sections 104(b), 502(c), and 503. *See also* 29 CFR 2520.104b–1 and 2560.503–1.

small employer is either fully-insured or partially-insured. This focus on insured coverage again is designed to narrowly address the potential for adverse selection by small, insured employers that was identified by commenters. Third, the restriction applies only if the Secretary of HHS makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for STLDI by excepted benefit HRAs in a state has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

Fourth, this finding may be made only after submission of a written recommendation by the applicable state regulatory authority of such state, in the form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of STLDI premiums by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including on small group market premiums. The evidence may include the State Insurance Commissioner's documented overall assessment of the small group market in the state. It may also include representations made by small group market issuers that an increase in the purchase of STLDI coverage by employees of small employers has caused issuers to increase premiums for small group market insurance, due to the issuers' reasonable belief about adverse selection. HHS will evaluate each recommendation on a case-by-case basis. Factors that HHS may consider in determining whether significant harm had occurred include, but are not limited to, the impact on issuers' presence in the small group market, whether there has been more than a de minimis increase in premiums in the small group market, enrollment declines in the small group market related to individuals purchasing STLDI, and changes to the health of the small group market risk pool.

Finally, the restriction (or discontinuance of the restriction) must be imposed by publication of a notice by the Secretary of HHS in the **Federal Register** and will be effective prospectively only, and with a reasonable time for plan sponsors to comply.

9. Other Comments on Excepted Benefit HRAs and Comments Outside the Scope of This Rulemaking

Some commenters raised issues that relate to types of excepted benefits other than excepted benefit HRAs. For example, several commenters requested that the Departments extend the pilot program for limited wraparound coverage.[231] One commenter requested that the Departments amend the criteria for health FSAs to incorporate the excepted benefit HRA, instead of adding a new excepted benefit HRA, to avoid the appearance of too many limited excepted benefits. Other commenters requested that the Departments address questions regarding fixed indemnity and hospital indemnity insurance. However, the proposed excepted benefit rules were limited to establishing criteria for certain HRAs to qualify as excepted benefits and, therefore, those comments are outside the scope of this rulemaking.

Notwithstanding that fact, the Departments do not intend to extend the pilot program for limited wraparound coverage, due to minimal take up and overlap with various other benefit options, including the new excepted benefit HRA, which, like the limited wraparound coverage excepted benefit, can be used for cost sharing under and expenses for services not covered by individual health insurance coverage, while not causing covered individuals to be ineligible for the PTC.

One commenter suggested that the excepted benefit HRA should only be allowed to be offered by an employer that has not previously offered health coverage, which the commenter appears to have suggested due to a concern about employers offering an excepted benefit HRA instead of comprehensive coverage. The Departments decline to limit excepted benefit HRAs in this way as the excepted benefit HRA is intended to provide flexibility and additional healthcare options to all employers and their employees. However, to the extent the commenter is concerned about plan sponsors no longer offering traditional group health plans, the Departments reiterate that in order to offer the excepted benefit HRA, a plan sponsor must also offer those eligible for the HRA a traditional group health plan.

Some commenters expressed confusion regarding the interaction of the excepted benefit HRA and the employer shared responsibility provisions under Code section 4980H. The Departments note for the sake of clarity, as explained earlier in this preamble, that coverage that consists solely of excepted benefits is not MEC.[232] Therefore, the offer of an excepted benefit by an employer is not considered to be an offer of MEC under an eligible employer-sponsored plan for purposes of Code section 4980H. Although an employer will not avoid potential liability for a payment under Code section 4980H by virtue of an offer of an excepted benefit, including an excepted benefit HRA, the traditional group health plan that is required to be offered in order to offer the excepted benefit HRA would constitute an offer of MEC under an eligible employer-sponsored plan.[233]

One commenter inquired whether an individual enrolled in an excepted benefit HRA would have a special enrollment right in the employer's traditional group health plan if the individual had enrolled in STLDI and then coverage under the STLDI was rescinded because the individual became sick. The Departments clarify that under the special enrollment rules for group health plans, in general, an employee or dependent is eligible for special enrollment if they are otherwise eligible for the benefit package; when coverage under the plan was previously offered, the employee had group health plan or health insurance coverage; and then the employee loses eligibility for other coverage.[234] STLDI is health insurance coverage and, therefore, loss of eligibility for STLDI will create a special enrollment opportunity to enroll in a group health plan, if the employee otherwise satisfies the special enrollment opportunity requirements. However, under the special enrollment rules for individual market coverage, loss of eligibility for STLDI will not trigger an SEP in the individual market.[235]

Other comments not responsive to the provisions and topics addressed by the proposed rules, or otherwise beyond the scope of the proposed and final rules, are not addressed.

C. Interaction Between Individual Coverage HRAs and Excepted Benefit HRAs

Under the final rules, as under the proposed rules, a plan sponsor is permitted to offer an individual coverage HRA to a class of employees so long as it does not also offer a traditional group health plan to the same class of employees, subject to

[231] *See* 26 CFR 54.9831–1(c)(3)(vii), 29 CFR 2590.732(c)(3)(vii), and 45 CFR 146.145(b)(3)(vii).

[232] *See* Code section 5000A(f)(3).

[233] *See* Code section 4980H(a)(1) and (b)(1). *See also* 26 CFR 54.4980H–1(a)(14).

[234] *See* Code section 9801(f), ERISA section 701(f), and PHS Act section 2704(f). *See also* 26 CFR 54.9801–6(a)(2)(i) and (3)(i), 29 CFR 2590.701–6(a)(2)(i) and (3)(i), and 45 CFR 146.117(a)(2)(i) and (3)(i).

[235] *See* 45 CFR 155.420(d)(1)(i), which provides an SEP in the individual market only for loss of coverage that constitutes MEC. *See also* 45 CFR 147.104(b)(2) and 83 FR 38212, 38225 (Aug. 3, 2018) (stating that STLDI ''. . . is not individual health insurance coverage, nor is it MEC.'').

additional applicable conditions discussed elsewhere in this preamble. However, a plan sponsor may only offer an excepted benefit HRA if traditional group health plan coverage is also made available to the employees who are eligible to participate in the excepted benefit HRA. Thus, a plan sponsor cannot offer both an individual coverage HRA and an excepted benefit HRA to any employee.[236]

III. Overview of Final Rules Regarding the Premium Tax Credit—Department of the Treasury and the IRS

A. In General

Consistent with the objectives in Executive Order 13813 to expand the use of HRAs, the proposed rules included an amendment to the rules under Code section 36B to provide guidance for individuals who are offered or covered by an individual coverage HRA and who otherwise may be eligible for the PTC. As explained earlier in this preamble, an employee who is offered coverage under an eligible employer-sponsored plan, and an individual who may enroll in the coverage because of a relationship to the employee (a related individual), are not eligible for a PTC for any month the eligible employer-sponsored plan is affordable and provides MV.[237] Further, an employee or related individual who enrolls in an eligible employer-sponsored plan for a month is ineligible for a PTC for that month regardless of whether the coverage is affordable or provides MV.[238]

Because an HRA is a self-insured group health plan, under existing rules, an individual who is covered by an individual coverage HRA is ineligible for the PTC.[239] However, guidance was needed regarding the PTC eligibility of an individual who is offered, but opts out of, an individual coverage HRA, and, therefore, the Treasury Department and the IRS issued the proposed PTC rules.

Consistent with the rule for traditional group health plans under Code section 36B and the existing rules thereunder, the proposed rules provided that an employee and a related individual offered an individual coverage HRA (a related HRA individual) would not be eligible for a PTC for any month the individual coverage HRA is affordable. Relatedly, the proposed rules provided that an affordable individual coverage HRA would be deemed to provide MV. Therefore, under the proposed rules, if an employee and a related HRA individual are offered an individual coverage HRA that is affordable, the employee and related HRA individual are ineligible for a PTC even if the employee opts out of the individual coverage HRA. However, an employee and a related HRA individual offered an individual coverage HRA that is not affordable will be eligible for the PTC (assuming they are otherwise eligible) if the employee opts out of the individual coverage HRA.

Commenters generally acknowledged that guidance was needed, and some commenters agreed with the proposed rules relating to the effect of an individual coverage HRA offer on an individual's PTC eligibility. However, a number of commenters expressed concern that the proposed rules would adversely affect lower-paid employees and their ability to obtain adequate subsidies for their healthcare coverage. The commenters pointed out that the PTC generally is more valuable than the individual coverage HRA would be for lower-paid employees. These commenters suggested that the individual coverage HRA would subsidize the cost of coverage for higher paid employees while making coverage more expensive, and likely out of reach, for the lower-paid employees who would have been eligible for a PTC but for the offer of an individual coverage HRA. Some commenters expressed a concern that the complexity of the rules would make it difficult for employees to make optimal decisions about their coverage and whether to opt out of the individual coverage HRA, with some noting a concern that employees may mistakenly opt out of an affordable individual coverage HRA because they believe that the opt-out preserves their PTC eligibility, only to find out that they have lost both PTC eligibility and the right to reimbursements under the individual coverage HRA. Some commenters expressed concern that employers might inadvertently offer an individual coverage HRA that leaves employees worse off than they would have been had the employer not offered the HRA, whether or not the employees opt out of the arrangement. The Departments note that this concern, however, is mitigated by the fact that employers seek to maximize overall employee welfare in order to recruit and retain talented workers.

To address these concerns, some commenters suggested that employees who are otherwise eligible for the PTC should be allowed both the PTC and the individual coverage HRA offered to them by their employers. Other commenters suggested a rule to allow employees to choose between an individual coverage HRA and the PTC. Under this suggested rule, an employee would be able to opt out of the individual coverage HRA and receive the PTC in situations in which the PTC would provide a more generous subsidy than the individual coverage HRA. Employees would have this choice regardless of whether the individual coverage HRA was affordable or provided MV.

The final rules retain the rule as proposed that an employee and a related HRA individual are not eligible for a PTC for any month the employee is offered an individual coverage HRA that is affordable, even if the employee opts out of the arrangement. An individual coverage HRA is an eligible employer-sponsored plan for purposes of Code section 36B. Code section 36B(c)(2)(B) and 26 CFR 1.36B–2(a)(2) provide that an employee and a related individual who are offered coverage under an eligible employer-sponsored plan are not eligible for a PTC for any month that the eligible employer-sponsored coverage is affordable and provides MV. Under these provisions, an individual generally is ineligible for a PTC for a month in which the individual had an opportunity to enroll in affordable, MV employer-sponsored coverage, regardless of whether the individual actually chose to enroll. Therefore, Code section 36B and the applicable rules do not allow individuals to choose between an offer of employer-sponsored coverage that is affordable and that provides MV or Exchange coverage with a PTC. Furthermore, many of the concerns raised by commenters also apply to traditional group health plans; for example, lower-income individuals may be better off with the PTC than a traditional group health plan. Thus, consistent with the rules for traditional group health plans, the final rules retain the rule that a PTC is not allowed for any month in which the individual coverage HRA is affordable.

As to the suggestion by commenters that individuals should be allowed to both enroll in the individual coverage HRA and claim the PTC if otherwise

[236] The Departments note that an employer may not provide a QSEHRA to any employee if it offers any employee a group health plan. Accordingly, an employer may not provide a QSEHRA to any employee if it offers any employee an individual coverage HRA (which is a group health plan) or an excepted benefit HRA (which is a group health plan and which requires an offer of a traditional group health plan). *See* Code section 9831(d)(3)(B)(ii).

[237] Code section 36B and 26 CFR 1.36B–2(c)(3)(i).

[238] 26 CFR 1.36B–2(c)(3)(vii)(A).

[239] See the discussion earlier in this preamble of the related requirement under the final integration rules that plan sponsors provide participants with an annual opportunity to opt-out of and waive future reimbursements under an individual coverage HRA.

eligible, this is precluded by Code section 36B(c)(2)(C)(iii). Under that Code section, and as noted earlier in this preamble, an individual who is covered for one or more months by a group health plan, including an individual coverage HRA, is ineligible for the PTC for his or her Exchange coverage for those months. Therefore, the final PTC rules do not adopt this suggestion.

The Treasury Department and the IRS agree with commenters that some lower-paid employees may be adversely affected by an employer's offer of an individual coverage HRA because the PTC, if available, could provide a larger subsidy for the employee's Exchange coverage as compared to the individual coverage HRA. However, this dynamic already exists under current rules, as an individual may be required to pay a greater portion of his or her household income for a traditional group health plan than the individual would, in the absence of an offer of employer-sponsored coverage, have to pay for Exchange coverage with a PTC. Under Code section 36B(b)(3)(A) and current PTC rules, an individual's contribution amount for 2019 Exchange coverage may be as little as 2.08 percent of household income for an individual who claims the PTC whereas the same individual may have to pay up to 9.86 percent of household income for coverage offered by the individual's employer and still be considered to have an affordable offer and therefore ineligible for the PTC. Nevertheless, an employee in this situation is not permitted to forego the employer coverage and choose the Exchange coverage with a PTC to take advantage of the smaller contribution amount. Under the final rules, the same treatment applies to offers of an individual coverage HRA: That is, individuals are not allowed to forego an individual coverage HRA that is affordable (and thus deemed to provide MV) and instead choose the Exchange coverage with a PTC.

The Departments also appreciate the concerns expressed by commenters regarding the burden on employees to properly determine whether the HRA they have been offered is affordable and provides MV and whether they should opt out of the individual coverage HRA. These concerns are the primary reason that the Departments proposed to require employers that offer individual coverage HRAs to provide a written notice to each participant. The final rules strengthen the notice requirement and the Departments are providing model notice language regarding the PTC, separate from, but contemporaneous with, the final rules. Further, the Departments will work closely with the State Exchanges to ensure that Exchanges' applications and other relevant materials are updated to assist individuals with an individual coverage HRA offer who are applying for, or considering applying for, individual health insurance coverage, in determining whether they are eligible for APTC.

Lastly, the Treasury Department and the IRS note that under the final rules, an individual coverage HRA may be integrated with Medicare, if certain conditions are satisfied. Individuals who are enrolled in Medicare for one or more months during the calendar year are not eligible for the PTC for their Exchange coverage for those months.[240] Therefore, the final PTC rules regarding when an offer of an individual coverage HRA is considered affordable are not relevant for individuals enrolled in Medicare. Those individuals are ineligible for the PTC without regard to whether they are offered or covered by an individual coverage HRA.[241]

B. Use of Lowest Cost Silver Plan To Determine Affordability of an Individual Coverage HRA

The proposed rules provided that an individual coverage HRA is affordable for an employee and a related HRA individual for a month if the employee's required HRA contribution does not exceed 1/12 of the product of the employee's household income and the required contribution percentage (defined in 26 CFR 1.36B–2(c)(3)(v)(C)). The proposed rules defined an employee's required HRA contribution as the excess of: (1) The monthly premium for the lowest cost silver plan for self-only coverage available to the employee through the Exchange for the rating area in which the employee resides; over (2) the monthly self-only HRA amount provided by the employee's employer.[242] The monthly self-only HRA amount was proposed to be the self-only HRA amount newly made available to the employee under the individual coverage HRA for the plan year, divided by the number of months in the plan year the individual coverage HRA is available to the employee.

In the preamble to the proposed rules, the Treasury Department and the IRS explained that the lowest cost silver plan was chosen because, in the individual market, the lowest cost silver plan is the lowest cost Exchange plan for which the plan's share of the total allowed costs of benefits provided under the plan is certain to be at least 60 percent of such costs, as required by Code section 36B(c)(2)(C)(ii) for a plan to provide MV. In selecting the lowest cost plan for which it is certain that the plan's share of the total allowed costs of benefits provided under the plan will be at least 60 percent of such costs, the proposed rules sought to most closely approximate the PTC eligibility rules that apply to offers of eligible-employer sponsored coverage that is not an HRA.[243] The proposed rules also provided that an individual coverage HRA that is affordable is treated as providing MV, because the plan used to determine affordability will always provide MV and so an employee who is offered an affordable individual coverage HRA has the ability to purchase affordable coverage that provides MV. In the preamble to the proposed rules, the Treasury Department and the IRS requested comments on whether the lowest cost silver plan is the appropriate metal-level plan to use to determine affordability of an individual coverage HRA for PTC eligibility purposes.

A number of commenters advocated for retaining the proposed rule's use of the lowest cost silver plan as the

[240] *See* Code section 36B(c)(2)(B) and 26 CFR 1.36B–2(a)(2). An individual generally is eligible for Medicare if the individual meets the criteria for coverage under the program as of the first day of the first full month the individual may receive benefits under the program. *See* 26 CFR 1.36B–2(c)(2)(i). However, an individual who meets the criteria for eligibility for Medicare must complete the requirements necessary to receive benefits. *See* 26 CFR 1.36B–2(c)(2)(ii). An individual who fails by the last day of the third full calendar month following the event that establishes eligibility for Medicare to complete the requirements to obtain that coverage is treated as eligible for Medicare as of the first day of the fourth calendar month following the event that establishes eligibility. *Id.*

[241] The Treasury Department and the IRS are considering whether clarification is needed regarding how to determine whether an offer of an individual coverage HRA to an employee enrolled in Medicare is considered affordable and to provide MV for purposes of Code section 4980H. The Treasury Department and the IRS anticipate addressing that issue in guidance in the near term.

[242] If the employer offers an HRA that provides for a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage, the monthly maximum amount available to the employee is used to determine affordability. The monthly maximum amount was proposed to be the maximum amount available to the employee divided by the number of months in the plan year the individual coverage HRA is available to the employee.

[243] With regard to an offer of eligible employer-sponsored coverage that is not an HRA, an individual is eligible for the PTC for his or her Exchange coverage only if the employee's required contribution, which is the portion of the annual premium that would be paid for the lowest cost self-only MV coverage offered by the employer to the employee, exceeds a certain percentage of the employee's household income. *See* Code section 36B(c)(2)(C).

appropriate plan to determine affordability and MV of an individual coverage HRA for PTC eligibility. These commenters stated that although the lowest cost silver plan generally would have an actuarial value that is higher than is required to provide MV under a traditional group health plan, a bronze-level plan would not always be sufficient to provide MV.[244] Therefore, the commenters found the use of the lowest cost silver plan to be a reasonable approximation of the PTC eligibility rules that apply to offers of traditional group health plans.

Some commenters suggested using a gold-level plan to determine affordability, contending that the coverage benefits provided by a gold-level plan more closely resemble the coverage benefits under a traditional group health plan. According to these commenters, using a gold-level plan for the affordability determination would ensure that an employee who is offered an individual coverage HRA would not pay more for health coverage that provides fewer benefits than the employee would have paid for under either a traditional group health plan or Exchange coverage with a PTC.

Other commenters suggested that a bronze-level plan should be used for determining affordability of an individual coverage HRA, arguing that a bronze-level plan is comparable to coverage under a traditional group health plan which provides MV because a bronze-level plan generally has an actuarial value of 60 percent. According to these commenters, using a silver-level plan to determine affordability and MV for PTC eligibility would provide employees (and related HRA individuals) with greater coverage benefits than required under traditional group health plans.

A plurality of the commenters on the issue of the appropriate affordability plan suggested that the second lowest cost silver plan (SLCSP) should be used to determine the affordability of an individual coverage HRA. These commenters generally pointed to administrative ease and the affordability rules for QSEHRAs as the reasons for modifying the proposed rule. Under Code section 36B, a taxpayer who is eligible for the PTC computes his or her PTC amount using the premiums for the SLCSP available to the taxpayer. Therefore, the commenters asserted that information concerning the premiums for a taxpayer's applicable SLCSP is already readily available to taxpayers and providing this information to taxpayers for their individual coverage HRA affordability determinations would not require additional Exchange resources. In addition, in light of the fact that the SLCSP is already used for certain PTC purposes, the commenters expressed concern that using premiums for the lowest cost silver plan instead of the SLCSP could lead to confusion and miscalculations. Commenters also noted that the premiums for the SLCSP are used to determine affordability for QSEHRAs. Some commenters expressed concern that using the lowest cost silver plan for affordability would result in three different affordability calculations depending on whether an employee was offered a traditional group health plan, a QSEHRA, or an individual coverage HRA. However, some commenters opposed the use of the SLCSP, contending that the higher premiums for a SLCSP, which may not always provide greater benefits than the lowest cost silver plan, do not warrant modifying the proposed rule's use of the lowest cost silver plan to determine affordability of an individual coverage HRA.

After consideration of the comments, the final rules adopt as proposed the use of the lowest cost silver plan for self-only coverage available through the Exchange in the rating area in which the employee resides to determine whether an individual coverage HRA is affordable. As explained in the preamble to the proposed rules, using the lowest cost silver plan to determine the affordability of an individual coverage HRA is consistent with, and most closely approximates, the rules that apply to an offer of a traditional group health plan, under which an offer is affordable if the employee's required contribution for the lowest cost, self-only MV coverage offered by the employer to the employee does not exceed a specified percentage of the employee's household income. Further, using the lowest cost silver plan, which will not have an actuarial value lower than 66 percent, to determine affordability of an individual coverage HRA ensures that the plan used to determine affordability will always provide MV. As a result, a determination that an individual coverage HRA is affordable, using this standard, is sufficient to ensure that an employee who is offered an affordable individual coverage HRA has the ability to purchase affordable coverage that provides MV. Therefore, the Treasury Department and the IRS are also adopting as proposed the rule that an individual coverage HRA that is affordable is treated as providing MV.

The final rules result in consistent treatment for purposes of Code section 36B for employees offered an individual coverage HRA and employees offered a traditional group health plan. In both instances, the employees may be allowed the PTC if they decline the offer and the coverage is either unaffordable or does not provide MV. Further, in both instances, the employee's required contribution is based on the amount the employee must pay for self-only coverage that provides MV because under the final rules affordability is determined based on the lowest cost silver plan offered in the Exchange for the rating area in which the employee resides (which, by definition, will always provide MV). If the amount the employee must pay is more than the product of the required contribution percentage and the employee's household income, the employee may be allowed the PTC. As such, the final rules are consistent with the affordability and MV rules that apply to offers of traditional group health plans.

Although commenters suggested using a bronze-level or gold-level plan for the affordability determination, the final rules do not adopt either of those suggestions. Using a bronze-level plan could result in individuals being determined ineligible for the PTC based on the cost of a plan that does not provide MV under Code section 36B(c)(2)(C)(ii) (because a bronze plan may have an actuarial value as low as 56 percent). While use of a gold-level plan (which generally has an actuarial value no lower than 76 percent) would ensure that the plan used to determine affordability provides MV, it would be inconsistent with, and require the use of, a plan with a higher actuarial value than in the rules that apply for a traditional group health plan.

The final rules do not adopt the suggestion that the SLCSP plan be used for the affordability determination. The Treasury Department and the IRS acknowledge that the SLCSP applies for other PTC purposes, including calculation of the PTC amount and the determination of affordability of a QSEHRA. However, affordability for a traditional group health plan is based on the amount an employee would pay for a plan for which the share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs and the lowest cost silver plan, not the SLCSP, is the plan that most closely approximates that rule and provides consistency with these same

[244] In the individual market, a bronze plan may have an actuarial value of 56 percent, which would not ensure the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs, as required by Code section 36B(c)(2)(C)(ii) for a plan to provide MV. *See* 45 CFR 156.140.

rules as applied to traditional group health plans under Code section 36B. Consequently, the final rules provide a rule that is comparable to the affordability and MV rules that apply for traditional group health plans.

As to the concerns expressed by commenters regarding the potential for confusion for individuals due to the different health coverage arrangements that exist and the different PTC eligibility rules that apply, see earlier in this preamble for a discussion of the steps the Departments are taking to address those concerns, including providing a model notice that will explain the PTC consequences of an individual coverage HRA.

C. Other Issues Under the PTC Rules

The proposed rules provided that the affordability of an individual coverage HRA for a related HRA individual would be based on the cost of self-only, not family, coverage available to the employee through the Exchange for the rating area in which the employee resides. One commenter stated that affordability of an individual coverage HRA should be based on the cost of Exchange coverage for all members of the employee's family offered the individual coverage HRA, not just the self-only cost. The final rules do not adopt this suggestion. Under 26 CFR 1.36B–2(c)(3)(v)(A)(*2*), an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed a percentage of the employee's household income. Similarly, under Code section 36B(c)(4), the affordability of a QSEHRA for a spouse or dependent of an employee is based on the cost of self-only Exchange coverage to the employee. Consequently, the final rules are consistent with the existing rules for other types of employer coverage in providing that affordability of an individual coverage HRA for employees and related HRA individuals is based on the cost of self-only coverage.

One commenter stated that because of the likelihood of confusion in the early years on the part of taxpayers whose employers offer individual coverage HRAs, the IRS should waive the requirement that taxpayers increase their tax liability for excess APTC (the excess of a taxpayer's APTC over his or her allowed PTC) resulting from an offer of an affordable individual coverage HRA. Under Code section 36B(f)(2), a taxpayer must increase his or her tax liability for a taxable year by the excess of the APTC paid on the taxpayer's behalf over the PTC the taxpayer is allowed for the year, subject to a limitation for taxpayers with household income less than 400 percent of the applicable federal poverty line for the taxpayer's family size. The Treasury Department and the IRS do not have the authority to suspend this statutory rule. Thus, the final rules do not adopt this suggestion. The Departments understand, however, that there is potential for taxpayer confusion about individual coverage HRAs and have taken measures to ensure that taxpayers are aware of the PTC implications of accepting or opting out of an individual coverage HRA. In particular, as described earlier in this preamble, the final integration rules require that an individual coverage HRA provide eligible participants with a written notice setting forth certain information about the individual coverage HRA, including the potential availability of PTC if they opt out of the HRA and the PTC eligibility consequences if they accept the HRA. Individuals applying for Exchange coverage will provide information about the individual coverage HRA they have been offered to the Exchange during the application process, which will help prevent the improper payment of APTC.

A few commenters raised issues regarding the application of the PTC rules to individual coverage HRAs that are negotiated pursuant to a CBA, with the commenters asking for special rules to account for the fact that CBAs are often negotiated over multiple years, including that the affordability status that is determined as of the effective date of a CBA should apply for all years covered by the CBA. The final rules do not adopt the suggestion that special rules should apply to employees covered by CBAs. The existing rules under Code section 36B do not include special rules for determining the affordability of traditional group health plans for employees covered by CBAs. In addition, such special rules would likely result in undue complexities for Exchanges and others. Thus, employees covered by CBAs must determine affordability consistent with the rules that apply to individuals not covered by such agreements.

A number of comments were received expressing concerns about the effective date for the final rules generally, but many with a specific focus on issues related to implementing the final PTC rules by 2020. These comments are addressed later in this preamble.

Also, commenters expressed concern about the availability of resources for verifying eligibility for APTC for individuals who are offered an individual coverage HRA. While Exchanges are required to verify certain eligibility requirements that affect Exchange enrollees' APTC eligibility with electronic data sources, commenters stated that electronic data sources are not available to allow State Exchanges to verify APTC eligibility based on an offer of an individual coverage HRA. Commenters urged the Departments to dedicate additional funding to the State Exchanges for electronic verification of information about individual coverage HRA offers that consumers will be required to provide to Exchanges. In response to these comments, the Departments note that Congress generally appropriates funding for the federal government. The Departments do not generally have the authority to determine additional uses of funds beyond those established by Congress, including with respect to additional funding for State Exchanges.

One commenter asked that the Treasury Department and the IRS confirm which premium applies in determining the affordability of an individual coverage HRA if more than one premium is available for the lowest cost silver plan, for example, because there is one rate for tobacco users and one rate for non-tobacco users. Existing rules at 26 CFR 1.36B–3(e) provide that, in determining a taxpayer's SLCSP premium, a monthly premium may not include any adjustments for tobacco use. Consequently, in response to the commenter, the final rules provide that if there is a silver-level plan that has one rate for tobacco users and one rate for non-tobacco users, the rate for non-tobacco users will apply to determine affordability of the individual coverage HRA.

In addition, in the context of a traditional group health plan, existing rules at 26 CFR 1.36B–2(c)(3)(v)(A)(*4*) provide that nondiscriminatory wellness program incentives [245] that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability to the extent the incentives relate exclusively to tobacco use. The rules further provide that wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. Consequently, the Treasury Department and the IRS are clarifying in these final rules that similar rules apply for purposes of determining the affordability of an individual coverage HRA. Thus, if a wellness program incentive is allowed in the individual

[245] For this purpose, the term ''wellness program incentive'' has the same meaning as the term ''reward'' in 26 CFR 54.9802–1(f)(1)(i).

market, the lowest cost silver plan premium will be determined without regard to any premium discount or rebate under that program unless the wellness program incentive relates exclusively to tobacco use.

The final rules also address a situation in which the silver-level QHP used to determine a taxpayer's lowest cost silver plan at enrollment later terminates or closes to enrollment during the plan year. Specifically, the final rules provide that, in such a case, the silver-level QHP that is used to determine a taxpayer's lowest cost silver plan will not cease to be the taxpayer's lowest cost silver plan solely because the plan later terminates or closes to enrollment. However, a taxpayer's lowest cost silver plan used to determine affordability could change during the tax year under other circumstances, such as if the taxpayer moves into a different rating area.

With respect to which HRA amounts are taken into account in determining affordability, the proposed rules provided that only amounts that are newly made available and that are determinable within a reasonable period of time before the beginning of the plan year of the HRA are considered. The proposed rules further provided that amounts made available from a prior plan year that carry over to the current plan year are not taken into account. The final rules retain these provisions and also provide that, similarly, amounts made available under an HRA to account for amounts remaining in a different HRA the employer previously provided to the employee and under which the employee is no longer covered are not taken into account for purposes of determining affordability. This clarification is generally intended to address the situation in which an employee moves between classes of employees and, as a result, moves between different HRAs, as discussed earlier in this preamble.

One commenter asked the Treasury Department and the IRS to clarify the application of the PTC rules to an employee opting out of, or accepting, an individual coverage HRA with a non-calendar year plan year.[246] As noted earlier in this preamble, the final integration rules clarify that individual coverage HRAs must provide participants with one advance opportunity to opt into, or out of, the individual coverage HRA for each plan year, but generally may not provide participants multiple opportunities to opt into, or out of, the individual coverage HRA over the course of the plan year. In addition, the final PTC rules provide specific rules to determine affordability of an individual coverage HRA for each employment period that is less than a full calendar year or for the portions of the plan year of an individual coverage HRA that fall in different taxable years of a taxpayer. Although affordability of an individual coverage HRA and thus eligibility for PTC generally are determined on a monthly basis, the opt-out rules and the part-year affordability rules work in conjunction with the employee safe harbor to provide a taxpayer with an affordability determination that generally will apply for the entire plan year of the individual coverage HRA, barring any change in circumstance of the taxpayer. For example, if a taxpayer opts out of an individual coverage HRA that begins on July 1, 2020, and an Exchange determines that the HRA is unaffordable and the taxpayer is eligible for APTC, the employee safe harbor in the final rules provides that the HRA generally will be treated as unaffordable for the entire plan year of the HRA (from July 1, 2020–June 30, 2021). If the taxpayer decides to forego both APTC and the individual coverage HRA and pay the enrollment premium out-of-pocket, the taxpayer still may claim PTC on a tax return for the months the individual coverage HRA was unaffordable if the taxpayer otherwise is eligible for PTC.[247]

D. Employer Shared Responsibility Provisions Under Code Section 4980H

As part of implementing the objectives of Executive Order 13813, the Treasury Department and the IRS are considering how Code section 4980H applies to an employer offering an individual coverage HRA.

Only ALEs are subject to Code section 4980H.[248] For an employer that is an ALE, the employer may owe a payment for a month under Code section 4980H(a) or Code section 4980H(b) or neither. In general, an ALE will owe a payment under Code section 4980H(a) if it fails to offer an eligible employer-sponsored plan to at least 95 percent of its full-time employees and their dependents and at least one full-time employee is allowed the PTC for the month.[249] An ALE that offers an eligible employer-sponsored plan to at least 95 percent of its full-time employees and their dependents (and therefore is not liable for a payment under Code section 4980H(a)) may be liable for a payment under Code section 4980H(b) if at least one full-time employee is allowed the PTC, which may occur if the eligible employer-sponsored plan offered is not affordable or does not provide MV, or if the employee was not offered coverage.

