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The President

Proclamation 9967 of November 22, 2019

National Family Week, 2019

By the President of the United States of America

A Proclamation

The strength of our Republic is not measured only by our military might and robust economy but also by the strength of our family bonds. Families shape our values, develop our character, and teach us to love, forgive, and become productive citizens and responsible members of society. During National Family Week, we pause to reflect on the importance of the family—the bedrock of our Nation.

Since I took office, my Administration has empowered families. We are currently in the midst of the longest economic recovery in our Nation's history, which is improving quality of life and stability for families of all types. Thanks to our economic policies, which include eliminating unnecessary and burdensome regulations and the enactment of the Tax Cuts and Jobs Act, we have seen the unemployment rate drop to a half-century low, real median household income reach a record high, and the poverty rate fall to its lowest level since 2001. We have fought for families by securing a doubling of the Child Tax Credit, preserving the Child and Dependent Care Credit, signing into law the largest ever increase in child care and development block grants—a major new investment in child care affordability—and developing a tax credit for employers who offer paid family and medical leave. We continue to call on the Congress to pass a nationwide paid family leave program.

Last year, I signed into law the Family First Prevention Services Act, which reimagines and reorients our Nation's child welfare system toward keeping at-risk families intact in their own homes and communities and minimizing the need for foster care. This legislation provides funding for mental health therapy, family counseling, addiction treatment, and parenting classes. Additionally, we are working to expand adoption providers so that children of all ages in the foster care system can experience what every child deserves—a loving family in a forever home.

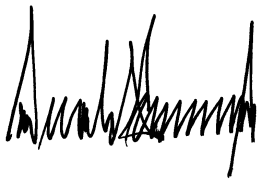
For some of our Nation's families, the incarceration of a loved one is a tremendous challenge. My Administration is proud that the reunification and strengthening of families is one of the many benefits of our criminal justice reform efforts. Since maintaining family and community ties is key to the successful reentry of prisoners into society, the bipartisan First Step Act, which I signed into law in 2018, includes provisions that allow inmates to be placed closer to their home communities, which facilitates family visitation. Further, it includes reasonable sentencing reforms that make our criminal justice system fairer by reducing excessive penalties for certain drug offenders, which allows families to reunify more quickly.

This week, we vow always to cherish, honor, protect, and respect the incredible gift of family and renew our commitment to strengthening and celebrating all of our Nation's families. A stable, loving family is one of life's greatest blessings. It provides support, comfort, guidance, acceptance, and joy.

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim November 24 through

November 30, 2019, as National Family Week. I invite communities, churches, and individuals to observe this week with appropriate ceremonies and activities to honor our Nation's families.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-second day of November, in the year of our Lord two thousand nineteen, and of the Independence of the United States of America the two hundred and forty-fourth.



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DEPARTMENT OF AGRICULTURE

Federal Crop Insurance Corporation

7 CFR Part 457

RIN 0563–AC65

[Docket ID FCIC–19–0008]

Common Crop Insurance Regulations; Coarse Grains Crop Insurance Provisions

AGENCY: Federal Crop Insurance Corporation, USDA.

ACTION: Final rule with request for comments.

SUMMARY: The Federal Crop Insurance Corporation (FCIC) amends the Common Crop Insurance Regulations, Coarse Grains Crop Insurance Provisions (Crop Provisions). The intended effect of this action is to allow separate enterprise and optional units by the cropping practices Following Another Crop (FAC) and Not Following Another Crop (NFAC). The changes will be effective for the 2020 and succeeding crop years.

DATES:

Effective date: This final rule is effective November 30, 2019.

Comment date: We will consider comments that we receive on this rule by the close of business January 27, 2020. FCIC will consider these comments and make changes to the rule if warranted in a subsequent rulemaking.

ADDRESSES: We invite you to submit comments on this rule. In your comments, include the date, volume, and page number of this issue of the **Federal Register**, and the title of rule. You may submit comments by any of the following methods, although FCIC prefers that you submit comments electronically through the Federal eRulemaking Portal:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and search for Docket ID FCIC–19–0008. Follow the online instructions for submitting comments.
- *Mail:* Director, Product Administration and Standards Division, Risk Management Agency, United States Department of Agriculture, P.O. Box 419205, Kansas City, MO 64133–6205.

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FOR FURTHER INFORMATION CONTACT: Francie Tolle; telephone (816) 926–7829; email *francie.tolle@usda.gov.* Persons with disabilities who require alternative means of communication should contact the USDA Target Center at (202) 720–2600 (voice).

SUPPLEMENTARY INFORMATION:

Background

The FCIC serves America's agricultural producers through effective, market-based risk management tools to strengthen the economic stability of agricultural producers and rural communities. FCIC is committed to increasing the availability and effectiveness of Federal crop insurance as a risk management tool. Approved Insurance Providers (AIP) sell and service Federal crop insurance policies in every state and in Puerto Rico through a public-private partnership. FCIC reinsures the AIPs who share the risks associated with catastrophic losses due to major weather events. FCIC's vision is to secure the future of agriculture by providing world class risk management tools to rural America.

Federal crop insurance policies typically consist of the Basic Provisions, the Crop Provisions, the Special Provisions, the Commodity Exchange Price Provisions, if applicable, other applicable endorsements or options, the actuarial documents for the insured agricultural commodity, the Catastrophic Risk Protection Endorsement, if applicable, and the applicable regulations published in 7 CFR chapter IV.

FCIC amends the Common Crop Insurance Regulations (7 CFR part 457) by revising 7 CFR 457.113 Coarse Grains Crop Insurance Provisions to be effective for the 2020 and succeeding crop years.

The changes to 7 CFR 457.113 Coarse Grains Crop Insurance Provisions are as follows:

1. Section 1—FCIC is adding the terms ''Following another crop (FAC)'' and ''Not following another crop (NFAC)'' to accommodate the changes in section 2. These terms are currently defined in the Special Provisions and vary depending on the county. FCIC is adding these terms to the Crop Provisions because the terms are now referenced in a newly-added section 2.

2. Section 2—FCIC is redesignating sections 2 through 12 as section 3 through 13, respectively, and adding a new section 2. FCIC is adding a section 2 to allow enterprise units and optional units by the cropping practices Following Another Crop (FAC) and Not Following Another Crop (NFAC). The new language allows separate enterprise units and optional units for FAC acreage of the crop or NFAC acreage of the crop.

The cropping practices FAC and NFAC have different risks of loss. For example, soil conditions for crops following another crop on the same acreage in the same crop year are likely to have different moisture and nutrient availability than crops not following another crop which could impact crop yields and losses. Producers have raised concerns that when the two cropping practices are combined in a single unit, the losses from one of these cropping practices may be offset by gains on the other. By contrast, this offset would likely not occur if all insurable acreage was insured as a single practice, or if the acreage is insurable by separate practice at the enterprise or optional unit level, which is the change this rule seeks to make effective. This change allows producers to better manage the unique risks of each practice by separating FAC and NFAC units.

If the insured elects enterprise or optional units for these cropping practices, additional enterprise or optional units by irrigation practices are not allowed. The insured may elect one enterprise unit for all FAC cropping practices, all NFAC cropping practices, or separate enterprise units for both. Additionally, both the FAC and NFAC acreage must each separately qualify for enterprise units and will be subject to the current requirements in the Basic Provisions. The insured is only eligible if both FAC and NFAC cropping practices are allowed by the actuarial documents for each irrigation practice the insured uses. For example, if the non-irrigated practice for the insured's

county allows both FAC and NFAC cropping practices in the actuarial documents, but the irrigated practice does not specify either FAC or NFAC, enterprise units are available as follows:

- If the insured uses the irrigated practice, separate enterprise units for FAC and NFAC cropping practices are not available because they are not specified as separate cropping practices in the actuarial documents for the irrigated practice;
- If the insured uses only the non-irrigated practice, with FAC and NFAC cropping practices, separate enterprise units for non-irrigated FAC and NFAC cropping practices are available, because they are specified as separate cropping practices in the actuarial documents for the non-irrigated practice.

If an insured does not qualify for separate FAC and NFAC enterprise units, there are two options based on the timing of the discovery: (1) If the AIP discovers the insured does not qualify on or before the acreage reporting date, the insured may have one enterprise unit comprised of all FAC and NFAC acreage in the county of the crop, or basic or optional units depending on which unit structure the insured reported on the acreage report; or (2) if the AIP discovers the insured does not qualify after acreage reporting date, the insured may have one enterprise unit comprised of all FAC and NFAC acreage combined in the county of the crop, or the AIP will assign a basic unit structure.

If an insured does not qualify for a separate enterprise unit on one cropping practice when a different unit structure is on the other cropping practice, there are two options based on the timing of the discovery:

(1) If the AIP discovers the insured does not qualify on or before the acreage reporting date, the insured may have basic or optional units depending on which unit structure the insured reported on the acreage report; or

(2) If the AIP discovers the insured does not qualify after the acreage reporting date, the AIP will assign a basic unit structure.

Effective Date and Notice and Comment

In general, the Administrative Procedure Act (APA, 5 U.S.C. 553) requires that a notice of proposed rulemaking be published in the **Federal Register** for interested persons to be given an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation and requires a 30-day delay in the effective date of rules, except when the rule involves a matter relating to public property, loans, grants, benefits, or contracts. This rule involves matters relating to contracts and therefore the requirements in section 553 do not apply. Although not required by APA, FCIC has chosen to request comments on this rule.

The Office of Management and Budget (OMB) designated this rule as not major under the Congressional Review Act, as defined by 5 U.S.C. 804(2). This rule is not major under the Congressional Review Act, as defined by 5 U.S.C. 804(2). Therefore, FCIC is not required to delay the effective date for 60 days from the date of publication to allow for Congressional review.

This final rule is effective November 30, 2019.

Executive Orders 12866, 13563, 13771 and 13777

Executive Order 12866, ''Regulatory Planning and Review,'' and Executive Order 13563, ''Improving Regulation and Regulatory Review,'' direct 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 emphasized the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. Executive Order 13777, ''Enforcing the Regulatory Reform Agenda,'' established a federal policy to alleviate unnecessary regulatory burdens on the American people.

The Office of Management and Budget (OMB) designated this rule as not significant under Executive Order 12866, ''Regulatory Planning and Review,'' and therefore, OMB has not reviewed this rule.

Executive Order 13771, ''Reducing Regulation and Controlling Regulatory Costs,'' requires that in order to manage the private costs required to comply with Federal regulations that for every new significant or economically significant regulation issued, the new costs must be offset by the elimination of at least two prior regulations. As this rule is designated as not significant, it is not subject to Executive Order 13771.

Clarity of the Regulation

Executive Order 12866, as supplemented by Executive Order 13563, requires each agency to write all rules in plain language. In addition to your substantive comments on this rule, we invite your comments on how to make the rule easier to understand. For example:

- Are the requirements in the rule clearly stated? Are the scope and intent of the rule clear?
- Does the rule contain technical language or jargon that is not clear?
- Is the material logically organized?
- Would changing the grouping or order of sections or adding headings make the rule easier to understand?
- Could we improve clarity by adding tables, lists, or diagrams?
- Would more, but shorter, sections be better? Are there specific sections that are too long or confusing?
- What else could we do to make the rule easier to understand?

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601–612), as amended by SBREFA, generally requires an agency to prepare a regulatory analysis of any rule whenever an agency is required by APA or any other law to publish a proposed rule, unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. This rule is not subject to the Regulatory Flexibility Act because as noted above, this rule is exempt from APA and no other law requires that a proposed rule be published for this rulemaking initiative.

Environmental Review

In general, the environmental impacts of rules are to be considered in a manner consistent with the provisions of the National Environmental Policy Act (NEPA, 42 U.S.C. 4321–4347) and the regulations of the Council on Environmental Quality (40 CFR parts 1500–1508). FCIC conducts programs and activities that have been determined to have no individual or cumulative effect on the human environment. As specified in 7 CFR 1b.4, FCIC is categorically excluded from the preparation of an Environmental Analysis or Environmental Impact Statement unless the FCIC Manager (agency head) determines that an action may have a significant environmental effect. The FCIC Manager has determined this rule will not have a significant environmental effect. Therefore, FCIC will not prepare an environmental assessment or environmental impact statement for this action and this rule serves as documentation of the programmatic environmental compliance decision.

Executive Order 12372

Executive Order 12372, ''Intergovernmental Review of Federal

Programs,'' requires consultation with State and local officials that would be directly affected by proposed Federal financial assistance. The objectives of the Executive Order are to foster an intergovernmental partnership and a strengthened Federalism, by relying on State and local processes for State and local government coordination and review of proposed Federal financial assistance and direct Federal development. For reasons specified in the final rule related notice regarding 7 CFR part 3015, subpart V (48 FR 29115, June 24, 1983), the programs and activities in this rule are excluded from the scope of Executive Order 12372.

Executive Order 12988

This rule has been reviewed under Executive Order 12988, ''Civil Justice Reform.'' This rule will not preempt State or local laws, regulations, or policies unless they represent an irreconcilable conflict with this rule. Before any judicial actions may be brought regarding the provisions of this rule, the administrative appeal provisions of 7 CFR part 11 are to be exhausted.

Executive Order 13132

This rule has been reviewed under Executive Order 13132, ''Federalism.'' The policies contained in this rule do not have any substantial direct effect on States, on the relationship between the Federal government and the States, or on the distribution of power and responsibilities among the various levels of government, except as required by law. Nor does this rule impose substantial direct compliance costs on State and local governments. Therefore, consultation with the States is not required.

Executive Order 13175

This rule has been reviewed in accordance with the requirements of Executive Order 13175, ''Consultation and Coordination with Indian Tribal Governments.'' Executive Order 13175 requires Federal agencies to consult and coordinate with Tribes on a government-to-government basis on policies that have Tribal implications, including regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects 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.

FCIC has assessed the impact of this rule on Indian Tribes and determined that this rule does not, to our knowledge, have Tribal implications that require Tribal consultation under E.O. 13175. The regulation changes do not have Tribal implications that preempt Tribal law and are not expected have a substantial direct effect on one or more Indian Tribes. If a Tribe requests consultation, FCIC will work with the USDA Office of Tribal Relations to ensure meaningful consultation is provided where changes, additions and modifications identified in this rule are not expressly mandated by Congress.

The Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA, Pub. L. 104–4) requires Federal agencies to assess the effects of their regulatory actions of State, local, and Tribal governments or the private sector. Agencies generally must prepare a written statement, including cost benefits analysis, for proposed and final rules with Federal mandates that may result in expenditures of $100 million or more in any 1 year for State, local or Tribal governments, in the aggregate, or to the private sector. UMRA generally requires agencies to consider alternatives and adopt the more cost effective or least burdensome alternative that achieves the objectives of the rule. This rule contains no Federal mandates, as defined in Title II of UMRA, for State, local, and Tribal governments or the private sector. Therefore, this rule is not subject to the requirements of sections 202 and 205 of UMRA.

Federal Assistance Program

The title and number of the Federal Domestic Assistance Program listed in the Catalog of Federal Domestic Assistance to which this rule applies is No. 10.450—Crop Insurance.

Paperwork Reduction Act of 1995

In accordance with the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35, subchapter I), the rule does not change the information collection approved by OMB under control numbers 0563–0053.

E-Government Act Compliance

FCIC is committed to complying 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.

List of Subjects in 7 CFR Part 457

Acreage allotments, Crop insurance, Reporting and recordkeeping requirements.

For the reasons discussed above, FCIC amends 7 CFR part 457, effective for the 2020 and succeeding crop years, as follows:

PART 457—COMMON CROP INSURANCE REGULATIONS

■ 1. The authority citation for part 457 continues to read as follows:

Authority: 7 U.S.C. 1506(l) and 1506(o).

■ 2. Amend § 457.113 as follows:
■ a. Revise the first sentence of the introductory text;
■ b. In section 1, add in alphabetical order definitions for ''Following another crop (FAC)'' and ''Not following another crop (NFAC)'';
■ c. Redesignate sections 2 through 12 as sections 3 through 13, respectively;
■ d. Add a new section 2;
■ e. Amend newly redesignated section 6 as follows:
■ i. In paragraph (a)(3)(i), remove the phrase ''5(b)(1)'' and add ''6(b)(1)'' in its place;
■ ii. In paragraph (b) introductory text, remove the phrase ''5(a),'' and add ''6(a),'' in its place;
■ iii. In paragraph (b)(1), remove the phrase ''5(c)'' and add ''6(c)'' in its place;
■ iv. In paragraph (b)(2)(i), remove the phrase ''5(b)(2)'' and add ''6(b)(2)'' in its place;
■ v. In paragraph (d) introductory text, remove the phrase ''5(a)'' and add ''6(a)'' in its place;
■ vi. In paragraph (e), remove the phrase ''5(a)'' and add ''6(a)'' in its place;
■ f. In newly redesignated section 9(h), remove the phrase ''sections 8(a) through (g)'' and add ''sections 9(a) through (g)'' in its place;
■ g. In newly redesignated section 10(a)(2), remove the phrase ''9(a)(1)'' and add ''10(a)(1)'' in its place;
■ h. In newly redesignated section 11(c), remove the phrase ''11(c)(1)(i)(E)'' and add ''12(c)(1)(i)(E)'' in its place;
■ i. Amend newly redesignated section 12 as follows:
■ i. In paragraph (b)(2), remove the phrase ''section 11(b)(1)(i) or 11(b)(1)(ii)'' and add ''section 12(b)(1)(i) or 12(b)(1)(ii)'' in its place;
■ ii. In paragraph (b)(4), remove the phrase ''section 11(b)(3)(i) or 11(b)(3)(ii)'' and add ''section 12(b)(3)(i) or 12(b)(3)(ii)'' in its place;
■ iii. In paragraph (b)(5), remove the phrase ''section 11(b)(4) from the result of section 11(b)(2)'' and add ''section 12(b)(4) from the result of section 12(b)(2)'' in its place;
■ iv. In paragraph (b)(6) introductory text, remove the phrase ''11(b)(5)'' and add ''12(b)(5)'' in its place;

■ v. In paragraph (c)(1)(iii), remove the phrase ''section 11(d)'' and add ''section 12(d)'' in its place;
■ vi. In paragraph (d) introductory text, remove the phrase ''11(e).'' and add ''12(e).'' in its place;
■ vii. In paragraph (d)(4), remove the phrase ''sections 11(d)(2) and (3)'' and add ''sections 12(d)(2) and (3)'' in its place;
■ viii. In paragraph (e)(2), remove the phrase ''7(b)'' and add ''8(b)'' in its place.

The revision and additions read as follows:

§ 457.113 Coarse grains crop insurance provisions.

The Coarse Grains Crop Insurance Provisions for the 2020 and succeeding crop years are as follows:

* * * * *

1. Definitions.

* * * * *

Following another crop (FAC). A cropping practice, as defined in the Special Provisions, in which a crop is planted following another crop.

* * * * *

Not following another crop (NFAC). A cropping practice, as defined in the Special Provisions, in which a crop is planted not following a crop.

* * * * *

2. Unit Division.

(a) In addition to the requirements of section 34(a) of the Basic Provisions, you may elect separate enterprise units for FAC or NFAC cropping practices if these cropping practices are allowed by the actuarial documents. If you elect enterprise units for these cropping practices, you may not elect enterprise or optional units by irrigation practices.

(1) You may elect one enterprise unit for all FAC cropping practices, all NFAC cropping practices, or separate enterprise units for both, unless otherwise specified in the Special Provisions. For example: You may choose an enterprise unit for all FAC acreage (soybeans irrigated practice and non-irrigated practice) and an enterprise unit for all NFAC acreage (soybeans irrigated practice and non-irrigated practice).

(2) You are only eligible if both FAC and NFAC cropping practices are allowed by the actuarial documents for each irrigation practice you use. If FAC and NFAC cropping practices are only allowed for the non-irrigated practice, separate enterprise units for FAC and NFAC cropping practices are not available if you use the irrigated practice; but if you use only non-irrigated FAC and NFAC cropping practices, separate enterprise units for non-irrigated FAC and NFAC cropping practices are available.

(3) You must separately meet the requirements in section 34(a)(4) for each enterprise unit.

(4) If you elected separate enterprise units for both cropping practices and we discover you do not qualify for an enterprise unit for one or the other cropping practice and such discovery is made:

(i) On or before the acreage reporting date, you may elect to insure all acreage of the crop in the county in one enterprise unit provided you meet the requirements in section 34(a)(4), or your unit division will be based on basic or optional units, whichever you report on your acreage report and qualify for; or

(ii) At any time after the acreage reporting date, your unit structure will be one enterprise unit provided you meet the requirements in section 34(a)(4). Otherwise, we will assign the basic unit structure.

(5) If you elected an enterprise unit on one cropping practice for FAC or NFAC and a different unit structure on the other cropping practice and we discover you do not qualify for an enterprise unit for the FAC or NFAC cropping practice and such discovery is made:

(i) On or before the acreage reporting date, your unit division will be based on basic or optional units, whichever you report on your acreage report and qualify for; or

(ii) At any time after the acreage reporting date, we will assign the basic unit structure.

(b) Instead of establishing optional units as provided in section 34(c) of the Basic Provisions, if allowed by the actuarial documents, you may have separate optional units for the FAC cropping practice and the NFAC cropping practice. These optional units will be by section, section equivalent, or FSA FN and by the FAC cropping practice and the NFAC cropping practice. These optional units cannot be further divided by irrigated and non-irrigated acreage or by acreage insured under an organic farming practice.

(c) If FAC or NFAC cropping practices are only available by written agreement, separate enterprise units or optional units for FAC or NFAC cropping practices are not available.

* * * * *

Martin Barbre,

Manager, Federal Crop Insurance Corporation.

[FR Doc. 2019–25862 Filed 11–26–19; 8:45 am]

BILLING CODE 3410–08–P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 923

[Doc. No. AMS–SC–19–0049; SC19–923–1 FR]

Marketing Order Regulating the Handling of Sweet Cherries Grown in Designated Counties in Washington; Decreased Assessment Rate

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: This final rule implements a recommendation from the Washington Cherry Marketing Committee (Committee) to decrease the assessment rate established for the 2019–2020 and subsequent fiscal periods. The assessment rate will remain in effect indefinitely unless modified, suspended, or terminated.

DATES: Effective December 27, 2019.

FOR FURTHER INFORMATION CONTACT: Dale Novotny, Marketing Specialist, or Gary Olson, Regional Director, Northwest Marketing Field Office, Marketing Order and Agreement Division, Specialty Crops Program, AMS, USDA; Telephone: (503) 326–2724, Fax: (503) 326–7440, or Email: *dalej.novotny@usda.gov* or *GaryD.Olson@usda.gov.*

Small businesses may request information on complying with this regulation by contacting Richard Lower, Marketing Order and Agreement Division, Specialty Crops Program, AMS, USDA, 1400 Independence Avenue SW, STOP 0237, Washington, DC 20250–0237; Telephone: (202) 720–2491, Fax: (202)720–8938, or Email: *Richard.Lower@usda.gov.*

SUPPLEMENTARY INFORMATION: This action, pursuant to 5 U.S.C. 553, amends regulations issued to carry out a marketing order as defined in 7 CFR 900.2(j). This final rule is issued under Marketing Order No. 923, as amended (7 CFR part 923), regulating the handling of sweet cherries grown in designated counties of Washington. Part 923 (referred to as the ''Order'') is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), hereinafter referred to as the ''Act.'' The Committee locally administers the Order and is comprised of sweet cherry growers and handlers operating within the area of production.

The Department of Agriculture (USDA) is issuing this rule in conformance with Executive Orders 13563 and 13175. This final rule falls within a category of regulatory actions

that the Office of Management and Budget (OMB) exempted from Executive Order 12866 review. Additionally, because this rule does not meet the definition of a significant regulatory action, it does not trigger the requirements contained in Executive Order 13771. See OMB's Memorandum titled ''Interim Guidance Implementing Section 2 of the Executive Order of January 30, 2017, titled 'Reducing Regulation and Controlling Regulatory Costs' '' (February 2, 2017).

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. Under the Order now in effect, Washington sweet cherry handlers are subject to assessments. Funds to administer the marketing order are derived from such assessments. The assessment rate will be applicable to all assessable Washington sweet cherries for the 2019–2020 fiscal period, and continue until amended, suspended, or terminated.