On November 19, 2018, the Treasury Department and the IRS released Notice 2018–88 which addressed the application of Code section 4980H to ALEs offering individual coverage HRAs. In order to provide clarity to stakeholders, Notice 2018–88 explained how Code section 4980H would apply to an ALE that offers an individual coverage HRA, described potential additional affordability safe harbors, requested comments, and provided examples.

The Treasury Department and the IRS intend to propose rules under Code section 4980H on the issues addressed in Notice 2018–88, taking into account the comments received. To the extent comments were received on the proposed integration rules specific to the application of Code section 4980H to employers offering individual coverage HRAs, those comments will be addressed in the preamble to the proposed rules under Code section 4980H.

[246] An employee who opts out of a non-calendar year individual coverage HRA, like an employee who opts out of a non-calendar year traditional group health plan, may qualify for an individual market SEP based on the employee's enrollment in a non-calendar year plan that is ending, regardless of whether he or she has the option to renew, per 45 CFR 155.420(d)(1)(ii). The employee may, therefore, choose to change his or her individual health insurance plan, though his or her plan options may be restricted based on 45 CFR 155.420(a)(4)(iii). Regardless of whether an employee changes his or her plan, an employee who is enrolled in Exchange coverage and opts out of an HRA when permitted to do so may apply to the Exchange for a redetermination of APTC eligibility.

[247] The proposed rules also clarified how the generally applicable employer-sponsored coverage PTC eligibility rules apply to individual coverage HRAs. The Treasury Department and the IRS are finalizing those rules as proposed. Further, existing guidance addresses when amounts newly made available under an HRA count toward the affordability or MV of another group health plan offered by the same employer. *See* 26 CFR 1.36B–2(c)(3)(v)(A)(*5*) and 26 CFR 1.36B–6(c)(4). *See also* IRS Notice 2015–87, Q&A–7. As under the proposed rules, the final rules do not make substantive revisions to those rules but do make clarifying updates to 26 CFR 1.36B–2(c)(3)(v)(A)(*5*), mainly to incorporate a reference to more recent guidance.

[248] The explanation of Code section 4980H provided here is a summary. For a complete explanation of the rules, including for definitions of terms used in this summary, see 26 CFR 54.4980H–1, *et seq.* (79 FR 8544 (Feb. 12, 2014)).

[249] Note that if an ALE offered coverage to all but five of its full-time employees (and their dependents), and five is greater than 5 percent of the employer's full-time employees, the employer will not owe an employer shared responsibility payment under Code section 4980H(a). *See* 26 CFR 54.4980H–4(a).

IV. Overview of the Final Rules Regarding Individual Health Insurance Coverage and ERISA Plan Status

A. In General

The proposed rules included an amendment to DOL rules defining the ERISA terms ''employee welfare benefit plan,'' ''welfare plan,'' and, derivatively ''group health plan,'' so that these terms would not include individual health insurance coverage, the premiums of which are reimbursed by an HRA and certain other arrangements, under certain conditions. As explained in the preamble to the proposed rules, the objective in proposing this clarification was to provide clarity and assurance to employees; employers, employee organizations, and other plan sponsors; health insurance issuers; state insurance regulators; and other stakeholders. Specifically, the objective was to provide assurance that the insurance policies sold as individual health insurance coverage (that is, policies generally subject to comprehensive federal and state individual market rules for minimum and uniform coverage, standardized rating requirements, guaranteed availability, and guaranteed renewability) would not be treated as part of an HRA or certain other arrangements for purposes of ERISA if certain conditions were satisfied.[250] Specifically, DOL proposed an amendment to 29 CFR 2510.3–1 on the definition of ''employee welfare benefit plan'' in ERISA section 3(1).[251] This proposed amendment would apply to individual health insurance coverage purchased through individual coverage HRAs. It would also apply to individual health insurance coverage purchased through certain other arrangements that reimburse participants for the purchase of individual health insurance coverage that are not subject to the market requirements (including QSEHRAs and HRAs that have fewer than two participants who are current employees on the first day of the plan year). Further, this proposed amendment would apply to an arrangement under which an employer allows employees to pay the portion of the premium for off-Exchange individual health insurance coverage that is not covered by the HRA with which the coverage is integrated by using a salary reduction arrangement under a cafeteria plan (supplemental salary reduction arrangement).[252]

ERISA section 3(1) broadly defines ERISA-covered welfare plans to include ''any plan, fund, or program'' that is ''established or maintained by an employer or employee organization'' for the provision of health benefits ''through the purchase of insurance or otherwise.'' At the same time, however, provisions in the PHS Act generally treat individual health insurance and group health insurance as mutually exclusive categories.[253] If individual health insurance coverage were considered to be a group health plan or part of a group health plan, the individual health insurance coverage typically would violate some of the group market requirements (for example, the single risk pool requirement for the small group market; the rating rules for the small group market; or the separate medical loss ratio requirements for large group insurance coverage, which is lower than that for individual or small group insurance).[254] As explained in the preamble to the proposed rules, treatment of such individual health insurance coverage as subject to both individual market and group market requirements thus would likely result in conflicting requirements, uncertainty and confusion which could inhibit or, in some instances, even preclude, the ability to integrate HRAs with individual health insurance coverage as contemplated by other provisions in the proposed rules.[255] Accordingly, DOL concluded that the ERISA status of this type of individual health insurance coverage should be clarified. Under the proposed rules, the individual health insurance coverage that is paid for by the HRA[256] is not covered by ERISA Title I if all of the conditions of the safe harbor are satisfied. The conditions in the safe harbor incorporate criteria well-recognized under similar ERISA safe harbor rules and under case law, where similar arrangements are considered to be exempt from ERISA Title I.

Under the proposed rules, the status under ERISA of an HRA, QSEHRA, or supplemental salary reduction arrangement would remain unaffected. Rather, the proposed rules clarified that individual health insurance coverage selected by the employee in the individual market and reimbursed by such a plan is not part of a group health plan, is not health insurance coverage offered in connection with a group health plan, and is not a part of any employee welfare benefit plan for purposes of ERISA Title I, provided all the following conditions are satisfied:

1. The purchase of any individual health insurance coverage is completely voluntary for employees.[257]
2. The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage.
3. Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage.
4. The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.[258]

[250] 83 FR 54420, 54440 (Oct. 29, 2018). For examples of other circumstances under which DOL has determined an arrangement is not a plan within the meaning of ERISA, see 29 CFR 2510.3–1(j), 29 CFR 2510.3–2(f), and 29 CFR 2509.99–1. *See also* DOL Field Assistance Bulletins No. 2004–01 and No. 2006–02.

[251] In light of the fact that ''group health plan'' is defined derivatively in ERISA section 733(a)(1), in relevant part, as an ''employee welfare benefit plan to the extent that the plan provides medical care . . . directly or through insurance, reimbursement, or otherwise[,]'' DOL has concluded that a separate rule relating to the definition of group health plan is not required.

[252] While the proposed rule under 29 CFR 2510.3–1(l) included in the term ''supplemental salary reduction arrangement'' cafeteria plan salary reduction arrangements paying premium amounts not covered by a QSEHRA, these final rules do not. *See* Code section 9831(d)(3)(B)(ii) and IRS Notice 2017–67, Q&A–55 (employer may allow employee to pay the excess of a health insurance premium over the amount paid by the QSEHRA with an after-tax payroll deduction (in contrast to a pre-tax salary reduction)).

[253] *See* ERISA section 733(b)(4) and PHS Act sections 2791(b)(4), (5), and (e)(1). *See also* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

[254] *See* PPACA section 1312 (which defines each issuer's enrollees in the individual market to be members of a single risk pool, and each issuer's enrollees in the small group market to be members of a separate single risk pool, unless a state has opted to merge the risk pools), PHS Act section 2701 (which sets forth maximum age rating ratios in the individual and small group markets), and PHS Act section 2718 (which sets forth medical loss ratio requirements that differ based on market).

[255] 83 FR 54420, 54441 (Oct. 29, 2018).

[256] For simplicity and readability, the discussion in this section IV of the preamble generally refers simply to HRAs, although it is intended to also capture other account-based group health plans, QSEHRAs and supplemental salary reduction arrangements. If the term HRA is intended to refer only to HRAs in this section IV, it will be clear from context. Moreover, the title of paragraph (l) of the DOL final rule is amended to refer to a ''Safe harbor for health reimbursement arrangements (HRAs) and certain other arrangements that reimburse individual health insurance coverage,'' to better reflect the regulatory text that follows.

[257] The fact that a plan sponsor requires the coverage to be purchased as a condition for participation in an HRA or supplemental salary reduction arrangement does not make the purchase involuntary. This issue should not arise in the context of a QSEHRA because in that case, although individuals must be enrolled in MEC, employers may not require employees to enroll in individual health insurance coverage.

[258] The limitation on employers, employee organizations, and other plan sponsors receiving consideration from an issuer or person affiliated with an issuer in connection with any participant's purchase or renewal of individual health insurance coverage was not intended to change any ERISA requirements governing the circumstances under

5. Each plan participant is notified annually that the individual health insurance coverage is not subject to ERISA.

Current rules issued by the Departments define ''group health insurance coverage'' as health insurance coverage offered in connection with a group health plan.[259] The proposed rules included an amendment to clarify that—subject to certain conditions—individual health insurance coverage is not group health insurance coverage (or ''health insurance offered in connection with a group health plan''). This amendment was intended to ensure consistency and avoid any potential conflicting interpretations regarding individual health insurance coverage. Accordingly, if the conditions in 29 CFR 2510.3–1(1) were satisfied, the individual health insurance coverage would not be ''health insurance coverage offered in connection with a group health plan'' for purposes of ERISA, the PHS Act, the Code, and PPACA, even though the premiums are reimbursed by an HRA.[260]

After consideration of the comments, the conditions set forth in the proposed amendment to 29 CFR 2510.3–1, and the proposed amendment to the Departments' rules defining ''group health insurance coverage,'' are being finalized without significant change, but with minor clarifications in response to comments.

B. Safe Harbor

The preamble to the proposed rules referred to the proposed amendment as a clarification. Some commenters asked DOL to clarify whether the conditions established in the proposed amendment would be considered a safe harbor, or absolute requirements for plan sponsors. These commenters asserted that it was unclear and expressed concern about the potential unintended consequences of non-compliance and confusion if all individual health insurance coverage reimbursed under an arrangement that did not satisfy the proposed criteria of the rule was treated as being subject to ERISA. Examples highlighted by commenters include how requirements under other federal laws such as HIPAA, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and PPACA would apply to the coverage (including the single risk pool requirement, the rating rules for the small group market, or the medical loss ratio requirements, as well as the PPACA section 9010 health insurance fee), whether health insurance issuers could be considered plan fiduciaries, and whether participants could bring legal actions against health insurance issuers under ERISA's private right of action provisions. They also stated that factors outside of a plan sponsor's control could result in the employer not satisfying the conditions of the rules. As one example, a commenter suggested that an insurance broker could endorse an insurance product in the context of a private exchange without the employer's knowledge, possibly resulting in a failure to satisfy the condition that the plan sponsor not select or endorse any particular issuer or insurance coverage.[261] These commenters suggested that flexibility would be appropriate to account for plan sponsors that make reasonable, good faith efforts to comply with the conditions in the proposed amendment but make de minimis errors.

As noted earlier in this section of the preamble, DOL has set forth several safe harbors in other rules and guidance under which DOL has determined an arrangement is not a plan within the meaning of ERISA.[262] These safe harbors are intended to clearly define circumstances in which a workplace arrangement falls outside of the scope of a plan under ERISA without necessarily specifying all the circumstances under which a workplace arrangement could avoid ERISA plan status. Here, too, DOL intended the proposed rules to constitute a safe harbor, as reflected in language in the proposed amendment providing that an ERISA plan ''shall not include'' individual health insurance coverage. The final rules make clear that the rule is a safe harbor.

The conditions of the various regulatory safe harbors noted earlier in this preamble are highly sensitive to the particular type of plan at issue, and the particular legal and factual context associated with that type of plan. Accordingly, DOL cautions that the particular conditions of the safe harbor provided here are not directly relevant to other types of plan arrangements, such as retirement plans, life insurance plans, or disability plans. In particular, the employer's funding of a benefit arrangement, in most circumstances, is sufficient to preclude the grant of a safe harbor. In the particular context of the individual health insurance policies at issue here, however, DOL has concluded that employer funding is not disqualifying based on its conclusion that Congress generally intended that individual and group health insurance coverage be regulated as mutually exclusive categories. In this unique context, DOL has concluded that employer funding, by itself, is an insufficient basis for treating the individual health insurance policy, as opposed to the HRA, as part of an ERISA-covered plan.

C. An Employer, Employee Organization, or Other Plan Sponsor May Not Select or Endorse Any Particular Issuer or Insurance Coverage

Paragraph (l)(2) of the proposed amendment required that the employer, employee organization, or other plan sponsor may not select or endorse any particular issuer or insurance coverage. The proposed rules clarified that an HRA plan sponsor would not be considered to have endorsed a particular issuer or insurance coverage if, for example, the plan sponsor offered general contact information regarding availability of health insurance in a state (such as providing information regarding *HealthCare.gov* or contact information for a state insurance commissioner's office) or providing general health insurance educational information (such as the uniform glossary of health coverage and medical terms available at: *https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf*).

Some commenters asked DOL to provide additional guidance on what types of activities would or would not constitute endorsement. These commenters stated that it would be important to provide HRA plan sponsors with flexibility to permit them to help employees shop for coverage, especially because many might be unfamiliar with the processes associated with obtaining health insurance in the individual market. Several commenters asked whether there would be circumstances in which a plan sponsor could connect participants or beneficiaries with an insurance agent or

which plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for certain expenses associated with administration of the plan.

[259] 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

[260] Note that the clarification with respect to the meaning of group health insurance coverage is not relevant for QSEHRAs because QSEHRAs generally are not group health plans. *See* Code section 9831(d)(1), ERISA section 733(a)(1), and PHS Act section 2791(a)(1).

[261] DOL notes that ''private exchange'' is a term that was not specifically defined in any public comments and is similarly undefined in this preamble. It is generally meant to refer to a tool or web-based platform that facilitates individuals' enrollment in the coverage of their choice. The term does not include any entity that meets the definition of an ''Exchange'' in 45 CFR 155.20.

[262] *See* 29 CFR 2510.3–1(j), 29 CFR 2510.3–2(f), and 29 CFR 2509.99–1. *See also* DOL Field Assistance Bulletins No. 2004–01 and No. 2006–02.

broker without running afoul of the prohibition on endorsement. A few commenters asked whether, or under what circumstances, an HRA could be offered in connection with a private exchange where participants could make a selection from a set of coverage options. One commenter stated that without an ability to use a private exchange model, most employers will be reluctant to offer an individual coverage HRA over a traditional group health plan, thereby undermining the purpose of the proposed rules to expand use and availability of HRAs. One commenter stated that DOL should incentivize the use of private exchanges that would provide price and quality transparency as well as navigational support for plan participants shopping for individual health insurance coverage, and possibly even require that private exchanges offer QHPs. Another commenter urged DOL to ensure that private exchanges could not be used in a manner that harms the risk pools or that is anti-competitive and promotes one issuer over another. This commenter suggested that the final rules specify that an employer cannot use an individual coverage HRA in conjunction with a plan purchased through a private exchange unless the private exchange is designed in such a way as not to constitute selection or endorsement by the employer.

A plan sponsor may provide assistance to participants and beneficiaries in shopping for individual health insurance coverage without being considered to endorse any particular coverage if that assistance is unbiased, neutral, uniformly available, and does not steer participants and beneficiaries towards a particular health insurance issuer or coverage. For example, an HRA plan sponsor could accommodate requests from insurance brokers to speak with employees or distribute informational materials at their worksite, so long as such accommodations are granted on an equal basis and also without any preference for brokers that represent a particular firm or have a relationship with a certain health insurance issuer.

DOL agrees with commenters that the use of private exchanges may be a helpful tool in shopping for coverage. However, DOL declines to adopt suggestions regarding adding incentives or requirements with respect to transparency standards, navigational support, or offering QHPs because any such rules are beyond the scope of this rulemaking.

Moreover, a private exchange may be designed in a way that satisfies the conditions of 29 CFR 2510.3–1(l), in which case individual health insurance coverage purchased through the private exchange would not be considered group health plan coverage. Alternatively, a private exchange could be designed in a way that limits employees' choice of issuer, or promotes certain issuers or coverage options over others. In that case, coverage offered through the private exchange would not satisfy the prohibition on endorsement in the safe harbor. The final rules provide a new option for employers to offer individual coverage HRAs together with private exchanges that work with all individual market insurance issuers in a neutral and unbiased fashion, and maintain the individual insurance nature of the individual health insurance coverage.

For example, under the final rules, an employer could maintain (or contract with) a tool or web-based platform that displays information about all coverage options in a state and facilitates enrollment. However, to be eligible for the safe harbor, the platform would be required to present all available coverage options in a way that is entirely neutral. The platform could not be designed or operated in a way that limits users' ability to select a coverage option that would otherwise be available to them or that promotes one option over another (for example, with ''recommended'' or ''starred'' listings), or the prohibition on endorsement would not be satisfied. However, an otherwise neutral platform that allows users to select certain criteria (such as a platform that allows participants to search for an HDHP or plans that contained specific providers in their network) and search for coverage options that fulfilled these criteria would not be considered to be an endorsement by the employer of any particular coverage, and would not violate this requirement of the final rule.

D. Reimbursement for Non-Group Health Insurance Premiums Must Be Limited Solely to Individual Health Insurance Coverage

Paragraph (l)(3) of the proposed amendment would require that reimbursement for non-group health insurance premiums must be limited solely to individual health insurance coverage, as defined in 29 CFR 2590.701–2.[263] DOL included this condition in order to limit the application of the proposed safe harbor to determining whether insurance policies sold as individual health insurance coverage would be treated as part of an employee welfare benefit plan subject to ERISA.

Several commenters asked DOL to clarify whether arrangements that provide reimbursement for individual health insurance coverage that consists solely of excepted benefits (for example, standalone limited-scope dental benefits) could be considered to satisfy the proposed safe harbor. For the reasons explained earlier in this section of the preamble, in DOL's view, the proposed safe harbor was a necessary clarification for the types of individual health insurance coverage that might be reimbursed by an individual coverage HRA or QSEHRA. However, coverage that is sold in the individual market that provides only excepted benefits is not subject to the market requirements and does not present the same concerns about incompatible individual and group market regulatory regimes. Thus, the proposed safe harbor was not intended to address excepted benefit policies sold in the individual market. The final rules include additional language to make this clearer.

In the preamble to the proposed rules, DOL also invited comments regarding which forms of payment are appropriately treated as ''reimbursement'' to participants for this purpose. DOL asked whether, for example, ''reimbursement'' should be interpreted to include direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsor to the insurance company.

Commenters generally favored an expansive interpretation of the types of payments that should be treated as reimbursements. These commenters argued that permitting employers to pay health insurance issuers directly would promote administrative simplicity, and would enable plan sponsors to substantiate that participants and beneficiaries are enrolled in individual health insurance coverage, as the final integration rules require. Some commenters asserted that ''reimbursement'' should be interpreted in a manner consistent with current industry practices for account-based plans, which permit the transfer of employer funds to debit cards that can be used to pay for certain qualified medical expenses. One commenter also stated that it should not matter whether

[263] While the HRA's reimbursement of non-group health insurance premiums is limited solely to individual health insurance coverage that does not consist solely of excepted benefits, the HRA may reimburse Medicare premiums for Medicare beneficiaries as permitted under 29 CFR 2590.702–2 without causing the reimbursement of individual health insurance coverage premiums for other individuals to fall outside the safe harbor.

employer funds paid from an HRA go directly to a participant or a health insurance issuer because the economic substance of the transaction is the same—that is, the funds are being used to discharge an employee's premium payment obligations.

DOL agrees with these commenters and, under the final rules, ''reimbursement'' may include employee-initiated payments made through use of financial instruments, such as pre-paid debit cards, as well as direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsor to the health insurance issuer.[264] However, DOL cautions that plan sponsors should take care to ensure that payment practices do not violate the prohibition on endorsements by effectively limiting participants' and beneficiaries' ability to select certain coverage options or favoring certain issuers or coverage options. For example, if a plan sponsor were to establish procedures for sending direct payments to health insurance issuers, but those procedures excluded certain health insurance issuers, or placed additional burdens on HRA participants if they chose health insurance coverage offered by some health insurance issuers, rather than others, the procedure would be considered an endorsement, and the criteria of the safe harbor would not be satisfied.

E. The Employer, Employee Organization, or Other Plan Sponsor Receives No Consideration in Connection With the Employee's Selection or Renewal of Any Individual Health Insurance Coverage

Paragraph (l)(4) of the proposed amendment would require that an employer, employee organization, or other plan sponsor receive no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage. Commenters requested more specific guidance on how a plan may comply with this condition.

As stated in the preamble to the proposed rules, this limitation in the DOL safe harbor rule for HRAs was focused on employers, employee organizations, and other plan sponsors receiving consideration, including from an issuer or person affiliated with an issuer in connection with any participant's purchase or renewal of individual health insurance coverage. The preamble to the proposed rules also explained that the provision was not intended to change any ERISA requirements governing the circumstances under which ERISA plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for certain expenses associated with administration of the plan.[265]

The requirement in the DOL final rule is different from the ''no compensation'' criteria established in the safe harbor rules regarding certain group or group-type insurance programs established at 29 CFR 2510.3–1(j)(4) and individual retirement accounts (IRAs) established at 29 CFR 2510.3–2(d)(iv). In the case of those rules, there is no ERISA plan, and the rules limit permissible compensation that an employer can receive, including from third parties, to reasonable compensation, excluding any profit, for administrative services actually rendered in connection with forwarding employee contributions to the insurer or IRA provider through payroll deductions or dues checkoffs.

In the context of the DOL final rule, the HRA is generally an ERISA-covered plan and the issue is the extent to which the plan sponsor of the HRA could receive payments from the HRA or third parties. As noted above, the preamble to the proposed rules explained that the rule was not intended to change any ERISA requirements governing the circumstances under which ERISA plans, including HRAs, may reimburse employers, employee organizations and other plan sponsors for expenses associated with administration of a plan. Thus, in the case of plan assets being used for HRA related payments, reimbursement could not be made for expenses associated with settlor functions and activities.[266] The fiduciary prohibitions in ERISA section 406(a) and 406(b) also would apply in such cases, so that any reimbursements would need to be permissible under ERISA section 408(b)(2) and 29 CFR 2550.408b–2(e). Subparagraph (e)(3) of those rules states: ''If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly and actually incurred in the performance of such services within the meaning of 2550.408c–2(b)(3)), the provision of such services does not, in and of itself, constitute an act described in section 406(b) of the Act.'' ERISA section 408(c) and 29 CFR 2550.408c–2 place additional restrictions on compensation for services in the case of a fiduciary who is already receiving full-time pay from an employer or employee organization sponsoring the plan. However, in the case of an unfunded HRA, with payments from the HRA made solely out of an employer's general assets, there would not be any plan assets; thus, there could be no payments to the employer from plan assets. Moreover, in the case of such an unfunded HRA, it seems extremely unlikely that an employer would apply debits to the notional employee accounts that are part of the HRA to ''reimburse'' itself from the HRA for expenses associated with sponsoring the HRA. Finally, in DOL's view, receipt of compensation from third parties to cover the cost of operating the HRA would be prohibited payments in connection with the employee's selection or renewal of any individual health insurance coverage, and, therefore, not permissible under paragraph (l)(4) of the final rules. Accordingly, such receipt of compensation would not be permissible under paragraph (l)(4) of the final rules.

F. Each Plan Participant Must Be Notified Annually That the Individual Health Insurance Coverage Is Not Subject to ERISA

Paragraph (l)(5) of the proposed amendment included a requirement that plans provide an annual notice to participants stating that individual health insurance coverage funded through an HRA is not subject to the requirements of ERISA. For an individual coverage HRA, the notice must satisfy the requirements set forth in the final integration rules at 29 CFR 2590.702–2(c)(6), discussed earlier in this preamble. For a QSEHRA or an HRA that is not subject to 29 CFR 2590.702–2(c)(6) (such as a retiree-only HRA), the proposal set forth model language to satisfy the condition.[267] The preamble to the proposed rules also explained that a supplemental salary reduction arrangement need not provide the required notice; instead, the notice

[264] Any direct payment should include an affirmative act by the employee requesting that the employer or plan administrator make the payment, as part of the enrollment process or otherwise. For example, as part of the insurance enrollment process, the employee might direct the employer or plan administrator to begin making monthly premium payments for so long as the employee remains enrolled in the individual health insurance coverage and remains eligible for HRA benefits.

[265] 83 FR 54420, 54442 (Oct. 29, 2018).

[266] *See* DOL Advisory Opinion 2001–01A.

[267] As stated in the preamble to the proposed rules, in DOL's view, the SPD for the HRA, QSEHRA, or other ERISA plan would fail to satisfy the style, format, and content requirements in 29 CFR 2520.102–3 unless it contained a discussion of the status of the HRA or QSEHRA and the individual health insurance coverage under ERISA sufficient to apprise the HRA or QSEHRA plan participants and beneficiaries of their rights and obligations under the plan and ERISA Title I. 83 FR 54420 at 54441 (Oct. 29, 2018).

could be provided by the HRA that the salary reduction arrangement supplements.[268] DOL invited comment on whether it would be helpful to issue additional rules or guidance addressing the application of ERISA reporting and disclosure requirements to HRAs integrated with such non-ERISA individual health insurance coverage (for example, SPD content and Form 5500 annual reporting requirements).

Commenters requested that DOL confirm that HRAs are subject to the reporting and disclosure requirements of ERISA, such as the SBC or (for plans of applicable size) the Form 5500 Annual Report. These commenters said that reporting and disclosure should be revised to allow state regulators and Exchanges to gather necessary information about the use of HRAs. One commenter also urged DOL to ensure that these requirements did not discourage employers from offering individual coverage HRAs to their employees by preserving, for example, any exemptions from filing reports for small businesses, or allowing the filing of simpler reports, such as the Form 5500–SF. Another commenter urged DOL to review the current required information, notices and disclosures that plan sponsors must convey to plan participants and beneficiaries and to simplify, combine or eliminate unnecessary or redundant material.

After considering the comments and feedback received from stakeholders, DOL has determined that adding additional new, potentially redundant[269] disclosure requirements beyond the scope of the proposed rules is not necessary. For example, individual coverage HRAs are group health plans and must, therefore, provide participants with an SBC.[270] ERISA also contains comprehensive reporting requirements that apply to group health plans, such as HRAs,[271] and DOL has determined that adding or changing those reporting requirements with respect to HRAs is not necessary at this time. In certain situations, DOL has provided for exemptions or reporting exemptions and simplified disclosure requirements.[272] Provided they satisfy the requirements under applicable DOL rules, HRAs and their administrators remain eligible for this relief.

G. Comments Outside the Scope

Some commenters raised issues relating to the separate safe harbor for certain group or group-type insurance programs at 29 CFR 2510.3–1(j).[273] Several commenters asked DOL to clarify whether other types of coverage, such as health care sharing ministries, might be considered part of an employee welfare benefit plan subject to ERISA if they were paid for through an HRA, QSEHRA, or supplemental salary reduction arrangement. The safe harbor is intended to provide assurance to stakeholders that insurance policies sold as individual health insurance coverage, and that are generally subject to comprehensive federal (and state) individual market rules, would not be treated as part of an employee welfare benefit plan subject to ERISA so long as the conditions of the safe harbor are satisfied. DOL has concluded that the safe harbor is appropriate because of the significant differences in legal requirements that would apply to health insurance coverage based on whether it is considered individual health insurance or group coverage. However, the safe harbor was not intended to address all circumstances in which health insurance coverage may be treated as part of an employee welfare benefit plan subject to ERISA. DOL may provide additional clarification in the future regarding other types of coverage.[274]

V. Overview of Final Rules Regarding Individual Market Special Enrollment Periods—Department of Health and Human Services

A. In General

With the ability to integrate HRAs with individual health insurance coverage, many employees may need access to individual health insurance coverage, or may want to change to other individual health insurance coverage in order to maximize the use of their individual coverage HRA. Therefore, HHS proposed a new SEP to allow employees and their dependents to enroll in individual health insurance coverage, or to change from one individual health insurance plan to another, outside of the individual market annual open enrollment period if they gain access to an individual coverage HRA.

In addition, because employees and dependents with a QSEHRA generally must be enrolled in MEC,[275] and one category of MEC is individual health insurance coverage, the proposed rules also applied the new SEP to individuals who are provided QSEHRAs.[276] Because the proposed rules allowed for HRAs to be integrated with individual health insurance coverage both on- and off-Exchange (and because individuals with QSEHRAs may enroll in individual health insurance coverage on- or off-Exchange), the proposed rules included this new SEP in the limited open enrollment periods available off-Exchange, in accordance with current rules at 45 CFR 147.104(b)(2).[277]

After considering the comments, HHS is adopting the proposed SEP parameters in these final rules, with some changes and clarifications in response to comments, as explained in more detail later in this section of the preamble.

1. SEP Triggering Event and Availability

The proposed rules included a new paragraph 45 CFR 155.420(d)(14) that would establish an SEP for when an employee or his or her dependent(s) gains access to and enrolls in an individual coverage HRA or is provided a QSEHRA, so that he or she may enroll in or change his or her enrollment in individual health insurance coverage. The proposed rules also offered the existing option for advanced availability to those enrolling through the new SEP. That is, per 45 CFR 155.420(c)(2), qualifying individuals would have the option to apply for coverage and select

[268] 83 FR 54420, 54441 (Oct. 29, 2018).

[269] *See e.g.,* 29 CFR 2520.104b–2 and 2520.104b–3(a) and (d)(3).

[270] *See* PHS Act section 2715. *See also* 26 CFR 54.9815–2715, 29 CFR 2590.715–2715, and 45 CFR 147.200.

[271] *See e.g.,* ERISA sections 101, 103, and 104; and PHS Act section 2715A (incorporated in Code section 9815 and ERISA section 715).

[272] *See* ERISA sections 104(a)(3) and PHS Act section 2715 (incorporated in Code section 9815 and ERISA section 715). *See also* 26 CFR 54.9815–2715(a)(1)(iii); 29 CFR 2520.104–20, 2520.104–44, and 2590.715–2715(a)(1)(iii); and 45 CFR 147.200(a)(1)(iii).

[273] This safe harbor does not relate to HRAs, QSEHRAs, or other arrangements that constitute an employee welfare plan that provides reimbursement for premiums for individual health insurance coverage because it is limited to arrangements without employer contributions.

[274] As noted earlier in this preamble, an HRA generally may reimburse expenses for medical care, as defined under Code section 213(d), of an employee and certain of the employee's family members. Neither the proposed rules nor the final rules make any changes to the rules under Code section 213. Thus, any issues arising under Code section 213, and any guidance requested by commenters to address those issues, are beyond the scope of this rulemaking.

[275] Generally, payments from a QSEHRA to reimburse an eligible employee's medical care expenses are not includible in the employee's gross income if the employee has coverage that provides MEC as defined in Code section 5000A(f), which includes individual health insurance coverage.

[276] This preamble refers to a QSEHRA being ''provided'' as opposed to being ''offered'' because employees and dependents cannot opt out of a QSEHRA.

[277] The Departments note that the new SEP would not apply to individuals who gain access to an excepted benefit HRA, as those individuals are not required to be enrolled in individual health insurance coverage, and those HRAs are generally prohibited from reimbursing premiums for individual health insurance coverage.

a plan within 60 days before or after their SEP triggering event.

Many commenters supported providing an SEP to allow individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA to enroll in or change their health insurance coverage. One commenter asked for clarification that individuals who are already enrolled in individual health insurance coverage would be eligible for the SEP if they newly gain access to an individual coverage HRA. The final rules clarify that employees and dependents may qualify for the new SEP regardless of whether they are currently enrolled in individual health insurance coverage, in order to allow all individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA the flexibility to take this into account when choosing an individual health insurance plan for themselves, and, if applicable, for their families.

Additionally, the final rules include changes to the SEP triggering event at 45 CFR 155.420(d)(14) to reflect that employees and their dependents who had access to, but who were not enrolled in, an employer's individual coverage HRA during all or at the end of the preceding plan year may use the new SEP if they may newly enroll in an individual coverage HRA at the beginning of the subsequent HRA plan year. Similarly, employees and their dependents who at one time had an individual coverage HRA or a QSEHRA, but then had another type of health coverage (including but not limited to a different individual coverage HRA or a different QSEHRA), and are again newly offered an individual coverage HRA or newly provided a QSEHRA from the same employer (for example, because they moved from one class of employees to another, or because they were re-hired by a former employer), may qualify for this SEP, as they may need an opportunity to enroll in individual health insurance coverage, regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA by the same employer.

In many cases like these, employees also will be eligible for an SEP due to a loss of MEC in accordance with 45 CFR 155.420(d)(1)—for example, due to a loss of coverage sponsored by a previous employer or other coverage that they may have had during that time, such as coverage from a spouse's employer. However, some employees and dependents may not be eligible for another SEP, such as those who did not previously have other coverage, or who previously chose to enroll in coverage that was not MEC, such as STLDI. The final rules, therefore, provide that the SEP at 45 CFR 155.420(d)(14) is available when a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual is not covered by the HRA or QSEHRA on the day immediately prior to the triggering event (that is, for an individual coverage HRA, the first day on which coverage under the individual coverage HRA can become effective or for a QSEHRA, the first day on which coverage under the QSEHRA is effective). In other words, the new SEP will be available to individuals who have not previously been offered an individual coverage HRA or provided a QSEHRA, as well as those who had access to the individual coverage HRA or were provided a QSEHRA during a prior plan year(s) or earlier during the current plan year, but are not currently covered by the individual coverage HRA or the QSEHRA.

In order to clarify the specific date on which the coverage effective date and availability are based, as discussed later in this preamble, the final rules specify that the SEP triggering event at 45 CFR 155.420(d)(14) is the first day on which coverage for the individual under the individual coverage HRA can take effect or the first day on which coverage for the individual under the QSEHRA takes effect, as applicable. The Departments anticipate that the first day on which an individual coverage HRA can become effective or the date on which a QSEHRA is effective will generally be the first day of the plan year. In either case, the triggering event is the first day of the plan year. However, an individual coverage HRA may offer more than one effective date option to accommodate an individual who, under the final integration rules, is not required to be sent the notice setting forth the terms of the HRA at least 90 days before the beginning of the individual coverage HRA plan year, as required by 26 CFR 54.9802–4(c)(6), 29 CFR 2590.702–2(c)(6), and 45 CFR 146.123(c)(6) (for example, an individual who is newly hired and therefore newly offered the individual coverage HRA in the middle of the plan year).[278] For individuals who are newly hired or who otherwise newly gain access to an individual coverage HRA during the plan year, the triggering event is the first day on which the individual coverage HRA can take effect for those who enroll in individual health insurance coverage that itself takes effect no later than that date.[279] This is the case even for the individuals or dependents who do not actually enroll in the individual coverage HRA until a later date.

For example, assume an employer hires a new employee on June 15 and offers an individual coverage HRA to the employee that may take effect on either (1) July 1, if the employee is enrolled in individual health insurance coverage that takes effect no later than that date; or (2) August 1, if the employee enrolls in individual health insurance coverage that will take effect no later than that date. In this case, the employee's triggering event is July 1 because that is the first day on which coverage under the individual coverage HRA can take effect.

Several commenters supported applying the advanced availability rules at 45 CFR 155.420(c)(2) to the proposed new SEP in order to allow qualified individuals, enrollees, and dependents to enroll in or change to a different individual health insurance plan in advance of when their individual coverage HRA or QSEHRA would begin. As discussed earlier in this preamble in response to comments on the final integration rules, many commenters supported the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage and that the HRA must implement reasonable procedures to substantiate that participants and dependents will be enrolled in individual health insurance coverage for the plan year, or for the portion of the plan year during which the individual is covered by the HRA, as applicable. Several commenters noted the importance that individuals be enrolled in individual health insurance coverage by the time that their individual coverage HRA takes effect to ensure that they have health

[278] Because employees may not enroll in an individual coverage HRA if they are not enrolled in individual health insurance coverage, the Departments anticipate that some employers may want to provide employees who are not eligible to participate in the individual coverage HRA at least 90 days prior to the start of the HRA plan year with flexibility regarding the start date of their individual coverage HRA, so that the employees have sufficient time to enroll in individual health insurance coverage after receiving the notice.

[279] For individuals who are newly hired or who otherwise become newly eligible for a QSEHRA, the triggering event is the first day on which coverage under the QSEHRA is effective. However, a QSEHRA may not reimburse any incurred medical care expense until the participant substantiates that he or she (and the individuals whose expenses are being reimbursed) has MEC for the month during which the expense was incurred.

insurance coverage that complies with PHS Act sections 2711 and 2713 at all times during which they are covered by the individual coverage HRA. In order to avoid effectively forfeiting their HRA because they are not enrolled in individual health insurance coverage on the day that their individual coverage HRA can take effect, employees and dependents generally will need to make an individual health insurance plan selection before that date.

The final SEP rules include several changes in response to these comments. First, the proposed rules stated that the SEP applies to an individual who ''gains access to and enrolls in'' an individual coverage HRA or QSEHRA. The final SEP rules remove the phrase ''and enrolls in'' to clarify that currently being covered by the individual coverage HRA or QSEHRA is not necessary to trigger the SEP. This change is intended to better align with the requirement that participants and any dependents must be enrolled in individual health insurance coverage that will take effect no later than the date their individual coverage HRA takes effect, by ensuring that individuals will be able to enroll in individual health insurance coverage using the new SEP prior to the first day that their individual coverage HRA may take effect.

The final SEP rules also include changes to the advanced availability rules to ensure that, whenever possible, employees and their dependents are enrolled in individual health insurance coverage (which is generally a requirement for those with an individual coverage HRA and an option for satisfying the requirement to enroll in MEC for those with a QSEHRA) by the time coverage under their individual coverage HRA may take effect or that their QSEHRA takes effect. Specifically, the final rules include a new paragraph at 45 CFR 155.420(c)(3) to provide that a qualified individual, enrollee, or his or her dependent who is described in paragraph (d)(14) has 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such qualified individual or enrollee at least 90 days before the first day of the plan year, as specified in 26 CFR 54.9802–4(c)(6), 29 CFR 2590.702–2(c)(6) and 45 CFR 146.123(c)(6) or Code section 9831(d)(4), as applicable, and therefore the qualified individual, enrollee, or his or her dependent(s) may not have received sufficient advance notice of eligibility for the individual coverage HRA or QSEHRA to enroll in individual health insurance coverage that takes effect by the time their individual coverage HRA may take effect or their QSEHRA takes effect, in which case the qualified individual, enrollee, or his or her dependent(s) has 60 days before or after the triggering event to select a QHP.

In other words, qualified individuals and enrollees to whom employers must send a notice setting forth the terms of the individual coverage HRA at least 90 days before the first day of the individual coverage HRA plan year, and, if applicable, their dependents, must enroll in individual health insurance coverage within 60 days before the date the individual coverage HRA may take effect, which would be the first day of the individual coverage plan year. Similarly, employees, and, if applicable, their dependents, who will be provided a QSEHRA, and whose employer is required to send them a written notice at least 90 days before the beginning of the plan year, have 60 days prior to the first day of the QSEHRA plan year to enroll in individual health insurance coverage. This change will help ensure that the individual coverage HRA can comply with the annual coverage substantiation requirement by the time that an individual's or family member's individual coverage HRA takes effect, or that the QSEHRA satisfies the requirement that individuals who are provided the QSEHRA and who intend to satisfy their requirement to have MEC by enrolling in individual health insurance coverage have MEC. It will also reduce gaps in coverage by helping ensure that individuals and dependents who will be eligible for an individual coverage HRA and are notified at least 90 days before the beginning of the individual coverage HRA plan year are covered by individual health insurance coverage for the full HRA plan year and do not inadvertently forfeit their HRA.

In contrast, because individual coverage HRAs and QSEHRAs must only provide notice by the day that an individual coverage HRA may take effect or that a QSEHRA takes effect for employees who newly become eligible for an individual coverage HRA or are newly provided a QSEHRA less than 90 days prior to the beginning of the individual coverage HRA or QSEHRA plan year (or during the plan year), these employees are unlikely to receive this notice as far in advance of their SEP triggering event. Therefore, these employees may need time after their triggering event to select an individual health insurance plan for themselves, and, if applicable, for their dependent(s). To accommodate these employees and their dependents, the final SEP rules provide them with up to 60 days before or after their triggering event to enroll in individual health insurance coverage. Under this rule combined with the coverage effective date rules discussed in the next section of this preamble, newly hired employees and their dependents may enroll in individual health insurance coverage that does not take effect until up to 3 months after the earliest date that their individual coverage HRA may take effect, or up to 3 months after the date coverage begins under their QSEHRA.[280] For example, an employee who starts work on July 25, and whose individual coverage HRA may take effect on August 1 (or whose QSEHRA does take effect on August 1), will have until September 30—60 days following the triggering event date—to enroll in an individual health insurance plan. If the employee enrolls on September 30, then his or her individual health insurance coverage will take effect on October 1.[281] The Departments encourage employers to work with employees who do not receive substantial advance notice of their individual coverage HRA to help them understand the latest date by which they must enroll themselves, and, if applicable, their dependents, in individual health insurance coverage to avoid effectively forfeiting their individual coverage HRA.

2. Coverage Effective Dates

The proposed rules added a new paragraph at 45 CFR 155.420(b)(2)(vi) to

[280] The Departments note that nothing in the final SEP rules eliminates the requirement that individual coverage HRAs comply with the final integration rules. Individual coverage HRAs must be designed in accordance with all the applicable rules, including the final integration rules and the final SEP rules.

[281] Additionally, partial year individual coverage HRA or QSEHRA coverage may occur due to employees gaining new dependents during the plan year. 45 CFR 155.420(c)(1) provides qualified individuals who gain a new dependent due to the birth or adoption of a child, or due to a child support or other court order, and therefore qualify for the SEP at 45 CFR 155.420(d)(2)(i), with 60 days to enroll their new dependent in individual health insurance coverage. As provided at 45 CFR 155.420(b)(2)(i), this coverage takes effect retroactively to the child's date of birth or adoption, or the date of the child support or other court order, or, at the option of the Exchange, the qualified individual may request that it take effect prospectively. To the extent the HIPAA special enrollment rules or other rules require group health plans to make such coverage available under such circumstances, either retroactively or prospectively, employers should ensure that employees understand how much time they have to enroll their new dependent in their individual coverage HRA, especially if they will have less than the 60 days post-SEP triggering event that they have to enroll their new dependent in individual health insurance coverage. *See* Code section 9801(f) and 26 CFR 54.9801–6; ERISA section 701(f) and 29 CFR 2590.701–6; and PHS Act section 2704(f) and 45 CFR 146.117. The Departments note that QSEHRAs are not subject to the HIPAA special enrollment rules. *See* Code section 9831(d)(1).

provide that if plan selection is made before the day of the triggering event, then the coverage effective date is either the first day of the first month following the SEP triggering event, or, if the triggering event is on the first day of a month, the date of the triggering event. Under the proposed rules, if plan selection is made on or after the day of the triggering event, coverage would take effect the first day of the month following the date of plan selection. For example, under the proposed rules, if an individual newly gains access to an individual coverage HRA or is provided a QSEHRA for a plan year starting April 1 and enters April 1 in their application for individual health insurance coverage as their HRA or QSEHRA effective date, then so long as the individual selects an individual health insurance plan before April 1, the effective date of their new individual health insurance coverage will be April 1.

Several commenters supported providing a coverage effective date of the first day of the first month following the individual's plan selection and SEP triggering event. One commenter agreed that a first-of-the-month effective date was appropriate, but also stated that this may require issuers to allow an additional premium payment during an employee's first month of employment.[282]

The final rules include coverage effective dates for this SEP as proposed, with some edits to incorporate the changes at 45 CFR 155.420(d)(14) and for clarity. Additionally, with regard to timing of premium payments for individual health insurance coverage, HHS notes that in other contexts individual market plans on- and off-Exchange regularly receive enrollment information within the same timeframe that will apply for the new SEP's coverage effective date rules. For example, under current rules, if a qualified individual or dependent is going to lose MEC on March 31 and enrolls in coverage during March, his or her coverage effective date is April 1. Therefore, issuers that already participate in the individual health insurance market will be accustomed to setting premium payment deadlines for enrollees in this situation.

[282] Under 45 CFR 155.400(e)(1)(ii), if an individual has a coverage effective date of April 1, for example, then the issuer could set a premium payment deadline as early as April 1, but may, instead, adopt a policy setting a later due date (either 30 days after the enrollment transaction was received, or 30 days after the policy start date, whichever is later). Therefore, the new enrollee might have a similar deadline for his or her initial payment that he or she has for his or her subsequent payment.

3. Special Enrollment Period Verification

Several commenters expressed support for verifying SEP eligibility for employees newly enrolling in individual health insurance coverage based on the new SEP, and one commenter requested additional guidance on how the verification would be administered. HHS confirms that Exchanges that use the Federal *HealthCare.gov* platform will require these individuals to submit documentation to confirm their SEP eligibility prior to effectuating their enrollment in individual health insurance coverage through the Exchange. More information on the process for submitting documents to verify SEP eligibility is available on *HealthCare.gov*, and HHS will provide additional guidance on how the FFEs and State Exchanges on the Federal platform will confirm eligibility for the new SEP.

B. Individuals Re-Enrolling in Individual Coverage HRA or Being Provided a QSEHRA From the Prior Plan Year

The proposed rules requested comments on whether an employee who is enrolled in an individual coverage HRA or provided a QSEHRA should be eligible for the SEP at 45 CFR 155.420(d)(14) annually, at the beginning of each new plan year of the individual coverage HRA or QSEHRA, particularly if the new plan year is not aligned with the calendar year. The proposed rules noted that such annual availability would allow employees to change to new individual health insurance coverage in response to updated information about their individual coverage HRA or QSEHRA for each of their plan years, even if their individual coverage HRA or QSEHRA plan year is not based on a calendar year cycle. HHS notes that employees and dependents enrolled in an individual coverage HRA or provided a QSEHRA that has a calendar year plan year would have this option; that is, they would be able to change their individual health insurance plan in response to updated information about their individual coverage HRA or QSEHRA during the individual market open enrollment period.

Some commenters supported providing the new SEP annually for employees and dependents enrolled in an individual coverage HRA or provided a QSEHRA and whose individual coverage HRA or QSEHRA has a non-calendar year plan year, in order to allow employees to enroll in or change to a new plan in response to updated information about their individual coverage HRA or QSEHRA each plan year. Several commenters emphasized the importance of providing employees and their dependents with the opportunity to re-evaluate their individual health insurance coverage options at the same time that their individual coverage HRA or QSEHRA is likely to change, with one commenter suggesting that employers should not be permitted to make changes to their individual coverage HRA unless employees may also make changes to their individual health insurance coverage during the calendar year. Another commenter suggested that providing the new SEP annually would offer convenience for employees and employers who choose to begin their individual coverage HRA plan year on a date other than January 1.

However, some commenters opposed providing the new SEP on an annual basis due to concerns that allowing consumers to regularly change plans during the calendar year would harm the individual market risk pool. One commenter generally opposed providing the new SEP annually, but specified that if HHS chooses to do so, it should only be available to employees and dependents whose employer changes their individual coverage HRA contribution in excess of a certain amount, such as $100, and that this change be verified to prevent employees who do not qualify for the SEP from accessing it for reasons related to a health condition. To ensure that the SEP would not be available on an annual basis, one commenter suggested offering the SEP only after an employee becomes eligible for an individual coverage HRA following a period of at least 60 days during which they were not eligible for an HRA from the same employer.

Other commenters opposed offering the new SEP annually based on concerns that employees who changed individual health insurance coverage during the calendar year would be harmed because their deductibles and other accumulators would reset twice per year: Once after the calendar year individual coverage open enrollment period, and then again after their SEP. One commenter suggested that this could negate the potential advantage to the employee of changing plans to take advantage of an update to their individual coverage HRA or QSEHRA.

Several commenters suggested that to mitigate this challenge, employers should provide individual coverage HRAs on a calendar-year basis to align updates that they make to their individual coverage HRA with the

individual market open enrollment period, with one commenter recommending that the Departments require employers to do so. One commenter suggested that the final rules should permit employers to begin offering individual coverage HRAs at any time during the calendar year, and the Departments could then require these employers to transition to offering individual coverage HRAs based on a calendar plan year within a reasonable period of time, such as 5 years.

HHS determined that employees who are enrolled in an individual coverage HRA or who are provided a QSEHRA should have the option to re-evaluate their individual health insurance coverage options for each new individual coverage HRA or QSEHRA plan year, regardless of whether the HRA or QSEHRA is offered or provided (as applicable) on a calendar plan year basis. However, the final rules provide that the new SEP will not be available on an annual basis at the beginning of a new individual coverage HRA or QSEHRA plan year to individuals who are already enrolled in an individual coverage HRA or who are already provided a QSEHRA. This is because employees offered an individual coverage HRA or provided a QSEHRA with a calendar year plan year may re-evaluate their individual health insurance coverage options and change their individual health insurance plan, if they wish to do so, during the annual individual market open enrollment period. Further, individuals with an individual coverage HRA or QSEHRA with a non-calendar year plan year will have an opportunity through an existing SEP to re-evaluate their coverage options.

More specifically, because HRAs are group health plans, employees enrolled in an individual coverage HRA with a non-calendar year plan year may qualify for an SEP on an annual basis pursuant to existing rules at 45 CFR 155.420(d)(1)(ii) (the non-calendar year plan year SEP). This SEP applies to qualified individuals and dependents enrolled in a group health plan or an individual health insurance plan with a non-calendar year plan year, even if the qualified individual or his or her dependent has the option to renew the coverage. In addition, while Cures Act section 18001(c) provides that the term ''group health plan'' generally does not include a QSEHRA,[283] HHS will treat a QSEHRA with a non-calendar year plan year as a group health plan for the limited purpose of the non-calendar year plan year SEP, and intends to codify this interpretation in future rulemaking. For the non-calendar year plan year SEP, the triggering event is the last day of the plan year.

HHS has determined that the availability of the non-calendar year plan year SEP achieves an appropriate balance between providing employers with flexibility to offer an individual coverage HRA or provide a QSEHRA on a 12-month cycle that meets their needs and allowing employees and their dependents the flexibility to re-assess their individual health insurance coverage options at the same time that the terms of their individual coverage HRA or QSEHRA may change. Additionally, per 45 CFR 155.420(a)(4), the non-calendar year plan year SEP is subject to plan category limitations for Exchange enrollees, which HHS has determined will mitigate commenters' concerns about the potential risks to individual market stability that providing employees with the flexibility to choose a different plan annually, outside of the annual individual market open enrollment period, could pose. Employers that want to ensure their employees have the ability to change to a different individual health insurance policy each individual coverage HRA or QSEHRA plan year without being subject to plan category limitations, and consider potential changes to their individual coverage HRA or to their QSEHRA at the same time that their costs for individual health insurance coverage may also change, can align their individual coverage HRA or QSEHRA plan year with the calendar year. HHS will incorporate messaging into the *HealthCare.gov* application for Exchange individual health insurance coverage and other technical assistance materials to help employees understand that changing individual health insurance coverage during the calendar year will reset their deductibles and other accumulators. HHS encourages State Exchanges to adopt similar messaging.

C. Plan Category Limitations

To allow employees and their dependents the flexibility to adequately respond to newly gaining access to an individual coverage HRA or newly being provided a QSEHRA, the proposed rules included an amendment to 45 CFR 155.420(a)(4)(iii) to exclude Exchange enrollees who would qualify for the new SEP from plan category limitations.[284] Therefore, under the proposed rules, individuals eligible for the new SEP who are currently enrolled in individual health insurance coverage on an Exchange would be able to select any available Exchange plan without regard to the metal level of their current coverage.

Several commenters expressed support for the proposal to exempt the new SEP from plan category limitations, noting the importance of providing access to individual health insurance coverage or flexibility to change their current individual health insurance plan to employees and dependents who qualify for this new SEP.

HHS agrees with commenters about the importance of providing access to individual health insurance coverage or flexibility to change their current individual health insurance plan to employees and dependents who qualify for the new SEP, and is, therefore, finalizing the amendment to 45 CFR 155.420(a)(4)(iii) to exempt individuals eligible for the new SEP from plan category limitations. However, see the discussion earlier in this section of the preamble regarding the application of plan category limitations to individuals to whom the non-calendar year plan year SEP applies.

VI. Applicability Dates

The proposed integration rules and proposed excepted benefit HRA rules, as well as the proposed DOL clarification and the proposed clarification by the Departments regarding the meaning of ''group health insurance coverage,'' were proposed to apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. The proposed PTC rules were proposed to apply for taxable years beginning on or after January 1, 2020, and the proposed SEP rules were proposed to apply January 1, 2020. The proposed rules also provided that taxpayers and others could not rely on the proposed rules. The Departments solicited comments on the proposed applicability date.

Some commenters requested that the Departments either provide an earlier applicability date or maintain the proposed general applicability date of January 2020. Some urged finalization by the end of the first quarter of 2019 to account for the 2020 rate setting schedule and to allow for implementation by 2020.

Many commenters expressed concern that issuers, state insurance regulators, the Exchanges, and employers would not be prepared for implementation of the final rules by 2020 and requested various applicability date delays, including a 2021 applicability date, an

[283] A QSEHRA continues to be treated as a group health plan under the PHS Act for purpose of Part C Title XI of the Social Security Act.

[284] 45 CFR 155.420(a)(4) does not apply to SEPs in the individual market off-Exchange.

applicability date of 12 or 18 months following finalization of the rule, and an indefinite delay to allow further time to study the market. These commenters focused on the significance of the changes made by the proposed rules and the anticipated complexity of implementation. Several State Exchanges submitted comments urging the Departments to delay the applicability date for several plan years or until further support for states is available. These commenters stated that it would be very difficult, and in some instances impossible, to implement the system changes required by the proposed integration, PTC, and SEP rules for the 2020 plan year. One commenter suggested that individual coverage HRAs be implemented on a small scale for only certain employers and employees or only for a very limited time period, such as 2 years. Another commenter requested that the Departments postpone finalization of the integration rules until the Departments develop a federally-hosted electronic data source to verify individual coverage HRA offer information required to determine APTC eligibility.

The Departments considered the comments and the concerns raised by various State Exchanges, issuers, employers and other stakeholders related to the ability of the Exchanges to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. In particular, the Departments acknowledge the crucial role that the Exchanges have in implementation and operationalization of the final rules, and the Departments will work closely with the Exchanges on implementation. The Departments recognize that Exchanges may be unable to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. However, prior to full implementation, the Departments will work with the Exchanges on their strategies to provide information to consumers about affordability of individual coverage HRAs and eligibility for APTC, including how employees can access individual health insurance coverage through the Exchanges and determine whether they should use APTC. Ongoing technical assistance will be provided related to the development of Exchanges' tools and functionality to support employers and employees with understanding HRA affordability determinations and their impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. HHS has already discussed with State Exchanges what changes would likely be necessary if the rule were finalized as proposed to assist with planning, as well as what kind of assistance would be most helpful during implementation. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to support State Exchange efforts. In addition, the Departments will provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and the impact on APTC in the absence of system changes that can make those calculations for the employee.

The Departments have also considered that many individuals covered by an individual coverage HRA will prefer to select off-Exchange individual health insurance plans because salary reductions through a cafeteria plan may be used to pay premiums for off-Exchange coverage, if the employer so allows, and may not be used to pay premiums for Exchange coverage. To the extent a significant proportion of employees with individual coverage HRAs purchase individual health insurance coverage off the Exchange, concerns about burden on the Exchanges, and concerns regarding the effects of timely operationalization of the PTC rules, are mitigated.

The Departments have also worked to release the final rules as early in 2019 as possible, in recognition of the implementation timing issues raised. With regard to the concerns expressed about the interaction of the release of the final rules with rate filing for 2020, the Departments note that the proposed rules were published in October 2018, to provide sufficient notice of the Departments' proposals in advance of the 2020 plan year. While these final rules adopt some changes in response to comments, they are substantially similar to the proposed rules. Even though the proposed rules provided that taxpayers and others may not rely on the proposed rules, the Departments understand that issuers began considering the potential impact of the rules on rates well in advance of the final rules. Further, issuers generally will have an opportunity to make changes in response to the final rules before the rate filing deadlines for the 2020 plan year.

The Departments also note, and considered, that plan sponsors may choose if and when to offer an individual coverage HRA (or an excepted benefit HRA) and may do so any time on or after the applicability date. The Departments intend to provide the guidance necessary for plan sponsors to offer individual coverage HRAs and excepted benefit HRAs for the 2020 plan year, but the Departments also expect that plan sponsors will take the time they need to evaluate the final rules and to take advantage of these new coverage options if and when is best for their workforce.

The Departments have also considered that Executive Order 13813, issued in October 2017, set forth HRA expansion as an Administration priority ''in the near term,'' in order to provide Americans with more options for financing their healthcare. Taking all of these considerations into account, the Departments have determined that it is appropriate to finalize the applicability date, as proposed.

Relatedly, one commenter requested that a ''no inference'' standard be the benchmark for reliance prior to 2020 with regard to individual coverage HRAs, which the Departments understand to be a request that the Departments not take enforcement against HRAs that failed to comply with the market requirements prior to 2020, under the rules and guidance in effect prior to 2020. The Departments see no basis to provide such a rule and, therefore, the final rules do not include a ''no inference'' standard for reliance prior to the applicability date.

Finally, HHS clarifies that, while the new SEP generally provides advanced availability to allow eligible individuals to enroll in individual health insurance coverage up to 60 days prior to the first day of coverage under their HRA, employees who are offered an individual coverage HRA with a plan year that begins early in 2020 will not have the full 60 day advanced availability period to select individual health insurance coverage using an SEP because the new SEP rules take effect on January 1, 2020. Therefore, plan sponsors offering an individual coverage HRA with a plan year that begins on January 1, 2020 should help eligible employees understand that they must enroll in individual health insurance coverage during the open enrollment period, November 1, 2019 through December 15, 2019, for individual health insurance coverage that takes effect on January 1, 2020.

VII. Economic Impact and Paperwork Burden

A. Summary

The final rules remove the current prohibition on integrating HRAs with individual health insurance coverage, if certain conditions are satisfied. The final rules also set forth conditions under which certain HRAs will be recognized as limited excepted benefits. In addition, the Treasury Department and the IRS are finalizing rules regarding PTC eligibility for individuals offered an individual coverage HRA. Further, DOL is finalizing a safe-harbor clarification to provide assurance that the individual health insurance coverage the premiums of which are reimbursed by an HRA, a QSEHRA or a supplemental salary reduction arrangement does not become part of an ERISA plan, if certain safe harbor conditions are satisfied, and the Departments are finalizing a related clarification to the definition of group health insurance coverage. Finally, HHS is finalizing rules to provide an SEP in the individual market for individuals who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA.

The Departments have examined the effects of the final rules as required by Executive Order 13563 (76 FR 3821, January 21, 2011, Improving Regulation and Regulatory Review); Executive Order 12866 (58 FR 51735, October 4, 1993, Regulatory Planning and Review); the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354); section 1102(b) of the Social Security Act (42 U.S.C. 1102(b)); section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4); Executive Order 13132 (64 FR 43255, August 10, 1999, Federalism); the Congressional Review Act (5 U.S.C. 804(2)); and Executive Order 13771 (82 FR 9339, February 3, 2017, Reducing Regulation and Controlling Regulatory Costs).

B. Executive Orders 12866 and 13563

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis must be prepared for major rules with economically significant effects (for example, $100 million or more in any one year), and a ''significant'' regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments anticipate that this regulatory action is likely to have economic impacts of $100 million or more in at least one year, and thus meets the definition of a ''significant rule'' under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with the final rules. In accordance with the provisions of Executive Order 12866, the final rules were reviewed by OMB.

1. Need for Regulatory Action

This regulatory action is taken, in part, in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the flexibility and use of HRAs. In addition, this regulatory action is taken because, since the time that the Departments previously prohibited integration with individual health insurance coverage by regulation, the Departments have observed that many employers, especially small employers, continue to struggle to offer health insurance coverage to their employees. There has been a continued decline in the percentage of small firms offering health coverage [285] as well as a decline in the percentage of workers at small firms receiving health insurance coverage from their employer.[286] Moreover, 80 percent of firms that offer coverage only provide a single option,[287] and economic research demonstrates that there is a significant benefit of additional choice for employees.[288] Further, this regulatory action is being taken at this time because the Departments have had additional time to consider whether, and what type of, conditions would be sufficient to mitigate the risk of adverse selection and health factor discrimination that might otherwise result from allowing HRAs to be integrated with individual health insurance coverage, and the Departments expect that the conditions adopted in the final rules will significantly mitigate the risk of adverse selection. The final rules are intended to increase the usability of HRAs to provide more Americans, including employees who work at small businesses, with more healthcare options and to increase overall coverage. These changes will facilitate the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people by increasing consumer choice for employees and promoting competition in healthcare markets by providing additional options for employers and employees.

The Departments are of the view that the benefits of the final rules will substantially outweigh the costs of the rules. The final rules will increase flexibility and choices of health coverage options for employers and employees. The use of individual coverage HRAs could potentially reduce healthcare spending, particularly less efficient spending,[289] and ultimately

[285] Between 2010 and 2018, there has been a significant decline in the number of small firms offering coverage. For firms with 3 to 9 workers, the decline has been from 59 percent to 47 percent, for firms with 10 to 24 workers, the decline has been from 76 percent to 64 percent, and for firms with 25 to 49 workers, the decline has been from 92 percent to 71 percent. *See* Kaiser Family Foundation, ''Employer Health Benefits 2018 Annual Survey'', Figure 2.2, at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018*.

[286] Between 2010 and 2018, there has been a significant decline in the number of workers covered by their firm's health benefits. For firms with 3 to 24 workers, the decline has been from 44 percent to 30 percent and for firms with 25 to 49 workers, the decline has been from 59 percent to 44 percent. *Id.,* Figure 3.9.

[287] *Id.,* Figure 4.1

[288] An analysis of choices made in the large group market found that offering multiple plan choices (at large group prices) was as valuable to the median consumer as a 13 percent premium reduction. *See* Dafny, Leemore, Kate Ho and Mauricio Varela, ''Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange,'' *American Economic Journal: Economic Policy,* 2013, 5(1):32–58.

[289] By less efficient healthcare spending, the Departments generally mean spending that is of low value from the consumer's perspective, relative to the cost. The cost includes out-of-pocket spending

result in increased taxable wages for workers currently in firms that offer traditional group health plans. The final rules are also expected to increase the number of low- and moderate-wage workers (and their family members) with health insurance coverage.

2. Summary of Impacts of Individual Coverage HRAs

The expected benefits, costs and transfers of the final rules are summarized in Table 1 and discussed in detail later in this section of the preamble.