The Act provides that administrative proceedings must be exhausted before parties may file suit in court. Under section 608c(15)(A) of the Act, any handler subject to a marketing order may file with USDA a petition stating that the order, any provision of the marketing order, or any obligation imposed in connection with the marketing order is not in accordance with law and request a modification of the marketing order or to be exempted therefrom. Such handler is afforded the opportunity for a hearing on the petition. After the hearing, USDA would rule on the petition. The Act provides that the district court of the United States in any district in which the handler is an inhabitant, or has his or her principal place of business, has jurisdiction to review USDA's ruling on the petition, provided an action is filed not later than 20 days after the date of the entry of the ruling.

The Order authorizes the Committee, with the approval of USDA, to formulate an annual budget of expenses and collect assessments from handlers to administer the program. Committee members are familiar with the Committee's needs and with the costs of goods and services in their local area and can formulate an appropriate budget and assessment rate. The assessment rate is formulated and discussed in a public meeting where all directly affected persons have an opportunity to participate and provide input.

This final rule decreases the assessment rate from $0.25 to $0.20 per ton of Washington sweet cherries handled for the 2019–2020 and subsequent fiscal periods. The lower rate is necessary to fund the Committee's 2019–2020 fiscal period budgeted expenditures while maintaining the Committee's financial reserve fund at an amount not exceeding approximately one fiscal period's operational expenses. Based on input received from growers at an annual meeting, the 2019 crop of Washington sweet cherries is expected to be similar in volume compared to the 2018 crop. The Committee believes that decreasing the continuing assessment rate will allow the Committee to fully fund its 2019–2020 budgeted expenses and maintain its financial reserve within the limits established in the Order.

The Committee held a well-publicized meeting May 8, 2019, where all interested parties were encouraged to participate in the discussions. However, the Order's quorum requirement was not met, and the Committee was not able to conduct official business. The following day, the Committee conducted the vote by email and, with a vote of 15–1, recommended 2019–2020 fiscal period budgeted expenditures of $56,250 and an assessment rate of $0.20 per ton of sweet cherries handled. In comparison, last year's budgeted expenditures were $55,750. The assessment rate of $0.20 is $0.05 lower than the $0.25 per ton rate currently in effect. The Committee recommended the assessment rate decrease because of a normal size crop estimate and a financial reserve fund balance that was higher than the Committee believes is responsible. At the recommended assessment rate and budgeted expenditures, the Committee expects its financial reserve to be $55,093 at the end of the 2019–2020 fiscal period, which would be within the limits set in the Order.

The major expenditures recommended by the Committee for the 2019–2020 fiscal period include $25,000 for program management contract services provided by the Washington State Fruit Commission, $7,250 for administrative expenses, $7,000 for regulation proceedings, $5,000 for data management, $5,000 for research, $4,000 for an annual audit, and $3,000 for travel. In comparison, these major expense categories budgeted for the 2018–2019 fiscal period were $25,000, $6,950, $7,000, $5,000, $5,000, $3,800, and $3,000, respectively.

The assessment rate recommended by the Committee was derived by considering anticipated expenses, expected sweet cherry sales, and the amount of funds available in the authorized reserve. Expected income derived from handler assessments of $40,000 (200,000 tons of sweet cherries at $0.20 per ton), plus $5 interest income and $16,245 from the reserve would be adequate to cover budgeted expenses of $56,250. Funds from the reserve (estimated to be $71,338 at the beginning of the 2019–2020 fiscal period) will be used to supply part of the Committee's 2019–2020 expenses in an effort to keep the reserve within the maximum permitted by § 923.142(a).

The assessment rate established in this rule will continue in effect indefinitely unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other available information.

Although this assessment rate will be in effect for an indefinite period, the Committee will continue to meet prior to or during each fiscal period to recommend a budget of expenses and consider recommendations for modification of the assessment rate. The dates and times of Committee meetings are available from the Committee or USDA. Committee meetings are open to the public and interested persons may express their views at these meetings. USDA would evaluate Committee recommendations and other available information to determine whether modification of the assessment rate is needed. Further rulemaking would be undertaken as necessary. The Committee's budget for subsequent fiscal periods would be reviewed and, as appropriate, approved by USDA.

Final Regulatory Flexibility Act

Pursuant to requirements set forth in the Regulatory Flexibility Act (RFA) (5 U.S.C. 601–612), the Agricultural Marketing Service (AMS) has considered the economic impact of this final rule on small entities. Accordingly, AMS has prepared this final regulatory flexibility analysis.

The purpose of the RFA is to fit regulatory actions to the scale of businesses subject to such actions in order that small businesses will not be unduly or disproportionately burdened. Marketing orders issued pursuant to the Act are unique in that they are brought about through group action of essentially small entities acting on their own behalf.

There are approximately 1,450 growers and 37 handlers of sweet cherries in the regulated production area subject to regulation under the Order. Small agricultural service firms are defined by the Small Business Administration (SBA) as those having annual receipts of less than $30,000,000, and small agricultural producers are defined as those having annual receipts

of less than $1,000,000 (13 CFR 121.201).

According to data from USDA Market News, the 2018 season average f.o.b. price for Washington sweet cherries was approximately $35.14 per 15-pound carton. The Committee reported that the industry shipped 3,964 tons for the season, which equals approximately 27,394,133 cartons (204,456 tons at a net weight of 15 pounds per carton). Using the number of handlers, and assuming a normal distribution, most handlers would have average annual receipts of more than $30,000,000 ($35.14 times 27,394,133 cartons equals $962,629,845 divided by 37 handlers equals $26,017,022 per handler).

In addition, based on USDA National Agricultural Statistics Service data, the weighted average grower price for the 2018 season was $1,900 per ton of sweet cherries. Based on grower price, shipment data, and the total number of Washington sweet cherry growers, and assuming a normal distribution, the average annual grower revenue is below $1,000,000 ($1,900 times 205,456 tons equals $390,366,400 divided by 1,450 growers equals $269,218 per grower). Thus, most growers of Washington sweet cherries may be classified as small entities, but most of their handlers may be classified as large entities.

This final rule decreases the assessment rate collected from handlers for the 2019–2020 and subsequent fiscal periods from $0.25 to $0.20 per ton of Washington sweet cherries handled. The Committee recommended 2019–2020 fiscal period expenditures of $56,250 and the $0.20 per ton assessment rate with an affirmative vote of 15–1. The one dissenting voter gave no reason for their opposition. The assessment rate of $0.20 is $0.05 lower than the rate for the 2018–2019 fiscal period.

The Committee estimates that the industry will handle 200,000 tons of fresh, Washington sweet cherries during the 2019–2020 fiscal period. Thus, the $0.20 per ton rate should provide $40,000 in assessment income. Income derived from handler assessments, along with $5 interest income and $16,245 from the reserve, will cover all budgeted expenses.

The major expenditures recommended by the Committee for the 2019–2020 fiscal period include $25,000 for program management contract services provided by the Washington State Fruit Commission, $7,250 for administrative expenses, $7,000 for regulation proceedings, $5,000 for data management, $5,000 for research, $4,000 for an annual audit, and $3,000 for travel. In comparison, these major expense categories budgeted for the 2018–2019 fiscal period were $25,000, $6,950, $7,000, $5,000, $5,000, $3,800, and $3,000, respectively.

The lower assessment rate will cover most of the Committee's 2019–2020 fiscal period budgeted expenditures, with the remaining balance to come from the financial reserve. Decreasing the continuing assessment rate and using some funds from the reserve will allow the Committee to fully fund budgeted expenses and bring its financial reserve to a level that is compliant with the Order.

Prior to arriving at this budget and assessment rate, the Committee considered maintaining the current assessment rate of $0.25 per ton. However, after grower input and discussions at the May 8, 2019, meeting, the Committee projected the 2019 crop to be similar in volume to the previous year. This amount of production at the current assessment level of $0.25 per ton would generate enough assessment income to fund the Committee's operations for the 2019–2020 fiscal period, but its financial reserve would be too high and not in compliance with the Order. Based on estimated shipments, the recommended assessment rate of $0.20 per ton of sweet cherries should provide $40,000 in assessment income. The Committee determined assessment revenue will be adequate to cover most of its budgeted expenditures for the 2019–2020 fiscal period, with the remaining balance coming from its financial reserve. Reserve funds will be kept within the amount authorized in the Order.

A review of historical data and preliminary information pertaining to the upcoming fiscal period indicates that the average grower price range for the 2019–2020 season should be approximately $1,598–$3,081 per ton of Washington sweet cherries. Therefore, the estimated assessment revenue for the 2019–2020 fiscal period as a percentage of total grower revenue would be between 0.007 and 0.013 percent.

The Committee's meetings are widely publicized throughout the Washington sweet cherry industry. All interested persons are invited to attend the meetings and participate in Committee deliberations on all issues. Like all Committee meetings, the May 8, 2019, meeting was a public meeting and all entities, both large and small, were able to express views on this issue. Interested persons were invited to submit comments on this rule, including the regulatory and information collection impacts of this action on small businesses.

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Order's information collection requirements have been previously approved by the OMB and assigned OMB No. 0581–0189, Fruit Crops. No changes in those requirements will be necessary because of this action. Should any changes become necessary, they will be submitted to OMB for approval.

This final rule will not impose any additional reporting or recordkeeping requirements on either small or large Washington sweet cherry handlers. As with all Federal marketing order programs, reports and forms are periodically reviewed to reduce information requirements and duplication by industry and public sector agencies. As noted in the final regulatory flexibility analysis, USDA has not identified any relevant Federal rules that duplicate, overlap, or conflict with this final rule.

AMS is committed to complying 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.

A proposed rule concerning this action was published in the **Federal Register** on September 23, 2019 (84 PR 49682). Copies of the proposed rule were provided to all Washington sweet cherry handlers. The proposal was also made available through the internet by USDA and the Office of the Federal Register. A 30-day comment period ending October 23, 2019, was provided for interested persons to respond to the proposal. No comments were received. Accordingly, no changes will be made to the rule as proposed.

A small business guide on complying with fruit, vegetable, and specialty crop marketing agreements and orders may be viewed at: *http://www.ams.usda.gov/rules-regulations/moa/small-businesses.* Any questions about the compliance guide should be sent to Richard Lower at the previously mentioned address in the **FOR FURTHER INFORMATION CONTACT** section.

After consideration of all relevant material presented, including the information and recommendation submitted by the Committee and other available information, it is hereby found that this rule will tend to effectuate the declared policy of the Act.

List of Subjects in 7 CFR Part 923

Marketing agreements, Fruits, Reporting and recordkeeping requirements, Cherries.

For the reasons set forth in the preamble, 7 CFR part 923 is amended as follows:

PART 923—MARKETING ORDER REGULATING THE HANDLING OF SWEET CHERRIES GROWN IN DESIGNATED COUNTIES IN WASHINGTON

Authority: 7 U.S.C. 601–674.

■ 2. Revise 923.236 to read as follows:

§ 923.263 Assessment rate.

On and after April 1, 2019, an assessment rate of $0.20 per ton is established for the Washington Cherry Marketing Committee.

Dated: November 21, 2019.

Bruce Summers,

Administrator, Agricultural Marketing Service.

[FR Doc. 2019–25650 Filed 11–26–19; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Food Safety and Inspection Service

9 CFR Parts 310, 327, 381, 424, 557, and 590

[Docket No. FSIS–2018–0027]

RIN 0583–AD72

Publication Method for Lists of Foreign Countries Eligible To Export Meat, Poultry, or Egg Products to the United States

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: The Food Safety and Inspection Service (FSIS) is amending its regulations to remove lists of foreign countries eligible to export meat, poultry, and egg products to the United States. FSIS will maintain a single list of eligible foreign countries on its website. The criteria FSIS uses to evaluate whether a foreign country is eligible to export meat, poultry, or egg products has not changed. This rule will allow FSIS to more efficiently and clearly communicate equivalence determinations by maintaining a single list of exporting countries on its website, rather than maintaining one list on the website and outdated lists in the codified regulations. In addition, the Agency is amending it regulations to remove references to the lists.

DATES: Effective December 27, 2019.

FOR FURTHER INFORMATION CONTACT: Terri Nintemann, Assistant Administrator, Office of Policy and Program Development; Telephone: (202) 720–0089.

SUPPLEMENTARY INFORMATION:

Background

On April 12, 2019, FSIS proposed to amend its regulations to remove lists of foreign countries eligible to export meat, poultry, or processed egg products to the United States and, instead, maintain such lists on its website (84 FR 14894). The proposal noted that it did not include any changes to the criteria FSIS uses to evaluate whether a foreign country is eligible. The proposal also described how removing the lists from the regulations would affect FSIS's process for implementing equivalence determinations. Instead of publishing proposed and final rules in the **Federal Register**, FSIS will now implement equivalence determinations through **Federal Register** notices with requests for public comment. FSIS will respond to public comments in any **Federal Register** notice that finalizes an equivalence determination. FSIS will also use this process when it is necessary to terminate the eligibility of a foreign country. This final rule will allow FSIS to convey more clearly information on countries' equivalence status. Once the rule is in place, the list posted on the website will not conflict with any outdated information in the **Federal Register**. In addition to removing the lists from the regulations, the Agency proposed to amend six parts of 9 CFR Chapter III (310, 327, 381, 424, 557, 590) to remove references to the lists.

After reviewing comments on the proposed rule, FSIS is finalizing it without changes, except for non-substantive changes, for clarity, to the regulatory language proposed for 9 CFR 327.2(b).

Responses to Comments

FSIS received 15 comments, from 13 individuals, an industry association representing egg processors, and a consumer advocacy organization. The issues raised in the comments and the Agency responses are summarized below.

Comments: FSIS received comments relating to the use of online lists. One individual questioned the use of online lists as potentially confusing or difficult to locate by stakeholders. Another recommended that FSIS ensure that the online lists are updated soon after determinations are finalized. The consumer advocacy organization believed that keeping equivalence determinations on FSIS's website could invite hacking or mistakes and expressed concern that some individuals do not have access to the internet.

Response: FSIS does not believe these concerns warrant reconsideration of the use of online lists. This rule's amendments to the Code of Federal Regulations (CFR) direct readers to the web address where FSIS maintains the list, *www.fsis.usda.gov/importlibrary.* FSIS will additionally publish notice of equivalence determinations in the **Federal Register** and include links to these determinations in its *Constituent Update,* which is posted weekly on FSIS's website. FSIS will ensure that its web content managers update the online lists shortly after any final determination is published in the **Federal Register**. FSIS's website is protected to ensure that only authorized users may gain access or make changes. The system keeps track of past versions, which may be restored if needed. Therefore, no hacking event could permanently alter the entries on the lists.

Comments: The industry group supported the proposed rule, but urged FSIS not to weaken its equivalence standards, reduce opportunities for public participation, or make any currently public aspects of the equivalence process non-public. It also urged FSIS to be more transparent in its investigations, audits, and determinations and ensure that the offices of the Under Secretary for Food Safety and the Secretary of Agriculture provide oversight for equivalence determinations. The consumer advocacy organization opposed the proposed rule as undermining the importance of equivalence determinations.

Response: Under this final rule, FSIS is not changing its equivalence standards or opportunities for public comment. FSIS will continue to maintain the same level of transparency in these determinations by publishing its on-site audit reports and allowing for public comment on preliminary equivalence determinations. The offices of the Under Secretary for Food Safety and the Secretary of Agriculture currently review every preliminary and final equivalence determination made by FSIS and will continue to do so under this final rule.

Comments: The industry group also recommended that FSIS create specific regulatory requirements establishing a comment period for **Federal Register** notices of equivalence determinations and a provision mandating that the Agency will respond to comments in the **Federal Register**. The consumer advocacy organization advocated for a 60-day comment period for all

equivalence determinations, and a minimum 30-day period for any rulemaking that removes a country's equivalence.

Response: Consistent with other Federal agencies, FSIS regulations do not establish length of comment periods for any proposal rules. The Agency will retain flexibility to set and extend comment periods as needed to adequately receive and consider public feedback. Also, consistent with other Federal agencies, FSIS regulations do not state that FSIS will respond to public comments in a second **Federal Register** notice. That being said, after a preliminary equivalence determination, FSIS will publish a **Federal Register** notice, including the response to public comments, to finalize (or decline to finalize) any equivalence determination.

Comment: The industry group sought clarification with regard to the FSIS's proposal to amend the current version of the regulations at 9 CFR 590.910 to remove the list of foreign countries eligible to export processed egg products to the United States and instead refer to the list of countries eligible to export on the FSIS website. As FSIS explained in Footnote 2 of the proposed rule, FSIS already had proposed to revise § 590.910 of the regulations in an earlier proposed rule concerning egg products (83 FR 6314, February 13, 2018), but only for more consistency with the existing regulations for meat and poultry.

Response: FSIS proposed to amend the version of § 590.910 in effect at the time. Because the February 2018 proposed rule regarding egg products has not been made final, those regulations are still in effect. FSIS is thus amending those regulations, as proposed. If the February 2018 rulemaking is made final, its version of § 590.910 will incorporate the changes made by this final rule regarding the listing of foreign countries with equivalent egg products inspection systems.

Comment: The consumer advocacy organization sought clarification on the time period before a country would be listed as inactive on FSIS's website.

Response: FSIS states on its website and in instructions to Agency personnel that, after three or more years without shipping, a country will be considered ''inactive'' and must apply for a reinstatement of equivalence. See FSIS Directive 9770.1, *Determining Initial and Reinstating the Equivalence of Foreign Food Safety Inspection Systems.* Therefore, consistent with current practice, if a country does not ship for three years, FSIS will move the country to the ''inactive'' chart on the FSIS website.

Comment: An individual commenter asked how the rule would promote efficiency and if there were other costs to FSIS.

Response: As FSIS explained in the economic analysis, the change in publication method will not create additional costs to FSIS, which will continue to implement equivalence determinations through the **Federal Register**. Similarly, there will not be additional costs for industry or foreign countries seeking to export to the United States. This final rule will allow FSIS to more efficiently propose and finalize equivalence determinations without changing the substantive criteria or level of evaluation of foreign food safety systems. This will save staff time and allow FSIS's list of exporting countries to more quickly reflect changes in foreign counties' equivalence status. FSIS will also gain efficiency by maintaining a single list of exporting countries on its website, rather than maintaining one list on the website and a separate list in the codified regulations.

Comments: The industry group urged FSIS to apply stricter scrutiny to foreign food safety systems. It also expressed concern about whether the processed egg products system in the Netherlands is genuinely equivalent to the U.S. system. An individual commenter suggested that imported meat and poultry products be monitored and tested for safety by the FDA.

Response: These comments are outside the scope of this rulemaking, which focuses solely on the publication method of lists of foreign countries eligible to export meat, poultry, and egg products to the United States.

Executive Orders 12866 and 13563

Executive Orders (E.O.s) 12866 and 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This final rule has been designated as a ''non-significant'' regulatory action under section 3(f) of E.O. 12866. Accordingly, the rule has not been reviewed by the Office of Management and Budget under E.O. 12866.

Expected Costs of the Final Rule

This final rule doesn't change the requirements for importing meat, poultry, and egg products to the United States. FSIS will continue to determine whether a foreign country's food safety inspection system for meat, poultry, or egg products is equivalent to FSIS's inspection system. FSIS will announce the results of equivalence determinations through a notice with a request for comments in the **Federal Register**, rather than a proposed rule. In addition, FSIS will continue to assess the costs and benefits of new countries becoming eligible to ship product to the United States. This change in procedure will not alter U.S. production, imports, or consumption; therefore, FSIS does not expect a change in U.S. consumer price due to this final rule. The change in procedure is also not expected to add any additional cost to the countries applying for eligibility to import meat, poultry, and egg products to the United States, nor does it add costs to FSIS, or the U.S. meat, poultry, or egg products industries.

Expected Cost Savings and Benefits of the Final Rule

While there are no additional costs associated with this final rule, the benefit from the final rule is an increase in the efficient use of FSIS resources. FSIS will continue to use the **Federal Register** to receive and respond to public comments on equivalence determinations, but the notice process will allow FSIS to more efficiently propose and finalize equivalence determinations. FSIS expects that the notice process will take less time than the current rulemaking process. FSIS will also gain efficiency by maintaining a single list of exporting countries on its website, rather than maintaining one list on the website and separate lists in the codified regulations.

Regulatory Flexibility Act Assessment

The FSIS Administrator certifies that, for the purposes of the Regulatory Flexibility Act (5 U.S.C. 601–602), this final rule will not have a significant economic impact on a substantial number of small entities in the United States. Under this final rule, the requirements for importing meat, poultry, and egg products to the United States will not change. Thus, no market effect is expected from this final rule. Small entities, therefore, will not bear additional costs, as market factors remain unchanged.

Executive Order 13771

Consistent with E.O. 13771 (82 FR 9339, February 3, 2017), FSIS has

estimated that this final rule will yield cost savings. Therefore, this final rule is an E.O. 13771 deregulatory action.

Paperwork Reduction Act

FSIS has reviewed the paperwork and recordkeeping requirements in this final rule in accordance with the Paperwork Reduction Act (44 U.S.C. 3501, *et seq.*). Foreign countries seeking to export meat, poultry, or egg products to the United States are required to provide information to FSIS certifying that their inspection systems provide standards equivalent to those of the United States, and that the legal authority for the system and their implementing regulations are equivalent to those of the United States. FSIS provides countries with questionnaires asking for detailed information about the country's inspection practices and procedures to assist that country in organizing its materials. This information collection was approved under OMB control number 0583–0094. This final rule only affects FSIS's methods of proposing and finalizing equivalence determination after the Agency has made a preliminary determination. It contains no new or expanded paperwork requirements.

Executive Order 12988, Civil Justice Reform

This final rule has been reviewed under Executive Order 12988, Civil Justice Reform. Under this rule: (1) All State and local laws and regulations that are inconsistent with this rule will be preempted; (2) no retroactive effect will be given to this rule; and (3) no administrative proceedings will be required before parties may file suit in court challenging this rule.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not a ''major rule,'' as defined by 5 U.S.C. 804(2).

E-Government Act

FSIS and USDA are committed to achieving the purposes of the E-Government Act (44 U.S.C. 3601, *et seq.*) by, among other things, promoting the use of the internet and other information technologies and providing increased opportunities for citizen access to Government information and services, and for other purposes.

Executive Order 13175

This rule has been reviewed in accordance with the requirements of Executive Order 13175, ''Consultation and Coordination with Indian Tribal Governments.'' E.O. 13175 requires Federal agencies to consult and coordinate with tribes on a government-to-government basis on policies that have tribal implications, including regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects 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.

FSIS has assessed the impact of this rule on Indian tribes and determined that this rule does not, to our knowledge, have tribal implications that require tribal consultation under E.O. 13175. If a Tribe requests consultation, the Food Safety and Inspection Service will work with the Office of Tribal Relations to ensure meaningful consultation is provided where changes, additions and modifications identified herein are not expressly mandated by Congress.

USDA Non-Discrimination Statement

No agency, officer, or employee of the USDA shall, on the grounds of race, color, national origin, religion, sex, gender identity, sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, or political beliefs, exclude from participation in, deny the benefits of, or subject to discrimination any person in the United States under any program or activity conducted by the USDA.

How To File a Complaint of Discrimination

To file a complaint of discrimination, complete the USDA Program Discrimination Complaint Form, which may be accessed online at *http://www.ocio.usda.gov/sites/default/files/docs/2012/Complain_combined_6_8_12.pdf,* or write a letter signed by you or your authorized representative.

Send your completed complaint form or letter to USDA by mail, fax, or email:

Mail: U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue SW, Washington, DC 20250–9410
Fax: (202) 690–7442
Email: program.intake@usda.gov

Persons with disabilities who require alternative means for communication (Braille, large print, audiotape, etc.), should contact USDA's TARGET Center at (202) 720–2600 (voice and TDD).

Additional Public Notification

Public awareness of all segments of rulemaking and policy development is important. Consequently, FSIS will announce this **Federal Register** publication on-line through the FSIS web page located at: *http://www.fsis.usda.gov/federal-register.*

FSIS will also announce and provide a link to it through the FSIS *Constituent Update,* which is used to provide information regarding FSIS policies, procedures, regulations, **Federal Register** notices, FSIS public meetings, and other types of information that could affect or would be of interest to our constituents and stakeholders. The *Constituent Update* is available on the FSIS web page. Through the web page, FSIS is able to provide information to a much broader, more diverse audience. In addition, FSIS offers an email subscription service which provides automatic and customized access to selected food safety news and information. This service is available at: *http://www.fsis.usda.gov/subscribe.* Options range from recalls to export information, regulations, directives, and notices. Customers can add or delete subscriptions themselves, and have the option to password protect their accounts.