TABLE 1—ACCOUNTING TABLE

Benefits:				
Qualitative: • Gain of health insurance and potentially improved financial or health outcomes for some employees who are newly offered or newly accept benefits. • Increased choice and flexibility for employees and employers around compensation arrangements, potentially resulting in more efficient use of healthcare and more efficient labor markets (including higher taxable wages). • Decreased administrative costs for some employers who no longer offer traditional group health plans for some, or all, employees.				
Costs:				
Qualitative: • Loss of health insurance and potentially poorer financial or health outcomes for some individuals who experience premium increases. • Less comprehensive coverage and fewer health benefits for some individuals with individual health insurance coverage as compared to traditional group health plan coverage. • Increased administrative costs for employers, employees, and government agencies to learn about and/or use a new health benefits option.				
Transfers	Estimate (billion)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	$4.5	2020	7	2020–2029
(Net tax revenue loss)	4.9	2020	3	2020–2029
Quantitative: [290] • Reduced tax revenue as a result of new individual coverage HRAs offered by employers previously offering no health benefits, less reduced PTC from employees in such firms.. • Increase in average individual market premiums of about 1 percent and resulting increase in PTC.. • Small decrease in per capita Medicare premiums and increase in net Medicare outlays..				
Qualitative: • Increased out-of-pocket costs for some employees who move from traditional group health plans to individual health insurance coverage and decreased costs for other employees who move from traditional group health plans to individual health insurance coverage (*i.e.,* transfers from reduced within-firm cross-subsidization).. • Reduced tax revenue as a result of new excepted benefit HRA..				

In all cases, the counterfactual baseline for analysis is current law. That is, the analysis assumes as the baseline statutes enacted and regulations that are final as of date of issuance of the final rules.

Benefits

Gain of health insurance coverage. Some individuals could experience a gain in health insurance coverage, greater financial security and potentially improved health outcomes, if employees are newly offered and accept individual coverage HRAs. As explained in greater detail in the Transfers section later in this section of the preamble, the Departments estimate that, on net, the number of insured persons will increase by about 800,000 by 2029, due to the final rules. Most of these newly insured individuals are expected to be low- and moderate-income workers in firms that currently do not offer a traditional group health plan.

Some commenters agreed that the allowance of individual coverage HRAs creates new options for small employers who have otherwise been unable to offer health insurance coverage. Some commenters mentioned that some segments of their workforce might particularly benefit. One commenter suggested that large employers might newly provide individual coverage HRAs to part-time or seasonal/temporary workers while maintaining

such as copayments and deductibles plus amounts paid by the health plan.

[290] The monetized estimates are of the net tax revenue loss, including reduced income and payroll tax revenue from employees who would receive individual coverage HRAs and would not otherwise have a tax exclusion for a traditional group health plan, reduced PTC from individuals who would receive individual coverage HRAs and would otherwise receive PTC, and increased PTC due to the increase in Exchange premiums; plus the increased Medicare outlays net of increased total premiums paid. As noted in the text later in this section of the preamble, the quantitative estimates are subject to considerable uncertainty. For example, the rule could cause tax revenue to increase if the adoption of individual coverage HRAs leads to reduced healthcare spending and higher taxable wages. Or the rule could result in larger premium increases in the individual market, or in premium decreases, if the rule results in more substantial changes in the health of the individual market risk pool.

traditional benefits for their full-time employees.

Increased choice and flexibility for employees and employers. As a result of the final rules, employees will be able to purchase insurance with a tax subsidy by use of an individual coverage HRA, without being locked into a specific plan or selection of plans chosen by their employer. As explained later in this section of the preamble, a relatively small number of employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, and some might be unable to find a new individual health insurance plan that covers their preferred healthcare providers. However, small firms are more likely to offer individual coverage HRAs than large firms and small firms that offer a traditional group health plan typically offer a single option. Therefore, employees at the vast majority of firms are likely to have more options through an individual coverage HRA than through a traditional group plan. The expansion of enrollment in the individual market due to the final rules could also induce additional insurers to provide individual market coverage. The Departments are of the view that on net, the final rules will significantly increase choice and flexibility for employees. Employers also will benefit from having another choice of a tax-preferred health benefit to offer their employees, giving them another tool to attract and retain workers.

Current compensation arrangements can result in less efficient labor markets and inefficient healthcare spending. Employees within a firm (or employees within certain classes of employees within a firm) are generally offered the same set of health benefits. As a result, some employees receive a greater share of compensation in the form of benefits than they would prefer, while others receive less. An individual coverage HRA will allow employees to choose coverage that better suits their preferences, allowing those who want a less comprehensive plan to select one and pay less, while allowing those who want a more comprehensive plan to pay more. In addition, some employers offer plans with a wide choice of providers, reflecting the diverse preferences and healthcare needs of their employees. While a broader network contains certain benefits, it also weakens the ability of employers and issuers to negotiate lower provider prices or otherwise manage employee care. In contrast, in the individual market insurers have an incentive to keep premiums low relative to the SLCSP, which is used to determine the PTC. Hence, insurers are more likely to have a narrower choice of providers in order to negotiate lower prices.

By expanding the ability of consumers to choose coverage that fits their preferences, the final rules will reduce these inefficiencies in labor markets and healthcare spending. Some employees who will be offered individual coverage HRAs under the final rules might choose plans with lower premiums and higher deductibles and copayments (all of which could potentially be paid out of the HRA) and narrower provider networks than they would choose if offered a traditional group health plan. Employees facing higher cost sharing could become more cost-conscious consumers of healthcare. Narrower provider networks could strengthen the ability of purchasers (through their insurers) to negotiate lower provider prices. Both effects could lead to reduced healthcare spending, which could in turn lead to reductions in amounts made available under individual coverage HRAs and corresponding increases in taxable wages. However, these benefits are uncertain and would take some time to occur.[291] Moreover, the provision of a new health benefit that can be used to pay cost-sharing as well as premiums and that is available to employees who were previously uninsured or enrolled in unsubsidized coverage would be expected to increase, rather than decrease, healthcare utilization by some consumers.

Individual coverage HRAs provide flexibility for small employers in particular that might have little expertise or skill in choosing traditional group health plans or in administering coverage effectively for employees. However, some small employers can already obtain lower-cost coverage in the small group market or through AHPs than they could otherwise provide on their own. Small employers that are not ALEs can also forego offering health benefits and allow their employees to obtain individual health insurance coverage, often with PTC subsidization, without liability under Code section 4980H. Qualified small employers can also pursue establishment of QSEHRAs. Thus, small employers whose employees have particularly high healthcare costs or small employers that have little skill or interest in administering health benefits might use these other options to control costs even in the absence of the final rules. If so, the increased efficiency gain from providing an additional incentive for small employers to drop traditional group health plans in favor of individual coverage HRAs could be modest.

Some commenters agreed that the proposed rules would enable employers to offer more affordable health coverage alternatives to employees. Some commenters expressed general support for allowing employers to move to a defined contribution approach for health insurance coverage. The Departments agree that a defined contribution approach is more flexible for employers because it is easier for employers to plan for the future. Furthermore a defined contribution approach reduces the risk that an employer's healthcare costs increase due to factors outside an employer's control.

Reduced administrative costs for some employers. Employers that offer an individual coverage HRA rather than a traditional group health plan could experience reduced administrative costs. For example, such employers will no longer need to choose health insurance plans or self-insured health benefits for their employees and manage those plans. Some of these costs will be borne by HRA recipients. However, overall costs may be lower, particularly for small employers and their employees, as loading fees (that is, premiums in excess of expected insurance claims) appear to be quite high for small firms that provide traditional group coverage.[292]

[291] The individual coverage HRA provides an income and payroll tax exclusion that is available only to workers and, unlike the PTC, benefits workers at all income levels, including workers with incomes in excess of 400 percent of the federal poverty level. Thus, it is possible that the final rules could encourage individuals to join the labor force or to work more hours or seek higher-paying employment, generating further economic benefits. In addition, the final rules could increase labor force mobility (*i.e.,* encourage workers to move more freely to employers where their productivity is highest), because workers enrolled in individual health insurance coverage could find it easier to retain their coverage when they change jobs. However, these effects are highly uncertain, are likely to be relatively small, and might take some time to occur. Labor supply changes are not reflected in the revenue estimates provided in the transfers section later in this section of the preamble.

[292] One study using data for 1997 through 2001 finds that firms with 50 or fewer employees face loading fees of 42 percent of premiums, whereas firms with more than 10,000 employees pay loading fees of just 4 percent. The authors note that these estimates are roughly consistent with the findings of earlier research. The authors caution that the introduction of Exchanges and medical loss ratio requirements provided for under PPACA should reduce loading fees for small firms, but conclude that loading factors for small firms might still be quite high. *See* Karaca-Mandic, Pinar, Jean M. Abraham and Charles E. Phelps, ''How Do Health Insurance Fees Vary by Group Size? Implications

Some commenters stated that the proposed rules would be simpler to administer than traditional group health plans, thereby reducing administrative cost for employers. One commenter noted that while the costs of administering an individual coverage HRA could be lower than the cost of administering a traditional group health plan, the difference is not likely to be large. The Departments are of the view that it is possible that there will be modest reductions in administrative costs for employers who offer an individual coverage HRA rather than a traditional group health plan.

Costs

Loss of health insurance coverage. The Departments recognize that some individuals could experience a loss in health insurance coverage and that some of these people might experience worse financial or health outcomes as a result of the final rules.[293] Loss of coverage could occur if employers drop traditional group health plans and if some previously covered employees do not accept the individual coverage HRA and fail to obtain their own coverage. Loss of coverage also could occur if the addition of new enrollees to the individual market causes premiums to rise, resulting in dropping of coverage by current individual market enrollees. Finally, loss of coverage could occur if employees who are currently purchasing coverage in the Exchange with the PTC become ineligible for the PTC by an offer of (or coverage under) an individual coverage HRA and experience increases in out-of-pocket premiums.

In addition, while most employers that currently offer traditional group health plans offer only one type of plan, some employers offer more choices.[294] As a result, a relatively small number of employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, and some might be unable to find new individual health insurance coverage that covers their preferred healthcare providers. The Departments requested comments on this finding and the extent to which the proposed rules could reduce employee choice or cause some individuals to become uninsured.

Some commenters stated that the proposed rules would lead to adverse selection, increased premiums and overall destabilization of the individual market, causing some to become uninsured. (Adverse selection and resulting premium increases are discussed in greater detail in the Transfers section of this preamble.) Several commenters expressed concern that the offer of an individual coverage HRA could eliminate consumers' eligibility for the PTC, increasing the cost of coverage. Some commenters suggested that some of these consumers would become uninsured. One commenter noted that this problem would be magnified for families, since affordability is determined by comparing the HRA employer contribution amount to the cost of a self-only plan, rather than to a family plan. Several commenters suggested that increased administrative costs and confusion would cause some employees who are offered an individual coverage HRA to fail to enroll and become uninsured.

The Departments acknowledge these concerns, but, as discussed later in this section of the preamble, estimate that the number of individuals with insurance coverage will be increased, rather than decreased, by adoption of the final rules. One reason for this is that the individual coverage HRA contribution that is offered will render an individual ineligible for the PTC only if it is of a sufficient size to make the offer affordable for the employee (and, in the case of ALEs, employers must make amounts available under an individual coverage HRA sufficient for the offer to be considered affordable in order to avoid liability under Code section 4980H). Thus, even if employees do transition from receiving PTC to receiving an offer of an individual coverage HRA, they are not necessarily expected to become uninsured. In addition, the final rules require employers to notify employees of the effect of individual coverage HRA offers and enrollment on PTC eligibility and require employees to substantiate enrollment in individual health insurance coverage in order to receive reimbursement from an individual coverage HRA, reducing the likelihood that confusion will lead to loss of insurance coverage.

Less comprehensive coverage, fewer benefits. Some commenters suggested that some individuals with individual coverage HRAs, and, therefore, individual health insurance coverage, could experience a reduction in the comprehensiveness or affordability of healthcare benefits. For example, commenters noted that an employee might not be able to afford a policy with as high an actuarial value as their current traditional group health plan, or might be limited to narrower networks of providers in the individual market. Another commenter noted that patients may newly have limited choices, particularly among physician specialty care providers. Another commenter said that some employees could have fewer choices of plans in the individual market than the number of group health plan choices previously provided by their employer, or might be unable to find new individual health insurance coverage that covers their preferred healthcare providers. Another commenter stated that the proposed rules would result in poorer financial and health outcomes.

The Departments recognize that some individuals who choose health plans with less comprehensive benefits or higher out-of-pocket payments could experience adverse health or financial outcomes. However, this is unlikely because an individual coverage HRA must be integrated with individual health insurance coverage, which generally is required to provide coverage of all essential health benefits and at least 60 percent actuarial value (subject to a de minimis variation). Moreover, to the extent that commenters' assertions about narrower networks and higher cost sharing in the individual market are accurate, the Departments note that higher cost sharing and narrower networks could also be beneficial in that they encourage consumers to be more cost-conscious, reducing unnecessary and potentially counterproductive health care utilization, and thereby reducing premiums. Such premium decreases could, in turn, lead to increased wages across employees in a firm. For example, an employee might currently

for Healthcare Reform,'' *International Journal of Health Care Finance and Economics* (2011) 11: 181–207.

[293] The Departments note however that increased insurance coverage does not necessarily result in better physical health. For example, Baicker et al. found that increased Medicaid coverage in Oregon ''generated no significant improvements in measured physical health outcomes in the first two years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.'' *See* Baicker, K., S. Taubman, H. Allen, M. Bernstein, J. Gruber, J. Newhouse, E. Schneider, B. Wright, A. Zaslavsky, and A. Finkelstein. 2013. ''The Oregon Experiment: Effects of Medicaid on Clinical Outcomes.'' *New England Journal of Medicine* 368: 1713–22. *http://www.nejm.org/doi/full/10.1056/NEJMsa1212321;* and survey of the literature in Chapter 6 of *Economic Report of the President,* February 2018, *https://www.whitehouse.gov/wp-content/uploads/2018/02/ERP_2018_Final-FINAL.pdf.*

[294] Among firms that offer traditional group coverage, an estimated 81 percent of firms with 3 to 199 employees offer only one type of plan, whereas 42 percent larger firms offer one plan, 45 percent offer two and 13 percent offer three or more plans. *See* Kaiser Family Foundation Employer Health Benefits 2018 Annual Survey, Figure 4.1, at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

have access to only one 80 percent actuarial value traditional group health plan with a relatively broad network, but under an individual coverage HRA will have access to a choice of plans, with actuarial values generally ranging from 60 to 80 percent or higher. If he or she chooses a 60 or 70 percent actuarial value plan, he or she will have a greater incentive to be cost-conscious and will likely spend less on healthcare, leaving more resources for other forms of consumption or saving.

Increased administrative costs. In the impact analysis of the proposed rules, the Departments noted that the proposed rules could increase some administrative costs for employers, employees, and government entities.

Under the final rules, all employers will have a new health benefits option about which to learn. Employers who offer individual coverage HRAs but did not offer employer-sponsored health benefits before will face increased costs of administering a health benefit. In addition, all employers that offer individual coverage HRAs will be required to establish reasonable procedures to substantiate that individuals covered by the HRA are enrolled in individual health insurance coverage or Medicare; to provide a notice to all employees who are eligible for the HRA explaining the PTC eligibility consequences of the HRA offer and acceptance and other information; and to comply with various other generally applicable group health plan requirements, such as maintaining a plan document and complying with various reporting requirements. Employers offering individual coverage HRAs will need to establish systems to reimburse premiums and employee out-of-pocket medical care expenses, or hire third-party administrators to do so. In addition, to the extent an employer is subject to Code section 4980H, the employer will need to learn about the final PTC regulations and any other related guidance under Code section 4980H that the Treasury Department and the IRS may issue. As noted earlier in this preamble, administrative costs associated with individual coverage HRAs could be lower than costs for traditional group health plans for some employers. The Departments expect that third-party administrators and other benefit experts will work to minimize these costs for employers. Because offering an individual coverage HRA is voluntary, ultimately, employers that offer this benefit will do so only because they experience a net benefit from doing so.

As to increased administrative burden and costs for employees, employees who previously enrolled in a traditional group health plan and who now receive an individual coverage HRA will need to shop for and choose their own insurance and learn new procedures for accessing their HRA benefits. In addition, employees who receive an individual coverage HRA will need to substantiate enrollment in individual health insurance coverage once per plan year and in connection with each request for reimbursement.

Further, Exchange enrollees might experience increased compliance burdens, to the extent that they must become familiar with the circumstances in which an offer of an individual coverage HRA precludes them from claiming the PTC. For employees who previously did not receive an offer of a traditional group health plan, this may require learning some of the PTC eligibility rules, and for employees who previously received an offer of a traditional group health plan, this may require learning new or different rules for PTC eligibility. Specifically, an employee who is offered a traditional group health plan is not eligible to claim the PTC for his or her Exchange coverage unless the premium of the lowest cost employer plan providing MV for self-only coverage less the employer contribution for self-only coverage exceeds 9.5 percent (indexed for inflation after 2014) of the employee's household income (assuming the employee meets various other PTC eligibility requirements). In contrast, under the final PTC rules, an employee who is offered an individual coverage HRA will not be eligible to claim the PTC for his or her Exchange coverage unless the premium of the lowest cost silver plan for self-only coverage offered by the Exchange for the rating area in which the employee resides less the individual coverage HRA contribution amount exceeds 9.5 percent (indexed for inflation after 2014) of the employee's household income (assuming the employee meets various other PTC eligibility requirements). However, the Departments note that the final rules will require HRA plan sponsors to furnish a notice to participants providing some of the information necessary for an individual to determine if the offer of the HRA could render them ineligible for the PTC.

In addition, if an enrollee in Exchange coverage is eligible for the PTC, the amount of the PTC is based, in part, on the premium for the SLCSP for the coverage unit offered in the Exchange for the rating area in which the employee resides. As noted earlier, the final PTC rules use the premium for the self-only lowest cost silver plan available to an employee in the Exchange for the rating area in which they reside solely for purposes of determining their individual coverage HRA affordability and the resulting impact on PTC eligibility. Therefore, Exchange enrollees may need to understand which silver level plan premium applies to them for APTC eligibility purposes and which silver level plan premium applies to their PTC calculation.

Similarly, the FFEs and State Exchanges will incur one-time costs to incorporate the SEP and the PTC eligibility rules for individuals with an individual coverage HRA offer into their instructions for enrollees and Exchange employees, as well as in application system logic and automated calculations. HHS estimates that one-time costs to account for individual coverage HRAs for the FFEs will be approximately $3.9 million. HHS further estimates that the FFE call center, eligibility support contractors verifying SEP and application data, and other customer support functions will incur additional annual costs of approximately $56 million in 2020 to $243 million by 2022 to serve the expanded Exchange population. Assuming that State Exchanges will incur costs similar to the FFEs, total one-time costs incurred by the 12 State Exchanges will be approximately $46.8 million. Total additional ongoing costs incurred by the call centers, eligibility support contractors verifying SEP and application data, and other customer support functions for the 12 State Exchanges will be approximately $20 million in 2020 to $85 million by 2022.

Under the final rules, the IRS also will need to add information regarding employees offered individual coverage HRAs to instructions for IRS forms for taxpayers, employee training materials, and calculation programs.

In response to the Departments' request for comments on the extent to which employer administrative costs would be increased or decreased by the rule, some commenters stated that complying with the individual coverage HRA rules would be burdensome. Several commenters expressed particular concern about the ongoing substantiation requirement.

Some commenters noted that the proposed rules would create consumer confusion. Another commenter noted that recent cutbacks in funding for outreach and assistance in the individual market could exacerbate the confusion. One commenter stated that most Americans need a large amount of professional support when making

sound health insurance purchasing decisions and they also need a degree of help to manage their medical claims and coverage during the plan year, particularly in the face of any complex medical issue.

The Departments requested comments on the implementation and ongoing costs to State Exchanges of individual coverage HRAs, and several stakeholders expressed concerns about these increased administrative costs. Although commenters did not quantify the costs, one State Exchange said it estimates a significant expense given the scope and complexity of the proposal. Costs identified include administering a new SEP; making IT changes involving new definitions and explanation texts; user testing; adding a table for the lowest cost silver plan; delaying implementation of other functions; administering appeals; and adding additional staffing for administration, training and oversight such as for increased call center activity and increased complexity. Another Exchange noted the need to update Exchange eligibility software to account for new forms for HRAs, new rules affecting PTC eligibility and new SEPs. Several states requested that the effective date of the final rules be delayed until State Exchanges have had sufficient time to implement the new requirements.

As noted earlier in this preamble, the Departments have included in the final rules some provisions to mitigate these concerns and associated costs. For example, to ensure that employees who are eligible to receive an individual coverage HRA understand the potential effect on PTC eligibility, employers must provide a written notice to eligible participants. To mitigate burden on employers, the Departments are providing model language contemporaneously on certain aspects of the notice, including model language describing the PTC consequences. In addition, ongoing technical assistance will be provided to State Exchanges related to system development activities that will support employers and employees with HRA affordability determinations and the impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. HHS has already discussed with State Exchanges what changes would likely be necessary if the rule were finalized as proposed to assist with planning, as well as what kind of assistance would be most helpful during implementation. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to support State Exchange efforts. This assistance could help State Exchanges implement changes related to the individual coverage HRA more quickly and with less overall cost. The Departments will also provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and the impact on APTC in the absence of system changes that can make those calculations for the employee.

Transfers

The Treasury Department performed microsimulation modeling to evaluate the coverage changes and transfers that are likely to be induced by the final rules. The Treasury Department's model of health insurance coverage assumes that workers are paid the marginal product of their labor. Employers are assumed to be indifferent between paying wages and paying compensation in the form of benefits (as both expenses are deductible in computing employers' taxable incomes). The model therefore assumes that total compensation paid by a given firm is fixed, and the employer allocates this compensation between wages and benefits based on the aggregated preferences of their employees. As a result, employees bear the full cost of employer-sponsored health coverage (net of the value of any tax exclusion), in the form of reduced wages and the employee share of premiums.[295]

The Treasury Department's model assumes that employees' preferences regarding the type of health coverage (or no coverage) are determined by their expected healthcare expenses and the after-tax cost of employer-sponsored insurance, Exchange coverage with the PTC, or Exchange or other individual health insurance coverage integrated with an individual coverage HRA, and the quality of different types of coverage (including actuarial value).[296] The tax preference for the individual coverage HRA is the same as that for a traditional group health plan, and this estimate assumes that employers will contribute the same amount towards an individual coverage HRA as they would contribute for a traditional group health plan.[297] Therefore, an employee will prefer an individual coverage HRA to a traditional group health plan if the price of individual health insurance coverage is lower than the price of traditional group health plan coverage, as long as the value of the higher quality of the traditional group health plan coverage (if any) does not outweigh the lower cost of individual health insurance coverage. The cost of individual health insurance coverage for an employee could be lower than the cost of the firm's traditional group health plan if the individual health insurance coverage is less generous, if the individual health insurance coverage risk pool is healthier than the firm's risk pool, or if the cost of individual health insurance coverage to a particular employee is lower than the cost of the firm's coverage (because, for example, the employee is younger than the average-age worker in the firm).[298]

[295] Note that the wage reduction for an employee who is offered a health benefit may be greater or less than the expected cost of coverage for that particular employee. Because employees are generally paid the same regardless of age, health status, family size or acceptance of benefits, the model assumes that each employee bears the same share of the cost of the firm's coverage. The model allows for some limited variation of the wage reduction by wage class and educational status. All costs and benefits of coverage are taken into account and assumed to accrue to employees, including all income and employer and employee payroll tax exclusions and the avoidance of the employer shared responsibility payment under Code section 4980H by firms that offer coverage.

[296] Expected healthcare expenses by type of coverage, age, family size and other characteristics are estimated using the Medical Expenditure Panel Survey—Household Component (MEPS–HC). These predictions are then statistically matched to the Treasury Department tax data. The MEPS–HC is conducted by the United States Census Bureau for the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services.

[297] It is possible that employers that switch from offering traditional group health plans to offering individual coverage HRAs will contribute less to individual coverage HRAs than they pay for group coverage, and increase taxable wages by a corresponding amount. This could happen because there is greater transparency around health care costs with an individual coverage HRA than with a traditional group health plan, and greater awareness of the cost will likely lower worker demand for health insurance benefits relative to wages. On the other hand, it is not clear why an employer that (based on the incomes and preferences of its workforce) wants to substitute contributions to health benefits for wages would not do so today, in the absence of the availability of individual coverage HRAs, particularly because the final rules generally require that individual coverage HRAs be offered on the same terms to all employees in a class of employees, as described earlier in this preamble.

[298] The Treasury Department model assumes that both the employee and employer shares of premiums for traditional group health plan coverage are fully tax exempt. In modeling the choice between an individual coverage HRA and traditional group health plan coverage, the Treasury Department assumes that the total amount currently paid for traditional group health plan coverage will continue to be tax preferred. If this amount exceeds the individual health insurance coverage premium, the excess is assumed to be used for copayments and deductibles. However, the Treasury Department

Continued

When evaluating the choice between an individual coverage HRA and the PTC for Exchange coverage, the available coverage is assumed to be the same but the tax preferences are different. Hence, an employee will prefer the individual coverage HRA if the value of the income and payroll tax exclusion (including both the employee and employer portion of payroll tax) is greater than the value of the PTC. In modeling this decision, the Departments assume that premiums paid by the employee are tax preferred through the reimbursement of premiums from the individual coverage HRA, with any additional premiums (up to the amount that would have been paid under a traditional group health plan) paid through a salary reduction arrangement.[299]

In the Treasury Department's model, employees are aggregated into firms, based on tax data.[300] The expected health expenses of employees in the firm determine the cost of employer-sponsored insurance for the firm.[301] Employees effectively vote for their preferred coverage, and each employer's offered benefit is determined by the preferences of the majority of employees. Employees then decide whether to accept any offered coverage, and the resulting enrollment in traditional or individual health insurance coverage determines the risk pools and therefore premiums for both employer coverage and individual health insurance coverage. The Treasury Department's model, thus, predicts enrollment and premiums in each type of coverage.

Transitions from traditional group health plans to individual coverage HRAs. Based on microsimulation modeling, the Departments expect that the final rules will cause some participants (and their dependents) to move from traditional group health plans to individual coverage HRAs. As previously noted, the estimates assume that for this group of firms and employees, employer contributions to individual coverage HRAs are the same as contributions to traditional group health plans would have been, and the estimates assume that tax-preferred salary reductions for individual health insurance coverage are the same as salary reductions for traditional group health plan coverage. Thus, by modeling construction there is no change in income or payroll tax revenues for this group of firms and employees (other than the changes in the PTC discussed later in this preamble). The Departments solicited comments on these assumptions, and comments received are summarized further below.

While the tax preference is assumed to be unchanged for this group, after-tax out-of-pocket costs could increase for some employees (whose premiums or cost sharing are higher in the individual market than in a traditional group health plan) and decrease for others.

A small number of employees who are currently offered a traditional group health plan nonetheless obtain individual health insurance coverage and the PTC, because the traditional group health plan is unaffordable to them or does not provide MV. Some of these employees would no longer be eligible for the PTC for their Exchange coverage when the employer switches from a traditional group health plan to an individual coverage HRA because the HRA is determined to be affordable under the final PTC rules.[302] In addition, some employees who are offered individual coverage HRAs would not accept them, and would be newly able to obtain the PTC because the offer of the HRA would be considered to be unaffordable under the final PTC rules, even though the traditional group health plan they were previously offered is affordable under current rules.[303]

Transitions from no employer-sponsored health benefit to individual coverage HRAs. The Departments expect some employees to be offered individual coverage HRAs when they previously received no offer of an employer-sponsored health plan. As a result, taxable wages will fall and non-taxable wages will rise, reducing income tax and payroll tax revenues. Under this circumstance, some Exchange enrollees who previously claimed the PTC will be precluded from claiming the PTC as a result of the offer or acceptance of the HRA, reducing PTC transfers. As explained further below, the Departments assume that PTC spending is reduced only among Exchange enrollees with incomes greater than 200 percent of the federal poverty level.

Transitions from traditional group health plans to individual coverage HRAs integrated with Medicare. Currently, there are about 2.5 million people for whom employer coverage is the primary payer and Medicare is secondary. Earlier in this preamble, the Departments clarify that plan sponsors may allow amounts made available under an individual coverage HRA to be used to pay for Medicare and Medigap premiums, as well as other medical care expenses.[304] Once premiums (and deductibles for medical care expenses) are paid by the individual coverage HRA, there would be few funds available to pay for medical care expenses. Hence, Medicare would effectively become the primary payer in the vast majority of cases.

The total costs to the Medicare Part A program will increase because Medicare Part A will effectively become the primary payer. Because enrollment in Medicare Part A and B or Part C[305] is a requirement to be covered by an individual coverage HRA that is integrated with Medicare and because employees offered an individual coverage HRA will not have access to a traditional group health plan through their employer, the vast majority of employees are expected to enroll in Medicare Part B (and many in Part D).

does not increase the amount that is tax preferred in the case where the individual health insurance coverage premium exceeds the traditional group health plan premium.

[299] The assumption that coverage subsidized by the PTC is the same as coverage subsidized by an individual coverage HRA may be incorrect to the extent that coverage on an Exchange differs from off-Exchange individual health insurance coverage. In addition, the assumption that the full premium for an employee with or without an individual coverage HRA is tax preferred may be incorrect if the employer does not offer a salary reduction arrangement, if the employee does not elect the salary reduction, or if the employee chooses on-Exchange rather than off-Exchange coverage. Salary reduction arrangements may not be used to pay premiums for Exchange coverage.

[300] A crucial component of the model is the use of Form W–2, Wage and Tax Statement, filed by employers to report wages and other benefits of employees. Forms W–2 with the same employer identification number are grouped together to represent the employees of the firm.

[301] Some small firms—generally those with sicker than average employees—are able to purchase community rated coverage in the small group market at lower cost than they could obtain by self-insuring or would pay if they had to purchase coverage in the underwritten large-group market. Firm coverage costs are over-estimated in the Treasury Department's model for these firms. As a result, the Treasury Department model likely over-estimates the extent to which small firms will adopt individual coverage HRAs instead of traditional group health plan coverage and the premium increase from this rule.

[302] As noted later in this section of the preamble, however, the Departments' estimates assume that individuals with incomes below 200 percent of the federal poverty level are not newly ineligible for the PTC by individual coverage HRA offers.

[303] The number of persons newly eligible for the PTC is expected to be very small. Under the assumption that employers contribute the same amount towards an individual coverage HRA as they would for traditional group health plan coverage, employees would become newly eligible for the PTC (if otherwise eligible) only if the lowest cost silver plan premium for self-only individual health insurance coverage is greater than the total cost of the lowest cost MV plan offered by the employer (including the employee and employer share of premiums).

[304] Note, however, that an individual coverage HRA may not, under its terms, limit reimbursement only to expenses not covered by Medicare.

[305] Currently, very few working aged Medicare enrollees have enrolled in Medicare Part C and these estimates are based on the assumption that this is not likely to change.

Per enrollee premiums for Medicare Part B and D will be slightly lower due to the improved health of the Medicare risk pool; however, net costs to the Medicare program will increase due to increased enrollment and because premiums for Medicare Part B will not fully offset the costs of the program.[306]

Summary of estimated transfers and coverage changes. The Departments estimate that once employers fully adjust to the final rules, roughly 800,000 firms will offer individual coverage HRAs. The Departments further estimate that it will take employers and employees about five years to fully adjust to the final rules, with about 10 percent of take-up occurring in 2020 and the full effect realized in 2024 and beyond.

This would result in an estimated 1.1 million individuals receiving an individual coverage HRA in 2020, growing to 11.4 million in 2029. Conversely, the number of individuals in traditional group health plan coverage will fall by an estimated 0.6 million (0.4 percent) in 2020 and 6.9 million (4.5 percent) in 2029. Similarly, the number of individuals in individual health insurance coverage without an individual coverage HRA will fall by an estimated 0.4 million (2.4 percent) in 2020 and 3.8 million (24.8 percent) in 2029. The number of uninsured persons will fall by an estimated 0.1 million (0.1 percent) in 2020 and 0.8 million (1.4 percent) in 2029.[307] See Table 2 for details.