List of Subjects

9 CFR Part 310

Animal diseases, Meat inspection.

9 CFR Part 327

Food labeling, Food packaging, Imports, Meat inspection.

9 CFR Part 381

Administrative practice and procedure, Animal diseases, Crime, Exports, Food grades and standards, Food labeling, Food packaging, Government employees, Grant programs-agriculture, Intergovernmental relations, Laboratories, Meat inspection, Nutrition, Polychlorinated biphenyls (PCB's), Poultry and poultry products, Reporting and recordkeeping requirements, Seizures and forfeitures, Signs and symbols, Technical assistance, Transportation.

9 CFR Part 424

Food additives, Food packaging, Meat inspection, Poultry and poultry products.

9 CFR Part 557

Fish, Food grades and standards, Food labeling, Food packaging, Imports, Seafood.

9 CFR Part 590

Eggs and egg products, Exports, Food grades and standards, Food labeling, Imports, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, FSIS is amending 9 CFR Chapter III as follows:

PART 310—POST-MORTEM INSPECTION

■ 1. The authority citation for part 310 continues read as follows:

Authority: 21 U.S.C. 601–695; 7 CFR 2.18, 2.53.

■ 2. In § 310.22, revise paragraph (d)(1)(i) to read as follows:

§ 310.22 Specified risk materials from cattle and their handling and disposition.

* * * * *

(d) * * *

(1) * * *

(i) It is derived from cattle that were inspected and passed in an official establishment in the United States or in a certified foreign establishment in a country eligible to export meat and meat products to the United States under 9 CFR 327.2(b) and it is otherwise eligible for importation under 9 CFR 327.1(b), and

* * * * *

PART 327—IMPORTED PRODUCTS

■ 3. The authority citation for part 327 continues to read as follows:

Authority: 21 U.S.C. 601–695; 7 CFR 2.18, 2.53.

§ 327.2 [Amended]

■ 4. In § 327.2:

■ a. Remove the phrase ''by including the name of such foreign country in'' and add in its place ''in accordance with'' in paragraph (a)(1);

■ b. Revise paragraphs (a)(4) and (b); and

■ c. Remove paragraph (c).

The revisions read as follows:

§ 327.2 Eligibility of foreign countries for importation of products into the United States.

(a) * * *

(4) Meat and meat food products from foreign countries not deemed eligible in accordance with paragraph (b) of this section are not eligible for importation into the United States, except as provided by § 327.16 or § 327.17. Eligibility of any foreign country under this section may be withdrawn whenever the Administrator determines that the system of meat inspection maintained by such foreign country does not assure compliance with requirements equivalent to all the inspection, building construction standards, and other requirements of the Act and the regulations in this subchapter as applied to official establishments in the United States; or that reliance cannot be placed upon certificates required under this part from authorities of such foreign country; or that, for lack of current information concerning the system of meat inspection being maintained by such foreign country, such foreign country should be required to reestablish its eligibility.

(b) A list of countries eligible to export specific process categories of meat and meat food products is maintained at *http://www.fsis.usda.gov/importlibrary.* Meat and meat food products from listed countries must be accompanied by foreign inspection certificates of the country of origin, as required by § 327.4, and are eligible under the regulations in this subchapter for entry into the United States after inspection and marking as required by the applicable provisions of this part. Fresh, chilled, or frozen or other product from countries in which rinderpest, foot-and-mouth disease or African swine fever exist, as provided in part 94 of this title, are ineligible for importation into the United States.

PART 381—POULTRY PRODUCTS INSPECTION REGULATIONS

■ 5. The authority citation for part 381 continues to read as follows:

Authority: 7 U.S.C. 138f, 450; 21 U.S.C. 451–470; 7 CFR 2.7, 2.18, 2.53.

§ 381.145 [Amended]

■ 6. In § 381.145, amend paragraph (a) by removing the phrase ''listed in § 381.196(b),'' and adding in its place ''eligible to export such poultry and poultry products to the United States under § 381.196(b),''.

■ 7. In § 381.195, revise paragraph (c) to read as follows:

§ 381.195 Definitions; requirements for importation into the United States.

* * * * *

(c) Except as provided in § 381.207, slaughtered poultry and other poultry products may be imported only if they were processed solely in countries found eligible to export poultry products to the United States under § 381.196(b). Slaughtered poultry may be imported only if it qualifies as ready-to-cook poultry.

§ 381.196 [Amended]

■ 8. Amend § 381.196 as follows:

■ a. In paragraph (a)(1), remove the phrase ''by including the name of such foreign country in'' and add in its place ''in accordance with''; and

■ b. Revise paragraphs (a)(4) and (b).

The revisions read as follows:

§ 381.196 Eligibility of foreign countries for importation of poultry products into the United States.

(a) * * *

(4) Poultry products from foreign countries not deemed eligible in accordance with paragraph (b) of this section may not be imported into the United States, except as provided by §§ 381.207 and 381.209. Eligibility of any foreign country under this section may be withdrawn whenever the Administrator determines that the system of poultry inspection maintained by such foreign country does not assure compliance with requirements equivalent to all the requirements of the Act and the regulations as applied to official establishments in the United States; or that reliance cannot be placed upon certificates required under this subpart from authorities of such foreign country; or that, for lack of current information concerning the system of poultry inspection being maintained by such foreign country, such foreign country should be required to reestablish its eligibility.

(b) A list of countries eligible to export specific process categories of poultry products to the United States is maintained at *http://www.fsis.usda.gov/importlibrary.* Such products from listed countries must be accompanied by inspection certificates of the country of origin, as required by § 381.197, and are eligible under the regulations in this subpart for entry into the United States, after inspection and marking as required by the applicable provisions of this subpart.

PART 424—PREPARATION AND PROCESSING OPERATIONS

■ 9. The authority citation for part 424 continues to read as follows:

Authority: 7 U.S.C. 138f, 450; 21 U.S.C. 451–470; 7 CFR 2.7, 2.18, 2.53.

§ 424.21 [Amended]

■ 10. Amend § 424.21 as follows:

■ a. In paragraph (a)(2)(i), remove the phrase ''listed in'' and add in its place ''determined to be eligible to export such products to the United States under''; and

■ b. In paragraph (a)(3), remove the phrase ''listed in'' and add in its place ''determined to be eligible to export such products to the United States under''.

PART 557—IMPORTATION

■ 11. The authority citation for part 557 continues to read as follows:

Authority: 21 U.S.C. 601–602, 606–622, 624–695; 7 CFR 2.7, 2.18, 2.53.

■ 12. In § 557.2, revise paragraph (b) to read as follows:

§ 557.2 Eligibility of foreign countries for importation of fish and fish products into the United States.

* * * * *

(b) The countries eligible to export specific process categories of fish and fish products are listed at *http://www.fsis.usda.gov/importlibrary.* Such products must be covered by foreign inspection certificates of the country of origin as required by § 557.4. Products from such countries are eligible under the regulations in this subchapter for entry into the United States after inspection and marking as required by the applicable provisions of this part.

PART 590—INSPECTION OF EGGS AND EGG PRODUCTS (EGG PRODUCTS INSPECTION ACT)

■ 13. The authority citation for part 590 continues to read as follows:

Authority: 21 U.S.C. 1031–1056.

■ 14. Revise § 590.910 to read as follows:

§ 590.910 Eligibility of foreign countries for importation of egg products into the United States.

(a) Whenever it is determined by the Administrator that the system of egg products inspection maintained by any foreign country is such that the egg products produced in such country are processed, labeled, and packaged in accordance with, and otherwise comply with, the standards of the Act and these regulations including, but not limited to the same sanitary, processing, facility requirements, and continuous Government inspection as required in §§ 590.500 through 590.580 applicable to inspected articles produced within the United States, notice of that fact will be given according to paragraph (b) of this section. Thereafter, egg products from such countries shall be eligible for importation into the United States, subject to the provisions of this part and other applicable laws and regulations. Such products must meet, to the extent applicable, the same standards and requirements that apply to comparable domestic products as set forth in these regulations. Egg products from foreign countries not deemed eligible in accordance with paragraph (b) of this section are not eligible for importation into the United States, except as provided by § 590.960. In determining if the inspection system of a foreign country is the equivalent of the system maintained by the United States, the Administrator shall review the *COM007*inspection regulations of the foreign country and make a survey to determine the manner in which the inspection system is administered within the foreign country. The survey of the foreign inspection system may be expedited by payment by the interested Government agency in the foreign country of the travel expenses incurred in making the survey. After approval of the inspection system of a foreign country, the Administrator may, as often and to the extent deemed necessary, authorize representatives of the Department to review the system to determine that it is maintained in such a manner as to be the equivalent of the system maintained by the United States.

(b) A list of countries eligible to export egg products to the United States is maintained at *http://www.fsis.usda.gov/importlibrary.*

Done at Washington, DC.

Carmen M. Rottenberg,

Administrator.

[FR Doc. 2019–25750 Filed 11–26–19; 8:45 am]

BILLING CODE 3410–DM–P

FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 327

RIN 3064–AF16

Assessments

AGENCY: Federal Deposit Insurance Corporation (FDIC).

ACTION: Final rule.

SUMMARY: The Federal Deposit Insurance Corporation (FDIC) is amending the deposit insurance assessment regulations that govern the use of small bank assessment credits (small bank credits) and one-time assessment credits (OTACs) by certain insured depository institutions (IDIs). Under this final rule, now that the FDIC is applying small bank credits to quarterly deposit insurance assessments, such credits will continue to be applied as long as the Deposit Insurance Fund (DIF) reserve ratio is at least 1.35 percent (instead of, as originally provided, 1.38 percent). In addition, after small bank credits have been applied for four quarterly assessment periods, and as long as the reserve ratio is at least 1.35 percent, the FDIC will remit the full nominal value of any remaining small bank credits in lump-sum payments to each IDI holding such credits in the next assessment period in which the reserve ratio is at least 1.35 percent, and will simultaneously remit the full nominal value of any remaining OTACs in lump-sum payments to each IDI holding such credits.

DATES: This final rule is effective November 27, 2019, and is applicable beginning July 1, 2019 (the third quarterly assessment period of 2019).

FOR FURTHER INFORMATION CONTACT: Ashley Mihalik, Chief, Banking and Regulatory Policy Section, Division of Insurance and Research, (202) 898–3793, *amihalik@FDIC.gov;* Jithendar Kamuni, Manager, Assessment Operations Section, (703) 562–2568, *jikamuni@FDIC.gov;* Samuel B. Lutz, Counsel, Legal Division, (202) 898–3773, *salutz@FDIC.gov.*

SUPPLEMENTARY INFORMATION:

I. Policy Objectives

The FDIC maintains and administers the DIF in order to assure the agency's capacity to meet its obligations as the insurer of deposits and receiver of failed IDIs.[1] The FDIC considers the adequacy of the DIF in terms of the reserve ratio, which is equal to the DIF balance divided by estimated insured deposits. A higher reserve ratio reduces the risk that losses from IDI failures during an economic downturn will exhaust the DIF and also reduces the risk of large, pro-cyclical increases in deposit insurance assessments to maintain a positive DIF balance during such a downturn.

The FDIC is amending its regulations governing the use of small bank credits and OTACs.[2] As originally adopted, the regulations provided that after the reserve ratio reached or exceeded 1.38 percent, and provided that it remained at or above 1.38 percent,[3] the FDIC would automatically apply small bank credits up to the full amount of the IDI's credits or quarterly assessment, whichever is less.[4] Under the final rule,

[1] As used in this final rule, the term ''insured depository institution'' has the same meaning as the definition used in Section 3 of the Federal Deposit Insurance Act (FDI Act), 12 U.S.C. 1813(c)(2).

[2] *See* 12 CFR 327.11(c) (use of small bank credits) and 12 CFR 327.35 (use of OTACs).

[3] *See* 83 FR 14565 (April 5, 2018) (making technical amendments to FDIC's assessment regulations, including an amendment clarifying that small bank credits will be applied in assessment periods in which the reserve ratio is at least 1.38 percent).

[4] After the initial notice of an IDI's assessment credit balance, and the manner in which the credit was calculated, periodic updated notices will be provided to reflect adjustments that may be made as the result of credit use, request for review of credit amounts, any subsequent merger or consolidation. Under the rule, such notices will also reflect adjustments that may be made as a result of an IDI's amendment to its quarterly Consolidated Reports of Condition and Income or

Continued

the FDIC will continue to apply small bank credits if the reserve ratio falls below 1.38 percent, as long as it does not fall below the statutory minimum reserve ratio of 1.35 percent. The FDIC will remit the full nominal value of any remaining small bank credits after such credits have been applied for four quarterly assessment periods. At the same time that any remaining small bank credits are remitted, the FDIC will also remit the full nominal value of any remaining OTACs, issued under section 7(e)(3) of the FDI Act, to IDIs holding such credits.[5]

The primary objective of this rule is to make the application of small bank credits to IDIs' quarterly assessments more predictable, and to simplify the FDIC's administration of small bank credits, without materially impairing the ability of the FDIC to maintain the required minimum reserve ratio of 1.35 percent. The rule affects the timing of when small bank credits would be applied to an IDI's quarterly assessment, but it does not change the aggregate amount of credits that banks have been awarded. Based on data from Consolidated Reports of Condition and Income and quarterly Reports of Assets and Liabilities of U.S. Branches and Agencies of Foreign Banks (together, ''quarterly regulatory reports''), as of June 30, 2019, the aggregate amount of small bank credits, $764.5 million, represented less than one basis point of the reserve ratio. For the initial quarter in which small bank credits were applied, and for each future quarter of application, such credits represent less than one-half of one basis point of the reserve ratio.

In the FDIC's view, these changes lessen the likelihood that application of small bank credits would be suspended due to small variations in the reserve ratio. In particular, the rule lessens the likelihood that such credits would be applied in a quarter when the reserve ratio is at or above 1.38 percent and then immediately suspended in the next quarter if the reserve ratio falls below 1.38 percent. The rule is expected to result in more stable and predictable application of credits to quarterly assessments, permitting IDIs to better budget for their assessment cash flow, and could benefit certain IDIs that might realize the full value of their credits at an earlier date.

Additionally, the final rule simplifies the FDIC's administration of the DIF from an operational perspective. While the rule affects the timing of DIF revenues by reducing the period of time during which small bank credits are applied, the long-term adequacy of the DIF is not impacted because the total amount of credits awarded does not change.

An additional objective of the rule is to establish a reasonable time period during which the FDIC will administer the application of credits for the small bank credit program and the OTAC program. The FDIC will accomplish this by remitting, after four quarterly assessment periods, any remaining small bank credits and OTACs in lump-sum payments to each IDI holding such credits in the next quarterly assessment period in which the reserve ratio is at least 1.35 percent. The FDIC will then conclude both credit programs. This change will accelerate the time at which IDIs will receive the benefit of such credits and will permit more efficient administration of the DIF on a going-forward basis.

II. Background

A. Small Bank Assessment Credits

The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), which raised the minimum reserve ratio for the DIF to 1.35 percent (from the former minimum of 1.15 percent), required the FDIC to ''offset the effect of the increase in the minimum reserve ratio on insured depository institutions with total consolidated assets of less than $10 billion'' when setting assessments.[6] To offset the effect of increasing the minimum reserve ratio on IDIs with total consolidated assets of less than $10 billion (small IDIs), on March 25, 2016, the FDIC published a final rule (the 2016 final rule) that, among other things, provided assessment credits to small IDIs for the portion of their regular assessments that contributed to the growth in the reserve ratio between 1.15 percent and 1.35 percent.[7] Pursuant to the 2016 final rule, upon reaching the statutory minimum reserve ratio of 1.35 percent, small IDIs were awarded small bank credits for the portion of their assessments that contributed to the growth in the reserve ratio from 1.15 percent to 1.35 percent.[8] The regulations provided that these small bank credits would be applied to quarterly deposit insurance assessments when the reserve ratio is at least 1.38 percent.[9]

As of September 30, 2018, the DIF reserve ratio reached 1.36 percent, exceeding the statutorily required minimum reserve ratio of 1.35 percent. All IDIs that were small IDIs, including small IDI affiliates of large IDIs, at any time during the ''credit calculation period'' [10] were awarded a share of credits in January 2019.[11] As of June 30, 2019, the DIF reserve ratio reached 1.40 percent, exceeding the 1.38 percent threshold for the first time. As a result, for the second quarter assessment period, the FDIC applied $319.7 million of small bank credits to offset IDIs' assessments. After applying credits for the second quarter of 2019, $444.8 million in small bank credits remain.[12]

The share of the aggregate small bank credits allocated to each IDI was proportional to its credit base, defined as the average of its regular assessment base during the credit calculation period.[13] [14] IDIs eligible to receive a credit were notified of their individual credit allocation in January 2019 via FDIC*connect.* The FDIC will provide IDIs with periodic notices to reflect adjustments that may be made as the result of credit use or acquisition of an IDI with credits through merger or consolidation.[15]

quarterly Reports of Assets and Liabilities of U.S. Branches and Agencies of Foreign Banks (as applicable).

[5] *See* 12 U.S.C. 1817(e)(3); *see also* 12 CFR part 327, subpart B.

[6] Public Law 111–203, 334(e), 124 Stat. 1376, 1539 (12 U.S.C. 1817 (note)).

[7] *See* 81 FR 16059 (Mar. 25, 2016).

[8] *See* 81 FR 16065–16066.

[9] 12 CFR 327.11(c)(11).

[10] The ''credit calculation period'' covers the period beginning July 1, 2016 (the quarter after the reserve ratio first reached or exceeded 1.15 percent) through September 30, 2018 (the quarter in which the reserve ratio first reached or exceeded 1.35 percent). *See* 12 CFR 327.11(c)(2).

[11] If a small IDI acquired another small IDI through merger or consolidation during the credit calculation period, the acquiring small IDI's regular assessment bases for purposes of determining its credit base included the acquired IDI's regular assessment bases for those quarters during the credit calculation period that were before the merger or consolidation. *See* 12 CFR 327.11(c)(5).

[12] In January 2019, aggregate credits of $764.7 million were awarded to 5,381 institutions. As of June 30, 2019, due to mergers, IDI failures, and voluntary liquidations, 5,215 remaining institutions had credits totaling $764.5 million. Since then, the FDIC has applied $319.7 million of small bank credits, reducing the aggregate amount of remaining small bank credits to $444.8 million.

[13] Individual shares of credits were adjusted so that the assessment credits awarded to an eligible institution would not exceed the total amount of quarterly deposit insurance assessments paid by the institution during the credit calculation period in which it was a credit accruing institution. The adjusted amount was then reallocated to the other credit accruing institutions. *See* 12 CFR 327.11(c)(4)(iii).

[14] *See* 12 CFR 327.11(c)(4).

[15] If any IDI acquires an IDI with credits through merger or consolidation, the acquiring IDI will acquire any remaining small bank credits of the acquired institution. *See* 12 CFR 327.11(c)(9). Other than through merger or consolidation, credits are not transferrable. *See* 12 CFR 327.11(c)(12). Credits held by an IDI that fails or ceases to be an insured depository institution will expire.

B. One-Time Assessment Credits

The Federal Deposit Insurance Reform Act of 2005 (FDI Reform Act) required the FDIC to provide OTACs to IDIs that existed on December 31, 1996, and paid a deposit insurance assessment prior to that date, or that were successors to such an institution.[16] [17] The purpose of the OTAC, which was described as a ''transitional'' credit when it was enacted, was to recognize the contributions that certain institutions made to capitalize the Bank Insurance Fund and Savings Association Insurance Fund, which had been recently merged into the Deposit Insurance Fund.[18] In October 2006, the FDIC adopted a final rule implementing the OTAC required by the FDI Reform Act.[19] The aggregate amount of the OTAC was estimated to be approximately $4.7 billion. The FDIC began to apply OTACs to offset an IDI's quarterly deposit insurance assessments beginning with the first assessment period of 2007. As of June 30, 2019, only two IDIs have outstanding OTACs totaling approximately $300,000. The assessment bases of these two IDIs have decreased significantly since December 31, 1996, which was the date used to calculate assessment bases when awarding OTACs to each eligible IDI. Based on the assessment bases of the two IDIs reported as of June 30, 2019, the FDIC estimates that application of the OTACs could continue for more than 13 years.

C. The Proposed Rule

On August 20, 2019, the FDIC Board approved a Notice of Proposed Rulemaking (NPR) to amend the deposit insurance assessment regulations that govern the use of small bank assessment credits and OTACs by certain IDIs.[20] Under the proposed rule, the FDIC would continue to apply small bank credits if the reserve ratio falls below 1.38 percent, as long as it does not fall below the statutory minimum reserve ratio of 1.35 percent. The FDIC proposed to remit the full nominal value of any remaining small bank credits after such credits had been applied for eight quarterly assessment periods. At the same time that any remaining small bank credits are remitted, the FDIC also proposed to remit the full nominal value of any remaining OTACs, issued under section 7(e)(3) of the FDI Act, to IDIs holding such credits. The FDIC received two comments on the NPR. The comments are discussed in the relevant sections below.

III. The Final Rule

A. Summary

The FDIC received two comments from trade associations in response to the NPR. Both commenters generally supported the proposed rule. After careful consideration of all of the comments received, the FDIC is finalizing the rule as proposed with one modification to the amount of time during which the FDIC will apply small bank credits before remitting any remaining balances of such credits and OTACs to IDIs. With respect to that aspect of the rule, the FDIC is adopting an alternative proposed in the NPR. Under the alternative and this final rule, the FDIC will remit any remaining balance of small bank credits and OTACs to IDIs after small bank credits have been applied for four quarterly assessment periods, instead of eight assessment periods as proposed in the NPR. The FDIC applied small bank credits for the assessment period ending June 30, 2019, the first quarter that the reserve ratio was at least 1.38 percent. Pursuant to this final rule, and as proposed in the NPR, the FDIC will continue to apply small bank credits as long as the DIF reserve ratio is at least 1.35 percent. After small bank credits have been applied for four quarterly assessment periods (rather than after eight quarterly assessment periods, as proposed in the NPR), the FDIC will remit the full amount of any remaining small bank credits in lump-sum payments to each IDI holding such credits in the next quarterly assessment period in which the reserve ratio is at least 1.35 percent. Also, as proposed in the NPR, at the same time that any remaining small bank credits are remitted, the FDIC also will remit the nominal value of any remaining OTACs in lump-sum payments to each IDI holding such credits. Finally, the final rule allows for the recalculation of credits applied each quarter as a result of subsequent amendments to the quarterly regulatory reports.

The primary objective of this rule is to make the application of small bank credits to quarterly assessments more predictable for IDIs with these credits, and to simplify the FDIC's administration of these credits, without materially impairing the ability of the FDIC to maintain the required minimum reserve ratio of 1.35 percent. The final rule is effective upon publication in the **Federal Register** with an application date of July 1, 2019 (the beginning of the third quarter assessment period).

B. Application of Small Bank Credits as Long as Reserve Ratio Is at or Above 1.35 Percent

As proposed in the NPR, the final rule amends the deposit insurance assessment regulations to suspend the application of small bank credits to an IDI's deposit insurance assessment when the reserve ratio is below 1.35 percent (instead of 1.38 percent, as originally provided). The rule also allows for the recalculation of credits applied each quarter as a result of subsequent amendments to quarterly regulatory reports.[21]

In the FDIC's view, the final rule results in more predictable application of credits to quarterly assessments and simplifies the FDIC's administration of the DIF. Otherwise, a small change in the reserve ratio—caused by, for example, insured deposit growth, changing interest rates, or losses from bank failures—could cause the reserve ratio to fluctuate one basis point above or below 1.38 percent. This uncertainty would make it difficult for IDIs with small bank credits to predict each quarter whether their deposit insurance assessments would be offset by credits, and would complicate the FDIC's ability to administer the DIF.