The modeling suggests that employees in firms that would switch from offering traditional group health plan coverage to offering an individual coverage HRA would have, on average, slightly higher expected healthcare expenses than employees in other firms and current individual market enrollees. As a result, premiums in the individual market would be expected to increase by about 1 percent as a result of the final rules, throughout the 2020–2029 period examined. The Treasury Department model is nationally representative and does not necessarily reflect the expected experience for every market. The premium increase could be larger in some markets if some adverse selection results, and premiums could fall in other markets. Furthermore, some employers might take longer to adopt the individual coverage HRA, preferring to wait to see how premiums change; and, this delay in adoption might be more likely in markets that are currently in worse condition. Such differing behavior adds uncertainty to the estimates.

Income and payroll tax revenue is expected to fall by about $500 million in fiscal year 2020 and $15.5 billion in 2029, as firms newly offer tax-preferred health benefits in the form of individual coverage HRAs. At the same time, total PTC (including the refundable and non-refundable portion of the credit) is expected to fall by about $300 million in 2020 and by about $6.2 billion in 2029. In total, the final rules are estimated to reduce tax revenue by about $200 million in fiscal year 2020, $9.3 billion in fiscal year 2029, and $51.2 billion over the 10-year period through fiscal year 2029.[308]

The Departments assume that about 1 percent of the 2.5 million individuals for whom employer coverage is the primary payer and Medicare is the secondary payer will enroll in an individual coverage HRA integrated with Medicare by the end of the projection period. As a result, the final integration rules are estimated to increase costs to the Medicare trust funds by less than $50 million in 2020, $0.3 billion in 2029, and $1.9 billion over the ten-year period through fiscal year 2029. The impacts for Medicare Part B and D reflect the net impact to the federal government after the payment of premiums.

TABLE 2—ESTIMATED EFFECTS OF INDIVIDUAL COVERAGE HRAS ON INSURANCE COVERAGE AND TAX REVENUES, 2020–2029

Calendar year	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Change in Coverage [Millions]: [a]										
Individual health insurance coverage with HRA	1.1	2.7	5.3	8.1	10.9	11.0	11.2	11.4	11.4	11.4
Traditional group health plan	−0.6	−1.7	−3.3	−5.0	−6.7	−6.8	−6.8	−6.8	−6.9	−6.9
Individual health insurance coverage without HRA	−0.4	−0.9	−1.8	−2.7	−3.6	−3.6	−3.7	−3.8	−3.8	−3.8
Uninsured	−0.1	−0.2	−0.3	−0.5	−0.6	−0.7	−0.7	−0.7	−0.7	−0.8
Fiscal year	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**
Change in Revenue [Billions]:										
Premium Tax Credit Reduction	0.3	0.8	1.8	3.0	4.4	4.7	5.4	5.7	6.0	6.2
Other Income and Payroll Tax Reduction	0.5	1.7	3.8	6.4	9.4	10.9	12.6	13.9	14.7	15.5
Net Revenue Reduction	0.2	1.0	1.9	3.4	5.0	6.2	7.2	8.3	8.8	9.3
Medicare Part A [b]	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Medicare Part B	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Medicare Part D	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1
Total Medicare Outlay Cost [c]	0.0	0.0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Total Cost [d]	0.2	1.0	2.0	3.6	5.2	6.4	7.5	8.5	9.1	9.6

Notes:
a. Millions of covered lives, annualized.
b. 0 = less than $50 million.
c. Note that the sum of estimated impacts for Medicare Part A, B and D may not equal net Medicare Outlay Cost due to rounding.
d. May not add to sum, due to rounding.

[306] Employees who are entitled to Medicare on the basis of age generally tend to have lower healthcare costs than the average Medicare beneficiary, improving the overall health of the Medicare risk pool.

[307] These estimates are annualized counts (*e.g.,* two persons with six months of coverage each count as one covered person), and reflect only coverage for persons under age 65. For more information about the Treasury Department's baseline estimates, see ''Treasury's Baseline Estimates of Health Coverage, Fiscal Year 2019 Budget Exercise'' June 2018, available at *https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/Treasury%27s-Baseline-Estimates-of-Health-Coverage-FY-2019.pdf.*

[308] These revenue estimates do not account for the possibility that the final rules could lead to increased taxable wages.

At least one commenter stated that the negative effects of the proposed rules, particularly the increase in the individual market premiums and the attendant fiscal costs, are likely to outweigh the benefits to employers and their employees. As noted earlier in the preamble, the increase in individual market premiums is a modest 1 percent. While the net fiscal cost in 2025 is $6.2 billion, this includes the cost of new coverage for 0.7 million individuals. In addition, as discussed earlier, the integrated coverage HRA provides employers and employees with an additional option for providing health benefits, a benefit that the Departments have not quantified. Therefore, the Departments have concluded that the benefits of allowing integration of individual coverage with HRAs substantially outweigh the costs.

The Departments acknowledge that the extent to which firms will offer individual coverage HRAs and the results on individual market risk pools and premiums, federal tax revenues, and private costs and benefits are highly uncertain. The Departments invited comments on the modeling assumptions and proposed estimates of the proposed rules and assumptions.

Several commenters stated that the Departments' analysis failed to take account of variation in individual market risk across geographic areas. The Departments' acknowledge that the quantitative estimates are derived from a nationally representative model, largely because the MEPS–HC is a nationally representative survey. The Departments do not know of any readily available data on the distribution of health claims at the firm level for specific rating areas or states. If the health risk in the individual market relative to that of employer risk pools varies across geographic areas, a nationally based model will understate the extent to which employees might transition to individual markets with healthier risk pools and overstate movement into less healthy individual markets. This would understate potential premium increases in some markets and overstate them or understate premium decreases in others. To examine this possibility, the Departments estimated the correlation between individual market premiums and traditional group coverage premiums in all rating areas across the country.[309] The Departments found that premiums in the two markets are positively correlated, and that the correlation is statistically significant. In other words, where premiums for individual health insurance coverage are higher, premiums in the traditional employer market also tend to be higher. The Departments also do not find any evidence that, to date, employers have substantially dropped coverage or disproportionately dropped coverage and sent less healthy employees to individual markets with healthier risk pools. Even if the difference between individual market health risk and group market health risk currently varies across location, there is no clear reason why that variation would not persist when the individual coverage HRA is available. As a result of these observations, the Departments conclude that there is little indication that the individual coverage HRA will be disproportionately used in areas with healthier individual market risk pools. Moreover, it is not evident that adverse selection into the individual market would be much more likely in these lower cost areas, or that those risk pools would not be able to absorb additional enrollees from the group market.

One commenter suggested that the Treasury Department model does not adequately account for variation in expected claims risk across employers, because it does not explicitly account for the tendency of sicker workers to work alongside otherwise sicker workers, and for healthy workers to work alongside other healthy workers. The Treasury Department model imputes the expected health care expenses of families from MEPS–HC data, controlling for type of coverage, age, gender, family size and type, employment status, education, race, health status, geographic characteristics and other characteristics. The Treasury Department constructed firms using Form W–2 and other tax data. The Treasury Department then matched the MEPS–HC health expenses of families to families in the tax data (and thereby to employees within firms), by income, family size and type, age, gender and other variables common to the MEPS–HC and tax data sets. The model should reflect the clustering of sicker or healthier workers within firms if such clustering is correlated with the characteristics used in the health expense imputation and matching of MEPS–HC and tax data. In addition to conducting a survey of households' health expenditures (the MEPS–HC), the U.S. Census Bureau conducts a survey of employers regarding their health insurance costs (the Medical Expenditure Panel Survey—Insurance Component, or MEPS–IC.) To evaluate whether the distribution of imputed healthcare costs within and across firms in the Treasury Department model is in fact reasonable, the Departments obtained MEPS–IC premiums for single and family plans at each percentile of the premium distribution, and compared these to premiums in the Treasury Department model. The Departments found that the distributions looked very similar. That is, the imputed premiums appear similar to those reported in the MEPS–IC, for both lower and higher cost firms. Therefore, the Departments conclude that there is no evidence to suggest that the Treasury Department model does not reflect clustering by health status or any other important determinants of health risk and premiums.

As explained earlier in this section of the preamble, the Departments explicitly assume that persons with incomes below 200 percent of the federal poverty level who are enrolled in subsidized individual health insurance coverage in the baseline do not move to an individual coverage HRA or to uninsured status as a result of the final rules. The Departments also assume that employees with incomes above 400 percent of the federal poverty level who are currently enrolled in a traditional group health plan do not become uninsured as a result of his or her employer switching to an individual coverage HRA, even if individual health insurance coverage premiums are substantially higher than the cost of their traditional group health plan coverage. These assumptions are consistent with allowing the individual coverage HRA offer to vary across employees in certain cases, and are intended to provide estimates that reasonably reflect expected employer

[309] Specifically, the Departments extracted premiums reported on the population of Forms W–2, and estimated per person annual premiums from this information using coverage data from Forms 1095–B and C. See *https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/Treasury%27s-Baseline-Estimates-of-Health-Coverage-FY-2019.pdf* for a description of this estimation process. The Departments then compared this to SLCSP premiums. The Departments specifically compared single plan premiums for firms including any 30-year old covered employee to SLCSP premiums for a 30 year old, and did the same for firms including any 50-year old covered employee and SLCSP premiums for a 50 year old in the same rating area. In both cases the Departments estimated that traditional group coverage premiums increase by about 20 cents for every dollar increase in individual market premiums ($p<01$). The commenter provided some evidence of geographic variation in health claims in the individual market relative to claims in the small group insured market. This analysis is of limited use, because most employees who are expected to be offered an individual coverage HRA are in the large group market. The Treasury Department data for this sensitivity analysis includes premiums in firms of all sizes, but is heavily weighted to firms filing more than 250 Forms W–2, as these employers are required to report premium information.

and employee behavior. The Departments acknowledge that imposition of these assumptions reduces both the amount of estimated PTC savings and the amount of estimated individual coverage HRA revenue costs. In addition, by imposing this restriction, the analysis does not reflect the extent to which lower-income employees would face higher insurance costs if an individual coverage HRA offer renders them ineligible for the PTC.

One commenter suggested that the Departments explicitly model coverage choices for individuals with incomes below 200 percent or above 400 percent of the federal poverty level. Other commenters expressed concern that low-income workers likely would face higher coverage costs (and perhaps take-up less coverage and face worse financial or health outcomes) because they will lose eligibility for PTC. One commenter suggested that the individual coverage HRA rules could only benefit families with incomes in excess of 400 percent of the federal poverty level. However this commenter did not take into account the decline in PTC as income rises as well as the tax benefit of employer-provided individual coverage HRAs. In order to consider these concerns more fully, the Departments performed additional analysis to evaluate the potential effect of the individual coverage HRA on receipt of PTC and changes in tax liability across income classes, under the Departments' preferred assumption that persons with low incomes do not lose PTC and an alternative scenario where the Departments do not impose this assumption.

Under the Departments' preferred set of assumptions, the individual coverage HRA reduces tax revenues by a total of $6.2 billion in calendar year 2025, consisting of $10.9 billion in reduced income and payroll taxes partly offset by $4.7 billion in reduced PTC (including both the refundable and non-refundable portions of the credit). In comparison, the individual coverage HRA increases tax revenues $1.1 billion among taxpayers who are enrolled in individual health insurance coverage in the Exchange in the baseline. Over 0.9 million families with incomes between 200 and 400 percent of the federal poverty level pay $2.1 billion more in taxes (that is, on net the loss in PTC exceeds the value of income and payroll tax exclusions received for the individual coverage HRA), or an average of nearly $2,300. However, they are not expected to become uninsured, because while the tax preference for the HRA is less than the PTC, the after-tax cost of coverage is less than the expected cost of healthcare. About 0.4 million families with incomes over 400 percent of the poverty level pay nearly $1.1 billion less in taxes, with an average tax cut of nearly $2,900. Note that these estimates include only the effects on families with individuals currently enrolled in individual health insurance coverage in the Exchange, and do not reflect the tax decreases experienced by newly insured persons, or by persons currently enrolled in individual health insurance coverage outside of the Exchange. In addition, the estimates for families with incomes below 400 percent of the federal poverty level are net changes, and include gains for families for whom the tax exclusion value of the individual coverage HRA exceeds the PTC offset by losses for families for whom the PTC exceeds the value of tax exclusion gained.

Under an alternative assumption where persons with incomes below 200 percent of the federal poverty level also lose PTC if their employer offers an affordable individual coverage HRA, about 0.9 million additional families would pay an additional $3.5 billion in taxes (in the form of lost PTC that is not offset by the value of income and payroll taxes received for individual coverage HRA), with an average tax increase of nearly $4,000. These families are not projected to become uninsured. The 10-year cost of the final rules would fall from an estimated $51.2 billion to $23.7 billion. However, as noted earlier, the Departments do not expect such large tax increases among lower-income families to occur. Rather, the Departments expect employees who currently receive substantial amounts of PTC but are in firms where employees overall are better off with an individual coverage HRA will seek out employers that do not offer an individual coverage HRA or traditional group health plan, or that employers will reduce individual coverage HRA offers or decide not to offer an individual coverage HRA, so as not to render all or certain classes of employees ineligible for the PTC. This may be particularly true for firms that do not offer a traditional group health plan in the baseline.

In addition, the Departments performed an alternative analysis of the number of persons with incomes in excess of 400 percent of the federal poverty level who are predicted to become uninsured if employers do not vary contributions to individual coverage HRAs by age and employees do not switch employers to avoid an increase in health insurance costs. (In other words, in this scenario the Departments relax their assumption that no higher income persons become uninsured as a result of moving from traditional group health plan coverage to being offered an individual coverage HRA.) In this alternative simulation, about 1 percent of persons in families with incomes above 400 percent of the federal poverty level with traditional group health plan coverage under the baseline become uninsured (or nearly 900,000 individuals). However, as noted earlier in this section of the preamble, the Departments do not expect such transitions to occur. Under this alternative simulation, older individuals are more likely to become uninsured, in large part because the Treasury Department's model fails to account for the variation in individual coverage HRA contributions by age as permitted under the final rules. Under the final rules, we expect that employers will vary individual coverage HRA offers so as not to completely unwind the cross-subsidies of older employees by younger employees and avoid markedly increasing older employees' coverage costs. In the event that coverage costs for particular employees substantially increase, those employees are expected to seek employment at firms that continue to offer traditional group health plan coverage.

Several commenters stated that employers would likely provide the same amount of individual coverage HRA contributions to all employees in a class of employees, without age variation. As a result, older workers could face higher coverage costs and younger workers could face lower costs when they move from traditional group health plan coverage to an age-rated individual health insurance plan. However, varying HRA amounts based on age is allowed under the final rules, subject to certain limits, and other commenters suggested that employers would utilize this option, thereby maintaining existing cross-subsidies of older workers, which clearly has economic utility to firms, to some extent.

Several commenters suggested that the Departments' estimates of individual coverage HRA take-up are overstated, because the estimates do not account for increased hassle costs of enrolling in individual health insurance coverage, compared to the cost of enrolling in a traditional group health plan. The Departments acknowledge earlier in this section of the preamble that some individuals will face higher administrative costs associated with choosing individual health insurance plans and enrolling in coverage. This could result in fewer employers offering individual coverage HRAs and fewer

employees enrolling in individual health insurance coverage integrated with an HRA. However, commenters did not attempt to quantify such costs. Because the magnitude of these costs (in total and relative to the cost of enrolling in a traditional group health plan) is uncertain, the Departments are unable to quantify the likely effect on individual coverage HRA take-up.

The Departments particularly emphasize that these estimates assume that every employee in a firm would be offered either an individual coverage HRA or a traditional group health plan (but not both and not a choice between the two), or no employer health benefit. The estimates further assume that a firm offering an individual coverage HRA would offer the same benefit to each employee in the firm, and would not vary the contribution by location, age, or other permitted factors other than self-only versus non-self-only benefits.[310] In other words, the estimates assume that the final rules will be effective in preventing firms from dividing their employees by health status or other factors in a way that would allow firms to capture greater tax subsidies or increase individual market premiums or the PTC.

In estimating the impact of the final rules on individual coverage HRA participation and transfers, including individual market premium increases, it is important to take into account the relative sizes of the employer market and the individual health insurance market and the relative health risk of individuals that are likely to transition from group to individual market coverage. Because the number of individuals in traditional group health plans is large relative to the number of individuals in individual health insurance coverage, relatively small changes in employer offers of coverage can result in large changes in individual market premiums.[311]

The Departments invited comments on the extent to which firms with healthy or less healthy risk pools would utilize individual coverage HRAs. The Departments specifically sought comments on the extent to which employers would offer different benefits to different classes of employees, including the rating area class and combinations of the classes, and the resulting effect on individual market premiums. Many commenters responded, generally emphasizing the importance of a stable individual health insurance market and the need to maintain and, if possible, strengthen conditions to prevent adverse selection as a result of the individual coverage HRA.

Many commenters noted that, because the employer group market is very large relative to the individual market, even a relatively minor shift of higher-cost individuals from traditional group health plans to the individual market would markedly increase individual market premiums. In a similar vein, one commenter noted that the individual market in their state is too small to absorb the high health costs from the few employers who have high enough health costs to make the individual coverage HRA strategy economically attractive. Commenters also noted that healthcare costs are distributed very unevenly, and that, as a result, moving a small number of the highest-cost employees to the individual market can have a large impact on premiums. Several commenters provided their own scenarios showing that if employers are able to send a relatively small number of high-cost individuals to the individual market it could result in a very large increase in premiums in the individual market. Under one example, if 1 percent to 4 percent of the employer market with various above-average-fractions of higher-cost employees migrates to the individual market, premiums have the potential to increase 3 percent to 83 percent. In an example presented by another commenter, if as few as 5 percent of the persistent top spenders in the large group market move to individual market coverage, the average individual market claim would increase by 15 percent. Under a third example discussed by a third commenter, if 10 percent of employers designed individual coverage HRAs to shift the sickest individuals into the individual market, premiums would increase by 17.3 percent. If however 100 percent of employers engage in shifting their sickest employees, premiums would increase by 93.1 percent in the individual market. The Departments note that these scenarios do not take into account the conditions in the proposed or final rules intended to prevent adverse selection. As such they help to illustrate why the Departments proposed, and are finalizing, conditions designed to prevent adverse selection. These examples are not inconsistent with the illustrative scenario presented by the Departments in the preamble to the proposed rules.

Many commenters said it was important that the final rules not give employees a choice between a traditional group health plan and an individual coverage HRA in order to prevent adverse selection in the individual market, as was prohibited under the proposed rules. One commenter gave specifics noting that it is the employer that is empowered with deciding which health benefits to offer. Thus, according to the commenter, it is not likely that employers would offer both an individual coverage HRA and a traditional group health plan if the employer anticipated that such a choice would increase claims cost in its traditional group health plan. The commenter noted that without the condition in the proposed and final rules prohibiting plan sponsors from offering employees a choice between a traditional group health plan and an individual coverage HRA, there would be market segmentation caused by incenting high-cost individuals to enroll in individual market coverage as well as potential adverse selection based on difference in benefits, cost-sharing levels, and networks.

Many commenters said that it is important that the final rules retain the condition that individuals be required to obtain individual health insurance coverage in order to be covered by an individual coverage HRA. One commenter suggested that, otherwise, healthy individuals might opt out of the individual market (comprehensive coverage) and use the individual

[310] The Departments imposed two constraints on the microsimulation that could be consistent with allowing the individual coverage HRA offer to vary across classes of employees within a firm. First, the Departments assume that persons with incomes below 200 percent of the federal poverty level who are enrolled in subsidized individual health insurance coverage in the baseline do not move to an individual coverage HRA or to uninsured status as a result of the final rules. This is consistent with assuming that employers with low-wage workers currently receiving Medicaid or the PTC do not begin to offer individual coverage HRAs large enough to render such employees ineligible for the PTC or from receiving public coverage. This constraint is also consistent with the assumption that employees who would experience a substantial subsidy loss will move to other jobs that allow them to retain their current coverage. This assumption reduces the amount of PTC savings generated by the final rules, and also reduces the tax revenue cost of providing individual coverage HRAs to such employees. Second, the Departments assume that employees with incomes above 400 percent of the federal poverty level who are enrolled in a traditional group health plan do not become uninsured as a result of the final rules, even if individual health insurance plan premiums are substantially higher than the cost of their traditional group health plan coverage. This is consistent with assuming that employers will provide larger individual coverage HRAs to older employees or to employees in higher-cost markets than they will provide to other employees in their firms, in order to ensure affordable coverage. It is also consistent with assuming that employees will move to other firms, if they face large premium or cost-sharing increases when their employers switch from traditional group health plan coverage to individual coverage HRAs.

[311] The Treasury Department projects that over 150 million persons under age 65 will be enrolled in employer-sponsored group health plans in 2020, compared to about 15 million in the individual market.

coverage HRA to cover out-of-pocket spending or for noncompliant coverage, potentially increasing adverse selection in the individual market. Relatedly, many commenters supported the prohibition on integration of an HRA with STLDI. If enrollees were given a choice of individual health insurance coverage or STLDI, in conjunction with an individual coverage HRA, commenters explained that healthy employees would be more likely to purchase the less expensive STLDI plans, creating adverse selection for the individual market.

Commenters generally supported the condition that individual coverage HRAs be offered on the same terms to an entire class of employees and that the classes to which a plan sponsor may offer HRAs on different terms be limited to the classes enumerated in the proposed rules and any combinations of those classes. One commenter noted that the same terms requirement and the enumerated classes reduce the ability of employers to target high-cost workers by targeting particular worker classes. The commenter explained that allowing employers to define classes more narrowly would increase the opportunity for employers to target high-cost workers, thereby increasing the adverse selection risk in the individual market. Some commenters recommended that the number of permitted classes not be expanded in general to avoid increasing the risk of adverse selection in the individual market.

One commenter noted that the proposed permitted classes of employees could be combined to offer employers opportunities to segment highly specific subsets of employees, including the more costly populations, resulting in higher premiums in the individual market. Several other commenters expressed concerns that the proposed integration conditions would not be adequate to protect against additional risk segmentation. Another commenter suggested that premiums in the individual market could rise because the proposed rules create uncertainty, causing insurers to include an additional risk factor when setting premiums. Further, the commenter urged that the proposed rules be withdrawn as they would be detrimental to consumers and health insurance markets in that particular state. One state with an approved PPACA section 1332 state innovation waiver authorizing a re-insurance program asserted that the proposed rules could dismantle the market stability that has been achieved through state based mechanisms and that states with re-insurance programs will unintentionally subsidize employer health plans due to the influx of people with high claims.

After consideration of these comments and related economic literature,[312] the Departments concluded that the conditions contained in the proposed rules intended to mitigate the risk of adverse selection (including the prohibition on offering an employee a choice between an individual coverage HRA or a traditional plan, the same terms requirement, the requirement that individuals with individual coverage HRAs be enrolled in individual health insurance coverage, and the prohibition on integration with STLDI) are necessary and, as retained in the final rules, support the Departments' finding that the effect of the rule on individual market premiums will be modest.

Several commenters suggested that additional rules should be adopted to prevent adverse selection. For example, one commenter stated that employers should be forbidden from using health status of any individual or class of employees as a factor when differentiating between classes of employees. Another encouraged strong federal oversight to ensure employer compliance with the conditions. Yet another commenter recommended the Departments use a facts and circumstances test to determine whether individual coverage HRAs are targeted to high cost employees, in addition to requiring compliance with the conditions in the final rules.

The Departments decline to add a facts and circumstances test to the final rules. DOL has enforcement jurisdiction over private sector employer-sponsored group health plans, and HHS has enforcement jurisdiction over public sector group health plans, such as those sponsored by state and local governments. Individual coverage HRAs are group health plans, and DOL and HHS will monitor individual coverage HRAs' compliance with applicable requirements, consistent with the general approach to enforcement with respect to other group health plans. The Departments are of the view that it is unnecessary to include specific enforcement guidance for individual coverage HRAs in the final rules. However the Departments may provide additional guidance if the Departments become aware of arrangements that are inconsistent with the conditions of the final rules.

One commenter noted that the lack of a limit on the maximum individual coverage HRA amount could result in more employers with older or sicker employee populations providing very large individual coverage HRAs and sending those high-cost individuals to the individual market. This commenter suggested limiting individual coverage HRA contributions to a maximum amount. Another commenter pointed out that an employer could provide an individual coverage HRA that covered both the premiums and cost-sharing expenses up to the maximum out-of-pocket limit ($7,900 in 2019) for an expensive employee and still reduce health costs. This commenter supported the same terms requirement and other rules preventing benign discrimination to shield against market segmentation. In previous guidance on HRAs, including on integration of HRAs with other coverage, the Departments provided no minimum or maximum contribution amount. Similarly, the Departments decline to impose a minimum or maximum contribution amount on individual coverage HRAs under the final rules, in order to provide employers with flexibility and because the Departments have imposed other conditions to address the potential for adverse selection.

Commenters also recommended that the conditions to prevent adverse selection in the proposed rules be strengthened by applying the integration conditions to the aggregated controlled group of employers rather than to the common-law employer. The Departments have concluded that applying the classes of employees at the common law employer level will avoid complexity for employers and that applying a minimum class size requirement in certain circumstances, at the common law employer level, is a

[312] Although adverse selection has been observed in many instances, relatively recent empirical research suggests that any harm from adverse selection could, in some circumstances, be modest. Most of the literature is related to choices between plans within a firm or other contexts that are not directly analogous to an employer's choice between offering a traditional group plan or an individual coverage HRA, and as a result the applicability of the research is somewhat unclear. Therefore the Departments are including in the final rule provisions specifically intended to mitigate against adverse selection while at the same time giving employers an important new way to provide health benefits. *See e.g.,* Einav, Liran, Amy Finkelstein, and Jonathan Levin, ''Beyond Testing: Empirical Models of Insurance Markets,'' *Annual Review of Economics,* 2010, 2: 311–326; Einav, Liran, Amy Finkelstein, and Mark Cullen, ''Estimating Welfare in Insurance Markets Using Variation in Prices,'' *Quarterly Journal of Economics,* 2010, 125 (3): 877–921; Bundorf, M. Kate, Jonathan Levin, and Neale Mahoney, ''Pricing and Welfare in Health Plan Choice,'' *American Economic Review,* 2012, 102 (7): 3214–3248; and Cardon, James H. and Igal Hendel, ''Asymmetric Information in Health Insurance: Evidence from the National Medical Expenditure Survey.'' *RAND Journal of Economics,* 2001, 32 (3): 408–427.

more straightforward way of addressing the adverse selection concerns raised by some commenters. Therefore, the Departments are not adopting the suggestion.

One commenter suggested the final rules should not allow using rating area as a separate class of employees because it presents risk for health factor discrimination, allowing employers to isolate an employee or a few employees with costly medical expenses who happen to work at the same primary site. While the Departments appreciate and considered the concern raised by commenters, the Departments have determined, based on information regarding the significant differences in individual market premiums between rating areas within some states and significant differences in the number of individual health insurance plans available between rating areas within some states, that it would be an unreasonable limitation on employer flexibility, and, thus, employee welfare, to prohibit employers from offering different benefits based on different work site rating areas.

One commenter argued that the allowable variation in individual coverage HRA contributions by employee age and number of dependents would need to be parallel to the variation in premiums by age and family size in the individual market to avoid the risk that employers target large contributions to high-cost employees. Another commenter pointed out that employers' ability to vary individual coverage HRA amounts by age should not be limitless, but should be subject to sound actuarial guardrails, such as the 3 to 1 PPACA age band between the youngest and oldest employees. The Departments agree. In the final rules, employers are permitted to vary contributions based on the age of the participant as long as the contribution for the oldest participant is within a 3 to 1 ratio of the contribution for the youngest participant. Further, the same maximum dollar amount attributable to the increase in age must be made available to all participants of the same age in the same class of employees.

Some commenters recommended removing as a permitted class of employees the class based on employees who have not yet attained 25 years of age because this would enable employers to offer individual coverage HRAs to older employees while keeping young, generally healthier employees in a traditional group health plan, increasing adverse selection risk for the individual market. In addition, commenters noted that there is no clear need for this class of employees as employers do not typically vary current coverage offering for employees over and under age 25. After consideration of these comments, the Departments are omitting this class in the final rules.

Several commenters suggested a minimum class size requirement so that employers cannot combine classes in a way that less healthy employees can be isolated into separate classes from healthy employees. According to these commenters, each classification should be required to include a certain minimum number and/or percentage of employees. The Departments agree and sought to develop a rule that is narrowly tailored to mitigate the risk of adverse selection, especially when combining classes, and to avoid overly burdening employers or unnecessarily hampering the increased use and flexibility of individual coverage HRAs. In order to balance these considerations, the final rules include a minimum class size requirement that varies based on employer size and that applies only to certain classes of employees in certain circumstances in which the potential for health factor discrimination is greatest. In general, the minimum is equal to 10 employees for an employer with fewer than 100 employees; equal to 10 percent of the total number of employees (rounded down to a whole number), for an employer with 100 to 200 employees; and equal to 20 employees for an employer that has more than 200 employees. See earlier in this preamble and the final rules for more detail.

Multiple commenters noted that large employers and self-insured employers with a greater share of less-healthy employees could be more likely to offer individual coverage HRAs than employers with healthier employees. The resulting adverse selection could worsen the individual market risk pool and increase premiums. The Departments acknowledge that the integration conditions generally do not address this potential problem. This effect has been included in the modeling and hence is reflected in the overall results. As discussed earlier in this preamble, this effect along with other effects of the final rules result in a premium increase of only about 1 percent, indicating a very small effect on the individual market risk pool.

Other commenters thought individual coverage HRAs could reduce adverse selection in the individual market. Some commenters noted that the proposed rules would result in many employees moving to the individual market, thereby expanding the market and stabilizing premiums. One commenter argued that although some employers may have a higher-risk group of employees, in general, working employees are lower-risk than individuals in the individual market. Other commenters stated that employers may not necessarily be incentivized to segment their risk, that is, they may be interested in offering individual coverage HRAs for reasons unrelated to risk. Another commenter argued that commonly purchased stop-loss coverage mitigates the incentive to move individuals to the individual market; that HIPAA generally prohibits group health plans and health insurance issuers in the group market from discriminating against individuals based on health factors; that the requirement that to provide MV employer plans provide ''substantial coverage'' of inpatient hospital services and physician services makes it hard for employers to incentivize high cost individuals to move to the individual market by providing limited benefits; and that the proposed rules' same terms requirement and the restriction on integration of individual coverage HRAs with STLDI all work together to eliminate the opportunities for employers to encourage higher-risk employees to obtain coverage in the individual market. One commenter noted that the Departments struck an important balance between providing additional alternatives for employers while curtailing the opportunity for some employers to selectively segment risk and shift their highest-cost employees to the already fragile individual market. The Departments agree that the final rules, with the integration conditions, strike the right balance and have the potential to strengthen the individual market.

Several commenters further recommended that the Departments add as a permitted class to the final rules, salaried and hourly employees, so that employers may be permitted to make different offers of coverage, to salaried and non-salaried workers. Commenters in support of allowing salaried and hourly workers as permitted classes of employees explained that this would provide additional flexibility for employers without increasing the risk of adverse selection. Reasons for this conclusion included: The classification is used for a variety of purposes and reclassifying employees may violate the FLSA, ERISA and other laws that prohibit employers from reclassifying workers solely for the purposes of interfering with health benefits. One commenter stated that under such a rule employers would have more potential for risk selection than in the permitted

classes under the proposed rules. After consideration of these comments, the Departments are allowing employees who are paid on a salaried basis and non-salaried employees (such as hourly employees) as permitted classes of employees in the final rule, subject to the minimum class size requirement.

The Departments also recognized that transition from coverage under a traditional group health plan to coverage under an individual coverage HRA could represent a substantial change from an employee perspective, and as a result employers may find it difficult to transition to individual coverage HRAs. Because new hires are unlikely to increase adverse selection in the individual market and, if added to the individual market, would likely lower average risk, the Departments have added flexibility for employers by allowing employers to continue to offer traditional group health plans to current employees while offering individual coverage HRAs to newly hired employees. Recognizing that the new hire subclass will start small as employees are hired after the employer-specified hiring date for a class of individuals, the new hire subclass is not subject to the minimum class size requirement. However, if an employer later chooses to further subdivide a new hire subclass, each subdivision would be subject to any minimum class size requirements that otherwise would apply.