As explained in the NPR, the changes pursuant to this final rule will not materially impair the ability of the FDIC to maintain the required minimum reserve ratio of 1.35 percent. In the 2016 final rule, the FDIC noted that ''allowing credit use only when the reserve ratio is at or above 1.38 percent should provide sufficient cushion for the DIF to remain above 1.35 percent in the event of rapid growth in insured deposits and ensure that credit use alone will not result in the reserve ratio falling below 1.35 percent. Allowing credit use before the reserve ratio reaches this level, however,

[16] The FDI Reform Act was included as Title II, Subtitle B, of the Deficit Reduction Act of 2005, Public Law 109–171, 2107(a), 120 Stat. 4, 18 (12 U.S.C. 1817(e)(3)).

[17] By statute, the aggregate amount of credits equaled the amount that would have been collected if the FDIC had imposed a 10.5 basis point assessment on the combined assessment base of the Bank Insurance Fund and the Savings Association Insurance Fund as of December 31, 2001. *See* 12 U.S.C. 1817(e)(3)(B). Individual shares were required to be based on the ratio of the institution's assessment base on December 31, 1996, to the aggregate assessment base of all eligible IDIs on that date. *See* 12 U.S.C. 1817(e)(3)(A).

[18] *See* H.R. Rep., No. 109–362, at 197 (Conf. Rep.); 71 FR 61374, 61381 (Oct. 18, 2006).

[19] 71 FR 61375; 12 CFR part 327, subpart B (12 CFR 327.30 *et seq.*).

[20] 84 FR 45443 (Aug. 29, 2019).

[21] This aspect of the rule addresses the use of credits once the DIF reserve ratio reaches 1.38 percent and the FDIC begins to apply credits to an institution's regular quarterly deposit insurance assessments. This aspect of the rule will not affect the aggregate amount of credits that have been awarded to all eligible IDIs, nor will it affect the amount of credits awarded to an individual IDI.

would create a greater risk of the reserve ratio falling below 1.35 percent, triggering the need for a restoration plan.'' [22] However, as described below, the FDIC now projects that the reserve ratio will not decline below 1.35 percent due to credit use alone.

First, based on quarterly regulatory report data as of June 30, 2019, the aggregate amount of small bank credits awarded to banks, $764.5 million, represented less than one basis point of the reserve ratio. Furthermore, the FDIC applied approximately 42 percent of all small bank credits during the second quarter assessment period of 2019 (the first time that small bank credits were eligible to be applied). Moreover, the application of small bank credits in future quarters is projected to represent increasingly smaller portions of the reserve ratio. The largest expected subsequent quarterly effect will be equal to approximately one-third of a basis point of the reserve ratio. Therefore, the application of small bank credits in any one quarter will not be sufficient on its own to cause the reserve ratio to fall below 1.35 percent in future quarters. Second, recent history suggests a generally positive near-term outlook for the banking sector (implying lower costs to the DIF). For example, since the beginning of 2018 only four IDIs have failed, with an estimated cost to the DIF of $36.2 million. As of June 30, 2019, the number of ''problem banks'' was 56, the lowest since the first quarter of 2007.

Lowering the reserve ratio threshold at which the application of small bank credits is suspended permits the FDIC to balance its goal of adequately maintaining the reserve ratio while increasing the likelihood that the application of small bank credits to quarterly assessments will remain stable and predictable over time. Furthermore, suspending the application of small bank credits when the reserve ratio falls below 1.35 percent is consistent with the statutory requirement that the FDIC adopt a restoration plan under the FDI Act when the reserve ratio falls below that level.[23]

The FDIC received two comments on this aspect of the rule. Both commenters supported the FDIC's proposal to amend the deposit insurance assessment regulations so that the application of small bank credits to a bank's deposit insurance assessment would be suspended only if the reserve ratio falls below 1.35 percent rather than 1.38 percent. The commenters agreed that the proposal would result in more predictable application of credits to quarterly assessments and would simplify the FDIC's administration of the DIF.

Finally, as mentioned above, the final rule allows for the recalculation of credits applied each quarter as a result of subsequent amendments to the quarterly regulatory reports. The FDIC received one comment in support of this change, and the commenter noted that, for banks with credit balances, this amendment would mitigate the impact on assessments due from Call Report revisions, thus limiting the impact on bank earnings. The 2016 final rule prohibited recalculation of the amount of small bank credits applied for a prior quarter's assessment resulting from subsequent amendments to a bank's quarterly regulatory reports.[24] Removing this prohibition results in a more appropriate assignment of credits to the assessment period in which the credits originally would have been applied under a correct filing of the quarterly regulatory report, without materially affecting the reserve ratio. Consistent with this final rule, if small bank credits or OTACs are restored due to a recalculation of a prior quarter's assessment, such credits will be applied to future assessments, as applicable, or, in the event that small bank credits have been applied for four quarterly assessment periods, remitted in a lump-sum payment into the deposit accounts designated by the IDIs for deposit insurance assessment payment purposes.

C. Remitting Small Bank Credits and One-Time Assessment Credits

Under the NPR, the FDIC proposed that after small bank credits have been applied for eight quarterly assessment periods, and as long as the reserve ratio is at least 1.35 percent, the FDIC will remit in the next assessment period the full balance of any remaining small bank credits to each IDI holding such credits in lump-sum payments. The FDIC received one comment in support of this aspect of the proposed rule. Another commenter supported remitting the full balance of any remaining small bank credits after small bank credits have been applied for four quarterly assessment periods, noting that the FDIC should ''return the credit funds as expeditiously as is feasible'' and that ''the credits will serve a better purpose when disbursed to these banks where these funds can support the institutions' lending and liquidity.'' [25]

Based on current data and projections, remitting the full balance of any remaining small bank credits after four quarterly assessment periods will not materially impair the ability of the FDIC to maintain adequacy of the DIF reserve ratio. Therefore, under the final rule, after small bank credits have been applied for four quarterly assessment periods, and as long as the reserve ratio is at least 1.35 percent, the FDIC will remit in the next assessment period the full balance of any remaining small bank credits to each IDI holding such credits in lump-sum payments.

In addition, and as proposed in the NPR, at the same time that the FDIC remits payment for any remaining small bank credits, FDIC will remit the full balance of any remaining OTACs to each IDI holding such credits in lump-sum payments. One commenter requested that these funds be paid out ''without delay.'' The FDIC is adopting this aspect of the rule as proposed. For purposes of operational efficiency, the FDIC will remit the remaining balances of OTACs on the same schedule as small bank credits.

The FDIC anticipates that after applying small bank credits for three more quarterly assessment periods, 233 institutions will hold an estimated $6.2 million in small bank credits. Under the final rule, these 233 institutions will receive a payment for the nominal amount of the remaining balance. Similarly, as of June 30, 2019, two institutions held OTACs of about $300,000. After three more quarters of applying OTACs, the FDIC estimates that the two IDIs will have approximately $275,000 in remaining OTACs. Therefore, remittance of all remaining small bank credits and OTACs in individual lump-sum payments will affect only a small number of institutions, and the total amount of such payments should not be sufficient on its own to cause the DIF reserve ratio to fall below 1.35 percent.

Moreover, in the FDIC's view, remitting the full balance of remaining small bank credits, as well as OTACs, after four quarters of applying small bank credits will provide a benefit to an IDI that was awarded small bank credits or OTACs. From an operational perspective, implementation of this aspect of the rule allows the FDIC to conclude both the small bank credit and OTAC programs at the same time, thereby simplifying the FDIC's administration of the DIF.

[22] 81 FR 16066.

[23] *See* 12 U.S.C. 1817(b)(3)(E).

[24] *See* 12 CFR 327.11(c)(11)(iii).

[25] *See* American Bankers Association, comment letter, (September 30, 2019), *https://www.fdic.gov/regulations/laws/federal/2019/2019-assessments-3064-af16-c-002.pdf.*

IV. Economic Effects

The FDIC expects that the economic effects of the rule are likely to be small and positive for affected IDIs. As stated previously, the rule reduces the possibility that the FDIC will suspend the application of small bank credits due to a decline in the reserve ratio. The rule affects the timing of when small bank credits will be applied to an IDI's quarterly assessment, but it does not change the aggregate amount of credits that IDIs have been awarded. Therefore, the economic effect of this aspect of the rule is a reduction in any potential future costs associated with a disruption in the application of small bank credits to the assessments of IDIs if the reserve ratio drops below 1.38 percent but remains at or above 1.35 percent. It is difficult to accurately estimate the magnitude of these benefits to IDIs because it depends, among other things, on future economic and financial conditions, the operational and financial management practices at affected IDIs, and future levels of the reserve ratio.

As of June 30, 2019, the DIF reserve ratio reached 1.40 percent, and the FDIC began applying small bank credits to institutions' quarterly assessment for the second assessment period of 2019. As of that date, 5,215 IDIs had small bank credits totaling $764.5 million. For the second assessment period, the FDIC applied $319.7 million of these small bank credits to IDIs' assessments. The FDIC expects that in the next assessment period of credit application (*i.e.,* the next assessment period where the reserve ratio is at or above 1.35 percent), $237.7 million of credits will be applied. Cumulatively, about 73 percent of the aggregate amount of small bank credits will be applied in the first two assessment periods. Therefore, the dollar amount of remaining small bank credits is expected to decline substantially after the first two periods of application, reducing the economic effects if credit application is suspended due to a decrease in the reserve ratio. Additionally, as mentioned above, recent history suggests a generally positive near-term outlook for the banking sector (implying lower costs to the DIF), therefore the probability of suspending the application of small bank credits is low, particularly in the near-term quarters.

Using the same data, the FDIC estimates that 4,982 IDIs (or 95.5 percent) will exhaust their individual shares of small bank credits within four assessment periods of application, leaving 233 with residual small bank credits available for immediate remittance. The FDIC estimates that these IDIs will hold an aggregate of $6.2 million in credits. Under the final rule, the FDIC will remit the remaining individual small bank credit balances to each of these 233 institutions in a lump-sum payment.

Under the final rule and as proposed in the NPR, the FDIC similarly will remit the outstanding balances of remaining OTACs in a lump-sum payment at the same time that the outstanding small bank credit balances are remitted. The FDIC believes that this aspect of the rule is likely to provide a small benefit to affected institutions. As of June 30, 2019, two institutions held OTACs of approximately $300,000. After three more quarters of OTAC use, the two banks will have approximately $275,000 remaining. The benefit of this aspect of the rule to the IDIs with OTACs is that they will receive and can utilize these funds after three more quarters of use, rather than the expected program duration of more than 13 years. Since the IDIs holding OTACs are not currently earning any returns on these funds, and assuming the funds are invested in risk-free assets for 12 years and earn 0.25 percent real rate of return,[26] this aspect of the rule provides an estimated benefit of $8,374 to the affected institutions.

The FDIC requested comments on all aspects of the information provided in the Economic Effects section of the NPR, but did not receive any comments.

V. Alternatives Considered

The FDIC considered several alternatives while developing this rule. In response to comments received, the FDIC is adopting the rule as proposed with one modification to the amount of time during which FDIC will apply small bank credits before remitting any remaining balances of such credits and OTACs to IDIs. With respect to that aspect of the rule, the FDIC is adopting an alternative proposed in the NPR. Under the alternative and this final rule, the FDIC will remit any remaining balance of small bank credits and OTACs to IDIs after small bank credits have been applied for four quarterly assessment periods, instead of eight assessment periods as proposed in the NPR.

The first alternative the FDIC considered would be to leave its regulation governing the use of small bank credits and OTACs unchanged. The FDIC rejected this alternative because, as discussed above, small variations in the reserve ratio could result in the application of credits in one quarter and suspension of credit application in the next, reducing the stability and predictability of assessment obligations. Changing the threshold for suspending application of small bank credits benefits institutions receiving credits at no material cost to the DIF, since the aggregate amount of credits does not change under the final rule and the rule will not materially impair the ability of the FDIC to maintain the required minimum reserve ratio of 1.35 percent.

Second, the FDIC considered remitting any remaining balances of small bank credits and OTACs to IDIs after fewer than eight assessment periods. For example, the FDIC considered immediately issuing a single lump sum payment in the amount of each IDI's aggregate credit to all eligible IDIs and holders of OTACs after the reserve ratio first reached or exceeded 1.38 percent. The FDIC also considered applying credits for four quarterly assessment periods, then remitting the remaining balance of small bank credits and OTACs to IDIs. The FDIC received one comment in support of remitting the remaining balance of small bank credits to IDIs after four quarters and chose to adopt this alternative upon further consideration. The FDIC has determined that the impact of remitting any remaining balances of small bank credits and OTACs after four quarterly assessment periods will have minimal effects on the volatility of the DIF and will not materially impair the ability of the FDIC to maintain adequacy of the DIF reserve ratio. The FDIC rejected time periods shorter than four quarters because applying credits over a longer period of time would result in less volatility for the DIF.

The FDIC also considered increasing the amount of time during which it would apply small bank credits before remitting any remaining balances of such credits and OTACs to IDIs. The FDIC rejected this alternative because delaying the remittance of any remaining balances of small bank credits and OTACs would affect relatively few institutions, would unnecessarily complicate FDIC's administration of the DIF from an operational perspective, and would not provide a material benefit to the DIF.

VI. Effective Date and Application Date

The rule will be immediately effective upon publication of the final rule in the **Federal Register**. The application date for the rule is July 1, 2019. Because the reserve ratio exceeded 1.38 percent as of

[26] Board of Governors of the Federal Reserve System, 10-Year Treasury Inflation-Indexed Security, Constant Maturity [DFII10] (July 22, 2019), *https://fred.stlouisfed.org/series/DFII10.*

June 30, 2019, the FDIC first applied small bank credits to invoices for the second quarterly assessment period, which began on April 1, 2019, and for which payment was due on September 30, 2019. Making this rule immediately effective and applying the rule beginning with the third quarterly assessment period of 2019—*i.e.,* the period beginning July 1, 2019, and ending September 30, 2019, for which payment is due on December 30, 2019—will allow for application of credits if the reserve ratio falls below 1.38 percent as of September 30, 2019. The application date provides certainty to IDIs with small bank credits that the rule will apply to the third assessment period of 2019, and that the FDIC will continue to apply small bank credits even if the DIF reserve ratio is less than 1.38 percent (but at least 1.35 percent) for that assessment period. The FDIC received two comments on the proposed effective date; both commenters supported making the rule effective upon publication in the **Federal Register**.

As discussed below in Section VII.A (Administrative Procedure Act), the FDIC finds good cause for an immediate effective date, because IDIs will benefit by having increased stability and predictability in the FDIC's application of small bank credits to quarterly assessments over time.

VII. Regulatory Analysis and Procedure

A. The Administrative Procedure Act

Under the Administrative Procedure Act, ''[t]he required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except as otherwise provided by the agency for good cause found and published with the rule.'' [27] Under the final rule, the amendments to the FDIC's deposit insurance assessment regulations will be effective upon publication in the **Federal Register**, and the FDIC finds good cause that the publication of a final rule can be less than 30 days before its effective date because IDIs would benefit from increased stability and predictability in the application of small bank credits to quarterly assessments before the final rule would otherwise become effective.

As explained above in the **SUPPLEMENTARY INFORMATION** section and in the NPR, because the FDIC invoices for quarterly deposit insurance assessments in arrears, invoices for the third quarterly assessment period of 2019 will be made available to IDIs in December 2019, with a payment date of December 30, 2019. To address any possibility that the reserve ratio, which exceeded 1.38 percent as of June 30, 2019 (the end of the second quarterly assessment period), may decrease below 1.38 percent as of September 30, 2019 (the end of the third quarterly assessment period), the FDIC is establishing an immediate effective date concurrent with the publication in the **Federal Register** and will apply the rule beginning with the third quarterly assessment period of 2019. This effective date will provide certainty to IDIs with small bank credits that the final rule will apply to the third quarterly assessment period of 2019, and that the FDIC will continue to apply small bank credits even if the DIF reserve ratio is less than 1.38 percent (but at least 1.35 percent) for that assessment period.

B. Solicitation of Comments on the Use of Plain Language

Section 722 of the Gramm-Leach-Bliley Act [28] requires the federal banking agencies to use plain language in all proposed and final rules published after January 1, 2000. The FDIC invited comment regarding the use of plain language but did not receive any comments.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) [29] generally requires that, in connection with a final rulemaking, an agency prepare and make available for public comment a final regulatory flexibility analysis describing the impact of the proposed rule on small entities. However, a regulatory flexibility analysis is not required if the agency certifies that the final rule will not have a significant economic impact on a substantial number of small entities. The Small Business Administration (SBA) has defined ''small entities'' to include banking organizations with total assets of less than or equal to $600 million that are independently owned and operated or owned by a holding company with less than or equal to $600 million in total assets.[30] [31] Generally, the FDIC considers a significant effect to be a quantified effect in excess of 5 percent of total annual salaries and benefits per institution, or 2.5 percent of total non-interest expenses. The FDIC considers effects in excess of these thresholds to typically represent significant effects for FDIC-insured institutions.

In addition, certain types of rules, such as rules of particular applicability relating to rates or corporate or financial structures, or practices relating to such rates or structures, are expressly excluded from the definition of ''rule'' for purposes of the RFA.[32] The final rule relates directly to the rates imposed on IDIs for deposit insurance and to the deposit insurance assessment system that measures risk and determines each established small bank's assessment rate and is, therefore, not subject to the RFA. Nonetheless, the FDIC is voluntarily presenting information in this RFA section.

Based on quarterly regulatory report data as of June 30, 2019, the FDIC insures 5,312 depository institutions, of which 3,947 are defined as small entities by the terms of the RFA.[33] Further, 3,939 RFA-defined small, FDIC-insured institutions have small bank credits totaling $179.7 million.

As stated previously, the final rule reduces the possibility that small bank credits would be suspended due to a decline in the reserve ratio. Therefore, the economic effect of this aspect of the final rule is a reduction in the potential future costs associated with a disruption of the type just described in the application of small bank credits by affected small, FDIC-insured institutions. It is difficult to accurately estimate the magnitude of this benefit to affected small, FDIC-insured institutions because it depends, among other things, on future economic and financial conditions, the operational and financial management practices at affected small, FDIC-insured institutions, and the future levels of the reserve ratio. However, the FDIC expects that the economic effects of the final rule are likely to be small because 41 percent of the aggregate amount of small bank credits have already been applied to the second quarter assessment period

[27] 5 U.S.C. 553(d)(3).

[28] Public Law 106–102, 113 Stat. 1338, 1471 (Nov. 12, 1999).

[29] 5 U.S.C. 601 *et seq.*

[30] The SBA defines a small banking organization as having $600 million or less in assets, where an organization's ''assets are determined by averaging the assets reported on its four quarterly financial statements for the preceding year.'' 13 CFR 121.201 (as amended by 84 FR 34261, effective August 19, 2019). In its determination, the ''SBA counts the receipts, employees, or other measure of size of the concern whose size is at issue and all of its domestic and foreign affiliates. . . .'' 13 CFR 121.103. Following these regulations, the FDIC uses a covered entity's affiliated and acquired assets, averaged over the preceding four quarters, to determine whether the covered entity is ''small'' for the purposes of RFA.

[31] The FDIC supplemented the RFA analysis in the NPR with an updated regulatory flexibility analysis to reflect changes to the Small Business Administration's monetary-based size standards, which were adjusted for inflation as of August 19, 2019. *See* 84 FR 52826 (Oct. 3, 2019).

[32] 5 U.S.C. 601(2).

[33] Consolidated Reports of Condition and Income for the quarter ending June 30, 2019.

of 2019, when the reserve ratio was first at or above 1.38 percent. Cumulatively, about 73 percent of the aggregate amount of small bank credits will be applied in the first two assessment periods. Further, the FDIC estimates that for 3,794 small, FDIC-insured institutions, $54.4 million of small bank credits will be applied in the next assessment period of credit application in which the reserve ratio is at or above 1.35 percent. Therefore, the dollar amount of remaining small bank credits declines substantially following the initial application of credits, reducing the effects of credit application being suspended due to a decrease in the reserve ratio. Additionally, recent history suggests a generally positive near-term outlook for the banking sector (implying lower costs to the DIF), therefore the probability that application of small bank credits will be suspended is low, particularly in the near-term quarters.

As stated previously, under the final rule, the FDIC will remit the outstanding balances of remaining OTACs in a lump-sum payment, in the next assessment period in which the reserve ratio is at least 1.35 percent, at the same time that the outstanding small bank credit balances are remitted. As of June 30, 2019, only two IDIs have outstanding OTACs totaling approximately $300,000. However, both institutions are subsidiaries of large banking organizations and therefore do not qualify as small entities under the RFA. Therefore, this aspect of the final rule does not affect any small, FDIC-insured institutions.

The FDIC solicited comments on all aspect of the supporting information provided in the RFA section of the notice of proposed rulemaking, but none were received.

D. The Paperwork Reduction Act

In accordance with the requirements of the Paperwork Reduction Act (PRA) of 1995,[34] the FDIC may not conduct or sponsor, and the respondent is not required to respond to, an information collection unless it displays a currently-valid Office of Management and Budget (OMB) control number. The FDIC's OMB control numbers for its assessment regulations are 3064–0057, 3064–0151, and 3064–0179. The final rule does not revise any of these existing assessment information collections pursuant to the PRA and consequently, no submissions in connection with these OMB control numbers will be made to the OMB for review.

[34] 44 U.S.C. 3501 *et seq.*

E. The Riegle Community Development and Regulatory Improvement Act of 1994

Pursuant to section 302(a) of the Riegle Community Development and Regulatory Improvement Act (RCDRIA),[35] in determining the effective date and administrative compliance requirements for new regulations that impose additional reporting, disclosure, or other requirements on IDIs, each federal banking agency must consider, consistent with principles of safety and soundness and the public interest, any administrative burdens that such regulations would place on IDIs, including small IDIs, and customers of IDIs, as well as the benefits of such regulations. In addition, subject to certain exceptions, section 302(b) of RCDRIA requires new regulations and amendments to regulations that impose additional reporting, disclosures, or other new requirements on IDIs generally to take effect on the first day of a calendar quarter that begins on or after the date on which the regulations are published in final form.[36]

The final rule does not impose additional reporting or disclosure requirements on IDIs, including small IDIs, or on the customers of IDIs. It provides for: Continued application of small bank credits as long as the reserve ratio is at least 1.35 percent; remittance of any remaining small bank credits in a lump-sum payment after such credits have been applied for four quarterly assessment periods, in the next assessment period in which the reserve ratio is at least 1.35 percent; and remittance of any remaining OTACs in a lump-sum payment at the same time that any remaining small bank credits are remitted. Accordingly, section 302 of RCDRIA does not apply. The FDIC invited comment regarding the application of RCDRIA to the final rule, but did not receive comments on this topic.

F. The Congressional Review Act

For purposes of Congressional Review Act, the OMB makes a determination as to whether a final rule constitutes a ''major'' rule.[37] The OMB has determined that the final rule is not a major rule for purposes of the Congressional Review Act. If a rule is deemed a ''major rule'' by the OMB, the Congressional Review Act generally provides that the rule may not take effect until at least 60 days following its publication.[38] The Congressional Review Act defines a ''major rule'' as any rule that the Administrator of the Office of Information and Regulatory Affairs of the OMB finds has resulted in or is likely to result in—(A) an annual effect on the economy of $100,000,000 or more; (B) a major increase in costs or prices for consumers, individual industries, Federal, State, or Local government agencies or geographic regions, or (C) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.[39] As required by the Congressional Review Act, the FDIC will submit the final rule and other appropriate reports to Congress and the Government Accountability Office for review.

[35] 12 U.S.C. 4802(a).

[36] 12 U.S.C. 4802(b).

[37] 5 U.S.C. 801 *et seq.*

[38] 5 U.S.C. 801(a)(3).

[39] 5 U.S.C. 804(2).

List of Subjects in 12 CFR Part 327

Bank deposit insurance, Banks, banking, Savings associations.

For the reasons set forth above, the FDIC amends part 327 of title 12 of the Code of Federal Regulations as follows:

PART 327—ASSESSMENTS

■ 1. The authority for part 327 continues to read as follows:

Authority: 12 U.S.C. 1441, 1813, 1815, 1817–19, 1821.

■ 2. Amend § 327.11 by revising paragraph (c)(11)(i), removing paragraph (c)(11)(iii), and adding paragraph (c)(13).