Several commenters suggested that the Departments delay implementation of the final rules until further analysis, particularly regarding risk segmentation, could be conducted. However, commenters offered few concrete suggestions to inform additional analysis. While the Departments acknowledge that the exact effects of the final rules are subject to uncertainty, the Departments conclude that the benefits of the rules will outweigh any costs, and that the benefits of promulgating the rules without further delay will outweigh the benefits of additional analysis. As recommended by a number of comments, the Departments will continue to closely monitor premiums and the stability of the individual market.

The Departments also emphasize that these estimates assume that employers would contribute the same amount to individual coverage HRAs as they would to traditional group health plans and that employees would elect the same amount of salary reduction to pay for individual health plans and cost sharing as they would if they were enrolled in a traditional group health plan. But, as noted above, some employees who would be offered individual coverage HRAs under the proposed rules would choose plans with lower premiums and higher deductibles and copayments and narrower provider networks than they would choose if offered a traditional group health plan. However, some workers would probably choose more expansive coverage than what they were offered in a traditional group health plan, and a key benefit of this rule is that it expands workers' ability to choose coverage that best suits their preferences. Those workers who choose plans with higher cost sharing and narrower provider networks and become more cost-conscious consumers of healthcare will likely reduce healthcare costs and insurance premiums, eventually reducing average HRA amounts and salary reductions. The Departments requested comments on the assumption that employer and employee tax-preferred spending on healthcare would be the same for individual coverage HRAs as for traditional group health plans.

One commenter questioned the Departments' basis for this assumption. Based on conversations with employers of all sizes and industries, the commenter concluded that it appears likely that a good portion of employers would contribute substantially less to individual coverage HRAs than what they are currently contributing to traditional group health plans. The commenter suggested that this would be particularly true for certain classes of employees, and that this may result in some employees and dependents becoming uninsured. Several commenters expressed concern that employers would contribute less to individual coverage HRAs than they currently contribute to their traditional group health plans, with the result that coverage would be less affordable for employees. One commenter suggested that employers offering an individual coverage HRA be required to provide a minimum amount to ensure that the HRAs are adequate for the purchase of individual health insurance coverage. As discussed above, the Departments decline to adopt this suggestion. In general, workers bear the cost of employer contributions to health benefits in the form of reductions in wages and non-health benefits. The current tax system subsidizes health benefits, and it is not clear that minimum employer contributions would improve employee welfare. Other commenters suggested that employers should be required to vary the amount of the individual coverage HRA by age, geographic region, and/or family size, as these factors result in variations in premiums for individual health insurance coverage. The Departments are not adopting this suggestion. The Departments recognize that the cost of individual health insurance coverage will vary across employees, and because the intent of the rule is to expand rather than restrict employer choices regarding how to provide coverage, the final rules allow (but do not require) employers to take these factors into account in certain circumstances and subject to certain conditions. After consideration of these comments, the Departments acknowledge that introduction of the individual coverage HRA could lead employers to provide lower health benefits and higher taxable wages than they would if they provided a traditional group plan. However, because the extent to which employers will do so is uncertain, this effect is not accounted for in the Departments' quantitative estimates of transfers (that is, the fiscal cost) arising from the rules. Moreover, the Departments are of the view that employers will design employee compensation packages to the benefit of employees since employers aim to attract and maintain talent.

In addition, the estimates assume that the entire individual coverage HRA balance is spent on healthcare premiums and cost sharing each year. However, the Departments are of the view that many employers would allow employees to carry unspent individual coverage HRA balances over from year to year, and that some employers would allow employees to continue to spend accumulated individual coverage HRA funds even after separating from their employer. Moreover, individual coverage HRA benefits are generally subject to COBRA protections, such that, for example, some employees could elect to use accumulated funds for up to 18 months after separation from service. The ability to carry over benefits from year to year could further encourage employees to curtail healthcare spending, particularly less efficient spending. This effect could be modest for several reasons. First, unlike HSA balances, which can be withdrawn for non-health purposes subject to tax but without penalty after age 65 and with a 20 percent penalty before age 65, individual coverage HRAs may only be used to reimburse expenses for medical care. In addition, unlike HSAs, individual coverage HRAs are not the property of the employee and employers may limit the amount that can be carried over from year-to-year or accessed by the employee after separation, subject to applicable COBRA

or other continuation of coverage requirements.

These estimates further assume that all individual health insurance coverage integrated with an HRA would be treated as subject to and compliant with PHS Act sections 2711 and 2713. The proposed rules prohibit an individual coverage HRA from being integrated with STLDI and excepted benefits, which are not subject to or generally compliant with PHS Act sections 2711 and 2713. Grandfathered coverage in the individual market is not subject to the annual dollar prohibition in PHS Act section 2711 or to the preventive services requirements in PHS Act section 2713. However, the proposed rules provided that employees nor employers were required to confirm that individual health insurance coverage integrated with an HRA is not grandfathered coverage, as requiring such confirmation would be administratively burdensome and the Departments expected that the number of employees who might use an individual coverage HRA to buy such coverage would be extremely small, because individuals can only renew and cannot newly enroll in grandfathered individual health insurance coverage.

Commenters generally agreed that the vast majority of individual health insurance coverage is compliant with PHS Act sections 2711 and 2713. As noted earlier in the preamble, many commenters emphasized the importance of requiring individual coverage HRAs to be integrated with individual health insurance coverage, and not with STLDI, in order to ensure the health and stability of the individual market risk pool. The Departments considered these comments and are finalizing the requirement that individuals covered by an individual coverage HRA must be enrolled in individual health insurance coverage, as proposed. Further, under the final rules, an individual coverage HRA may not be integrated with STLDI.

In summary, the Departments recognize that allowing HRAs to be integrated with individual health insurance coverage creates the potential for some adverse selection and increased premiums in the individual health insurance market. To prevent that occurrence, the Departments are retaining in the final rules the key conditions intended to prevent adverse selection and health factor discrimination. In addition, the Departments are strengthening the conditions intended to prevent of adverse selection, including by adding a minimum class size requirement that applies to certain classes of employees in certain circumstances and removing as a permitted class of employees the class of employees under age 25, which had the potential to increase adverse selection. The addition of the special rule for new hires could also improve the health of the overall individual market risk pool. While the Departments have also made changes in the final rules in order to provide employers with additional flexibility, such as adding as new permitted classes of employees non-salaried and salaried employees as well as staffing firm temporary employees (as well as adopting the special rule for new hires), the Departments have done so in a way that is narrowly tailored to avoid creating the risk of adverse selection. Therefore, after consideration of these changes and public comments, the Departments are finalizing the economic modeling of the individual coverage HRA without changing the key assumptions.

In light of the Departments' quantitative estimates and qualitative analysis, the Departments conclude that the benefits of the individual coverage HRA outweigh the costs. In particular, the Departments estimate that the final rules will increase the number of individuals with health insurance and have only a small effect on individual market premiums. The final rules will significantly increase flexibility and choices of health coverage for employers and employees. As a result, employers will benefit from having another choice of a tax-preferred health benefit to offer their employees, potentially enabling them to attract and retain workers. In addition, the increased use of HRAs could potentially reduce healthcare spending and ultimately result in increased taxable wages.

3. Impact of Excepted Benefit HRA

The final rules also provide for recognition of a new limited excepted benefit HRA under which amounts newly made available for each plan year are limited to $1,800 (indexed for inflation for plan years beginning after December 31, 2020). Among other conditions, to offer the excepted benefit HRA, the employer must offer the employee a group health plan that is not limited to excepted benefits and that is not an HRA or other account-based group health plan, but the employee would not need to enroll in this group health plan. The benefit would be funded by the employer, and in the Treasury Department's modeling, this means that it would be paid for by all employees in the firm through an overall reduction in wages. The benefit could be used to pay for any medical expense, other than premiums for individual health insurance coverage, group health plan coverage (other than COBRA or other continuation coverage), or Medicare Part B or D. The excepted benefit HRA could be used to pay premiums for coverage that consists solely of excepted benefits and for other premiums, such as premiums for STLDI (subject to the exception described later in this section of the preamble).

Due to the availability of other tax preferences for health benefits, including the tax exclusion for employer-sponsored benefits, salary reductions for group and off-Exchange individual health insurance coverage premiums when integrated with an individual coverage HRA, health FSAs, and non-excepted benefit HRAs, the Departments are of the view that this new excepted benefit would be adopted by a small number of firms. However, it could provide flexibility for firms that want to provide a tax preference to employees that choose STLDI instead of the employer's traditional group health plan.

Several commenters noted that the excepted benefit HRA could adversely impact the small employer group market as employers in the small group market would be more likely to offer an excepted benefit HRA that reimburses STLDI premiums (because these employers are less likely to be directly affected by the risk shifting due to the fact that the small group market is community rated) and healthier employees would be more likely to opt out of the traditional small employer group plan and use the excepted benefit to pay for health coverage out of pocket or purchase STLDI. Several commenters also expressed concern about the negative impact on the individual market, as the excepted benefit HRA could draw some enrollees away to STLDI plans. One commenter expressed concern that sicker employees within a firm, who could not obtain STLDI, would bear greater costs. As explained earlier in this preamble, the Departments do not believe that allowing the excepted benefit HRA to be used to purchase STLDI creates a significant risk pooling concern. However, to mitigate potential adverse selection affecting the small group market, the final rules provide that the Departments may restrict excepted benefit HRAs from being able to reimburse STLDI premiums for certain employers in a state, if certain criteria are satisfied.

Several commenters opposed the new excepted benefit HRA because it would allow employers to provide a smaller health benefit. One commenter expressed particular concern that low-wage employers would be particularly

attracted to this option, to the detriment of employees. The Departments conclude that this is not an important risk or concern. First, employees must have the option to receive a traditional group health plan instead of the excepted benefit HRA, and ERISA-covered employers must provide a notice of the dollar limits and other limitations of the excepted benefit HRA. In addition, the costs of coverage are borne all or in part by employees, in the form of reduced wages, and any reduction in costly health benefits is expected to be offset by increased wages. Third, employees who decline an employer's offer of a traditional group health plan may obtain coverage through a spouse or the individual market, and this coverage may also be subsidized through a tax exclusion or PTC. Therefore, the availability of this new tax-preferred benefit is expected to benefit employees, not harm them.

Several commenters expressed concern that adding another type of excepted benefit and another type of HRA would create confusion among employers and employees, potentially resulting in costly mistakes. Some commenters expressed concern that the excepted benefit HRA would increase uninsurance among employees who forego coverage or use the benefit to purchase STLDI (which need not provide comprehensive benefits), thus putting employees at risk or poor financial or health outcomes.

Other commenters supported the provision of the excepted benefit HRA as proposed, including one who expressed support for providing employers with the greatest possible flexibility to provide health benefits on a tax preferred basis. The Departments agree that the excepted benefit HRA will provide additional flexibility for employers, and for employees who want to pay for their health care costs in ways other than enrolling in their employer-offered traditional group health plan. The Departments continue to expect that due to the availability of other tax preferences for health benefits, including larger tax preferences for employer-provided benefits and the PTC for individual health insurance coverage, that adoption of the excepted benefit HRA is likely to be modest, such that the risk of introducing adverse selection into other markets is low. The Departments conclude that the benefits of this additional choice and flexibility provided by this new tax preferred excepted benefit outweigh the likely costs.

C. Regulatory Alternatives

In developing the final rules, the Departments considered various alternative approaches.

Retaining prohibition on integration of HRAs with individual health insurance coverage. The Departments considered retaining the existing prohibition on integration of HRAs with individual health insurance coverage, in particular in light of commenters who raised concerns that allowing HRAs to be integrated with individual health insurance coverage could lead to adverse selection and health factor discrimination in the individual market. However, the Departments determined that the adverse selection concerns that gave rise to the prohibition, and which some commenters raised, can be adequately addressed by including appropriate mitigating conditions in the final rules. Moreover, the alternative approach of continuing to prohibit the integration of HRAs with individual health insurance coverage would foreclose the benefits that the Departments expect to result from allowing individual coverage HRAs, including increased flexibility and choices of health coverage options for employers and employees; possibly reduced healthcare spending and increased taxable wages for workers currently in firms that offer traditional group health plans; and increased numbers of low- and moderate-wage workers (and their family members) with health insurance coverage.

Integration conditions to prevent against adverse selection. The proposed rules contained a number of conditions intended to mitigate the risk of adverse selection, including that an employer may not offer any employee a choice between a traditional group health plan and an individual coverage HRA and that, if an employer offers an individual coverage HRA, it must do so on the same terms and conditions for all the employees in the class of employees subject to certain exceptions. The Departments considered a number of alternatives related to these conditions in developing the final rules. As to the prohibition on choice between an individual coverage HRA and a traditional group health plan, the Departments considered the alternative of allowing all employers, or, employers that would qualify to participate in the small group market, to offer employees a choice between an individual coverage HRA and a traditional group health plan. However, the Departments determined that retaining this condition as proposed is important to prevent against adverse selection and commenters generally agreed. The Departments did consider that the incentives for employers in the small group market to segment risk are lower than for other employers offering experience-rated coverage or self-insured plans. However, the Departments would not expect many small employers to offer this choice because the coverage in the small group market and individual market is quite similar and because small employers that purchase health insurance would not have an incentive to segment their risk pool. Although allowing small employers to offer a choice would not provide small employers much benefit, it would increase the complexity of the final rules for entities involved in implementation, such as the Exchanges, and could cause uncertainty for issuers. Accordingly, the Departments decline to provide an exception for small employers to the condition that a plan sponsor may not offer an employee a choice between a traditional group health plan and an individual coverage HRA. However, the Departments are generally supportive of maximizing employee choice and employer flexibility and so may revisit this issue in future rulemaking once the Departments have had the opportunity to gauge the results of the initial implementation of individual coverage HRAs.

With respect to the proposed condition that an employer must offer an individual coverage HRA on the same terms to all employees within a class of employees, the Departments considered whether to allow individual coverage HRAs to increase amounts based on age, without any related parameters, as proposed, or, as an alternative, whether to place an outer limit on the ability to age vary, as some commenters suggested the Departments should do to protect against adverse selection. Upon consideration of these comments, the Departments determined that imposing a limit on the ability to increase HRA amounts based on age is justified in order to protect against adverse selection. In designing that limitation on age variation, the Departments considered a number of alternatives, including incorporating the federal and state age curves and tying the variation to a specific premium for a specific policy that a participant in the class of employees could purchase. However, the Departments determined that these options would be unduly complex and that imposing the 3 to 1 limit on the variation of HRA amounts within a class based on age, which is generally based on the degree of age

variation allowed in individual market premiums under PHS Act section 2701, sufficiently limits the potential for abuse.

The proposed rules provided that plan sponsors may apply the integration conditions on a class-by-class basis such that an employer may offer an individual coverage HRA to a class of employees while offering a traditional group health plan to another class of employees or may offer different individual coverage HRAs, with different terms, to different classes of employees. The Departments considered whether to retain the ability of employers to offer or vary individual coverage HRAs for different classes of employees or whether employers should be required to offer all employees an individual coverage HRA if any employee is offered an individual coverage HRA. Although some commenters raised concerns that the classes of employees could be manipulated leading to health factor discrimination and adverse selection, the Departments decided to finalize the ability to offer and vary individual coverage HRAs on a class-by-class basis because this aspect of the rule provides employers with the flexibility needed to achieve increased HRA usability and to maximize employee welfare, which is a sentiment expressed by a number of commenters. However, the Departments acknowledge the concern regarding the potential for adverse selection and health factor discrimination and, therefore, have concluded that additional safeguards are needed in certain circumstances, as described later in this section of the preamble.

Under the proposed rules, the Departments enumerated eight permitted classes of employees and also allowed employers to combine the classes of employees. In the process of finalizing the rules, the Departments considered, as an alternative, whether to provide classes of employees based on a more general standard (like the one that applies under the HIPAA nondiscrimination rules, with a broader employment-based classification standard) or whether to finalize generally as proposed, such that the final rules would list the specific permitted classes. The Departments determined that a broad and open-ended standard would not be sufficient to mitigate the risk of adverse selection and therefore under the final rules, the Departments enumerate the permitted classes.

The Departments considered a number of alternatives with regard to which classes of employees should be permitted under the final rules. The proposed rules contained, as a permitted class of employees, employees who had not attained age 25. The Departments considered whether to retain this class in the final rules or whether to remove this from the list of permitted classes, in response to commenters who asserted that this class could lead to adverse selection and does not reflect the categories employers typically use to offer benefits. In response to these comments, the Departments determined that the final rules should not include the under-age-25 class of employees in the list of permitted classes.

Further, under the proposed rules, the Departments did not include salaried employees and hourly employees as permitted classes of employees. In finalizing the rules, the Departments considered whether to add hourly and salaried employees as permitted classes or whether to finalize the rule as proposed. In proposing the rules, the Departments had noted that they did not include these classes in the list of permitted classes due to a concern that employers might easily be able to change an employee's status from salaried to hourly (and in certain circumstances, from hourly to salaried), which could lead to adverse selection. Commenters asserted that contrary to the Departments' concerns these classes are not easy to manipulate and that hourly and salaried employees should be added as permitted classes, in order to increase the use of individual coverage HRAs. The Departments have concluded that the benefits of employer flexibility, increased utilization of individual coverage HRAs, and maximizing employee welfare outweigh the potential risk of adverse selection and health factor discrimination, due to a reconsideration of the extent to which these categories could be manipulated and because of the application of a minimum class size requirement, discussed later in this section of the preamble. Therefore, the Departments add employees paid on a salary basis and non-salaried employees (such as hourly employees) to the list of permitted classes in the final rules.

The Departments also considered, in response to comments, whether to add as a class of employees temporary workers employed by staffing firms. The Departments determined that adding this class could increase the usability of HRAs for staffing firms and benefit their employees. The Departments also determined that this class would be difficult to manipulate, and that, therefore, this class does not raise a substantial risk of adverse selection or health factor discrimination. Accordingly, the Departments add temporary workers employed by staffing firms to the classes of employees permitted under the final rules.

The Departments also considered whether or not to add other classes to the list of permitted classes, as suggested by commenters, including classes based on status as a field worker (such as craft workers and laborers), role or job title, employee tenure, being subject to the Davis Bacon Act and Related Acts or the Service Contract Act, exempt or non-exempt status under the Fair Labor Standards Act, and religion or status as a minister. The Departments considered each of these suggestions and determined that these suggested classes of employees should not be permitted as they raise various issues, including ease of manipulation and potential for adverse selection and health factor discrimination, industry-specificity, and administrability and definitional challenges.

Additional integration safeguards. The Departments considered a number of alternative regulatory approaches to address the concern, acknowledged by the Departments and expressed by a number of commenters, that there is a potential for certain of the permitted classes of employees to be manipulated in way that could lead to adverse selection and health factor discrimination. The Departments considered not adopting additional safeguards, in order to minimize burden and complexity and based on the possibility that other economic incentives related to attracting and retaining talented workers would discourage employers from using the classes to segment risk. However, the Departments have concluded that it is appropriate to apply a minimum class size requirement under the final rules in certain circumstances. The Departments sought to develop a rule that is narrowly tailored both to mitigate the risk of adverse selection and health factor discrimination while also avoiding overly burdening employers or unnecessarily hampering the use and flexibility of HRAs to maximize employee welfare.

The Departments considered a number of alternatives in designing the minimum class size requirement. The Departments considered whether to apply the minimum class size requirement to all permitted classes of employees or only to the classes of employees that raise more significant concerns about manipulation. The Departments determined that the minimum class size requirement should apply to only certain of the classes, referred to as the applicable classes (that

is, full-time employees, part-time employees, salaried employees, non-salaried employees, and, in general, employees whose primary site of employment is in a rating area). The Departments also determined that the minimum class size requirement should apply if any of these applicable classes are combined with any other class, except if the combined class is the result of one of the applicable classes and the class of employees in a waiting period, because the Departments determined that that combined classis not easily manipulable. Similarly, although a class of employees based on worksites in a rating area is an applicable class for purposes of the minimum class size requirement, a class of employees based on an entire state or a combination of two or more entire states is not subject to the minimum class size requirement, because in that case, weighing concerns about manipulability against the intent to provide employers with flexibility and choice, the Departments determined the application of the minimum class size requirement was not warranted.

If a class of employees is subject to the minimum class size requirement, the class must include a minimum number of employees for the individual coverage HRA to be offered to that class. As to the number of employees a class must contain to satisfy the minimum class size requirement, the Departments considered a number of alternatives including whether to provide one number for all employers or base the threshold on employer size. The Departments also considered providing a set number or a number calculated as a percentage of the employer's employees. The Departments determined that this safeguard should be narrowly tailored, so as to prevent against adverse selection without unduly restricting employer flexibility. Therefore, under the final rules, the applicable minimum class size varies based on the size of the employer for smaller employers (that is, those with under 200 employees) and for employers with 200 or more employees, the applicable class size minimum is set at 20.

In response to comments, the Departments also considered whether, in addition to, or instead of, a minimum class size requirement, the final rules should contain an anti-abuse rule that would give the Departments the discretion to determine whether an individual coverage HRA is offered in a manner that is intended to segment sicker workers based on all the facts and circumstances. Therefore, even if an employer followed the other rules set forth in the final rules, this additional rule would nevertheless permit the Departments to address instances of discrimination based on a health factor. The Departments decline to add a facts and circumstances test to the final rules, because the Departments have concluded that the minimum class size requirement adequately balances the need to prevent health factor discrimination with the need to provide employers with certainty in order to encourage expansion and use of individual coverage HRAs. Moreover, other applicable nondiscrimination laws continue to apply. A new facts and circumstances test would add significant uncertainty for employers while adding little additional protection mitigating adverse selection and health factor discrimination.

Additional flexibility for the transition to individual coverage HRAs from traditional group health plans. The Departments also considered regulatory alternatives that would allow employers to phase in offering individual coverage HRAs, in response to comments noting that the transition from traditional group health plans to individual coverage HRAs could be a substantial change from an employee perspective. The Departments considered whether additional flexibility was needed, in particular because the permitted classes of employees that apply under the final rules provide employers some flexibility to manage the transition to individual coverage HRAs. However, the Departments also considered that certain additional flexibility could benefit employers and employees, without adding significant complexity or increasing the risk of adverse selection. Accordingly, the final rules provide that, notwithstanding the general rule that a plan sponsor may only offer either a traditional group health plan or an individual coverage HRA to a class of employees, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer employees in that class hired on or after a certain date in the future an individual coverage HRA, while continuing to offer employees in the class hired before the new hire date a traditional group health plan.

Alternatives considered regarding excepted benefit HRAs. As proposed, the excepted benefit HRA would allow for the reimbursement of premiums for STLDI. In response to commenters requesting that the excepted benefit HRA not be permitted to reimburse STLDI premiums due to adverse selection concerns and concerns about the comprehensiveness of STLDI, the Departments considered whether to finalize as proposed or whether to prohibit the reimbursement of STLDI premiums under all excepted benefit HRAs. The Departments also considered whether to prohibit the reimbursement of STLDI premiums for only certain excepted benefit HRAs, more specifically, those sponsored by employers that offer traditional group health plans in the small group market, where commenters asserted this aspect of the rule would have particularly damaging effects because employers would not have a direct negative financial consequence from offering the excepted benefit for STLDI in addition to a traditional small group market plan in which case lower-risk employees would likely choose the STLDI and higher-risk employees would choose the traditional small group market health plan. The Departments determined that excepted benefit HRAs generally should be allowed to reimburse premiums for STLDI because it can be a viable health insurance option for many people in many circumstances, no individual is required to enroll in STLDI, and STLDI disclosure requirements are sufficient to apprise consumers of its limits. As explained earlier in this preamble, the Departments do not expect that allowing the excepted benefit HRA to reimburse STLDI premiums will produce adverse selection in the small group market. In particular, the Departments note that individuals who choose to use the excepted benefit HRA to purchase STLDI are likely to be uninsured otherwise, including lower-wage workers who are increasingly declining employer offers of traditional group coverage.[313] The purchase of STLDI coverage by these individuals will have no effect on the small group or individual market.

However, in response to concerns raised by commenters, the final rules also contain a special rule to address commenters' concerns about the potential for adverse selection in the small group markets. Under the special rule, the Departments may restrict excepted benefit HRAs from being able to reimburse STLDI premiums, for employers offering fully-insured or partially-insured traditional group health plans in the small group market in a state, if certain criteria are satisfied, including that HHS makes a finding, in consultation with DOL and the Treasury

[313] In 1999, 17 percent of workers eligible for employer coverage at small firms (those with 3 to 199 workers) turned down the offer of employer coverage. By 2011, this share had climbed to 22 percent, and in 2018 it was 27 percent. *See* Kaiser Family Foundation, ''Employer Health Benefits 2018 Survey,'' Figure 3.1, available at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.*

Department, that the reimbursement of premiums for STLDI by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer and this finding must be made after submission of a written recommendation by the applicable state regulatory authority of such state.

The proposed excepted benefit HRA rules did not contain a specific notice requirement. However, several commenters suggested that the final rules impose certain notice requirements for excepted benefit HRAs, including to inform participants and beneficiaries of the annual dollar limit for benefits under the excepted benefit HRA, other terms and conditions of the excepted benefit HRA, and participants' and beneficiaries' rights under the excepted benefit HRA. In response, the Departments considered whether to impose a notice requirement, whether to finalize as proposed with no notice requirement, or whether to explain the disclosure requirements otherwise applicable to excepted benefit HRAs. In the final rules, the Departments do not impose a notice requirement on private-sector, employment-based plans covered by ERISA but, instead, explain that excepted benefit HRAs that are subject to ERISA are already subject to a number of disclosure provisions, under which excepted benefit HRAs should generally provide information on eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits. However, for non-federal governmental plans, which are not subject to ERISA, the final rules announce HHS' intent to propose a notice requirement, similar to the disclosures required under ERISA.

Under the proposed excepted benefit HRA rules, the Departments proposed that annual amounts newly made available under the HRA would be limited to $1,800, indexed for inflation. Many commenters supported the proposed dollar limit as a reasonable mid-point of the different limits that would result in applying various methodologies, however some requested that the limit be increased, including to allow for the additional purchase of excepted benefit policies or for more expensive STLDI policies and others requested it not be subject to any dollar limit. Some of these commenters favored a higher limit for excepted benefit HRAs based on age and number of dependents to reflect that participants who are older or have dependents are likely to have higher healthcare costs. The Departments considered as regulatory alternatives the various limits suggested by commenters, including the annual salary reduction contribution limit for health FSAs or 15 percent of the cost of coverage under the employer's primary plan. The final rules do not remove or increase the dollar limit for the excepted benefit HRA. The Departments agree that increasing the dollar limit would encourage certain participants to rely solely on benefits reimbursed through the excepted benefit HRA and could lead to adverse selection. Also, in order to constitute a limited excepted benefit, as explained earlier in this preamble, because the benefit is not otherwise limited in scope, the HRA must have a strict dollar limit.

In determining the appropriate dollar limit for excepted benefit HRAs, the Departments considered other, similar limited excepted benefits. The Departments agree with commenters' assertions that the proposed limit was reasonable and rational, especially considering the relatively low cost of excepted benefits coverage, such as dental or vision coverage. Additionally, although the Departments recognize that healthcare expenses may be higher for participants who are older or have dependents, adopting a higher limit to account for a combination of factors like age and family size could allow an excepted benefit HRA to be too large and to resemble major medical coverage and would add significant complexity to the rule.

Applicability date. The proposed rules were generally proposed to be applicable for plan years beginning on or after January 1, 2020. In response to comments expressing concern that issuers, state insurance regulators, the Exchanges, and employers would not be prepared for implementation of the final rules by 2020, the Departments considered whether to finalize the applicability date as proposed or whether to delay the applicability date until 2021. The Departments have determined that, in consideration that Executive Order 13813, issued in October 2017, set forth HRA expansion as an Administration priority ''in the near term,'' and in order to provide Americans with more options for financing their healthcare, the regulations should be applicable, as proposed, for 2020. However, the Departments acknowledge and also considered the crucial role that the Exchanges have in implementation and operationalization of the final rules, and the Departments will work closely with the Exchanges on implementation. The Departments considered the comments and the concerns raised by various State Exchanges, issuers, employers and other stakeholders related to the ability of the Exchanges to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. The Departments recognize that Exchanges may be unable to fully implement changes related to the final rules in time for open enrollment for the 2020 plan year. However, prior to full implementation, the Departments will work with the Exchanges on their strategies to provide information to consumers about affordability of individual coverage HRAs and eligibility for APTC, including how employees can access individual health insurance coverage through the Exchanges and determine whether they should use APTC. In fact, multiple conversations have already occurred between program and operational experts at HHS and officials from State Exchanges regarding implementation in the event the rule was finalized as proposed (including with an applicability date as proposed). Ongoing technical assistance will be provided related to the development of tools and functionality by Exchanges to support employers and employees with understanding HRA affordability determinations and their impact on APTC eligibility, as well as the SEP for those with an offer of an individual coverage HRA. Specific assistance could include sharing technical and educational documentation from FFE implementation that can be leveraged to support State Exchange efforts. In addition, the Departments will provide assistance to Exchanges in developing information and tools that could be provided to employers and employees to help ensure smooth implementation before the full system changes are complete. This could include State Exchanges providing employees with information on how they can calculate HRA affordability and determine the impact on APTC in the absence of system changes that can make those calculations for the employee.

The Departments also considered that many individuals covered by an individual coverage HRA will prefer to select off-Exchange individual health insurance plans because salary reductions through a cafeteria plan may be used to pay premiums for off-Exchange coverage, if the employer so allows, and may not be used to pay premiums for Exchange coverage. To the extent a significant proportion of employees with individual coverage HRAs purchase individual health insurance coverage off the Exchange, concerns about burden on the Exchanges, and concerns regarding the

effects of timely operationalization of the PTC rules, are mitigated.

Further, the Departments have worked to release the final rules as early in 2019 as possible, in recognition of the implementation timing issues raised and the Departments note, and considered, that plan sponsors may choose if and when to offer an individual coverage HRA (or an excepted benefit HRA) and may do so any time on or after the applicability date. The Departments intend to provide the guidance necessary for plan sponsors to offer individual coverage HRAs and excepted benefit HRAs for the 2020 plan year, but the Departments also expect that plan sponsors will take the time they need to evaluate the final rules and to take advantage of these new coverage options if and when it is best for their workforce.

D. Paperwork Reduction Act—Department of Health and Human Services

Under the Paperwork Reduction Act of 1995 (PRA), HHS is required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that HHS solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of HHS' estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

1. Wage Estimates

To derive wage estimates, the Departments generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead) for estimating the burden associated with the information collection requirements (ICRs).[314] Table 3 below presents the mean hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and the Departments are of the view that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

TABLE 3—ADJUSTED HOURLY WAGES USED IN BURDEN ESTIMATES

Occupation title	Occupational code	Mean hourly wage ($/hour)	Fringe benefits and overhead ($/hour)	Adjusted hourly wage ($/hour)
Compensation and Benefits Manager	11–3111	$62.50	$62.50	$125.00
Lawyer	23–1011	68.22	68.22	136.44
All Occupations	00–0000	24.34	24.34	48.68

2. ICRs Regarding Substantiation of Individual Health Insurance Coverage (45 CFR 146.123(c)(5))

Under the final rules, an HRA must implement reasonable procedures to annually verify that participants or dependents, whose medical care expenses are reimbursable by the HRA are, or will be, enrolled in individual health insurance coverage or Medicare for the entire plan year on or before the first day of the plan year, or, for an individual who is not eligible to participate in the individual coverage HRA on the first day of the plan year, by the date HRA coverage begins (annual coverage substantiation requirement).