The revision and addition read as follows:

§ 327.11 Surcharges and assessments required to raise the reserve ratio of the DIF to 1.35 percent

* * * * *

(c) * * *

(11) *Use of credits.* (i) Effective as of July 1, 2019, the FDIC will apply assessment credits awarded under this paragraph (c) to an institution's deposit insurance assessments, as calculated under this part 327, beginning in the first assessment period in which the reserve ratio of the DIF is at least 1.38 percent, and in each assessment period thereafter in which the reserve ratio of the DIF is at least 1.35 percent, for no more than three additional assessment periods.

* * * * *

(13) *Remittance of credits.* After assessment credits awarded under this paragraph (c) have been applied for four assessment periods, the FDIC will remit the full nominal value of an institution's

remaining assessment credits in a single lump-sum payment to such institution in the next assessment period in which the reserve ratio is at least 1.35 percent.

* * * * *

■ 3. Amend § 327.35 by adding paragraph (c) to read as follows:

§ 327.35 Application of credits.

* * * * *

(c) *Remittance of credits.* Subject to the limitations in paragraph (b) of this section, in the same assessment period that the FDIC remits the full nominal value of small bank assessment credits pursuant to § 327.11(c)(13), the FDIC shall remit the full nominal value of an institution's remaining one-time assessment credits provided under this subpart B in a single lump-sum payment to such institution.

Federal Deposit Insurance Corporation.

By order of the Board of Directors.

Dated at Washington, DC, on November 19, 2019.

Annmarie H. Boyd,

Assistant Executive Secretary.

[FR Doc. 2019–25566 Filed 11–26–19; 8:45 am]

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FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 390

RIN 3064–AF07

Removal of Transferred OTS Regulations Regarding Deposits

AGENCY: Federal Deposit Insurance Corporation.

ACTION: Final rule.

SUMMARY: The Federal Deposit Insurance Corporation (FDIC) is adopting a final rule to rescind and remove a subpart from the Code of Federal Regulations entitled ''Deposits,'' applicable to State savings associations, because the subpart is duplicative of other rules and statutes and is unnecessary to the regulation of State savings associations. The FDIC did not receive any comments on the Notice of Proposed Rulemaking (NPR) and is finalizing the rule as proposed.

DATES: The final rule is effective on December 27, 2019.

FOR FURTHER INFORMATION CONTACT: Karen J. Currie, Senior Examination Specialist, (202) 898–3981, *KCurrie@FDIC.gov,* Division of Risk Management Supervision; Christine M. Bouvier, Assistant Chief Accountant, (202) 898–7289, Division of Risk Management Supervision; Cassandra Duhaney, Senior Policy Analyst, (202) 898–6804, Division of Depositor and Consumer Protection; Laura J. McNulty, Counsel, Legal Division, (202) 898–3817; or Jennifer M. Jones, Counsel, Legal Division (202) 898–6768.

SUPPLEMENTARY INFORMATION:

I. Policy Objective

The policy objective of the rule is to remove unnecessary and duplicative regulations in order to simplify them and improve the public's understanding of them. Thus, the FDIC is rescinding the regulations in part 390, subpart M and reserving the subpart for future use.

II. Background

Part 390, subpart M, was included in the regulations that were transferred to the FDIC from the Office of Thrift Supervision (OTS) on July 21, 2011, in connection with the implementation of applicable provisions of title III of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act).[1]

A. The Dodd-Frank Act

As of July 21, 2011, the transfer date established by section 311 of the Dodd-Frank Act,[2] the powers, duties, and functions formerly performed by the OTS were divided among the FDIC, as to State savings associations, the Office of the Comptroller of the Currency (OCC), as to Federal savings associations, and the Board of Governors of the Federal Reserve System (FRB), as to savings and loan holding companies. Section 316(b) of the Dodd-Frank Act[3] provides the manner of treatment for all orders, resolutions, determinations, regulations, and other advisory materials that have been issued, made, prescribed, or allowed to become effective by the OTS. The section provides that if such materials were in effect on the day before the transfer date, they continue in effect and are enforceable by or against the appropriate successor agency until they are modified, terminated, set aside, or superseded in accordance with applicable law by such successor agency, by any court of competent jurisdiction, or by operation of law.

Pursuant to section 316(c) of the Dodd-Frank Act,[4] on June 14, 2011, the FDIC's Board of Directors (Board) approved a ''List of OTS Regulations to be Enforced by the OCC and the FDIC Pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act.'' This list was published by the FDIC and the OCC as a Joint Notice in the **Federal Register** on July 6, 2011.[5]

Although § 312(b)(2)(B)(i)(II) of the Dodd-Frank Act[6] granted the OCC rulemaking authority relating to both State and Federal savings associations, nothing in the Dodd-Frank Act affected the FDIC's existing authority to issue regulations under the Federal Deposit Insurance Act (FDI Act)[7] and other laws as the ''appropriate Federal banking agency'' or under similar statutory terminology. Section 312(c)(1) of the Dodd-Frank Act[8] revised the definition of ''appropriate Federal banking agency'' contained in § 3(q) of the FDI Act,[9] to add State savings associations to the list of entities for which the FDIC is designated as the ''appropriate Federal banking agency.'' As a result, when the FDIC acts as the appropriate Federal banking agency (or under similar terminology) for State savings associations, as it does here, the FDIC is authorized to issue, modify, and rescind regulations involving such associations, as well as for State nonmember banks and insured State-licensed branches of foreign banks.

As noted above, on June 14, 2011, operating pursuant to this authority, the Board issued a list of regulations of the former OTS that the FDIC would enforce with respect to State savings associations. On that same date, the Board reissued and redesignated certain regulations transferred from the former OTS. These transferred OTS regulations were published as new FDIC regulations in the **Federal Register** on August 5, 2011.[10] When the FDIC republished the transferred OTS regulations as new FDIC regulations, it specifically noted that its staff would evaluate the transferred OTS rules and might later recommend incorporating the transferred OTS regulations into other FDIC regulations, amending them, or rescinding them, as appropriate.[11]

B. Transferred OTS Regulations (Transferred to the FDIC's Part 390, Subpart M)

One of the regulations transferred to the FDIC from the OTS was former 12 CFR 557.20, concerning the maintenance of deposit records by State savings associations.[12] That provision was transferred to the FDIC and now comprises part 390, subpart M. The OTS had issued § 557.20 as part of a

[1] 12 U.S.C. 5301 *et seq.*

[2] 12 U.S.C. 5411.

[3] 12 U.S.C. 5414(b).

[4] 12 U.S.C. 5414(c).

[5] 76 FR 39246 (July 6, 2011).

[6] 12 U.S.C. 5412(b)(2)(B)(i)(II).

[7] 12 U.S.C. 1811 *et seq.*

[8] 12 U.S.C. 5412(c)(1).

[9] 12 U.S.C. 1813(q).

[10] 76 FR 47652 (Aug. 5, 2011).

[11] *See* 76 FR 47653.

[12] *See* 76 FR 47659.

streamlining of its regulations in 1997.[13] At that time, the OTS regulations included several specific deposit recordkeeping requirements, and the OTS sought to replace those with one provision. In the associated NPR, the OTS explained that ''[a]s part of its reinvention effort, OTS is endeavoring to eliminate regulations that are outdated or micromanage thrift operations. For example, OTS proposes to replace several specific deposit-related recordkeeping requirements with a general recordkeeping regulation that is tied more closely to safety and soundness.'' [14]

III. Proposed Rule

Removal of Part 390, Subpart M—Deposits

On August 26, 2019, the FDIC published an NPR regarding the removal of part 390, subpart M (former OTS regulation 12 CFR 557.20), which addressed deposits at State savings associations.[15] The former OTS rule was transferred to the FDIC with only nominal changes. The NPR proposed removing part 390, subpart M from the Code of Federal Regulations, because, after careful review and consideration, the FDIC believes it is unnecessary, redundant, and duplicative of existing statutes and regulations currently applicable to State savings associations.

IV. Comparison of Other Applicable Statutes and Regulations With the Transferred OTS Regulations To Be Rescinded

The following is a description of existing statutes and regulations that provide for complete and accurate recordkeeping of deposits and account transactions at State savings associations, obviating the need for a new regulation or amendment of existing regulations upon rescission of part 390, subpart M. Accordingly, the FDIC proposed that §§ 390.230 and 390.231, part 390, subpart M, be rescinded as unnecessary, redundant of, or otherwise duplicative of the provisions of law delineated in 12 U.S.C. 1817(a)(9); 31 CFR 1020.410(c)(2); 12 CFR part 364, Appendix A II; 12 CFR 330.1(e); and 12 CFR 1005, each discussed individually below.

A. Former OTS Safety and Soundness—Part 390, Subpart M, Sections 390.230 and 390.231

1. § 390.230—What does this subpart do?

Section 390.230 simply states that subpart M ''applies to the deposit activities of State savings associations.'' There is no substantively similar provision in the FDIC's regulations, nor is one necessary. Accordingly, the FDIC proposed that section 390.230 be rescinded.

2. § 390.231—What records should I maintain on deposit activities?

Former OTS § 557.20, as modified by the FDIC in transferred § 390.231, provided general information on what records should be maintained by State savings associations on their deposit activities. Existing statutes and regulations that are applicable to State savings associations (discussed in greater detail below) already require the maintenance of accurate records of deposits and transactions by State savings associations.

B. Data Collection at Insured Depository Institutions

Section 7(a)(9) of the FDI Act [16] provides that ''the Corporation shall take such action as may be necessary to ensure that—(A) each insured depository institution maintains; and (B) the Corporation receives on a regular basis from such institution, information on the total amount of all insured deposits, preferred deposits, and uninsured deposits at the institution.'' In issuing regulations under that statutory provision, the FDIC has stated that it ''has a right and a duty'' under § 7(a)(9) to require the maintenance of accurate deposit account records and that ''requiring covered institutions to maintain complete and accurate records regarding the ownership and insurability of deposits . . . will facilitate the FDIC's prompt payment of deposit insurance and enhance the ability to implement the least costly resolution of these institutions.'' [17] Due to the requirements for accurate recordkeeping pursuant to its existing statutory authority, the FDIC takes the position that no new regulation will be needed upon the rescission of part 390, subpart M.

C. Treasury Department Bank Secrecy Act Regulations [18]

Section 1020.410(c)(2) of title 31, Code of Federal Regulations, requires banks (defined to include savings associations [19]) to maintain certain records, including ''[e]ach statement, ledger card or other record on each deposit or share account, showing each transaction in, or with respect to, that account.'' This rule specifically requires that such records be maintained at State savings associations, rather than the merely suggestive language included in part 390, subpart M.

D. Activities Implicating Safety and Soundness; Part 364 [20]

In 1995, the FDIC published 12 CFR 364 as a final rule with an appendix that implements section 39(a) of the FDI Act [21] regarding standards for safety and soundness (Appendix A).[22] The OCC, the FRB, and the OTS also issued their versions of Appendix A.[23] The FDIC's Appendix A II (Operational and Managerial Standards) provides that an institution should have internal controls and information systems that are appropriate to the size of the institution and the nature, scope, and risk of its activities and that provide for, among other things: ''timely and accurate financial, operational and regulatory reports.'' An Appendix B (regarding information security) was also published to implement § 39 of the FDI Act.[24] Section 364.101 of part 364 provides that Appendix A and Appendix B apply to all insured State nonmember banks, State-licensed insured branches of foreign banks, and State savings associations. FDIC-supervised institutions are required to file quarterly Reports of Condition.[25] In

[13] 62 FR 55759 (Oct. 22, 1997).

[14] 62 FR 15627 (Apr. 2, 1997).

[15] 84 FR 44558 (Aug. 26, 2019).

[16] 12 U.S.C. 1817(a)(9).

[17] 81 FR 87735 (Dec. 5, 2016).

[18] 31 CFR 1020.

[19] 31 CFR 1010.100(d)(3).

[20] 12 CFR part 364, Appendix A II.

[21] 12 U.S.C. 1831p–1. § 132 of the Federal Deposit Insurance Corporation Improvement Act of 1991, Public Law 102–242, 105 Stat. 2236 (codified at 12 U.S.C. 1831p–1) added § 39 to the FDI Act. Section 39 was later amended by § 956 of the Housing and Community Development Act of 1992, Public Law 102–550, 106 Stat. 3672, and § 318 of the Riegle Community Development and Regulatory Improvement Act of 1994, Public Law 103–325, 108 Stat. 2160.

[22] 60 FR 35674 (July 10, 1995).

[23] *See* 12 CFR part 30, Appendix A, 60 FR 35678; 12 CFR part 208, Appendix D–1, 60 FR 35682; (former) 12 CFR part 570, Appendix A, 60 FR 35687, respectively (July 10, 1995).

[24] Appendix B was added in accordance with section 501 of the Gramm-Leach-Bliley Financial Modernization Act of 1999, Public Law 106–102, 113 Stat. 1338, codified at 15 U.S.C. 6801, which statute required the agencies to establish appropriate information security standards in order to protect nonpublic personal information.

[25] 12 U.S.C. 1817(a)(3)–(6); 12 U.S.C. 1464(v).

addition, the accounting principles applicable to reports or statements that insured depository institutions file with the Federal banking agencies are required to be uniform and consistent with generally accepted accounting principles.[26]

Taken together, part 364 and appendix A constitute the FDIC's long-standing expectations for all prudently managed insured depository institutions, but leave specific methods of achieving these objectives to each institution. These regulations provide a framework for sound corporate governance and the supervision of operations designed to prompt an institution to identify emerging problems and correct deficiencies before capital becomes impaired. Pursuant to § 39(e) of the FDI Act,[27] an FDIC-supervised institution's failure to meet the standards may cause the FDIC to require the institution to submit a safety and soundness compliance plan, and if the institution does not comply with its plan, the FDIC will issue an order to correct safety and soundness deficiencies.[28] Hence, in order to accurately report their financial condition, including deposit liabilities, and to meet applicable safety and soundness criteria, insured depository institutions, including State savings associations, must keep accurate and up-to-date records of account transactions and balances.

E. FDIC's Deposit Insurance Coverage Criteria [29]

Part 330 of the FDIC's regulations governs the criteria for deposit insurance coverage at insured depository institutions, including insured State savings associations. Section 330.3(h) of part 330 states that deposit insurance coverage is ''a function of the deposit account records of the insured depository institution . . . which, in the interest of uniform national rules for deposit insurance coverage, are controlling for purposes of determining deposit insurance coverage.'' Further, § 330.1(e) defines the term ''deposit account records'' to include documents such as ''account ledgers . . . and other books and records of the insured depository institution . . . which relate to the insured depository institution's deposit taking function.'' This existing regulation on criteria for deposit insurance also requires State savings associations to maintain records of their deposit transactions, eliminating the need for part 390, subpart M.

F. Bureau of Consumer Financial Protection—Regulation E

Regulation E,[30] issued by the Bureau of Consumer Financial Protection, relates to electronic fund transfers at financial institutions, including any savings association.[31] It states that ''[f]or an account to or from which electronic fund transfers can be made, a financial institution shall send a periodic statement for each monthly cycle in which an electronic fund transfer has occurred; and shall send a periodic statement at least quarterly if no transfer has occurred.'' [32] Thus, in order to comply with existing Regulation E, a State savings association must be capable of generating periodic statements for each of its deposit accounts, whether or not electronic transfers are made from that account, again serving the intended purpose of part 390, subpart M.

Accordingly, as explained in the analysis above, the FDIC proposed removing §§ 390.230 and 390.231, subpart M because these sections are unnecessary, redundant of, or otherwise duplicative of the safety and soundness and other standards described above.

V. Comments

The FDIC issued the NPR with a 30-day comment period, which closed on September 25, 2019. The FDIC received no comments on its Proposed Rule, and consequently the final rule is adopted as proposed.

VI. Explanation of the Final Rule

As discussed in the NPR, the requirements for State savings associations in part 390, subpart M, are duplicative of the regulations and statutes described in Section IV above. To that effect, the Final Rule removes and rescinds 12 CFR part 390, subpart M, in its entirety.

VII. Expected Effects

As explained in detail in Section III of this Supplemental Information section, certain OTS regulations transferred to the FDIC by the Dodd-Frank Act relating to records of deposit transactions and activities are either unnecessary or effectively duplicate existing regulations. This rule would eliminate one of those transferred OTS regulations.

As of June 30th, 2019, the FDIC supervises 3,424 insured depository institutions, of which 38 (1.1%) are State savings associations.[33] The rule primarily would affect regulations that govern State savings associations.

As explained previously, the rule would remove sections §§ 390.230 and 390.231, subpart M, because these sections are unnecessary, redundant of, or otherwise duplicative of other statutes and regulations, including those relating to safety and soundness. Because these regulations are redundant, rescinding them will not have any substantive effects on FDIC-supervised institutions.

VIII. Alternatives

The FDIC has considered alternatives to the rule but believes that the amendments represent the most appropriate option for covered institutions. As discussed previously, the Dodd-Frank Act transferred certain powers, duties, and functions formerly performed by the OTS to the FDIC. The FDIC's Board reissued and redesignated certain transferred regulations from the OTS, but noted that it would evaluate them and might later incorporate them into other FDIC regulations, amend them, or rescind them, as appropriate. The FDIC has evaluated the existing regulations relating to the maintenance of deposit account records. The FDIC considered the status quo alternative of retaining the current regulations, but did not choose to do so. The FDIC believes it would be procedurally complex for FDIC-supervised institutions to continue to refer to these separate sets of regulations, and is therefore amending and streamlining them in accordance with this final rulemaking.

IX. Regulatory Analysis and Procedure

A. The Paperwork Reduction Act

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA),[34] the FDIC may not conduct or sponsor, and the respondent is not required to respond to, an information collection unless it displays a currently valid Office of Management and Budget (OMB) control number.

The final rule rescinds and removes from FDIC regulations part 390, subpart M. The final rule will not create any new or revise any existing collections of information under the PRA. Therefore, no information collection request will be submitted to the OMB for review.

[26] 12 U.S.C. 1831n.

[27] 12 U.S.C. 1831p–1(e).

[28] *See* 12 U.S.C. 1831p–1(e); 12 CFR 308.300, *et seq.*

[29] 12 CFR 330.

[30] 12 CFR part 1005.

[31] 12 CFR 1005.2(i).

[32] 12 CFR 1005.9(b).

[33] Based on data from the June 30, 2019, Consolidated Reports of Condition and Income (Call Report) and Report of Assets and Liabilities of U.S. Branches and Agencies of Foreign Banks.

[34] 44 U.S.C. 3501–3521.

B. The Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires that, in connection with a final rulemaking, an agency prepare and make available for public comment a final regulatory flexibility analysis that describes the impact of the rule on small entities.[35] However, a regulatory flexibility analysis is not required if the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities, and publishes its certification and a short explanatory statement in the **Federal Register**, together with the rule. The Small Business Administration (SBA) has defined ''small entities'' to include banking organizations with total assets of less than or equal to $600 million.[36] [37] Generally, the FDIC considers a significant effect to be a quantified effect in excess of 5 percent of total annual salaries and benefits per institution, or 2.5 percent of total noninterest expenses. The FDIC believes that effects in excess of these thresholds typically represent significant effects for FDIC-supervised institutions. For the reasons provided below, the FDIC certifies that the final rule would not have a significant economic impact on a substantial number of small banking organizations. Accordingly, a regulatory flexibility analysis is not required.

As of June 30, 2019, the FDIC supervised 3,424 insured depository institutions, of which 2,665 are considered small banking organizations for the purposes of RFA. The proposed rule primarily affects regulations that govern State savings associations. There are 36 State savings associations considered to be small banking organizations for the purposes of the RFA.[38]

As explained previously, the rule would remove §§ 390.230 and 390.231, part 390, subpart M, because these sections are unnecessary, redundant of, or otherwise duplicative of other statutes and regulations, including safety and soundness standards. Therefore, rescinding subpart M would not have any substantive effects on small FDIC-supervised institutions.

Based on the information above, the FDIC certifies that the rule would not have a significant economic impact on a substantial number of small entities.

C. The Congressional Review Act

For purposes of Congressional Review Act, the OMB makes a determination as to whether a final rule constitutes a ''major'' rule.[39] If a rule is deemed a major rule by the OMB, the Congressional Review Act generally provides that the rule may not take effect until at least 60 days following its publication.[40]

The Congressional Review Act defines a ''major rule'' as any rule that the Administrator of the Office of Information and Regulatory Affairs of the OMB finds has resulted in or is likely to result in—(A) an annual effect on the economy of $100,000,000 or more; (B) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies or geographic regions, or (C) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.[41]

The OMB has determined that the final rule is not a major rule for purposes of the Congressional Review Act and the FDIC will submit the final rule and other appropriate reports to Congress and the Government Accountability Office for review.

D. Plain Language

Section 722 of the Gramm-Leach-Bliley Act[42] requires the Federal banking agencies to use plain language in all proposed and final rules published after January 1, 2000. The FDIC has sought to present the final rule in a simple and straightforward manner and did not receive any comments on the use of plain language.

E. The Economic Growth and Regulatory Paperwork Reduction Act

Under section 2222 of the Economic Growth and Regulatory Paperwork Reduction Act of 1996 (EGRPRA), the FDIC is required to review all of its regulations, at least once every 10 years, in order to identify any outdated or otherwise unnecessary regulations imposed on insured institutions.[43] The FDIC, along with the other Federal banking agencies, submitted a Joint Report to Congress on March 21, 2017 (''EGRPRA Report'') discussing how the review was conducted, what has been done to date to address regulatory burden, and further measures the FDIC will take to address issues that were identified.[44] As noted in the EGRPRA Report, the FDIC is continuing to streamline and clarify its regulations through the OTS rule integration process. By removing outdated or unnecessary regulations, such as part 390, subpart M, this final rule complements other actions that the FDIC has taken, separately and with the other Federal banking agencies, to further the EGRPRA mandate.

F. Riegle Community Development and Regulatory Improvement Act of 1994

Pursuant to section 302(a) of the Riegle Community Development and Regulatory Improvement Act of 1994 (RCDRIA),[45] in determining the effective date and administrative compliance requirements for new regulations that impose additional reporting, disclosure, or other requirements on insured depository institutions (IDIs), each Federal banking agency must consider, consistent with principles of safety and soundness and the public interest, any administrative burdens that such regulations would place on depository institutions, including small depository institutions, and customers of depository institutions, as well as the benefits of such regulations. In addition, section 302(b) of RCDRIA requires new regulations and amendments to regulations that impose additional reporting, disclosures, or other new requirements on IDIs generally to take effect on the first day of a calendar quarter that begins on or after the date on which the regulations are published in final form.[46]

Because the final rule does not impose additional reporting, disclosure, or other new requirements on IDIs, section 302 of the RCDRIA does not apply.

List of Subjects in 12 CFR Part 390

Deposits.

[35] 5 U.S.C. 601 *et seq.*

[36] The SBA defines a small banking organization as having $600 million or less in assets, where ''a financial institution's assets are determined by averaging the assets reported on its four quarterly financial statements for the preceding year.'' See 13 CFR 121.201 (as amended by 84 FR 34261, effective August 19, 2019). ''SBA counts the receipts, employees, or other measure of size of the concern whose size is at issue and all of its domestic and foreign affiliates.'' See 13 CFR 121.103. Following these regulations, the FDIC uses a covered entity's affiliated and acquired assets, averaged over the preceding four quarters, to determine whether the FDIC-supervised institution is ''small'' for the purposes of RFA.

[37] The FDIC supplemented the original notice of proposed rulemaking with updated supporting information for the RFA section that reflected changes to the SBA's monetary-based size standards which were adjusted for inflation as of August 19, 2019. *See* 84 FR 52834 (Oct. 3, 2019).

[38] Based on data from the June 30, 2019, Call Report and Report of Assets and Liabilities of U.S. Branches and Agencies of Foreign Banks.

[39] 5 U.S.C. 801 *et seq.*

[40] 5 U.S.C. 801(a)(3).

[41] 5 U.S.C. 804(2).

[42] Public Law 106–102, 113 Stat. 1338, 1471 (1999).

[43] Public Law 104–208, 110 Stat. 3009 (1996).

[44] 82 FR 15900 (March 31, 2017).

[45] 12 U.S.C. 4802(a).