In addition to the annual substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the final rules provide that the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation that the individual on whose behalf reimbursement of medical care expenses are requested to be reimbursed were enrolled in individual health insurance coverage or Medicare for the month during which the medical care expenses were incurred. The attestation may be part of the form used for requesting reimbursement.

To satisfy these substantiation requirements, the HRA may require that the participant submit a document provided by a third party (for example, an explanation of benefits or insurance card) showing that the participant and any dependent(s) covered by the individual coverage HRA are, or will be, enrolled in individual health insurance coverage or Medicare during the plan year or an attestation by the participant stating that the participant and any dependent(s) are, or will be, enrolled in individual health insurance coverage or Medicare, the date coverage began or will begin, and the name of the provider of the coverage. Additionally, nothing in the final rules would prohibit an individual coverage HRA from establishing procedures to comply with the substantiation requirements through electronic means, so long as the procedures are reasonable to verify enrollment. The ongoing substantiation may be in the form of a written attestation by the participant, which may be part of the form used for requesting reimbursement and which will minimize the burden on plan sponsors and participants. The ongoing substantiation requirement may also be satisfied by a document from a third party. The associated cost of substantiation will be minimal and is, therefore, not estimated.

The Departments are releasing guidance providing model attestation language, separate from the final rules. However, the Departments note that individual coverage HRAs will not be required to use the model attestation. For those HRAs that elect to use the model attestation language provided by the Departments, it will further reduce burden for HRAs and participants.

The burden related to these ICRs will be reviewed under emergency review

[314] *See* May 2017 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates, available at *https://www.bls.gov/oes/current/oes_nat.htm.*

and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

3. ICRs Regarding Notice Requirement for Individual Coverage HRA (45 CFR 146.123(c)(6))

These final rules include a requirement that an HRA provide written notice to eligible participants. In general, the HRA will be required to provide a written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA must provide the notice no later than the date on which the HRA may first take effect for the participant. However, the Departments encourage the HRA to provide the notice as soon as practicable prior to the date the HRA may first take effect. The final rules provide that if the HRA is sponsored by an employer that is established less than 120 days prior to the beginning of the first plan year of the HRA, the notice may be provided no later than the date on which the HRA may first take effect for the participant.

The written notice will be required to include certain relevant information, including a description of the terms of the HRA, including the maximum dollar amount made available that is used in the affordability determination under the Code section 36B rules including information on when the amounts will be made available (for example, monthly or annually at the beginning of the plan year); a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; a description of the potential availability of the PTC for a participant who opts out of and waives an HRA if the HRA is not affordable under the PTC rules; a description of the PTC eligibility consequences for a participant who accepts the HRA; a statement on how the participant may find assistance for determining their individual coverage HRA affordability; a statement that the participant must inform any Exchange to which they apply for advance payments of the PTC of certain relevant information; contact information (including at least a phone number) of an individual or a group of individuals who participants may contact with questions regarding the individual coverage HRA; a statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed the PTC; a statement that the HRA may not reimburse any medical care expense unless the substantiation requirements are satisfied; a statement of availability of an SEP for employees and dependents who newly gain access to the HRA; the date as of which coverage under the HRA may first become effective and the date on which the HRA plan year ends; and a statement to clarify further that there are multiple types of HRAs and the type the participant is being offered is an individual coverage HRA.

The written notice may include other information, as long as the additional content does not conflict with the required information. The written notice will not need to include information specific to a participant.

The Departments are providing model language contemporaneously on certain aspects of the notice that are not employer-specific, including model language describing the PTC consequences of being offered and accepting an individual coverage HRA, how the participant may find information to determine whether the individual coverage HRA offered is affordable, and language to meet the requirement to include a statement regarding the availability of an SEP in the individual market for individuals for whom an individual coverage HRA is newly made available. While the Departments hope it will be useful to employers, plan sponsors will not be required to use the model language and the final rules do not prohibit an employer from providing more individualized notices, such as different notices for different classes of employees, if the employer so chooses.

The Departments estimate that for each HRA plan sponsor, a compensation and benefits manager will need 2 hours (at $125 per hour) and a lawyer will need 1 hour (at $136.44 per hour) to prepare the notices. The total burden for an HRA plan sponsor will be 3 hours with an equivalent cost of approximately $386. This burden will be incurred the first time the plan sponsor provides an individual coverage HRA. In subsequent years, the burden to update the notice is expected to be minimal and therefore is not estimated. If the HRA plan sponsor elects to use the model notice, the burden may be reduced.

HHS estimates that in 2020, an estimated 1,203 state and local government entities will offer individual coverage HRAs.[315] The total burden to prepare notices will be approximately 3,610 hours with an equivalent cost of approximately $464,984. In 2021 approximately 1,805 additional state and local government entities will offer individual coverage HRAs for the first time and will incur a burden of approximately 5,415 hours with an equivalent cost of approximately $697,476. In 2022, approximately 3,008 additional state and local government entities will offer individual coverage HRAs for the first time and will incur a burden of approximately 9,024 hours with an equivalent cost of approximately $1.16 million.

HRA plan sponsors will provide the notice to eligible participants every year. HHS estimates that HRA plan sponsors will provide printed notices to approximately 99,178 eligible participants[316] in 2020, 243,438 eligible participants in 2021 and 477,859 eligible participants in 2022. The Departments anticipate that the notices will be approximately 6 pages long and the cost of materials and printing will be $0.05 per page, with a total cost of $0.30 per notice. It is assumed that these notices will be provided along with other benefits information with no additional mailing cost. The Departments assume that approximately 54 percent of notices will be provided electronically and approximately 46 percent will be provided in print along with other benefits information. Therefore, in 2020, state and local government entities providing individual coverage HRAs will print approximately 45,622 notices at a cost of approximately $13,687. In 2021, approximately 111,981 notices will be printed at a cost of approximately $33,594 and in 2022, approximately 219,815 notices will be printed at a cost of approximately $65,945.

[315] U.S. Department of the Treasury, Office of Tax Analysis simulation model suggests that in 2020, approximately 80,000 employers will offer individual coverage HRAs, with 1.1 million individuals receiving an offer of an individual coverage HRA. These numbers will increase to 200,000 employers and 2.7 million individuals in 2021 and to 400,000 employers and 5.3 million individuals in 2022. The Departments estimate that there is, on average, 1 dependent for every policyholder. The Departments also estimate that approximately 2 percent of employers are state and local government entities, accounting for approximately 14 percent of participants.

[316] U.S. Department of the Treasury, Office of Tax Analysis simulation model provides estimates of the number of participants and dependents offered an individual coverage HRA. Number of eligible participants is estimated based on the assumption that 75 percent of eligible participants will enroll in their employers' plans. *See* Kaiser Family Foundation, ''2017 Employer Health Benefits Survey'', Section 3, *https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/*.

TABLE 4—ANNUAL BURDEN AND COSTS

Year	Estimated number of employers newly offering HRAs	Estimated number of notices to all eligible participants	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost
2020	1,203	99,178	3,610	$464,984	$13,687
2021	1,805	243,438	5,415	697,476	33,594
2022	3,008	477,859	9,024	1,162,461	65,945
3 year average	2,005	273,492	6,016	774,974	37,742

The burden related to these ICRs will be reviewed under emergency review and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

4. ICRs Regarding Notice Requirement for Excepted Benefit HRAs

In response to commenters' concerns, the final rules announce HHS' intent to propose a notice requirement with respect to excepted benefit HRAs sponsored by nonfederal governmental plan sponsors in future notice and comment rulemaking. It is anticipated that the proposed excepted benefit HRA notice would describe conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the plan, and a description or summary of the benefits consistent with the requirements of 29 CFR 2520.102–3(j)(2), (3). At that time, HHS will estimate the burden associated with this requirement, solicit public comment, and request OMB approval in accordance with the PRA, as may be necessary.

5. ICRs Regarding Notification of Termination of Coverage (45 CFR 146.123(c)(1)(iii))

Under the final rules, if an individual's health insurance coverage is cancelled or terminated, including retroactively, for failure to pay premiums or any other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. The associated cost of this notification will be minimal and is, therefore, not estimated.

The burden related to these ICRs will be reviewed under emergency review and approval. They have been submitted to OMB in conjunction with this final rule and are pending approval.

6. ICRs Regarding Special Rule for Excepted Benefit HRAs (45 CFR 146.145(b)(3)(viii)(F))

Under the final rules, an excepted benefit HRA offered by certain small employers must not reimburse premiums for STLDI in a state, if the Secretary of HHS makes a finding (in consultation with the Secretaries of Labor and the Treasury) that the reimbursement of premiums for STLDI by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer. The finding by the Secretary of HHS may be made only after submission of a written recommendation by the applicable state authority of such state, in a form and manner as specified in guidance published by HHS. The written recommendation must include evidence that the reimbursement of premiums for STLDI by excepted benefit HRAs established by fully-insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums. HHS anticipates fewer than 10 states will submit recommendations annually.

Under 5 CFR 1320.3(c)(4), this ICR will not be subject to the PRA as we anticipate it will affect fewer than 10 entities in a 12-month period.

7. ICRs Regarding SEPs (45 CFR 155.420(d)(14))

The final SEP rules include a new SEP at 45 CFR 155.420(d)(14), to allow individuals who newly gain access to an individual coverage HRA or are newly provided a QSEHRA to enroll in or change their individual health insurance coverage. As stated earlier in the preamble, the FFEs will require individuals to submit documentation to confirm their SEP eligibility prior to effectuating their enrollment, and encourages State Exchanges to do so, as well. Consistent with other SEPs subject to pre-enrollment verification, individuals will be required to provide supporting documentation, such as the HRA notice required under the final rules, within 30 days of plan selection.

HHS estimates that an additional 330,000 consumers will submit documents in 2020 to verify their eligibility to enroll through the SEP in the Exchanges, and that a consumer will, on average, spend approximately 1 hour gathering and submitting required documentation. Using the average hourly wage for all occupations (at an hourly rate of $48.68), the opportunity cost to a consumer completing this task is estimated to be approximately $48.68. The total annual burden on those consumers submitting documentation will be approximately 330,000 hours with an equivalent cost of approximately $16,064,400. As new individual coverage HRA enrollments increase, these costs also increase in subsequent years. In 2021, an additional 480,000 consumers will submit documents and incur burden of 480,000 hours with an equivalent cost of approximately $23,366,400 and in 2022 an additional 780,000 consumers will submit documents and incur burden of 780,000 hours with an equivalent cost of approximately $37,970,400. The three-year average is 530,000 additional consumers submitting documents, with a total burden of 530,000 hours and an equivalent cost of $25,800,400 per year.

HHS will amend the information collection currently approved under OMB control number 0938–1207 (Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (CMS–10468)) to account for this additional burden.

TABLE 5—ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting	Total labor cost of reporting	Printing and materials cost	Total cost
§ 146.123(c)(6) (Notice for Individual Coverage HRAs).	0938–NEW	2,005	273,492	3	6,016	$128.81	$774,974	$37,742	$812,716
45 CFR 155.420(d)(14) (SEP)	0938–1207	530,000	530,000	1	530,000	48.68	25,800,400	0	25,800,400
Total		532,005	803,492		536,016		26,575,374	37,742	26,613,116

8. Submission of PRA-Related Comments

HHS has submitted a copy of the final rules to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed in this rule, please visit CMS' website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326. HHS invites public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–9918–F), the ICR's CFR citation, CMS ID number, and OMB control number. Comments and recommendations must be received by the OMB desk officer via one of the following transmissions:

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, *Fax:* (202) 395–5806 *OR, Email: OIRA_submission@omb.eop.gov.*

To obtain copies of a supporting statement and any related forms for the collection(s) summarized in this rule, you may make your request using one of following:

1. Access CMS' website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

ICR-related comments are due July 22, 2019.

E. Paperwork Reduction Act—Department of Labor and Department of the Treasury

As part of the continuing effort to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the PRA. This helps to ensure that the public understands the Departments' collection instructions, respondents can provide the requested data in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the Departments can properly assess the impact of collection requirements on respondents.

Under the PRA, an agency may not conduct or sponsor, and an individual is not required to respond to, a collection of information unless it displays a valid OMB control number. In accordance with the requirements of the PRA, DOL published notice on October 29, 2018 (83 FR 54420, 54454) requesting an OMB control number for three new information collections (ICs) contained in the proposed rules. Two ICs are sponsored jointly by DOL and the Treasury Department: (1) Verification of Enrollment in Individual Health Insurance Coverage (26 CFR 54.9802–4(c)(5), 29 CFR 2590.702–2(c)(5) and 45 CFR 146.123(c)(5)); and (2) HRA Notice to Participants (26 CFR 54.9802–4(c)(6), 29 CFR 2590.702–2(c)(6) and 45 CFR 146.123(c)(6)). A third IC is sponsored solely by DOL (29 CFR 2510.3–1): (3) Notice to Participants that Individual Health Insurance Coverage Policy is Not Subject to Title I of ERISA. In response to comments received on the proposal, the Departments have added two additional information collections entitled *Participant Notify Individual Coverage HRA of Cancelled or Terminated Coverage* (26 CFR 54.9802–4(c)(1)(iii), 29 CFR 2590.702–2(c)(1)(iii) and 45 CFR 146.123(c)(1)(iii)) and *Notice for Excepted Benefit HRAs* (26 CFR 54.9831–1(c)(3)(viii)(E), 29 CFR 2590.732(c)(3)(viii)(E) and 45 CFR 146.145(c)(3)(viii)(E)).

With regard to the Treasury Department, the collection of information contained in these regulations is submitted to OMB for review in accordance with the PRA as follows. The collection of information in these regulations is in 26 CFR 54.9815–2711(d)(4) and 26 CFR 54.9802–4(c)(1)(iii), (c)(5) and (c)(6). The burden for the collection of information contained in these regulations is reflected in the burden for OMB Control Number 1545–0123 for the U. S. Business Income Tax Return, 1545–0074 for U.S. Individual Income Tax Return, and 1545–0047 Return of Organizations Exempt From Income Tax. The estimated annual burden per respondent, estimated annual burden per recordkeeper, or estimated number of respondents is updated annually.

The Departments submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d) contemporaneously with the publication of the proposed rules for OMB's review. A copy of the ICR may be obtained by contacting the PRA addressee identified or at *http://www.RegInfo.gov.* PRA Addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Room N– 5718, Washington, DC 20210. Telephone (202) 693–8410; Fax: (202) 219–5333. These are not toll-free numbers. ICRs submitted to OMB also are available at *http://www.RegInfo.gov.*

In connection with the final rules, the Departments are submitting an ICR to OMB requesting approval of a new collection of information under OMB Control Number 1210–0160. Below is a description of the information collections contained in the final rules and their burden.

1. Verification of Enrollment in Individual Health Insurance Coverage

In order for an HRA to be integrated with individual health insurance coverage (or Medicare, if applicable), among other requirements, in general, the HRA must implement, and comply with, reasonable procedures to substantiate that participants and dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (or Medicare, if applicable) for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). This requirement may be satisfied by providing a document from a third party, like an issuer, verifying coverage. As an alternative procedure, this requirement may also be satisfied if the

HRA requires participants to provide an attestation of coverage, including the date coverage begins and the provider of the coverage.

In addition, following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse participants for any medical care expenses unless, prior to each reimbursement, the participant provides substantiation that the individual whose medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage (or Medicare, if applicable) for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used for requesting reimbursement, or a document from a third party (for example, a health insurance issuer).

Documentation, including proof that expenditure of funds is for a medical care expense, is currently universal when seeking reimbursement from an HRA. For the new requirements contained in the final rules regarding verification of enrollment in individual health insurance coverage (or Medicare, if applicable), the HRA can require proof of coverage or attestations of coverage as part of the processes that already exist for when participants seek reimbursement from HRAs for premiums or other medical care expenses. The additional burden is de minimis, because the attestation can be a part of the information already required when seeking reimbursement. To the extent an HRA develops additional processes for the requirement that individuals verify enrollment in individual health insurance coverage (or Medicare) for the plan year, the additional burden is also expected to be de minimis because it involves either attestation or providing documents that already exist.

The Departments are providing model attestation language, separate from the final rules. However, the Departments note that individual coverage HRAs will not be required to use the model attestation. For those HRAs that elect to use the model attestation language provided by the Departments, it will further reduce burden for the HRAs and participants.

Section II.A.8 of this preamble discusses comments received on the requirement to verify enrollment including II.A.8.a In General, II.A.8.b Methods of Substantiation, and II.A.8.c Reliance on Documentation or Attestation.

2. HRA Notice to Participants

The final rules (29 CFR 2590.702–2(c)(6)(ii)) require an HRA to provide written notice to eligible participants including, among other things, the following information: (1) A description of the terms of the HRA, including the amounts newly made available as used in the affordability determination under the Code section 36B final rules; (2) a statement of the right of the participant to opt-out of and waive future reimbursement under the HRA; (3) a description of the potential availability of the PTC for a participant who opts out of and waives an HRA if the HRA is not affordable under the final PTC rules; and (4) a description of the PTC eligibility consequences for a participant who accepts the HRA. The written notice may include other information, as long as the additional information does not conflict with the required information. The written notice does not need to include information specific to a participant. In response to public comments, the Departments are separately publishing a model notice that can be used to satisfy these requirements, although the HRA will be required to add certain information specific to the particular HRA. The Departments note that individual coverage HRAs will not be required to use the model notice. For those HRAs that elect to use the model notice language provided by the Departments, it will further reduce burden for the HRAs.

In general, the HRA must provide the written notice to each participant at least 90 days before the beginning of each plan year. For participants who are not yet eligible to participate at the beginning of the plan year (or who are not eligible when the notice is provided at least 90 days prior to the beginning of the plan year), the HRA must provide the notice no later than the date on which the HRA may first take effect for the participant. Also, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA, the notice must be provided no later than the date on which the HRA may first take effect for the participant.

Section II.A.9 of the preamble discusses comments received on the notice, the Departments' responses and changes made to the notice requirement including II.A.9.a Notice Content, II.A.9.b Notice Individualization, II.A.9.c Model Notice, II.A.9.d Notice Timing and Delivery.

The Departments estimate that a compensation and benefits manager would require two hours (at $125 per hour) and a lawyer would require one hour (at $136.44 per hour) to prepare the notice for each HRA. Thus, the total hour burden for each HRA would be 3 hours with an equivalent cost of approximately $386. The Departments estimate that each notice would be six pages, with total materials and printing cost of $0.30 per notice ($0.05 per page). The Departments estimate that 78,797 private employers would [317] newly offer individual coverage HRAs in 2020 [318] as a result of the final rules in the first year. Therefore, the Departments estimate the total hour burden for these HRAs to prepare the notices would be 236,390 hours with an equivalent cost of $30,450,216.

All individual coverage HRAs are required to annually send the notice to all eligible participants (those eligible to enroll). The Departments estimate that there would be 634,155 eligible participants at private employers in 2020 that would need to receive the notice.[319] The Departments assume that approximately 54 percent of notices would be provided electronically and approximately 46 percent would be provided in print along with other benefits information. Therefore, a total of 291,711 notices will be printed at a

[317] U.S. Department of the Treasury, Office of Tax Analysis used a simulation model to obtain these estimates. For 2020, the model estimated that 80,000 employers will offer individual coverage HRAs and 1.1 million individuals will be offered those HRAs. Based on DOL estimates about 98 percent of these will be in the private market, and the rest will be through public employers like state and local governments. There are on average one dependent for every policy holder. ''Health Insurance Coverage Bulletin'', Abstract of the Auxiliary Data for the March 2016 Annual Social and Economic Supplement of the Current Population Survey, July 25, 2017. *https://www.dol.gov/sites/default/files/ebsa/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf.*

[318] Comparable numbers for 2021 are 118,195 private employers will newly offer individual coverage HRAs and 1,556,562 eligible participants in all individual coverage HRAs will receive notices, and for 2022 196,992 private employers will newly offer individual coverage HRAs and 3,055,474 eligible participants in all individual coverage HRAs will receive notices.

[319] Number of eligible participants is estimated based on Treasury estimates of the number of individuals enrolled in individual coverage HRAs, the assumption that there are two enrollees per employee participant, and the assumption that 75 percent of eligible participants would enroll in their employers' plans. *See* Kaiser Family Foundation, ''2017 Employer Health Benefits Survey'', Section 3, *https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/.*

cost of $87,513. Tables 6 and 7 provide estimates for years 2020, 2021 and 2022.

TABLE 6—BURDEN TO PREPARE HRA NOTICE FOR THE FIRST TIME-PRIVATE SECTOR EMPLOYERS

Year	Number of employers newly offering HRAs	Legal cost per hour	Number of hours for legal	Benefit manager cost per hour	Number of hours for benefit manager	Total hour burden	Total equivalent cost
(a)	(b)	(c)	(d) = 1 * (b)	(e)	(f) = 2 * (b)	(g) = (d) + (f)	(c) * (d) + (e) * (f)
2020	78,797	$136.44	78,797	$125.00	157,593	236,390	$30,450,216
2021	118,195	136.44	118,195	125.00	236,390	354,585	45,675,324
2022	196,992	136.44	196,992	125.00	393,984	590,976	76,125,539

TABLE 7—BURDEN TO PROVIDE NOTICE TO ALL ELIGIBLE PRIVATE SECTOR PARTICIPANTS

Year	Total number of notices	Number of notices sent by mail	Cost per notice	Total cost burden
(a)	(b)	(c)	(d)	(e) = (c) * (d)
2020	634,155	291,711	$0.30	$87,513
2021	1,556,562	716,019	0.30	214,806
2022	3,055,474	1,405,518	0.30	421,655

3. Notice to Participants That Individual Health Insurance Coverage Policy Is Not Subject to Title I of ERISA

In the final rules, DOL clarifies that individual health insurance coverage, the premiums of which are reimbursed by an HRA, QSEHRA, or supplemental salary reduction arrangement is not considered an ''employee welfare benefit plan'' with the consumer protections provided under ERISA, if certain safe harbor conditions are satisfied. HRA plan sponsors are required to notify participants of this fact (29 CFR 2510.3–1(l)(5)). For an HRA, this notice requirement is satisfied if annually the notice requirement in 26 CFR 54.9802–4(c)(6) and 29 CFR 2590.702–2(c)(6) is satisfied, which is part of the HRA Notice to Participants discussed earlier in this preamble. Therefore, this notice requirement imposes no additional burden. For QSEHRAs and for HRAs not subject to 26 CFR 54.9802–4(c)(6) and 29 CFR 2590.702–2(c)(6), but that reimburse premiums for individual health insurance coverage, the plan sponsor may use the following language to satisfy this condition: ''The individual health insurance coverage that is paid for by this plan, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.'' The Departments estimate that this burden will be de minimis, because the required text is provided in the rule and can be included with other notices.

Section II.A.9 of the preamble discusses comments received on the notice required to be provided to participants eligible for an individual coverage HRA.

4. Participant Notifies Individual Coverage HRA of Cancelled or Terminated Coverage

The final rules require that if a covered individual fails to pay the applicable premium(s) by the end of a grace period and the coverage is cancelled or terminated, including retroactively, or if individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), the individual coverage HRA must require that the individual notify the HRA that coverage has been cancelled or terminated and the date on which the coverage cancellation or termination is effective (26 CFR 54.9802–4(c)(1)(iii), 29 CFR 2590.702–254.9801–4(c)(1)(iii) and 45 CFR 146.123(c)(1)(iii)). The Departments have concluded that the burden associated with this notification requirement is de minimis for participants that cancel coverage, because they can satisfy the requirement by making a phone call or sending an email.

Other related comments are discussed in section II.A.2.d of this preamble.

5. Notice for Excepted Benefit HRAs

In response to commenters' concerns, the final rules announce HHS' intent to propose a notice requirement with respect to excepted benefit HRAs sponsored by non-federal governmental plan sponsors in future notice and comment rulemaking. It is anticipated that the proposed excepted benefit HRA notice would be required to state conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description of or summary of the benefits consistent with the content and timing of DOL's SPD requirements.

For private-sector, employment-based plans, other notice requirements under Part 1 of ERISA already apply. For example, excepted benefit HRAs that are ERISA-covered plans must provide a SPD, SMM, and summaries of material reductions in covered services or benefits.[320] The excepted benefit HRA's SPD must include, for example, the conditions pertaining to eligibility to receive benefits; a description or summary of the benefits; the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (for example, by exercise of subrogation or reimbursement rights) of any benefits; and the procedures governing claims for benefits under the excepted benefit HRA. Accordingly, for excepted benefit HRAs that are subject to ERISA, the burden for providing information regarding excepted benefit HRAs is captured under DOL's SPD information collection (OMB Control Number 1210–

[320] *See* 29 CFR 2520.104b–2, 2520.104b–3(a), and (d)(3).

0039), which includes a growth factor for new SPDs and SMMs provided to participants to notify them regarding coverage under new plans and plan amendments.

Additional comments are discussed in section II.B.7 of this preamble.

The information collections are summarized as follows:

Type of Review: New Collection.

Agency: DOL–EBSA, Treasury—IRS.

Title: Notice for Health Reimbursement Arrangements integrated with Individual Health Insurance Coverage.

OMB Numbers: 1210–0160 (DOL), 1545–0123, 1545–0074, and 1545–0047 (Treasury).

Affected Public: Private Sector.

Total Respondents: 1,442,876 three-year average.

Total Responses: 18,798,855 three-year average.

Frequency of Response: Annually.

Estimated Total Annual Burden Hours: 196,992 for each agency (combined total is 393,984 hours). Three year average.

Estimated Total Annual Burden Cost: $120,662 for each agency (combined total is $241,325). Three year average.

F. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a final rule is not likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency prepare a final regulatory flexibility analysis describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of ''small entity.'') The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

The Departments do not expect the final rules to produce costs or benefits in excess of 3 to 5 percent of revenues for small entities. Entities that choose to offer an individual coverage HRA instead of a traditional group health plan are likely to experience a modest increase or decrease in administrative burden associated with health benefits. Entities that newly offer health benefits in the form of an individual coverage HRA would bear modest administrative costs. However, offering an individual coverage HRA is entirely voluntary on the part of employers, and no employer that would experience substantial costs would be expected to offer an individual coverage HRA. In addition, the final rules would provide large and small employers with an additional choice of a tax-preferred health benefit to offer their employees, potentially enabling them to attract and retain workers and maintain a healthier workforce.

In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. The final rules will not have a direct effect on small rural hospitals though there may be an indirect effect. By reducing the number of uninsured persons, the final rules could reduce administrative costs, such as billing costs and the costs of helping patients obtain public health benefits. The final rules could also reduce the cost of uncompensated care borne by small rural hospitals and other healthcare providers (and shift such costs to insured persons). However, the Departments have determined that the final rules will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Impact of Regulations on Small Business—Department of the Treasury

Pursuant to section 7805(f) of the Code, the proposed rule that preceded this final rule was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

H. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any 1 year by state, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2019, that threshold is approximately $154 million. These final rules do not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or by the private sector in excess of that threshold.

I. Federalism

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have ''substantial direct effects'' on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the final rules. Federal officials have discussed the issues related to implementation of the policies in the proposed rules with state regulatory officials. Over multiple individual and group conversations, federal and state officials shared information about how and when Exchange systems and processes could be updated to support implementation of individual coverage HRAs while minimizing burden and confusion for both employers and consumers. State Exchanges expressed interest in how the FFEs would update information and systems to support employers and employees with HRA affordability determinations and the impact on APTC eligibility. The FFEs explained possible ways in which the federal platform would approach these issues and operations if the rules were finalized as proposed and agreed to share related documentation once implementation begins, to support state efforts. Some State Exchanges expressed concerns in these conversations that fully implementing these changes would take several months and likely would not be finished before individual coverage HRAs become available starting on January 1, 2020. The FFEs offered suggestions for information that could be provided to employers and consumers to address these concerns and ensure smooth implementation before system changes are complete.

J. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5

U.S.C. 801 *et seq.*) and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

K. Reducing Regulation and Controlling Regulatory Cost

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This final rule is an Executive Order 13771 deregulatory action.

Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1002, 1135, 1182, 1185d, 1191a, 1191b, and 1191c; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, 2792, and 2794 of the PHS Act (42 U.S.C. 300gg–300gg–63, 300gg–91, 300gg–92 and 300gg–94), as amended; sections 1311 and 1321 of PPACA (42 U.S.C. 13031 and 18041).

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2510

Employee benefit plans, Pensions.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

45 CFR Part 155

Exchange establishment standards and other related standards under the Affordable Care Act.

Kirsten Wielobob,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: June 6, 2019.

David J. Kautter,

Assistant Secretary of the Treasury (Tax Policy).

Signed at Washington, DC, this 10th day of June, 2019.

Preston Rutledge,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: June 7, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: June 7, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 54 are amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805.

* * * * *

■ **Par 2.** Section 1.36B–0 is amended by—

■ a. Adding entries for §§ 1.36B–2(c)(3)(i)(A) and (B).

■ b. Revising the entry for § 1.36B–2(c)(5).

■ c. Adding entries for §§ 1.36B–2(c)(5)(i) and (ii), 1.36B–2(c)(5)(iii), 1.36B–2(c)(5)(iii)(A) and (B), and 1.36B–2(c)(5)(iv) through (ix).

The additions and revision read as follows:

§ 1.36B–0 Table of contents.

* * * * *

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(c) * * *

(3) * * *

(i) In general.

(A) Plans other than health reimbursement arrangements (HRAs) or other account-based group health plans described in paragraph (c)(3)(i)(B) of this section.

(B) HRAs and other account-based group health plans integrated with individual health insurance coverage.

* * * * *

(5) Affordable HRA or other account-based group health plan.

(i) In general.

(ii) Required HRA contribution.

(iii) Monthly amounts.

(A) Monthly lowest cost silver plan premium.

(B) Monthly HRA amount.

(iv) Employee safe harbor.

(v) Amounts used for affordability determination.

(vi) Affordability for part-year period.

(vii) Related individual not allowed as a personal exemption deduction.

(viii) Post-employment coverage.

(ix) Examples.

* * * * *

■ **Par. 3.** Section 1.36B–2 is amended by:

■ a. Redesignating the text of paragraph (c)(3)(i) as paragraph (c)(3)(i)(A).

■ b. Revising the subject heading to newly designated paragraph (c)(3)(i)(A).

■ c. Adding paragraph (c)(3)(i)(B).

■ d. Adding a sentence at the end of paragraphs (c)(3)(ii) and (c)(3)(v)(A)(*1*) and (*2*).

■ e. Revising paragraphs (c)(3)(v)(A)(*3*) and (*5*).

■ f. Adding a sentence at the end of paragraph (c)(3)(vi).

■ g. Adding paragraph (c)(5).

■ h. Revising paragraph (e)(1).

■ i. Adding paragraph (e)(3).

The revisions and additions read as follows:

§ 1.36B–2 Eligibility for premium tax credit.

* * * * *

(c) * * *

(3) * * *

(i) * * *

(A) *Plans other than health reimbursement arrangements (HRAs) or other account-based group health plans described in paragraph (c)(3)(i)(B) of this section.* * * *

(B) *HRAs and other account-based group health plans integrated with individual health insurance coverage.* An employee who is offered an HRA or other account-based group health plan that would be integrated with individual health insurance coverage (or Medicare Part A and B or Medicare Part C), within the meaning of §§ 54.9802–4 and 54.9815–2711(d)(4) of this chapter, if the employee enrolls in individual health insurance coverage (or Medicare Part A and B or Medicare Part C), and an individual who is offered the HRA or

other account-based group health plan because of a relationship to the employee (a related HRA individual), are eligible for minimum essential coverage under an eligible employer-sponsored plan for any month for which the HRA or other account-based group health plan is offered if the HRA or other account-based group health plan is affordable for the month under paragraph (c)(5) of this section or if the employee does not opt out of and waive future reimbursements from the HRA or other account-based group health plan. An HRA or other account-based group health plan described in this paragraph (c)(3)(i)(B) that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month. For purposes of paragraphs (c)(3) and (5) of this section, the definitions under § 54.9815–2711(d)(6) of this chapter apply.

(ii) * * * The plan year for an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is the plan's 12-month coverage period (or the remainder of the 12-month coverage period for a newly eligible individual or an individual who enrolls during a special enrollment period).

* * * * *

(v) * * *

(A) * * *

(*1*) * * * See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for an employee for a month.

(*2*) * * * See paragraph (c)(5) of this section for rules for when an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a related HRA individual for a month.

(*3*) *Employee safe harbor.* An eligible employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a qualified health plan for a period coinciding with the plan year (in whole or in part), an Exchange determines that the eligible employer-sponsored plan is not affordable for that plan year. This paragraph (c)(3)(v)(A)(*3*) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. This paragraph (c)(3)(v)(A)(*3*) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate. See paragraph (c)(5) of this section for an employee safe harbor that applies when an Exchange determines that an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for an employee or a related HRA individual for the period of enrollment in a qualified health plan.

* * * * *

(*5*) *Employer contributions to HRAs integrated with eligible employer-sponsored plans.* Amounts newly made available for the current plan year under an HRA that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the HRA would be integrated, within the meaning of § 54.9815–2711(d)(2) of this chapter, with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the HRA must be offered by the same employer. Employer contributions to an HRA described in this paragraph (c)(3)(v)(A)(*5*) reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

* * * * *

(vi) * * * An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section that is affordable for a month under paragraph (c)(5) of this section is treated as providing minimum value for the month.

* * * * *

(5) *Affordable HRA or other account-based group health plan*—(i) *In general.* Except as otherwise provided in this paragraph (c)(5), an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a month if the employee's required HRA contribution (as defined in paragraph (c)(5)(ii) of this section) for the month does not exceed 1/12 of the product of the employee's household income for the taxable year and the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section).

(ii) *Required HRA contribution.* An employee's required HRA contribution is the excess of—

(A) The monthly premium for the lowest cost silver plan for self-only coverage of the employee offered in the Exchange for the rating area in which the employee resides, over

(B) The monthly self-only HRA or other account-based group health plan amount (or the monthly maximum amount available to the employee under the HRA or other account-based group health plan if the HRA or other account-based group health plan provides for reimbursements up to a single dollar amount regardless of whether an employee has self-only or other-than-self-only coverage).

(iii) *Monthly amounts*—(A) *Monthly lowest cost silver plan premium.* For purposes of paragraph (c)(5)(ii)(A) of this section, the premium for the lowest cost silver plan is determined without regard to any wellness program incentive that affects premiums unless the wellness program incentive relates exclusively to tobacco use, in which case the incentive is treated as earned. If the premium differs for tobacco users and non-tobacco users, the premium for the lowest cost silver plan is the premium that applies to non-tobacco users. For the purpose of this paragraph (c)(5)(iii)(A), the term wellness program incentive has the same meaning as the term reward in 26 CFR 54.9802–1(f)(1)(i). A silver-level qualified health plan that is used for purposes of determining a taxpayer's lowest cost silver plan for self-only coverage under paragraph (c)(5)(ii)(A) of this section does not cease to be the taxpayer's lowest cost silver plan for self-only coverage solely because the plan terminates or closes to enrollment during the taxable year.

(B) *Monthly HRA amount.* For purposes of paragraph (c)(5)(ii)(B) of this section, the monthly self-only HRA or other account-based group health plan amount is the self-only HRA or other account-based group health plan amount newly made available under the HRA for the plan year, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee. The monthly maximum amount available to the employee under the HRA or other account-based group health plan is the maximum amount

newly made available for the plan year to the employee under the plan, divided by the number of months in the plan year the HRA or other account-based group health plan is available to the employee.

(iv) *Employee safe harbor.* An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is not affordable for a month for an employee or a related HRA individual if, when the employee or related HRA individual enrolls in a qualified health plan for a period coinciding with the period the HRA or other account-based group health plan is available to the employee or related HRA individual (in whole or in part), an Exchange determines that the HRA or other account-based group health plan is not affordable for the period of enrollment in the qualified health plan. This paragraph (c)(5)(iv) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information about affordability. This paragraph (c)(5)(iv) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the relevant HRA or other account-based group health plan amount offered by the employee's employer. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.

(v) *Amounts used for affordability determination.* Only amounts that are newly made available for the plan year of the HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section and determinable within a reasonable time before the beginning of the plan year of the HRA or other account-based health plan are considered in determining whether an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable. Amounts made available for a prior plan year that carry over to the current plan year are not taken into account for purposes of this paragraph (c)(5). Similarly, amounts made available to account for amounts remaining in a different HRA or other account-based group health plan the employer previously provided to the employee and under which the employee is no longer covered are not taken into account for purposes of this paragraph (c)(5).

(vi) *Affordability for part-year period.* Affordability under this paragraph (c)(5) is determined separately for each employment period that is less than a full calendar year or for the portions of the plan year of an employer's HRA or other account-based group health plan that fall in different taxable years of an applicable taxpayer. An HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section is affordable for a part-year period if the employee's annualized required HRA contribution for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required HRA contribution is the employee's required HRA contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(5)(vi).

(vii) *Related individual not allowed as a personal exemption deduction.* A related HRA individual is treated as ineligible for minimum essential coverage under an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section for months that the employee opted out of and waived future reimbursements from the HRA or other account-based group health plan and the employee is not allowed a personal exemption deduction under section 151 for the related HRA individual.

(viii) *Post-employment coverage.* An individual who is offered an HRA or other account-based group health plan described in paragraph (c)(3)(i)(B) of this section, for months after an employee terminates employment with the employer offering the HRA or other account-based group health plan, is eligible for minimum essential coverage under the HRA or other account-based group health plan for months after termination of employment only if the employee does not forfeit or opt out of and waive future reimbursements from the HRA or other account-based group health plan for months after termination of employment.

(ix) *Examples.* The following examples illustrate the provisions of this paragraph (c)(5). The required contribution percentage is defined in paragraph (c)(3)(v)(C) of this section and is updated annually. Because the required contribution percentage for 2020 has not yet been determined, the examples assume a required contribution percentage for 2020 of 9.78 percent.

(A) *Example 1: Determination of affordability*—(*1*) *Facts.* In 2020 Taxpayer A is single, has no dependents, and has household income of $28,000. A is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $2,400 of medical care expenses for single employees with no children (the self-only HRA amount) and $4,000 for employees with a spouse or children for the medical expenses of the employees and their family members. A enrolls in a qualified health plan through the Exchange in the rating area in which A resides and remains enrolled for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of A that is offered in the Exchange for the rating area in which A resides is $500.

(*2*) *Conclusion.* A's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $300, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage of A) over $200 (1/12 of the self-only HRA amount provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and A's household income is $228 ($28,000 × .0978 = $2,738; $2,738/12 = $228). Because A's required HRA contribution of $300 exceeds $228 (1/12 of the product of 9.78 percent and A's household income), the HRA is unaffordable for A for each month of 2020 under paragraph (c)(5) of this section. If A opts out of and waives future reimbursements from the HRA, A is not eligible for minimum essential coverage under the HRA for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(B) *Example 2: Determination of affordability for a related HRA individual*—(*1*) *Facts.* In 2020 Taxpayer B is married and has one child who is a dependent of B for 2020. B has household income of $28,000. B is an employee of Employer X for all of 2020. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses $3,600 of medical care expenses for single employees with no children (the self-only HRA amount) and $5,000 for employees with a spouse or children for the medical expenses of the employees and their family members. B, B's spouse, and B's child enroll in a qualified health plan through the Exchange in the rating area in which B resides and they remain enrolled for all of 2020. No advance credit payments are made for their coverage. The monthly premium for the lowest cost silver plan for self-only coverage of B that is offered in the Exchange for the rating area in which B resides is $500.

(*2*) *Conclusion.* B's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for B) over $300 (1/12 of the self-only HRA amount

provided by Employer X to its employees). In addition, 1/12 of the product of 9.78 percent and B's household income for 2020 is $228 ($28,000 × .0978 = $2,738; $2,738/12 = $228). Because B's required HRA contribution of $200 does not exceed $228 (1/12 of the product of 9.78 percent and B's household income for 2020), the HRA is affordable for B under paragraph (c)(5) of this section, and B is eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section. In addition, B's spouse and child are also eligible for minimum essential coverage under an eligible employer-sponsored plan for each month of 2020 under paragraph (c)(3)(i)(B) of this section.

(C) *Example 3: Exchange determines that HRA is unaffordable*—(*1*) *Facts.* The facts are the same as in paragraph (c)(5)(ix)(B) of this section (*Example 2*), except that B, when enrolling in Exchange coverage for B's family, received a determination by the Exchange that the HRA was unaffordable, because B believed B's household income would be lower than it turned out to be. Consequently, advance credit payments were made for their 2020 coverage.

(*2*) *Conclusion.* Under paragraph (c)(5)(iv) of this section, the HRA is considered unaffordable for B, B's spouse, and B's child for each month of 2020 provided that B did not, with intentional or reckless disregard for the facts, provide incorrect information to the Exchange concerning the HRA.

(D) *Example 4: Affordability determined for part of a taxable year (part-year period)*—(*1*) *Facts.* Taxpayer C is an employee of Employer X. C's household income for 2020 is $28,000. X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that reimburses medical care expenses of $3,600 for single employees without children (the self-only HRA amount) and $5,000 to employees with a spouse or children for the medical expenses of the employees and their family members. X's HRA plan year is September 1 to August 31 and C is first eligible to participate in the HRA for the period beginning September 1, 2020. C enrolls in a qualified health plan through the Exchange in the rating area in which C resides for all of 2020. The monthly premium for the lowest cost silver plan for self-only coverage of C that is offered in the Exchange for the rating area in which C resides for 2020 is $500.

(*2*) *Conclusion.* Under paragraph (c)(3)(vi) of this section, the affordability of the HRA is determined separately for the period September 1 through December 31, 2020, and for the period January 1 through August 31, 2021. C's required HRA contribution, as defined in paragraph (c)(5)(ii) of this section, for the period September 1 through December 31, 2020, is $200, the excess of $500 (the monthly premium for the lowest cost silver plan for self-only coverage for C) over $300 (1/12 of the self-only HRA amount provided by X to its employees). In addition, 1/12 of the product of 9.78 percent and C's household income is $228 ($28,000 × .0978 = $2,738; $2,738/12 = $228). Because C's required HRA contribution of $200 does not exceed $228, the HRA is affordable for C for each month in the period September 1 through December 31, 2020, under paragraph (c)(5) of this section. Affordability for the period January 1 through August 31, 2021, is determined using C's 2021 household income and required HRA contribution.

(E) *Example 5: Carryover amounts ignored in determining affordability*—(*1*) *Facts.* Taxpayer D is an employee of Employer X for all of 2020 and 2021. D is single. For each of 2020 and 2021, X offers its employees an HRA described in paragraph (c)(3)(i)(B) of this section that provides reimbursement for medical care expenses of $2,400 to single employees with no children (the self-only HRA amount) and $4,000 to employees with a spouse or children for the medical expenses of the employees and their family members. Under the terms of the HRA, amounts that an employee does not use in a calendar year may be carried over and used in the next calendar year. In 2020, D used only $1,500 of her $2,400 maximum reimbursement and the unused $900 is carried over and may be used by D in 2021.

(*2*) *Conclusion.* Under paragraph (c)(5)(v) of this section, only the $2,400 self-only HRA amount offered to D for 2021 is considered in determining whether D's HRA is affordable for D. The $900 carryover amount is not considered in determining the affordability of the HRA.

* * * * *

(e) * * *

(1) Except as provided in paragraphs (e)(2) and (3) of this section, this section applies to taxable years ending after December 31, 2013.

* * * * *

(3) Paragraphs (c)(3)(i)(B) and (c)(5) of this section, and the last sentences of paragraphs (c)(3)(ii), (c)(3)(v)(A)(*1*) through (*3*), and (c)(3)(vi) of this section apply to taxable years beginning on or after January 1, 2020.

PART 54—PENSION EXCISE TAXES

Par. 4. The authority citation for part 54 is amended by adding an entry for § 54.9802–4 in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805.

* * * * *

Section 54.9802–4 is also issued under 26 U.S.C. 9833.

* * * * *

■ **Par. 5.** Section 54.9801–2 is amended by revising the definition of ''Group health insurance coverage'' to read as follows:

§ 54.9801–2 Definitions.

* * * * *

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

* * * * *

■ **Par. 6.** Section 54.9802–4 is added to read as follows:

§ 54.9802–4 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination In HRAs and Other Account-Based Group Health Plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 54.9815–2711(d)(6)(i) of this chapter. For ease of reference, the term ''HRA'' is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in section 9802 and PHS Act section 2705 (which is incorporated in section 9815) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any,

and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter and will not be considered to discriminate in violation of section 9802 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 54.9815–2711(d)(6)(ii) of this chapter and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage*—(i) *In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act section 2711 (and § 54.9815–2711(a)(2) of this chapter) and PHS Act section 2713 (and § 54.9815–2713(a)(1) of this chapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement*—(i) *In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same

maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(*1*) and (*2*) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(*1*) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(*2*) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted*—(*1*) *Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees $7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from $500 to $1,750 that are carried over to 2021 for those employees.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, $7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year*—(*1*) *Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, $7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, $7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents*—(*1*) *Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: $1,500, if the employee is the only individual covered by the HRA; $3,500, if the employee and one dependent are covered by the HRA; and $5,000, if the employee and more than one dependent are covered by the HRA.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's

dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages*—(*1*) *Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: $1,000 each for employees age 25 to 35; $2,000 each for employees age 36 to 45; $2,500 each for employees age 46 to 55; and $4,000 each for employees over age 55.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(*2*) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA*—(*1*) *Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to $10,000 for the year. Employee A enrolls in individual health insurance coverage with a $5,000 premium for the year and is reimbursed $5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an $8,000 premium for the year and is reimbursed $8,000 from the HRA.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the

participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3–1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under § 1.36B–2(c)(5) of this chapter, a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under § 1.36B–2(c)(5) of this chapter, a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under § 1.36B–2(c)(5) of this chapter, and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of ''full-time employees,'' ''part-time employees,'' and ''seasonal employees''; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining

classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H (and § 54.4980H–1(a)(21) of this chapter) or employees who are not part-time employees (as described in § 1.105–11(c)(2)(iii)(C) of this chapter);

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H (and under § 54.4980H–1(a)(21) of this chapter (which defines full-time employee)) or employees who are part-time employees as described in § 1.105–11(c)(2)(iii)(C) of this chapter;

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either § 54.4980H–1(a)(38) or § 1.105–11(c)(2)(iii)(C) of this chapter;

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in § 1.105–11(c)(2)(iii)(D) of this chapter);

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 54.9815–2708 of this chapter);

(ix) Non-resident aliens with no U.S.-based income (as described in § 1.105–11(c)(2)(iii)(E) of this chapter);

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o); or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(*1*) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(*2*) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum*—(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(*1*) 10, for an employer with fewer than 100 employees;

(*2*) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(*3*) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a

plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define ''full-time employee,'' ''part-time employee,'' and ''seasonal employee'' in accordance with the relevant provisions of sections 105(h) or 4980H, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) or each of the three classes of employees are defined in accordance with section 4980H for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires*—(i) *In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to ''individual health insurance coverage'' is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health*

plan; non-collectively bargained employees offered HRA—(A) *Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA*—(A) *Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 54.9815–2708 of this chapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 54.9815–2708 of this chapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA*—(A) *Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class

of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8)* because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA*—(A) *Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered*—(A) *Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees $2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees $500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA*—(A) *Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees $500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA*—(A) *Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-times employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement*—(A) *Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement*—(A) *Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees*—(A) *Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees*—(A) *Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively*—(A) *Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health

plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas*—(A) *Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of $3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of $5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of $7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area*—(A) *Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site in in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA*—(A) *Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ **Par. 7.** Section 54.9815–2711 is amended by revising paragraphs (c), (d), and (e) to read as follows:

§ 54.9815–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2), or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to satisfy the standards in 45 CFR 156.110; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark

plan selection at 45 CFR 156.111, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with 45 CFR 156.111(d)(1), and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2).

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans*—(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in 45 CFR 148.220.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the

forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 54.9802–4(c) of this chapter (as modified by § 54.9802–4(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2).

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under section 213(d).

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of 26 CFR part 54, contained in the 26 CFR, subchapter D, revised as of April 1, 2018.

■ **Par. 8.** Section 54.9831–1 is amended by revising paragraph (c)(3)(i) and adding paragraph (c)(3)(viii) to read as follows:

§ 54.9831–1 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) of this section.

* * * * *

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term ''HRA or other account-based group health plan'' has the same meaning as ''account-based group health plan'' set forth in § 54.9815–2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount—* (*1*) *Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term ''C–CPI–U'' means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values

so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of $50 shall be rounded down to the next lowest multiple of $50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(*2*) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(*3*) *Multiple HRAs or other account-based group health plans.* If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 54.9802–1(d) of this part, regardless of any health factor (as described in § 54.9802–1(a)).

(E) *Notice requirement. See* 29 CFR 2520.102–3(j)(2) and (3) and 29 CFR 2520.104b–2(a) for rules regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits) applicable to plans subject to Tile I of the Employee Retirement Income Security Act of 1974, as amended.

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 54.9801–2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(*1*) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(*2*) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(*3*) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(*4*) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(*5*) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

* * * * *

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor amends 29 CFR parts 2510 and 2590 as set forth below:

PART 2510—DEFINITION OF TERMS USED IN SUBCHAPTERS C, D, E, F, G, AND L OF THIS CHAPTER

■ 9. The authority citation for part 2510 is revised to read as follows:

Authority: 29 U.S.C. 1002(1), 1002(3), 1002(2), 1002(5), 1002(16), 1002(21), 1002(37), 1002(38), 1002(40), 1002(42), 1031, and 1135; Secretary of Labor's Order No. 1–2011, 77 FR 1088 (Jan. 9, 2012); Secs. 2510.3–21, 2510.3–101 and 2510.3–102 also issued under sec. 102 of Reorganization Plan No. 4 of 1978, 5 U.S.C. App. at 237 (2012), E.O. 12108, 44 FR 1065 (Jan. 3, 1979) and 29 U.S.C. 1135 note. Sec. 2510.3–38 is also issued under sec. 1, Pub. L. 105–72, 111 Stat. 1457 (1997).

■ 10. Section 2510.3–1 is amended by adding paragraph (l) to read as follows:

§ 2510.3–1 Employee welfare benefit plan.

* * * * *

(l) *Safe harbor for health reimbursement arrangements (HRAs) and certain other arrangements that reimburse individual health insurance coverage.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include individual health insurance coverage the premiums of which are reimbursed by a health reimbursement arrangement (HRA) (or other account-based group health plan), including an HRA or other account-based group health plan integrated with individual health insurance coverage (as described in § 2590.702–2 of this chapter), an HRA that covers fewer than two current employees (as described in § 2590.732(b) of this chapter) and that reimburses premiums for individual health insurance coverage, a qualified small employer health reimbursement arrangement (QSEHRA), as defined in section 9831(d)(2) of the Code, or an arrangement under which an employer allows employees to pay the portion of the premium for individual health insurance coverage that is not covered by an HRA or other account-based group health plan with which the coverage is integrated by using a salary reduction arrangement in a cafeteria plan under section 125 of the Code (supplemental salary reduction arrangement), if all the conditions of this paragraph (l) are satisfied.

(1) The purchase of any individual health insurance coverage is completely voluntary for participants and beneficiaries. The fact that a plan sponsor requires such coverage to be purchased as a condition for participation in an HRA or supplemental salary reduction arrangement does not make the purchase involuntary.

(2) The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage. In contrast, providing general contact information regarding availability of health insurance in a state (such as

providing information regarding *www.HealthCare.gov* or contact information for a state insurance commissioner's office) or providing general health insurance educational information (such as the uniform glossary of health coverage and medical terms available at: *https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf*) is permitted.

(3) Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage (as defined in § 2590.701–2 of this chapter) that does not consist solely of excepted benefits (as defined in § 2590.732(c) of this chapter).

(4) The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.

(5) Each plan participant is notified annually that the individual health insurance coverage is not subject to title I of ERISA. For an HRA that is integrated with individual health insurance coverage, the notice must satisfy the notice requirement set forth in § 2590.702–2(c)(6) of this chapter. A QSEHRA or an HRA not subject to the notice requirement set forth in § 2590.702–2(c)(6) of this chapter may use the following language to satisfy this condition: ''The individual health insurance coverage that is paid for by this plan, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.'' A supplemental salary reduction arrangement is not required to provide this notice as the notice will be provided by the HRA that such an arrangement supplements.

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS.

■ 11. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 12. Section 2590.701–2 is amended by revising the definition of ''group health insurance coverage'' to read as follows:

§ 2590.701–2 Definitions.

* * * * *

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

* * * * *

■ 13. Section 2590.702–2 is added to read as follows:

§ 2590.702–2 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination In HRAs and Other Account-Based Group Health Plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 2590.715–2711(d)(6)(i) of this part. For ease of reference, the term ''HRA'' is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Code. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in ERISA section 702 and PHS Act section 2705 (which is incorporated in ERISA section 715) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part and will not be considered to discriminate in violation of ERISA section 702 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 2590.715–2711(d)(6)(ii) of this part and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage*—(i) *In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711 (and § 2590.715–2711(a)(2) of this part) and PHS Act section 2713 (and § 2590.715–2713(a)(1) of this part), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after

the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement*—(i) *In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(*1*) and (*2*) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(*1*) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(*2*) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is

no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted*—(*1*) *Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees $7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from $500 to $1,750 that are carried over to 2021 for those employees.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, $7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year*—(*1*)

Facts. For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, $7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, $7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents*—(*1*) *Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: $1,500, if the employee is the only individual covered by the HRA; $3,500, if the employee and one dependent are covered by the HRA; and $5,000, if the employee and more than one dependent are covered by the HRA.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages*—(*1*) *Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: $1,000 each for employees age 25 to 35; $2,000 each for employees age 36 to 45; $2,500 each for employees age 46 to 55; and $4,000 each for employees over age 55.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(*2*) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA*—(*1*) *Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to $10,000 for the year. Employee A enrolls in individual health insurance coverage with a $5,000 premium for the year and is reimbursed $5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an $8,000 premium for the year and is reimbursed $8,000 from the HRA.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish

timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and

any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to the Employee Retirement Income Security Act if the conditions under § 2510.3–1(l) of this chapter are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B–2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B–2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B–2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of ''full-time employees,'' ''part-time employees,'' and ''seasonal employees''; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H–1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105–11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H–1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105–11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H–1(a)(38) or 26 CFR 1.105–11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105–11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 2590.715–2708 of this part);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105–11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(*1*) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(*2*) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum*—(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(*1*) 10, for an employer with fewer than 100 employees;

(*2*) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(*3*) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define ''full-time employee,'' ''part-time employee,'' and ''seasonal employee'' in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires*—(i) *In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special

rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 2590.715–2711(d)(4) of this part), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to ''individual health insurance coverage'' is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA*—(A)

Facts. For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size

requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 2590.715–2708 of this part each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 2590.715–2708 of this part a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA*—(A) *Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA*—(A) *Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12)* because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered*—(A) *Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees $2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees $500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA*—(A) *Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees $500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA*—(A) *Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-times employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph

(f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement*—(A) *Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement*—(A) *Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees*—(A) *Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees*—(A) *Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively*—(A) *Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas*—(A) *Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers

its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of $3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of $5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of $7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area*—(A) *Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site in in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA*—(A) *Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 14. Section 2590.715–2711 is amended by revising paragraphs (c), (d), and (e) to read as follows:

§ 2590.715–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2), or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to satisfy the standards in 45 CFR 156.110; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark plan selection at 45 CFR 156.111, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with 45 CFR 156.111(d)(1), and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2).

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans*—(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 2590.715–2713(a)(1) of this part, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713

and § 2590.715–2713(a)(1) of this part. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in 45 CFR 148.220.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 2590.702–2(c) of this part (as modified by § 2590.702–2(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group

health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in Code section 9831(d)(2).

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under Code section 213(d).

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of this part, contained in the 29 CFR parts 1927 to end edition, revised as of July 1, 2018.

■ 15. Section 2590.732 is amended by revising paragraph (c)(3)(i) and adding paragraph (c)(3)(viii) to read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) of this section.

* * * * *

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term ''HRA or other account-based group health plan'' has the same meaning as ''account-based group health plan'' set forth in § 2590.715–2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount*—(*1*) *Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term ''C–CPI–U'' means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of $50 shall be rounded down to the next lowest multiple of $50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(*2*) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(*3*) *Multiple HRAs or other account-based group health plans.* If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan

may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 2590.702(d) of this part, regardless of any health factor (as described in § 2590.702(a)).

(E) *Notice requirement. See* sections 2520.102–3(j)(2) and (3) and 2520.104b–2(a) of this chapter regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits).

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 2590.701–2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(*1*) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(*2*) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(*3*) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(*4*) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(*5*) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Chapter 1

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, 147, and 155 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 16. The authority for part 144 is revised to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 17. Section 144.103 is amended by revising the definition of ''Group health insurance coverage'' to read as follows:

§ 144.103 Definitions.

* * * * *

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

18. The authority citation for part 146 continues to read as follows:

Authority: 42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

■ 19. Section 146.123 is added to read as follows:

§ 146.123 Special rule allowing integration of Health Reimbursement Arrangements (HRAs) and other account-based group health plans with individual health insurance coverage and medicare and prohibiting discrimination in HRAs and other account-based group health plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 147.126(d)(6)(i) of this subchapter. For ease of reference, the term ''HRA'' is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 147.126(d)(4) of this subchapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter, subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Internal Revenue Code (Code). In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in PHS Act section 2705 and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter and will not be considered to discriminate in violation of PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 147.126(d)(6)(ii) of this subchapter and Exchange means Exchange as defined in § 155.20 of this subchapter.

(1) *Enrollment in individual health insurance coverage*—(i) *In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711

(and § 147.126(a)(2) of this subchapter) and PHS Act section 2713 (and § 147.130(a)(1) of this subchapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement*—(i) *In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(*1*) and (*2*) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(*1*) The same maximum dollar amount attributable to the increase in age is

made available to all participants who are the same age.

(*2*) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted*—(*1*) *Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees $7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from $500 to $1,750 that are carried over to 2021 for those employees.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, $7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year*—(*1*) *Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, $7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, $7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents*—(*1*) *Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: $1,500, if the employee is the only individual covered by the HRA; $3,500, if the employee and one dependent are covered by the HRA; and $5,000, if the employee and more than one dependent are covered by the HRA.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages*—(*1*) *Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: $1,000 each for employees age 25 to 35; $2,000 each for employees age 36 to 45; $2,500 each for employees age 46 to 55; and $4,000 each for employees over age 55.

(*2*) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(*2*) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA*—(*1*) *Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to $10,000 for the year. Employee A enrolls in individual health insurance coverage with a $5,000 premium for the year and is reimbursed $5,000 from the HRA. Employee B enrolls in individual

health insurance coverage with an $8,000 premium for the year and is reimbursed $8,000 from the HRA.

Conclusion. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than

self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3–1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B–2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B–2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B–2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of ''full-time employees,'' ''part-time employees,'' and ''seasonal employees''; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H–1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105–11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H–1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105–11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in § 147.102(b) of this subchapter;

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H–1(a)(38) or 26 CFR 1.105–11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105–11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 147.116 of this subchapter);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105–11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(*1*) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(*2*) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum*—(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(*1*) 10, for an employer with fewer than 100 employees;

(*2*) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(*3*) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define ''full-time employee,'' ''part-time employee,'' and ''seasonal employee'' in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires*—(i) *In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 147.126(d)(4) of this subchapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to ''individual health insurance coverage'' is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional*

group health plan and in another unit offered HRA—(A) *Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 147.116 of this subchapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 147.116 of this subchapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA*—(A) *Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage

and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage*—(A) *Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA*—(A) *Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered*—(A) *Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees $2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees $500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA*—(A) *Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA*—(A) *Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees $500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ

fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA*—(A) *Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-times employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement*—(A) *Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement*—(A) *Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees*—(A) *Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees*—(A) *Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively*—(A) *Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan

Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas*—(A) *Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of $3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of $5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of $7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area*—(A) *Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site in in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state*—(A) *Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA*—(A) *Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

■ 20. Section 146.145 is amended by revising paragraph (b)(3)(i) and adding paragraph (b)(3)(viii) to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (b)(3)(viii) of this section.

* * * * *

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (b)(3)(viii). See paragraph (b)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (b)(3)(viii), the term ''HRA or other account-based group health plan'' has the same meaning as ''account-based group health plan'' set forth in § 147.126(d)(6)(i) of this subchapter, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (b)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan must

be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount*—(*1*) *Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term ''C–CPI–U'' means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of $50 shall be rounded down to the next lowest multiple of $50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(*2*) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(*3*) *Multiple HRAs or other account-based group health plans.* If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (b)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 146.121(d), regardless of any health factor (as described in § 146.121(a)).

(E) [Reserved]

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 144.103 of this subchapter) if the conditions of this paragraph (b)(3)(viii)(F) are satisfied.

(*1*) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(*2*) The other group health plan coverage offered by the employer pursuant to paragraph (b)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(*3*) The Secretary makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(*4*) The finding by the Secretary is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(*5*) The restriction shall be imposed or discontinued by publication by the Secretary of a notice in the **Federal Register** and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 21. The authority citation for part 147 is revised to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.

■ 22. Section 147.126 is amended by revising paragraphs (c), (d), and (e) to read as follows:

§ 147.126 No Lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under § 156.110 of this subchapter, and including coverage of any additional required benefits that are considered essential health benefits consistent with § 155.170(a)(2) of this subchapter, or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by § 156.100(a)(3) of this subchapter, supplemented as necessary, to satisfy the standards in § 156.110 of this subchapter; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark plan selection at § 156.111 of this subchapter, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with § 156.111(d)(1) of this subchapter, and including coverage of any additional required benefits that are considered essential health benefits consistent with § 155.170(a)(2) of this subchapter.

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans*—(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as

applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 147.130(a)(1) of this subchapter, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713 and § 147.130(a)(1) of this subchapter. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in § 148.220 of this subchapter.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Code (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Code (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts

under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 146.123(c) of this subchapter (as modified by § 146.123(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2) of the Code.

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under section 213(d) of the Code.

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of this subchapter B, contained in the 45 CFR, subtitle A, parts 1–199, revised as of October 1, 2018.

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 23. The authority citation for part 155 is revised to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 24. Section 155.420 is amended

■ a. By revising paragraph (a)(4)(iii) introductory text;

■ b. By adding paragraph (b)(2)(vi);

■ c. By redesignating paragraph (c)(3) as paragraph (c)(4); By adding a new paragraph (c)(3);

■ d. In paragraph (d)(12) by removing ''; or'' and adding ''; '' in its place;

■ e. In paragraph (d)(13) by removing the period at the end of the paragraph and adding ''; or'' in its place; and

■ f. By adding paragraph (d)(14).

The revisions and additions read as follows:

§ 155.420 Special enrollment periods.

* * * * *

(a) * * *

(4) * * *

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible for cost-sharing reductions, and paragraphs (d)(8), (9), (10), (12), and (14) of this section:

* * * * *

(b) * * *

(2) * * *

(vi) If a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in paragraph (d)(14) of this section, and if the plan selection is made before the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following plan selection.

* * * * *

(c) * * *

(3) *Advanced availability for individuals with an individual coverage HRA or QSEHRA.* A qualified individual, enrollee, or his or her dependent who is described in paragraph (d)(14) of this section has 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR 146.123(c)(6), 26 CFR 54.9802–4(c)(6), and 29 CFR 2590.702–2(c)(6) or section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual, enrollee, or his or her dependent has 60 days before or after the triggering event to select a QHP.

* * * * *

(d) * * *

(14) The qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). The triggering event is the first day on which coverage for the qualified individual, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, enrollee, or dependent will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, enrollee, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

* * * * *

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