[46] *Id.*

Authority and Issuance

For the reasons stated in the preamble, the Federal Deposit Insurance Corporation amends 12 CFR 390 as follows:

PART 390—REGULATIONS TRANSFERRED FROM THE OFFICE OF THRIFT SUPERVISION

■ 1. The authority citation for part 390 is revised to read as follows:

Authority: 12 U.S.C. 1819.

Subpart F also issued under 5 U.S.C. 552; 559; 12 U.S.C. 2901 *et seq.*

Subpart G also issued under 12 U.S.C. 2810 *et seq.,* 2901 *et seq.;* 15 U.S.C. 1691; 42 U.S.C. 1981, 1982, 3601–3619.

Subpart O also issued under 12 U.S.C. 1828.

Subpart Q also issued under 12 U.S.C. 1462; 1462a; 1463; 1464.

Subpart R also issued under 12 U.S.C. 1463; 1464; 1831m; 1831n; 1831p–1.

Subpart S also issued under 12 U.S.C. 1462; 1462a; 1463; 1464; 1468a; 1817; 1820; 1828; 1831e; 1831o; 1831p–1; 1881–1884; 3207; 3339; 15 U.S.C. 78b; 78l; 78m; 78n; 78p; 78q; 78w; 31 U.S.C. 5318; 42 U.S.C. 4106.

Subpart T also issued under 12 U.S.C. 1462a; 1463; 1464; 15 U.S.C. 78c; 78l; 78m; 78n; 78w.

Subpart W also issued under 12 U.S.C. 1462a; 1463; 1464; 15 U.S.C. 78c; 78l; 78m; 78n; 78p; 78w.

Subpart Y also issued under 12 U.S.C. 1831o.

Subpart M—[Removed and Reserved]

■ 2. Remove and reserve subpart M, consisting of §§ 390.230 and 390.231.

Federal Deposit Insurance Corporation.

By order of the Board of Directors.

Dated at Washington, DC, on November 19, 2019.

Annmarie H. Boyd,

Assistant Executive Secretary.

[FR Doc. 2019–25697 Filed 11–26–19; 8:45 am]

BILLING CODE 6714–01–P

BUREAU OF CONSUMER FINANCIAL PROTECTION

12 CFR Part 1022

Fair Credit Reporting Act Disclosures

AGENCY: Bureau of Consumer Financial Protection.

ACTION: Final rule; official interpretation.

SUMMARY: The Bureau of Consumer Financial Protection (Bureau) is issuing this final rule amending an appendix for Regulation V, which implements the Fair Credit Reporting Act (FCRA). The Bureau is required to calculate annually the dollar amount of the maximum allowable charge for disclosures by a consumer reporting agency to a consumer pursuant to FCRA Section 609; this final rule establishes the maximum allowable charge for the 2020 calendar year.

DATES: This final rule is effective January 1, 2020.

FOR FURTHER INFORMATION CONTACT: Rachel Ross, Attorney-Advisor; Kristen Phinnessee, Senior Counsel, Office of Regulations, at (202) 435–7700. If you require this document in an alternative electronic format, please contact *CFPB_Accessibility@cfpb.gov.*

SUPPLEMENTARY INFORMATION: The Bureau is amending appendix O for Regulation V, which implements the FCRA, to establish the maximum allowable charge for disclosures by a consumer reporting agency to a consumer for 2020. The maximum allowable charge will remain at $12.50 for 2020.

I. Background

Under section 609 of the FCRA, a consumer reporting agency must, upon a consumer's request, disclose to the consumer information in the consumer's file.[1] Section 612(a) of the FCRA gives consumers the right to a free file disclosure upon request once every 12 months from the nationwide consumer reporting agencies and nationwide specialty consumer reporting agencies.[2] Section 612 of the FCRA also gives consumers the right to a free file disclosure under certain other, specified circumstances.[3] Where the consumer is not entitled to a free file disclosure, section 612(f)(1)(A) of the FCRA provides that a consumer reporting agency may impose a reasonable charge on a consumer for making a file disclosure. Section 612(f)(1)(A) of the FCRA provides that the charge for such a disclosure shall not exceed $8.00 and shall be indicated to the consumer before making the file disclosure.[4]

Section 612(f)(2) of the FCRA also states that the $8.00 maximum amount shall increase on January 1 of each year, based proportionally on changes in the Consumer Price Index, with fractional changes rounded to the nearest fifty cents.[5] Such increases are based on the Consumer Price Index for All Urban Consumers (CPI–U), which is the most general Consumer Price Index and covers all urban consumers and all items.

II. Adjustment

For 2020, the ceiling on allowable charges under section 612(f) of the FCRA will be $12.50, unchanged from 2019. The Bureau is using the $8.00 amount set forth in section 612(f)(1)(A)(i) of the FCRA as the baseline for its calculation of the increase in the ceiling on reasonable charges for certain disclosures made under section 609 of the FCRA. Since the effective date of section 612(a) was September 30, 1997, the Bureau calculated the proportional increase in the CPI–U from September 1997 to September 2019. The Bureau then determined what modification, if any, from the original base of $8.00 should be made effective for 2020, given the requirement that fractional changes be rounded to the nearest fifty cents.

Between September 1997 and September 2019, the CPI–U increased by 59.28 percent from an index value of 161.2 in September 1997 to a value of 256.759 in September 2019. An increase of 59.28 percent in the $8.00 base figure would lead to a figure of $12.74. However, because the statute directs that the resulting figure be rounded to the nearest $0.50, the maximum allowable charge is $12.50. The Bureau therefore determines that the maximum allowable charge for the year 2020 will remain at $12.50.

III. Procedural Requirements

A. Administrative Procedure Act

Under the Administrative Procedure Act, notice and opportunity for public comment are not required if the Bureau finds that notice and public comment are impracticable, unnecessary, or contrary to the public interest.[6] Pursuant to this final rule, in Regulation V, appendix O, is amended to update the maximum allowable charge for 2020 under section 612(f). The amendments in this final rule are technical and non-discretionary, as they merely apply the method previously established in Regulation V for determining adjustments to the thresholds. For these reasons, the Bureau has determined that publishing a notice of proposed rulemaking and providing opportunity for public comment are unnecessary. The amendments therefore are adopted in final form.

[1] 15 U.S.C. 1681g.

[2] 15 U.S.C. 1681j(a).

[3] 15 U.S.C. 1681j(b)–(d). The maximum allowable charge announced by the Bureau does not apply to requests made under section 612(a)–(d) of the FCRA. The charge does apply when a consumer who orders a file disclosure has already received a free annual file disclosure and does not otherwise qualify for an additional free file disclosure.

[4] 15 U.S.C. 1681j(f)(1)(A).

[5] 15 U.S.C. 1681j(f)(2).

[6] 5 U.S.C. 553(b)(B).

B. Regulatory Flexibility Act

Because no notice of proposed rulemaking is required, the Regulatory Flexibility Act does not require an initial or final regulatory flexibility analysis.[7]

C. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995,[8] the Bureau reviewed this final rule. No collections of information pursuant to the Paperwork Reduction Act are contained in the final rule.

D. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Bureau will submit a report containing this rule and other required information to the United States Senate, the United States House of Representatives, and the Comptroller General of the United States prior to the rule taking effect. The Office of Information and Regulatory Affairs (OIRA) has designated this rule as not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 12 CFR Part 1022

Banks, Banking, Consumer protection, Credit unions, Fair Credit Reporting Act, Holding companies, National banks, Privacy, Reporting and recordkeeping requirements, Savings associations, State member banks.

Authority and Issuance

For the reasons set forth in the preamble, the Bureau amends Regulation V, 12 CFR part 1022, as set forth below:

PART 1022—FAIR CREDIT REPORTING (REGULATION V)

■ 1. The authority citation for part 1022 continues to read as follows:

Authority: 12 U.S.C. 5512, 5581; 15 U.S.C. 1681a, 1681b, 1681c, 1681c-1, 1681e, 1681g, 1681i, 1681j, 1681m, 1681s, 1681s-2, 1681s-3, and 1681t; Sec. 214, Public Law 108–159, 117 Stat. 1952.

■ 2. Appendix O is revised to read as follows:

Appendix O to Part 1022—Reasonable Charges for Certain Disclosures

Section 612(f) of the FCRA, 15 U.S.C. 1681j(f), directs the Bureau to increase the maximum allowable charge a consumer reporting agency may impose for making a disclosure to the consumer pursuant to section 609 of the FCRA, 15 U.S.C. 1681g, on January 1 of each year, based proportionally on changes in the Consumer Price Index, with fractional changes rounded to the nearest fifty cents. The Bureau will publish notice of the maximum allowable charge each year by amending this appendix. For calendar year 2020, the maximum allowable charge is $12.50. For historical purposes:

1. For calendar year 2012, the maximum allowable disclosure charge was $11.50.
2. For calendar year 2013, the maximum allowable disclosure charge was $11.50.
3. For calendar year 2014, the maximum allowable disclosure charge was $11.50.
4. For calendar year 2015, the maximum allowable disclosure charge was $12.00.
5. For calendar year 2016, the maximum allowable disclosure charge was $12.00.
6. For calendar year 2017, the maximum allowable disclosure charge was $12.00.
7. For calendar year 2018, the maximum allowable disclosure charge was $12.00.
8. For calendar year 2019, the maximum allowable disclosure charge was $12.50.
9. For calendar year 2020, the maximum allowable disclosure charge is $12.50.

Dated: November 20, 2019.

Thomas Pahl,

Policy Associate Director, Bureau of Consumer Financial Protection.

[FR Doc. 2019–25695 Filed 11–26–19; 8:45 am]

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DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 35

[Docket No. RM19–5–000; Order No. 864]

Public Utility Transmission Rate Changes To Address Accumulated Deferred Income Taxes

AGENCY: Federal Energy Regulatory Commission.

ACTION: Final rule.

SUMMARY: In this final rule, the Federal Energy Regulatory Commission (Commission) is requiring public utility transmission providers with transmission formula rates under an Open Access Transmission Tariff, a transmission owner tariff, or a rate schedule to revise those transmission formula rates to account for changes caused by the Tax Cuts and Jobs Act of 2017. The Commission is requiring public utilities with transmission formula rates to include a mechanism in those transmission formula rates to deduct any excess accumulated deferred income taxes (ADIT) from or add any deficient ADIT to their rate bases. Public utilities with transmission formula rates are also required to incorporate a mechanism to decrease or increase their income tax allowances by any amortized excess or deficient ADIT, respectively. Finally, the Commission is requiring public utilities with transmission formula rates to incorporate a new permanent worksheet into their transmission formula rates that will annually track information related to excess or deficient ADIT. The Commission does not adopt the proposals in the notice of proposed rulemaking that were applicable to public utilities with transmission stated rates.

DATES: This rule is effective January 27, 2020.

FOR FURTHER INFORMATION CONTACT:

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[7] 5 U.S.C. 603(a), 604(a).

[8] 44 U.S.C. 3506; 5 CFR part 1320.

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I. Introduction

1. In this final rule, we require, pursuant to section 206 of the Federal Power Act [1] (FPA), all public utility transmission providers with transmission formula rates under an Open Access Transmission Tariff (OATT), a transmission owner tariff, or a rate schedule to revise those transmission formula rates to account for changes caused by the Tax Cuts and Jobs Act of 2017.[2] The requirements set forth in this final rule are designed to address the effects of the Tax Cuts and Jobs Act on the accumulated deferred income taxes (ADIT) reflected in transmission formula rates under an OATT, a transmission owner tariff, or a rate schedule of public utilities.

2. The requirements adopted in this final rule for public utilities with transmission formula rates track the proposals set forth in the notice of proposed rulemaking (NOPR) issued in this proceeding on November 15, 2018,[3] with certain modifications. However, as discussed below, we decline to adopt the requirements proposed in the NOPR that were applicable to public utilities with transmission stated rates. For transmission stated rates, we instead find that a public utility's next rate proceeding is the most appropriate place to address excess or deficient ADIT resulting from the Tax Cuts and Jobs Act.

3. We are adopting the requirements in the NOPR for all public utilities with transmission formula rates to include a mechanism in their formula rates to deduct any excess ADIT from or add any deficient ADIT to their rate bases (Rate Base Adjustment Mechanism). This requirement will ensure that a public utility's rate base continues to be treated in a manner similar to that prior to the Tax Cuts and Jobs Act (*i.e.,* that rate base neutrality is preserved).

4. We also adopt the NOPR proposal to require all public utilities with transmission formula rates to include a mechanism in their formula rates that decreases or increases their income tax allowances by any amortized excess or deficient ADIT, respectively (Income Tax Allowance Adjustment Mechanism). This requirement will ensure that public utilities with transmission formula rates return excess ADIT to or recover deficient ADIT from ratepayers.

5. Finally, we adopt the NOPR proposal to require all public utilities with transmission formula rates to incorporate a new permanent worksheet into their transmission formula rates that will annually track information related to excess or deficient ADIT (ADIT Worksheet). This requirement will increase the transparency surrounding the adjustment of rate bases and income tax allowances to account for excess or deficient ADIT by public utilities with transmission formula rates. However, we modify the NOPR proposal that public utilities with transmission formula rates submit an unpopulated worksheet in their compliance filings and instead require the worksheet to be populated. The populated worksheet will assist the Commission in analyzing the worksheet's function and help the Commission to assess whether the worksheet provides adequate transparency.

6. We require each public utility with transmission formula rates to submit a filing to demonstrate compliance with the final rule, including revisions to its transmission formula rates, as necessary, within the later of (1) 30 days of the effective date of this final rule or (2) the public utility's next annual informational filing following the issuance of this final rule.

II. Background

7. On December 22, 2017, the President signed into law the Tax Cuts and Jobs Act. The Tax Cuts and Jobs Act, among other things, reduced the federal corporate income tax rate from 35 percent to 21 percent, effective January 1, 2018. This means that, beginning January 1, 2018, companies subject to the Commission's jurisdiction compute income taxes owed to the IRS based on a 21 percent tax rate. The tax rate reduction will result in less federal corporate income tax expense going forward.[4]

8. Importantly, the tax rate reduction will also result in a reduction in ADIT liabilities and ADIT assets on the books of public utilities. ADIT balances are accumulated on the regulated books and records of public utilities based on the requirements of the Uniform System of Accounts (USofA). ADIT arises from timing differences between the method of computing taxable income for reporting to the IRS and the method of computing income for regulatory accounting and ratemaking purposes.[5] As a result of the Tax Cuts and Jobs Act reducing the federal corporate income tax rate from 35 percent to 21 percent, a portion of an ADIT liability that was

[1] *See* 16 U.S.C. 824e (2018).

[2] An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, Public Law 115–97, 131 Stat. 2054 (2017) (Tax Cuts and Jobs Act).

[3] *Public Utility Transmission Rate Changes to Address Accumulated Deferred Income Taxes,* 83 FR 59331 (Nov. 23, 2018), 165 FERC ¶ 61,117 (2018).

[4] *See* Tax Cuts and Jobs Act, Sec. 13001, 131 Stat. at 2096.

[5] *See* 18 CFR 35.24(d)(2) (2019) (''Timing differences means differences between the amounts of expenses or revenues recognized for income tax purposes and amounts of expenses or revenues recognized for ratemaking purposes, which differences arise in one time period and reverse in one or more other time periods so that the total amounts of expenses or revenues recognized for income tax purposes and for ratemaking purposes are equal.'').

collected from customers will no longer be due from public utilities to the IRS and is considered excess ADIT, which must be returned to customers in a cost of service ratemaking context.[6] Public utilities are required to adjust their ADIT assets and ADIT liabilities to reflect the effect of the change in tax rates in the period that the change is enacted.[7]

A. Overview of Public Utility Transmission Rates

9. The Commission is responsible for ensuring that the rates, terms, and conditions of service for wholesale sales and transmission of electric energy in interstate commerce are just, reasonable, and not unduly discriminatory or preferential. With respect to the transmission of electric energy in interstate commerce, most jurisdictional entities are subject to cost of service regulation. Cost of service regulation seeks to allow public utilities the opportunity to (1) recover operating costs, including income taxes, (2) recover the cost of capital investments, and (3) earn a just and reasonable return on investments.[8] Public utilities calculate their cost of service-based transmission rates predominately by using formula rates or stated rates. These transmission rates are contained in numerous agreements, including a public utility's OATT, a regional transmission operator's or independent system operator's OATT, coordination agreements, and wholesale distribution agreements.

10. When a public utility seeks to change its transmission stated rate, it files a rate case at the Commission to establish the cost of service revenue requirement, allocate costs to various customer groups, and set its rates. As an alternative, the Commission permits a public utility to establish its rates through a formula, in which the Commission accepts the public utility's cost of service calculation methodologies and input sources and allows the public utility to update those inputs every year.

11. Public utilities must seek changes to their transmission stated rates or formula rates through filings with the Commission under section 205 of the FPA,[9] while the Commission and third parties can challenge a rate in a proceeding initiated under section 206 of the FPA.

B. Order No. 144 and 18 CFR 35.24

12. The purpose of tax normalization is to match the tax effects of costs and revenues with the recovery in rates of those same costs and revenues.[10] As noted above, timing differences may exist between the method of computing taxable income for reporting to the IRS and the method of computing income for regulatory accounting and ratemaking purposes. The tax effects of these differences are placed in a deferred tax account to be used in later periods when the differences reverse.[11]

13. The Commission established its policy of tax normalization in Order No. 144, where it required use of ''the provision for deferred taxes [(*i.e.,* ADIT)] as a mechanism for setting the tax allowance at the level of current tax cost.'' [12] In keeping with this normalization policy, and as relevant to the Tax Cuts and Jobs Act's reduction of the federal corporate income tax rate, the Commission in Order No. 144 also required adjustments in the ADIT of public utilities' cost of service when excessive or deficient ADIT has been created as a result of changes in tax rates.[13] Furthermore, the Commission required ''a rate applicant to compute the income tax component in its cost of service by making provision for any excess or deficiency in its deferred tax reserves resulting . . . from tax rate changes.'' [14] The Commission required that such mechanism be consistent with a Commission-approved ratemaking method made specifically applicable to the rate applicant.[15] Where no ratemaking method has been made specifically applicable, the Commission required the rate applicant to advance some method in its next rate case.[16] The Commission stated that it would determine the appropriateness of any proposed method on a case-by-case basis, but as the Commission resolved the issue in a number of cases, a method with wide applicability may be adopted.[17] The Commission codified the requirements of Order No. 144 in its regulations in 18 CFR 35.24.[18]

C. Notice of Inquiry

14. Following the enactment of the Tax Cuts and Jobs Act, the Commission issued a Notice of Inquiry seeking comments on, among other things, whether, and if so, how, the Commission should address the effects of the Tax Cuts and Jobs Act on ADIT. The Commission noted that the Tax Cuts and Jobs Act's reduction of the federal corporate income tax rate would potentially create excess or deficient ADIT on the books of public utilities and sought comment on the appropriate treatment of excess and deficient ADIT in the transmission rates of public utilities.[19]

D. Notice of Proposed Rulemaking

15. In response to the Tax Cuts and Jobs Act, on November 15, 2018, the Commission issued the NOPR to address the fact that many, if not most, transmission formula rates of public utilities do not fully reflect any excess or deficient ADIT following a change in tax rates, as required by Order No. 144 and the Commission's regulations in 18 CFR 35.24. The Commission explained that, because the vast majority of public utilities have transitioned from stated rates to formula rates, a rate case no longer remains the appropriate vehicle for formula rates to reflect excess or deficient ADIT in a public utility's cost of transmission service, as contemplated by Order No. 144. The Commission further explained that a public utility's transmission formula rate should include mechanisms that accurately reflect excess or deficient ADIT in a public utility's cost of transmission service during the annual updates of the rest of the revenue requirement.[20]

16. As a result, the Commission proposed two requirements for public utilities with transmission formula rates to maintain an accurate cost of service following a change in income tax rates, such as that caused by the Tax Cuts and Jobs Act: (1) The Rate Base Adjustment

[6] The converse is true for public utilities that have ADIT assets.

[7] *See* 18 CFR 35.24 and 18 CFR 154.305 (2019); *see also Regulations Implementing Tax Normalization for Certain Items Reflecting Timing Differences in the Recognition of Expenses or Revenues for Ratemaking and Income Tax Purposes,* Order No. 144, FERC Stats. & Regs. ¶ 30,254 (1981) (cross-referenced at 18 FERC ¶ 61,163), *order on reh'g,* Order No. 144–A, FERC Stats. & Regs. ¶ 30,340 (1982)) (cross-referenced at 15 FERC ¶ 61,142).

[8] *See Pub. Sys.* v. *FERC,* 709 F.2d 73, 75 (D.C. Cir. 1983).

[9] *See* 16 U.S.C. 824d.

[10] Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,522, 31,530.

[11] *Id.* at 31,554.

[12] *Id.* at 31,530.

[13] *Id.* at 31,519.

[14] *Id.* at 31,560. *See also* 18 CFR 35.24(c)(1)(ii); 18 CFR 35.24(c)(2).

[15] Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,560. *See also* 18 CFR 35.24(c)(3).

[16] Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,560.

[17] *Id. See also* 18 CFR 35.24(c)(3).

[18] Originally promulgated as part of Order No. 144, the regulatory text was redesignated as 18 CFR 35.25 in Order No. 144–A. *See* Order No. 144–A, FERC Stats. & Regs. ¶ 30,340 at 30,140. In Order No. 545, the Commission again redesignated the regulatory text to its present designation as 18 CFR 35.24. *See Streamlining Electric Power Regulation,* Order No. 545, FERC Stats. & Regs. ¶ 30,955, at 30,713 (1992) (cross-referenced at 61 FERC ¶ 61,207).

[19] *Inquiry Regarding the Effect of the Tax Cuts and Jobs Act on Commission-Jurisdictional Rates,* 162 FERC ¶ 61,223 (2018) (NOI).

[20] NOPR, 165 FERC ¶ 61,117 at PP 15–16.

Mechanism, which preserves rate base neutrality through the removal of excess ADIT from or addition of deficient ADIT to rate base; and (2) the Income Tax Allowance Adjustment Mechanism, which returns excess ADIT to or recovery of deficient ADIT from ratepayers. Additionally, to provide greater transparency, the Commission proposed to require all public utilities with transmission formula rates to incorporate into their transmission formula rates the ADIT Worksheet, which is a new permanent worksheet that will annually track information related to excess or deficient ADIT. The Commission also proposed that the changes to transmission formula rates made in response to these requirements must be applicable to any future changes to tax rates that give rise to excess or deficient ADIT.[21]

17. Regarding public utilities with transmission stated rates, the Commission proposed maintaining Order No. 144's requirement that such public utilities reflect any adjustments made to their ADIT balances as a result of the Tax Cuts and Jobs Act (and any future tax changes) in their next rate case. However, to increase the likelihood that those customers who contributed to the related ADIT accounts receive the benefit of the Tax Cuts and Jobs Act, the Commission proposed to require public utilities with transmission stated rates to (1) determine any excess or deficient ADIT caused by the Tax Cuts and Jobs Act and (2) return or recover this amount to or from customers.[22]

18. Finally, the Commission proposed that, similar to the Commission's actions following the Tax Cuts and Jobs Act,[23] compliance filings made in response to this final rule's requirements may be considered on a single-issue basis given the limited scope of the proposed requirements.[24]

19. The Commission received comments from 14 entities in response to the NOPR.[25] In general, commenters supported the proposals in the NOPR relating to public utilities with transmission formula rates. However, commenters generally disagreed with the NOPR proposals relating to public utilities with transmission stated rates.

III. Discussion

A. Formula Rates

1. Ensuring Rate Base Neutrality

a. NOPR

20. In the NOPR, the Commission proposed to require all public utilities with transmission formula rates to include the Rate Base Adjustment Mechanism, which is a mechanism in their formula rates that deducts any excess ADIT from or adds any deficient ADIT to their rate bases, in order to preserve rate base neutrality. The Commission did not propose to prescribe a specific adjustment mechanism that would apply to all public utilities with transmission formula rates; rather, the Commission proposed to adopt a case-by-case approach that would allow public utilities to propose any necessary changes to their formula rates on an individual basis. The proposed case-by-case approach also included the ability for a public utility with transmission formula rates to demonstrate that its formula rate already meets the Rate Base Adjustment Mechanism requirements described in the NOPR.[26]

21. Additionally, the Commission did not propose new accounts for recording excess or deficient ADIT. Instead, the Commission noted that it had previously issued guidance on this accounting topic, finding that public utilities are required to record a regulatory asset (Account 182.3) associated with deficient ADIT or a regulatory liability (Account 254) associated with excess ADIT.[27]

b. Comments

22. Commenters generally supported the NOPR requirement to include mechanisms in the transmission formula rates of public utilities that adjust ADIT balances for any excess or deficient ADIT amounts in order to preserve rate base neutrality.[28] Similarly, commenters generally support the NOPR requirement that the Commission review the adjustments on a case-by-case basis and allow public utilities to demonstrate that their existing formula rates maintain rate base neutrality.[29] Industrial Customers assert that the underlying principle of tax normalization continues to be fully applicable and, given the insufficient mechanisms to reflect excess ADIT, provides ample support for the NOPR.[30] NRECA notes that its support is not intended to imply that additional Commission actions will not be needed for some public utilities in compliance filings and subsequent rate proceedings because the final rule may not address all details required to ensure just and reasonable rates.[31]

23. AMP states that the Commission should provide further guidance in, or use caution in reviewing compliance filings to, the final rule regarding transparency in excess and deficient ADIT adjustment mechanisms. AMP argues that the Commission-accepted method proposed by ITC Companies and Ameren Services Company erodes transparency because it requires manipulation of excess and deficient ADIT inputs prior to their inclusion in the formula rate.[32] AMP argues this also creates risk of error. AMP asserts that accounting for excess and deficient ADIT within the same ADIT accounts where the ADIT would have been recorded but for the change in tax rate, as described in its comments to the NOI, provides greater transparency.[33]

24. In contrast, MISO Transmission Owners contend that the Commission should rely on existing formula rate mechanisms to preserve rate base neutrality, such as the ones found in the formula rates of the MISO Transmission Owners that exclude excess ADIT from inputs to the formula rates and require that rate base be adjusted as excess and deficient ADIT are amortized.[34]

25. Eversource asserts that, where possible, any adjustments to preserve rate base neutrality should be done through existing mechanisms so long as they allow for the inclusion of Financial Accounting Standards Board Accounting Standards Codification (ASC) No. 740 (ASC 740) income tax

[21] *Id.* PP 17, 26.

[22] *Id.* P 18.

[23] *See AEP Appalachian Transmission Co., Inc.,* 162 FERC ¶ 61,225 (2018); *Alcoa Power Generating Inc.—Long Sault Division,* 162 FERC ¶ 61,224 (2018) (Tax Rate Related Orders to Show Cause).

[24] *See generally Indicated RTO Transmission Owners,* 161 FERC ¶ 61,018, at PP 13–14 (2017); *see also Rates Changes Relating to the Federal Corporate Income Tax Rate for Public Utilities,* Order No. 475, FERC Stats. & Regs. ¶ 30,752 (cross-referenced at 39 FERC ¶ 61,357), *order on reh'g,* 41 FERC ¶ 61,029 (1987) (cross-referenced at 41 FERC ¶ 61,029) (allowing public utilities to use a voluntary, abbreviated rate filing procedure to reduce their rates to reflect a reduction in the federal corporate income tax rate on a single-issue basis).

[25] A list of commenters to the NOPR and the abbreviated names used in this final rule appears in Appendix A.

[26] NOPR, 165 FERC ¶ 61,117 at PP 15–16.

[27] *See Accounting For Income Taxes,* Docket No. AI93–5–000 (April 23, 1993), *http://www.ferc.gov/enforcement/acct-matts/docs/AI93-5-000.asp* (Accounting for Income Taxes Guidance).

[28] *See* Eversource Comments at 7; AMP Comments at 2–3; EEI Comments at 4; Industrial Customers Comments at 4–5; NRECA Comments at 3–4.

[29] AMP Comments at 2–3; EEI Comments at 4; Eversource Comments at 9; MISO Transmission Owners Comments at 6–7.

[30] Industrial Customers Comments at 5.

[31] NRECA Comments at 3–4.

[32] AMP Comments at 3 (citing *Midcontinent Indep. Sys. Operator, Inc.,* 153 FERC ¶ 61,374 (2015); *Midcontinent Indep. Sys. Operator, Inc.,* 163 FERC ¶ 61,163 (2018)).

[33] AMP Comments at 2–4.

[34] MISO Transmission Owners Comments at 6–7.

regulatory deferral in rate base. To this end, Eversource agrees with the Commission that public utilities should record excess ADIT in Account 254 (Other Regulatory Liabilities) and deficient ADIT in Account 182.3 (Other Regulatory Assets) and notes that this requirement is consistent with USofA instructions.[35]

26. DEMEC requests that the Commission clarify that this final rule is intended to be consistent with the USofA, which only permits booking of regulatory assets and liabilities to Accounts 182.3 and 254 when those amounts cannot be booked to other accounts. DEMEC asserts that this will ensure that public utilities do not recover assets booked to Account 182.3 that are unrelated to excess or deficient ADIT that have been authorized for recovery by the Commission. DEMEC asserts that sufficient transparency could also be achieved by booking excess and deficient ADIT to new accounts, subaccounts of 182.3 and 254, or as subaccounts of Accounts 190, 281, and 283.[36]

27. DEMEC asserts that the final rule should incorporate the proper method for calculating any excess or deficient amounts of ADIT, which is to multiply ADIT balances as of December 31, 2017 by the ratio of the new tax rate, 21 percent, to the tax rate used to calculate the ADIT balance.[37]

c. Commission Determination

28. We adopt the proposal to require all public utilities with transmission formula rates to include the Rate Base Adjustment Mechanism in their transmission formula rates. The Rate Base Adjustment Mechanism is a mechanism by which public utilities deduct any excess ADIT from or add any deficient ADIT to their rate bases. Without such a mechanism, public utilities with transmission formula rates would violate the Commission's normalization requirements by overstating or understating their rate bases by the amount of any excess or deficient ADIT, respectively, generated as a result of a change to tax rates. Adopting this requirement will ensure that all public utilities with transmission formula rates offset their rate bases by any unamortized excess and deficient ADIT, thus maintaining rate base neutrality.

29. We affirm our statement in the NOPR that any Rate Base Adjustment Mechanism proposed in compliance with this rule must apply to any future changes to tax rates that give rise to excess or deficient ADIT.[38] We also find that any such mechanism should apply to state and local tax rate changes that give rise to excess and deficient ADIT. This general applicability will reduce the burden on public utilities with transmission formula rates in the long-term by avoiding the need for such public utilities to propose a new mechanism after every income tax rate change.

30. As proposed in the NOPR, we do not require that public utilities with transmission formula rates adopt a specific mechanism. Rather, we will allow public utilities to propose changes to their formula rates on a case-by-case basis. Similarly, public utilities may also demonstrate that their formula rates already meet the Rate Base Adjustment Mechanism requirements described in this final rule. Thus, because compliance filings will be evaluated on a case-by-case basis, we will not pre-approve or reject any specific adjustment method at this time as certain commenters suggest. However, in response to AMP's concern regarding transparency, we clarify that public utilities must clearly demonstrate in their compliance filings how their proposed mechanisms adjust rate base for excess and deficient ADIT through their transmission formula rates.[39]

31. We also find that, as noted in the NOPR, the Commission's previous accounting guidance interpreting the USofA regarding accounting for excess and deficient ADIT remains applicable.[40] In that guidance, the Commission stated that public utilities are required to record a regulatory asset (Account 182.3) associated with deficient ADIT or regulatory liability (Account 254) associated with excess ADIT.[41] As a result, we do not propose any changes to that accounting guidance.

2. Return or Recovery of Excess or Deficient ADIT

a. NOPR

32. The Commission proposed to require all public utilities with transmission formula rates to include the Income Tax Allowance Adjustment Mechanism in their formula rates. The Income Tax Allowance Adjustment Mechanism is a mechanism by which public utilities decrease or increase the income tax components of their formula rates by any amortized excess or deficient ADIT, respectively. Consistent with other aspects of the NOPR, the Commission proposed to review any such mechanisms on a case-by-case basis rather than proposing a single method for public utilities with transmission formula rates to adjust their income tax allowances for any amortized excess or deficient ADIT.[42]

33. Regarding the period over which the amortization of excess or deficient ADIT must occur, the Commission stated that public utilities should follow the guidance provided in the Tax Cuts and Jobs Act, where available. For certain excess and deficient ADIT, the Commission noted that the Tax Cuts and Jobs Act provides a method of general applicability and requires public utilities to return this excess ADIT no more rapidly than over the life of the underlying asset using the Average Rate Assumption Method, or, where a public utility's books and underlying records do not contain the vintage account data necessary, it must use an alternative method.[43] This excess and deficient ADIT is considered ''protected.'' In contrast, the Tax Cuts and Jobs Act does not specify what method public utilities must use for excess or deficient ADIT without such normalization requirements (*i.e.,* ''unprotected''), and therefore, the Commission proposed that it evaluate amortization periods for unprotected excess or deficient ADIT on a case-by-case basis.[44]

34. The Commission did not propose any specific requirements for transmission formula rates to ensure that customers receive the entire balance of excess ADIT caused by the Tax Cuts and Jobs Act (including the excess ADIT for the period beginning January 1, 2018 until the date a tariff revision to include the excess ADIT in the transmission formula rate becomes effective). Rather, the Commission explained that public utilities should not amortize an excess ADIT regulatory liability for accounting purposes until the Commission approves the ADIT regulatory liability for the public utility's transmission formula rate.[45] Accordingly, the Commission stated that excess ADIT scheduled to be

[35] Eversource Comments at 8–9.

[36] DEMEC Comments at 7–10.

[37] *Id.* at 10.

[38] NOPR, 165 FERC ¶ 61,117 at P 26.

[39] We note that the ADIT Worksheet required in this final rule will also address transparency concerns regarding how public utilities with transmission formula rates adjust their rate bases for excess and deficient ADIT.

[40] NOPR, 165 FERC ¶ 61,117 at P 28.

[41] Accounting for Income Taxes Guidance at 3, 8.

[42] NOPR, 165 FERC ¶ 61,117 at PP 36–37.

[43] Tax Cuts and Jobs Act, Sec. 13001(b)(6)(A), 131 Stat. at 2099. If a public utility must use an alternative method, Commission precedent provides that the public utility should use the Reverse South Georgia Method for excess ADIT or the South Georgia Method for deficient ADIT. *See Memphis Light, Gas & Water Div.* v. *FERC,* 707 F.2d 565, 569 (D.C. Cir. 1983).

[44] NOPR, 165 FERC ¶ 61,117 at P 38.

[45] *Id.* P 39.

returned to customers prior to the effective date of any tariff revisions made in compliance with the final rule should still be returned to customers. In other words, the full regulatory liability for excess ADIT should be captured in rates, beginning on the effective date of any proposed tariff provision.[46]

b. Comments

35. Most commenters agree with the Commission's proposal to require a mechanism in transmission formula rates that increases or decreases income tax allowances for any excess or deficient ADIT, respectively, and that such a mechanism should be evaluated on a case-by-case basis.[47] While agreeing with the basis for such a mechanism, AMP argues that the Commission should narrow the parameters of acceptable approaches by requiring the amortization of excess or deficient ADIT to occur within existing income tax expense and tax gross up calculations. Provided that such mechanisms are incorporated in existing income tax calculations, AMP also asserts that these mechanisms could be used for excess and deficient ADIT caused by state and local tax rate changes and that this will avoid redundant revisions that will be necessary if the Commission accepts mechanisms narrowly tailored to federal tax rate changes.[48]

36. Regarding the amortization of any excess or deficient ADIT, commenters also generally agree with the Commission that public utilities should rely on the guidance in the Tax Cuts and Jobs Act for protected excess ADIT.[49] Concerning unprotected excess ADIT, most commenters agree with the Commission that any amortization periods should be evaluated on a case-by-case basis.[50] DEMEC agrees with the Commission ''that those customers who contributed to the related ADIT accounts [should] receive the benefit of the Tax Cuts and Jobs Act.'' [51] As such, DEMEC argues that the Commission must reject any attempt to unduly delay return of unprotected excess ADIT to avoid any cross-generational cost allocation issues.[52]

37. However, certain commenters disagree with the Commission's statement that ''in applying a tax normalization method (*e.g.,* the Average Rate Assumption Method), public utilities are required to develop a schedule removing ADIT from rate base and returning it to customers, effective January 1, 2018, using the fastest allowable method to return the excess ADIT under the IRS' normalization requirements,'' to the extent the Commission is limiting its proposed case-by-case approach and shortening the range of acceptable amortization periods for unprotected excess and deficient ADIT to the ''fastest allowable method.'' [53] Accordingly, EEI and MISO Transmission Owners seek clarification that the final rule will not require public utilities to use a shortened amortization period for unprotected excess or deficient ADIT and that the Commission will evaluate amortization periods on a case-by-case basis.[54] EEI asserts that the diversity of assets giving rise to unprotected ADIT supports a case-by-case approach, as well as many other factors, including the desire to avoid different return or recovery periods at the state level.[55] MISO Transmission Owners also argue that a shortened amortization period could cause cash flow issues.[56] Xcel argues that excess and deficient ADIT should be amortized consistently across a public utility's various rate jurisdictions if possible.[57]

38. Furthermore, EEI and MISO Transmission Owners request that the Commission find that an amortization period matching the life of the asset that gave rise to the unprotected excess or deficient ADIT is *per se* just and reasonable.[58] MISO Transmission Owners assert that such a finding would not prevent public utilities from using shorter amortization periods, would increase administrative efficiency by minimizing future disputes, and is consistent with Commission precedent and the amortization approach established in Order Nos. 144 and 144–A.[59] Similarly, Eversource and Xcel argue that the amortization period for unprotected excess and deficient ADIT should be based on the approximate average life of the assets that gave rise to that excess or deficiency. Eversource argues that this is appropriate because the average remaining lives of assets are unique and distinct to each utility.[60] Xcel notes that the Commission accepted its operating company's, Southwestern Public Service Company (SPS), proposed five-year amortization period for unprotected excess and deficient ADIT and asserts that SPS's proposal takes into account the varying lives of its assets and intergenerational equity issues.[61]

39. Several commenters argue that the Commission should clarify that any such mechanism for transmission formula rates does not relieve a public utility of its obligation to submit an FPA section 205 filing to obtain Commission approval prior to reflecting regulatory assets or liabilities in rates. These commenters assert that Commission precedent supports a requirement for pre-approval.[62] DEMEC adds that such a requirement would be consistent with limits the Commission has placed on recovery of excess or deficient ADIT incurred prior to the Tax Cuts and Jobs Act.[63]

40. TAPS contends that, without a requirement for pre-approval, the NOPR could be read as providing public utilities unrestricted discretion to amortize a regulatory asset or liability over a period of their discretion.[64] Furthermore, TAPS argues, pre-approval of assets or liabilities holding excess or deficient ADIT will ensure rates are just and reasonable to accommodate the case-specific considerations of excess and deficient ADIT. TAPS additionally argues that a pre-approval requirement is similar to requirements for changes in depreciation rates.[65] TAPS contends that unlike other formula rate inputs that are verifiable and updated annually, the appropriate amortization period for excess and deficient ADIT is subjective. TAPS contends that the absence of a pre-approval requirement would violate the FPA by moving the burden to show the amortization of excess or deficient ADIT is just and reasonable from the public utility to the Commission or a customer to show that the proposed amortization is unjust and unreasonable.[66] APPA asserts that the Commission should require a footnote or other provision in transmission formula rates stating this obligation consistent with prior Commission

[46] *Id.*

[47] AMP Comments at 2–3; Eversource Comments at 10–11; NRECA Comments at 4; APPA Comments at 2; Industrial Customers Comments at 4–5.

[48] AMP Comments at 4–8.

[49] EEI Comments at 4–5; Eversource Comments at 12; MISO Transmission Owners Comments at 10–12.

[50] EEI Comments at 5–6; Eversource Comments at 12–13; MISO Transmission Owners Comments at 12–13; APPA Comments at 8; TAPS Comments at 6; Xcel Comments at 11–13.

[51] DEMEC Comments at 10.

[52] *Id.* at 10–11.

[53] EEI Comments at 4–6; MISO Transmission Owners Comments at 15–16; Xcel Comments at 12–13.

[54] EEI Comments at 4–6; MISO Transmission Owners Comments at 15–16.

[55] EEI Comments at 5.

[56] MISO Transmission Owners Comments at 14.

[57] Xcel Comments at 12.

[58] EEI Comments at 5–6.

[59] MISO Transmission Owners Comments at 13–14.

[60] Eversource Comments at 12.

[61] Xcel Comments at 12.

[62] AMP Comments at 8; APPA Comments at 8–9; DEMEC Comments at 5–6; TAPS Comments at 4–5.

[63] DEMEC Comments at 6.

[64] TAPS Comments at 4.

[65] *Id.* at 7.

[66] *Id.*

precedent.[67] APPA also recommends that the Commission clarify that the final rule does not allow recovery of past period deficient ADIT and does not modify or supersede the guidance the Commission provided in *Commonwealth Edison* regarding Order No. 144.[68]

41. In contrast, Eversource urges the Commission to allow public utilities to propose a return or recovery mechanism that adjusts the income tax allowance for any excess or deficient ADIT stemming from not only the Tax Cuts and Jobs Act but also future changes in federal and state income taxes without the need for future FPA section 205 filings.[69]

c. Commission Determination

42. We adopt the NOPR proposal to require all public utilities with transmission formula rates to include the Income Tax Allowance Adjustment Mechanism in their formula rates. Under this mechanism, public utilities decrease or increase the income tax components of their formula rates by any amortized excess or deficient ADIT, respectively. This mechanism will enable a public utility with transmission formula rates to ''compute the income tax component in its cost of service by making provision for any excess or deficiency in deferred taxes'' following changes in income tax rates, in compliance with Commission regulations and Order No. 144.[70]

43. While the Commission has accepted revisions to certain public utilities' transmission formula rates that adjust their income tax allowances as proposed by AMP (*i.e.,* within the existing income tax allowance calculation), we decline to narrow the range of possible approaches here. Consistent with other requirements in this final rule, we adopt the NOPR proposal to evaluate all such mechanisms on a case-by-case basis. Public utilities may also demonstrate that their formula rates already meet the Income Tax Allowance Adjustment Mechanism requirements described in this final rule. Additionally, any proposed mechanism must remain applicable to any future changes to tax rates that give rise to excess or deficient ADIT, including changes to state and local tax rates. We agree with AMP that the general applicability of a mechanism will avoid redundant revisions to transmission formula rates that might otherwise follow every tax rate change.

44. Regarding the period over which excess and deficient ADIT are amortized, we affirm our statement in the NOPR that public utilities should follow the guidance provided in the Tax Cuts and Jobs Act for protected excess ADIT. The Tax Cuts and Jobs Act provides a method of general applicability and requires public utilities to return protected excess ADIT[71] no more rapidly than over the life of the underlying asset using the Average Rate Assumption Method, or, where a public utility's books and underlying records do not contain the vintage account data necessary, it must use an alternative method.[72] We also adopt our proposal in the NOPR to evaluate any amortization periods for unprotected excess and deficient ADIT on a case-by-case basis. As noted in the NOPR, the Tax Cuts and Jobs Act does not specify a method to calculate amortization schedules for unprotected excess and deficient ADIT. Furthermore, a case-by-case evaluation will allow public utilities to propose amortization periods that better suit their and their customers' specific circumstances.

45. For both excess protected and unprotected ADIT, we affirm our statement in the NOPR that the full regulatory liability for excess ADIT should be captured in transmission formula rates, beginning on the effective date of any proposed tariff provision. In other words, the full amount of excess ADIT resulting from the Tax Cuts and Jobs Act must be returned to transmission formula rate customers.

46. We clarify that our statement that ''public utilities are required to develop a schedule removing ADIT from rate base and returning it to customers, effective January 1, 2018, using the fastest allowable method to return the excess ADIT under the IRS' normalization requirements'' was only in reference to the Tax Cuts and Jobs Act's requirement that *protected* excess ADIT may not be returned more rapidly than the life of the underlying asset. The Tax Cuts and Jobs Act places no restrictions on unprotected excess and deficient ADIT amortization schedules, and public utilities may propose amortization schedules that appropriately balance the respective circumstances of those public utilities and their customers, provided the full amount of excess ADIT resulting from the Tax Cuts and Jobs Act is returned to customers.

47. Additionally, we deny EEI's and MISO Transmission Owners' requests to find that an amortization period matching the life of the underlying asset for unprotected excess and deficient ADIT is *per se* just and reasonable. While certain public utilities have demonstrated that amortization periods matching the lives of their assets are just and reasonable, we find that a generally applicable determination that such amortization periods are *per se* just and reasonable runs counter to the case-by-case approach that the Commission will use to evaluate proposed amortization periods for excess and deficient ADIT. Moreover, the diverse sources of unprotected excess and deficient ADIT do not lend themselves to a general finding on an appropriate amortization period. We also note that, contrary to MISO Transmission Owners' assertion, Order No. 144 did not establish a generally applicable amortization method for excess and deficient ADIT.[73] Similarly, we will evaluate requests by public utilities to amortize excess and deficient ADIT using an amortization period approved in a state proceeding on a case-by-case basis.

48. Because of the requirements adopted in this final rule, we will not require that public utilities make a filing pursuant to FPA section 205 to obtain Commission approval prior to including excess and deficient ADIT in their transmission formula rates following future changes to tax rates, as some commenters have requested. While those commenters are correct that the Commission has previously required that public utilities obtain such Commission approval, we find that with the ADIT Worksheet adopted as part of this final rule and discussed below, it is no longer necessary to require an FPA section 205 filing prior to including excess and deficient ADIT in transmission formula rates. Specifically, the ADIT Worksheet will provide

[67] APPA Comments at 8–9 (citing *So. Cal. Edison Co.,* 166 FERC ¶ 61,006, at P 24 (2019); *PJM Interconnection, L.L.C.,* 165 FERC ¶ 61,275, at P 28 (2018) (*PJM*)).

[68] APPA Comments at 7 (citing *Commonwealth Edison Co.,* et al., 164 FERC ¶ 61,172 (2018) (*Commonwealth Edison*)). In *Commonwealth Edison,* the Commission announced a limited, one-year compliance period in which public utilities could file to recover past ADIT if the public utility did not file a rate case subsequent to the Commission's issuance of Order No. 144 or if the public utility properly preserved its right to recover past ADIT through settlement terms. *Commonwealth Edison,* 164 FERC ¶ 61,172 at P 132.

[69] Eversource Comments at 8, 11.

[70] 18 CFR 35.24(c)(2); Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,560.

[71] While the Tax Cuts and Jobs Act does not mention protected deficient ADIT specifically, we expect that public utilities will recover such protected deficient ADIT in the same manner prescribed for protected excess ADIT.

[72] *See supra* n.43.

[73] Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,560 (''Since the appropriateness of any method to accomplish the objective of full normalization at current tax rates has not been analyzed by the Commission on a generic basis, the Commission is, at this time, requiring resolution of this problem on a case-by-case basis.'').

transparency and allow for Commission and customer review of the public utility's calculation of excess and deficient ADIT, as well as the associated amortization schedule for returning or recovering excess and deficient ADIT, respectively.

49. We disagree with TAPS' assertion that not requiring public utilities with transmission formula rates to seek Commission approval prior to including excess and deficient ADIT in their transmission formula rates following future changes to tax rates will shift the burden of proof from the public utility to the Commission or customer. To be considered just and reasonable, the Commission-approved implementation protocols of public utilities with transmission formula rates must require that public utilities provide underlying data and calculations supporting all inputs that are not supported in the FERC Form No. 1 or in other tariff schedules in formula rate annual updates and, where applicable, true-ups.[74] As such, as with any other transmission formula rate input, customers can request information about and challenge the amortization period for excess or deficient ADIT.[75] Further, when a customer challenges the data that is flowed into the formula rate from worksheets like the ADIT Worksheet, the public utility continues to bear the burden to show ''the justness and reasonableness of the rate resulting from its application of the formula.'' [76]

50. We also disagree with TAPS' assertion that public utilities could have unrestricted discretion to amortize a regulatory asset or liability over a period of their choice. First, a public utility must support its chosen amortization period for excess or deficient ADIT in its annual update following a change in tax rates as just and reasonable, as discussed above. Second, our determination here applies only to excess or deficient ADIT, which are types of regulatory liabilities and assets, respectively; it does not relieve public utilities of their obligation to obtain Commission approval prior to including other regulatory assets and liabilities in their transmission formula rates.

51. Regarding APPA's comment, we clarify that the requirements adopted here apply only to excess and deficient ADIT caused by the Tax Cuts and Jobs Act and any future tax rate changes, not past period deficient ADIT, and, therefore, do not conflict with the Commission's determination in *Commonwealth Edison.*

3. Support for Excess and Deficient ADIT Calculation and Amortization

a. NOPR

52. The Commission proposed to require all public utilities with transmission formula rates to incorporate the ADIT Worksheet, which is a new permanent worksheet that will annually track information related to excess or deficient ADIT, into their transmission formula rates. The Commission did not propose to require this worksheet to be populated when submitted to the Commission on compliance with the final rule. Further, the Commission did not propose a *pro forma* worksheet and instead proposed broad categories of information that each worksheet should contain at a minimum, including: (1) How any ADIT accounts were re-measured and the excess or deficient ADIT contained therein; (2) the accounting for any excess or deficient amounts in Accounts 182.3 (Other Regulatory Assets) and 254 (Other Regulatory Liabilities); (3) whether the excess or deficient ADIT is protected or unprotected; (4) the accounts to which the excess or deficient ADIT are amortized; and (5) the amortization period of the excess or deficient ADIT being returned or recovered through the rates. The Commission specifically requested comments on whether it should consider additional guiding principles.[77]

b. Comments

53. In general, comments from transmission customers supported the proposal for the ADIT Worksheet,[78] while comments from transmission owners and groups representing transmission owners did not.[79]

54. Certain transmission customers supporting the Commission's proposal believe that additional requirements are necessary to ensure just and reasonable rates. AMP and Six Cities argue that the Commission should also require a standard template or *pro forma* worksheet. AMP asserts that, while a one-size-fits-all approach may not be appropriate for the other requirements proposed in the NOPR, a standard template could be provided akin to a FERC Form No. 1. AMP further asserts that such standardization will promote development of technical expertise and ratemaking efficiency, while benefiting customers by providing a better opportunity for meaningful review. AMP states that if the Commission does not adopt a standard template, it should, at a minimum, require public utilities to file an annual worksheet containing the minimum reporting requirements discussed by AMP.[80] Six Cities argue that a *pro forma* worksheet will reduce the need for information exchange and allow interested parties to better assess what was and was not included.[81]

55. AMP and Six Cities argue that the Commission should require public utilities to provide specific information in the proposed worksheet. AMP asserts that the Commission should require public utilities to provide item-by-item accounting to verify public utilities' classification of excess or deficient ADIT as protected or unprotected because the rate impact associated with this classification is generally significant and material. Six Cities argue that the worksheet should contain a breakdown of ADIT detailed enough to discern whether a public utility is seeking to recover ADIT items in contravention of USofA. AMP argues that public utilities should also provide line-by-line accounting for any excess or deficient ADIT or ADIT associated with other comprehensive income or that has been moved outside of regulated rate base or cost of service entirely. AMP argues that line-by-line accounting will enable customers to verify that they are made whole for all ADIT charged previously.[82]

56. AMP argues that the proposed worksheet should also include a public utility's proposed amortization period for protected and unprotected excess and deficient ADIT and all supporting documentation.[83] Six Cities contend that the proposed worksheet should also itemize protected and unprotected excess and deficient ADIT into more granular categories. In addition, Six Cities assert that public utilities should be required to specify items that are either below the line or inapplicable to customers to ensure deficient ADIT related to these items is not collected.[84] AMP and Six Cities argue that their

[74] *See Midwest Indep. Transmission Sys. Operator, Inc.,* 143 FERC ¶ 61,149, at P 86 (2013) (*MISO*). *See also The Empire Dist. Elec. Co.,* 148 FERC ¶ 61,030 (2014); *Black Hills Power, Inc.,* 148 FERC ¶ 61,035 (2014); *Kan. City Power & Light Co. and KCP&L Greater Mo. Operations Co.,* 148 FERC ¶ 61,034 (2014); *UNS Elec., Inc.,* 148 FERC ¶ 61,032 (2014); *PJM Interconnection, LLC,* 152 FERC ¶ 61,180 (2015).

[75] *Id.* PP 91, 118–120.

[76] *Id.* P 120 (quoting *Va. Elec. & Power Co.,* 123 FERC ¶ 61,098, at P 47 (2008)).

[77] NOPR, 165 FERC ¶ 61,117 at PP 46–47.

[78] AMP Comments at 9–11; NRECA Comments at 4–5; APPA Comments at 10; DEMEC Comments at 11; Industrial Customers Comments at 5.

[79] EEI Comments at 6–7; Eversource Comments at 14–15; MISO Transmission Owners Comments at 21–22; PSEG Comments at 2.

[80] APPA Comments at 10–11.

[81] Six Cities Comments at 7–8.

[82] AMP Comments at 6–11; Six Cities Comments at 7–10.

[83] AMP Comments at 8–10.

[84] Six Cities Comments at 8–10.

proposed additions to the worksheet should be included regardless of whether the Commission adopts its suggestion to require a *pro forma* worksheet.[85]

57. APPA argues that the Commission should require public utilities with transmission formula rates to submit a populated version of the proposed worksheet, including actual ADIT cost or accounting information relating to the ADIT effects of the Tax Cuts and Jobs Act. APPA states that, without this information, interested parties would not have an opportunity to review a public utility's ADIT accounting information until the first annual update following when the revised formula rate provisions become effective. APPA argues that this information will assist the Commission in evaluating whether the proposed mechanism and amortization periods are just and reasonable and consistent with Commission precedent.[86] APPA recommends that a public utility's transmission formula rate protocols must allow interested parties to request information concerning the information in the annual worksheet and the ADIT effects of the Tax Cuts and Jobs Act. To the extent that a given transmission formula rate protocol does not allow for this, APPA argues that public utilities should be required to make the necessary tariff revisions in their compliance filings.[87]

58. Conversely, many transmission owners or affiliated groups argue that the Commission's proposed worksheet is burdensome and not necessary. Certain commenters assert that the information provided annually in the FERC Form No. 1 and documentation under the existing requirements of transmission formula rate protocols provide sufficient transparency.[88] EEI and PSEG note that, under the Commission's 2014 Staff Guidance, inputs to formula rates must be fully supported, and, to the extent an input is not a specific line item in the FERC Form No. 1, public utilities must provide detailed workpapers showing the origin of the input in relation to the FERC Form No. 1 data.[89] PSEG argues that requiring additional information regarding ADIT calculations when the current requirements provide sufficient transparency is unnecessary and burdensome.[90] MISO Transmission Owners note that they committed in comments to the NOI to providing a workpaper in each annual update with excess and deficient ADIT information. MISO Transmission Owners argue that this workpaper, in combination with the required information exchange procedures that are part of the annual update filing, provides a just and reasonable process.[91] MISO Transmission Owners state that, to the extent any information required by the proposed worksheet is not provided in their FERC Forms No. 1, they could provide the additional information in footnotes.[92]

59. Certain transmission owners and associated groups also argue that the proposed worksheet is redundant because it seeks essentially identical information as the Commission's disclosure requirements in the Commission's ADIT Treatment Following Asset Sales and Retirements Policy Statement on the Accounting and Ratemaking Treatment of Accumulated Deferred Income Taxes and Treatment Following the Sale or Retirement of an Asset (ADIT Treatment Following Asset Sales and Retirements Policy Statement).[93] Eversource argues that the language in the ADIT Treatment Following Asset Sales and Retirements Policy Statement suggests that the disclosure requirements are intended to apply generally beyond the sale or retirement of an asset and, thus, it would be duplicative and confusing to also require public utilities to submit this information in their formula rates.[94] While not taking a position on whether the ADIT Worksheet would be duplicative, MISO Transmission Owners argue that no consensus or Commission guidance exists as to how public utilities should amortize excess and deficient ADIT following the ADIT Treatment Following Asset Sales and Retirements Policy Statement's guidance that public utilities should continue to amortize excess ADIT in rates even after the sale or retirement of an asset. MISO Transmission Owners contend that it is therefore unclear how public utilities would address this issue in the proposed worksheet.[95]

60. MISO Transmission Owners agree with the Commission that adequate transparency is necessary but contend that the calculations of excess and deficient ADIT balances will only occur once (*i.e.,* as of December 31, 2017) and the vast majority of information in the proposed worksheet will remain unchanged going forward. MISO Transmission Owners argue that creating an appropriate worksheet will be a time-consuming and tedious process because of the Commission's assertion that the proposed worksheet should be tailored to each public utility's unique circumstances. MISO Transmission Owners contend that requiring a worksheet may also be burdensome for the Midcontinent Independent System Operator, Inc. (MISO) to implement because MISO is responsible for administering its tariff and MISO's staff would need to familiarize themselves with many versions of the worksheets that are housed within MISO's tariff.[96] MISO Transmission Owners assert that public utilities could also provide ADIT workpapers to customers outside of a tariff-based procedure, such as an Open Access Same-Time Information System (OASIS) or website posting. MISO Transmission Owners argue that the Commission did not address in the NOPR why these alternatives are not just and reasonable.[97]

61. Xcel requests that, to the extent the final rule imposes administrative requirements such as a worksheet, the Commission should not require public utilities to revise settlements related to the specific contents for documenting the flow-back of excess and deficient ADIT.[98]

c. Commission Determination

62. We adopt the NOPR proposal to require all public utilities with transmission formula rates to include the ADIT Worksheet, which is a new permanent worksheet that will annually track information related to excess and deficient ADIT, in their transmission formula rates. We find that such a worksheet is necessary to provide interested parties and the Commission adequate transparency regarding how public utilities with transmission formula rates adjust their rate bases and income tax allowances to account for excess or deficient ADIT. We also find that making the worksheet a permanent part of transmission formula rates, as opposed to a one-time filing after the Tax Cuts and Jobs Act, will ensure that

[85] AMP Comments at 11; Six Cities Comments at 10.

[86] APPA Comments at 9–10.

[87] *Id.* at 10.

[88] EEI Comments at 6–7; MISO Transmission Owner Comments at 20–22; PSEG Comments at 2–3.

[89] EEI Comments at 6–7; PSEG Comments at 2–3.

[90] PSEG Comments at 3.

[91] MISO Transmission Owners Comments at 19–20.

[92] *Id.* at 22.

[93] *Accounting and Ratemaking Treatment of Accumulated Deferred Income Taxes and Treatment Following the Sale or Retirement of an Asset,* 83 FR 59,295 (Nov. 23, 2018), 165 FERC ¶ 61,115 (2018). *See* Eversource Comments at 13–15; EEI Comments at 6; PSEG Comments at 2.

[94] Eversource Comments at 13–15.

[95] MISO Transmission Owners Comments at 19.

[96] *Id.* at 18–19.

[97] *Id.* at 22.

[98] Xcel Comments at 11.

excess or deficient ADIT can be tracked as it is included in the annual revenue requirement. Additionally, the ADIT Worksheet will provide sufficient transparency for excess and deficient ADIT included in rates following future local, state, and federal tax rate changes. Finally, we find that the NOPR proposal to require five categories of information in the worksheet strikes an appropriate balance between transparency for interested parties and burden to the industry.

63. We agree with APPA's comments to require public utilities with transmission formula rates to submit worksheets populated with excess and deficient ADIT resulting from the Tax Cuts and Jobs Act. This represents a departure from the NOPR proposal that required the function of the worksheet to be clear when filed on compliance, but did not require the worksheet to be populated. We find that a populated worksheet will facilitate the review of the proposed worksheet's function by interested parties and the Commission prior to the first annual update. In addition, we believe that a populated worksheet will assist the Commission in determining whether the worksheet adequately addresses the transparency concerns that led the Commission in the NOPR to propose requiring the worksheet.

64. We also affirm the NOPR proposal to not require a *pro forma* or standard template worksheet despite comments requesting the adoption of such. We do not believe that the worksheet lends itself to a *pro forma* or standard template.[99] We find that any benefits flowing from adopting such a template are outweighed by the difficulty in developing such a template because excess and deficient ADIT depends on the circumstances of each public utility. This is especially true because of the diverse sources of unprotected excess and deficient ADIT.

65. We agree in part with AMP's and Six Cities' requests for public utilities to provide specific information in the proposed worksheet. We specifically find that the Commission's requirement for public utilities to include five categories of information in the proposed worksheet overlaps with AMP's and Six Cities' requests. For example, AMP's request for the worksheet to include the proposed amortization period for excess and deficient ADIT is covered by category five—the amortization period of the excess or deficient ADIT being returned or recovered through rates. Similarly, AMP's and Six Cities' request for an item-by-item accounting or itemization of excess or deficient ADIT in the worksheet is covered by category two—the accounting for any excess or deficient amounts in Accounts 182.3 and 254. We expect public utilities to identify each specific source of the excess or deficient ADIT, classify the excess or deficient ADIT as protected or unprotected, and list the proposed amortization period associated with each classification or source in their proposed worksheets, which will provide sufficient detail to verify excess and deficient ADIT resulting from the Tax Cuts and Jobs Act and future tax rate changes. Because we will also review the compliance filings to determine whether the proposed amortization periods for any excess and deficient ADIT resulting from the Tax Cuts and Jobs Act are just and reasonable,[100] we also expect public utilities to provide supporting documentation necessary to justify those proposed amortization periods. In addition, for future tax rate changes where excess and deficient ADIT will automatically be included in a public utility's formula rate without the need for an FPA section 205 filing, we expect public utilities to provide supporting documentation for the excess and deficient ADIT inputs to the ADIT Worksheet to customers as part of their annual update process. Further, public utilities should include the supporting documentation in their annual informational filings to the Commission following a tax rate change.

66. We acknowledge that, given the diverse sources of excess or deficient ADIT, a public utility or its transmission formula rate may have some unique attribute that requires additional categories of information to provide interested parties and the Commission with a complete understanding of that public utility's treatment of excess and deficient ADIT. As described elsewhere in this final rule, the Commission will consider public utilities' proposals to implement the ADIT Worksheet on a case-by-case basis.[101] We note that the five categories of information required to be included in the ADIT Worksheet represent the minimum information that the worksheet should contain.

67. We find that Commission precedent already requires a public utility's transmission formula rate protocols to allow interested parties to request the type of information contained in the ADIT Worksheet.[102] We therefore disagree with APPA's request and will not require revisions to a public utility's transmission formula rate protocols for purposes of this rulemaking proceeding.

68. We disagree with arguments that the worksheet is unnecessary or overly burdensome to administer, or will otherwise be overly time consuming to create. First, arguments that information in the ADIT Worksheet may overlap with information provided in FERC Form No. 1 are misplaced. The ADIT Worksheet will provide more detailed information than what is included in a public utility's FERC Form No. 1. Moreover, the level of detail and manner in which regulatory liabilities are disclosed in the FERC Form No. 1 vary across public utilities and may not uniformly support amounts used as inputs to the formula rate. Second, we affirm our position in the NOPR that public utilities already gathered the information required for the worksheet when they re-measured their ADIT balances as a result of the Tax Cuts and Jobs Act.

69. Third, while MISO Transmission Owners are correct that the calculation of excess and deficient ADIT will be performed once for the Tax Cuts and Jobs Act, the ADIT Worksheet will also reflect any excess or deficient ADIT resulting from future tax rate changes, including state and local tax changes. Furthermore, the worksheet will enable interested parties and the Commission to track the amortization of excess or deficient ADIT over time. Fourth, as discussed above, with the information provided in the ADIT Worksheet, we

[99] *See, e.g., Ariz. Pub. Serv. Co.,* Docket No. ER18–975–001 (May 22, 2018) (delegated order); *Pub. Serv. Co. of Colo.,* Docket Nos. ER19–2077–000 & ER19–2077–001 (Sep. 11, 2019) (delegated order).

[100] *See infra* P 104.

[101] We note that the public utility would need to demonstrate that its proposal is consistent with or superior to the requirements of the final rule. *See Promoting Wholesale Competition Through Open Access Non-Discriminatory Transmission Services by Public Utilities; Recovery of Stranded Costs by Public Utilities and Transmitting Utilities,* Order No. 888, 61 FR 21540, at 21619 (May 10, 1996), FERC Stats. & Regs. ¶ 31,036 (1996) (cross-referenced at 75 FERC ¶ 61,080), *order on reh'g,* Order No. 888–A, 62 FR 12274 (Mar. 14, 1997), FERC Stats. & Regs. ¶ 31,048 (cross-referenced at 78 FERC ¶ 61,220), *order on reh'g,* Order No. 888–B, 81 FERC ¶ 61,248 (1997), *order on reh'g,* Order No. 888–C, 82 FERC ¶ 61,046 (1998), *aff'd in relevant part sub nom. Transmission Access Policy Study Grp.* v. *FERC,* 225 F.3d 667 (D.C. Cir. 2000), *aff'd sub nom. N.Y.* v. *FERC,* 535 U.S. 1 (2002). An interested party could also protest a public utility's proposed worksheet and argue that additional categories of information are necessary given that public utility's unique attributes.

[102] *See MISO,* 143 FERC ¶ 61,149 at P 86 (finding that public utilities must provide ''sufficient detail and with sufficient explanation to demonstrate that each input to the formula rate is consistent with the requirements of the formula rate, without forcing interested parties to make extensive information requests to understand the transmission owner's implementation of the formula rate and to verify its correctness'').

will no longer require public utilities to make an FPA section 205 filing to include excess and deficient ADIT in rates after tax rate changes that result in excess and deficient ADIT. Instead, we will rely on the worksheet to provide the requisite transparency for excess and deficient ADIT. We find that relying on the worksheet instead of requiring a public utility to make an FPA section 205 filing after every tax change will result in an overall reduction in the burden of a public utility with a transmission formula rate over the long run.

70. Additionally, some commenters argue against the worksheet because their transmission formula rate protocols already require them to provide information on excess and deficient ADIT. To the extent that a public utility already provides information on excess and deficient ADIT due to existing requirements in its transmission formula rate protocols, we find that the ADIT Worksheet should not create an undue ongoing burden for the public utility. The Commission has also required public utilities to revise their transmission formula rates to include greater detail where the Commission deemed that certain inputs to the transmission formula rate are complex enough to warrant prior understanding of their effect.[103]

71. Similarly, we also disagree with comments that the worksheet is redundant because it seeks the same information that public utilities must disclose following the Commission's issuance of the ADIT Treatment Following Asset Sales and Retirements Policy Statement. The FERC Form No. 1 disclosures required under the ADIT Treatment Following Asset Sales and Retirements Policy Statement are not specific enough to identify the effect of excess and deficient ADIT for a particular transmission formula rate on file with the Commission. Therefore, we find that the worksheet will provide additional transparency to the Commission and interested parties on excess and deficient ADIT.

72. We disagree with MISO Transmission Owners' comments that it is unclear how public utilities should address the amortization of excess and deficient ADIT following the sale or retirement of an asset. The ADIT Treatment Following Asset Sales and Retirements Policy Statement states that, in cases for which the excess and deficient ADIT do not transfer to the purchaser of the plant asset, public utilities' balances of excess and deficient ADIT recorded in Account 254 and Account 182.3 continue to exist as regulatory liabilities and assets after an asset sale or an extraordinary retirement.[104] The ADIT Treatment Following Asset Sales and Retirements Policy Statement further states that public utilities should therefore continue to amortize excess or deficient ADIT balances upon such sales and retirements.[105] Because the Commission's guidance provides that public utilities should continue to record and amortize such liabilities and assets as any other excess ADIT liability or deficient ADIT asset, we reiterate that public utilities should treat these liabilities and assets as any other excess or deficient ADIT in their worksheets.

73. We decline to adopt MISO Transmission Owners' suggestion that public utilities could provide ADIT workpapers to customers through their OASIS or the Transmission Owner Rate Data section of the MISO website instead of including the worksheet as part of their transmission formula rates. We find that it is appropriate to require public utilities to include the worksheet as part of their transmission formula rates because these rates already provide a Commission-approved process that allows interested parties to request information about excess and deficient ADIT and provides a well understood framework to challenge information or data contained in the worksheet. Rather than creating an entirely new process, which could create additional burdens on industry, we believe that utilizing existing processes will help to ensure a fair and efficient process whenever tax rates change in the future.

74. We do not agree with Xcel that the Commission should exempt public utilities from revising settlement agreements to account for certain ''administrative requirements,'' such as the worksheet that documents the amortization of excess and deficient ADIT. Instead, in keeping with the Commission's decision to evaluate any revisions made in compliance with this final rule on a case-by-case basis, a public utility may show that its existing ADIT-related mechanisms, including those established by a Commission-approved settlement, meet the requirements of this final rule.

B. Stated Rates

1. NOPR

75. The Commission proposed to require all public utilities with transmission stated rates to (1) determine the excess and deficient ADIT created as a result of the Tax Cuts and Jobs Act and (2) return this amount to or recover this amount from customers under 18 CFR 35.24. The Commission further proposed to require these public utilities to calculate their excess or deficient ADIT using the ADIT approved in their last rate cases.[106] The Commission did not propose a specific mechanism for public utilities with transmission stated rates to return or recover the excess or deficient ADIT to or from ratepayers. In keeping with the proposal for public utilities with transmission formula rates, the Commission proposed to require public utilities with transmission stated rates to follow guidance in the Tax Cuts and Jobs Act for the appropriate amortization period for protected excess or deficient ADIT, while allowing amortization periods for unprotected excess or deficient ADIT to be determined on a case-by-case basis.[107]

2. Comments

76. EEI and Avista argue that any issues related to ADIT should be addressed in the rate cases of public utilities with transmission stated rates.[108] EEI and Avista assert that such a finding would be consistent with the Commission's decision in Order No. 144, issued at a time when all public utilities' transmission rates were stated.[109] EEI argues that the proposal in the NOPR would effectively order through the return of excess ADIT a reduction in existing transmission stated rates without claiming to act under FPA section 206 authority or first meeting the Commission's burden to demonstrate that those transmission stated rates are unjust and unreasonable. EEI contends that this stands in contrast to the Commission's actions in the Tax Rate-Related Orders to Show Cause. EEI agrees with the Commission's statement in the NOPR that, while ADIT balances may have changed as a result of the Tax Cuts and Jobs Act, many aspects other than ADIT balances that underlie a transmission stated rate may have

[103] *See* NOPR, 165 FERC ¶ 61,117 at P 49 (citing *Midcontinent Indep. Sys. Operator, Inc.,* 153 FERC ¶ 61,374 at P 14 (directing certain transmission companies to revise their transmission formula rates to include worksheets to ensure appropriate transparency)); *Xcel Energy Sw. Transmission Co., LLC,* 149 FERC ¶ 61,182 (2014); *Xcel Energy Transmission Dev. Co., LLC,* 149 FERC ¶ 61,181 (2014); *Transource Wisconsin, LLC,* 149 FERC ¶ 61,180 (2014); *Transource Kansas, LLC,* 151 FERC ¶ 61,010 (2015) (requiring revisions to new formula rates to provide greater transparency)).

[104] ADIT Treatment Following Asset Sales and Retirements Policy Statement, 165 FERC ¶ 61,115 at P 37, n.79.

[105] *Id.* P 36; *see also id.* PP 40–43.

[106] NOPR, 165 FERC ¶ 61,117 at P 40.

[107] *Id.* P 42.

[108] EEI Comments at 8–11.

[109] *Id.;* Avista Comments at 2–3.

changed.[110] EEI and Avista argue that addressing the ADIT-related effects of the Tax Cuts and Jobs Act in the next rate case is more reasonable, efficient, and accurate than the Commission's proposal.[111] Similarly, FirstEnergy supports the assertions and conclusions in EEI's comments.[112]

77. Furthermore, EEI contends, it may be infeasible for public utilities with transmission stated rates resulting from a black box settlement to identify ADIT balances because they were not individually negotiated. EEI requests that, if the Commission adopts the proposed requirements for public utilities with transmission stated rates, the Commission should clarify how such public utilities with black box settlements should perform the necessary calculations or allow them to address ADIT in their next rate cases.[113]

78. EEI argues, and Avista agrees, that the Commission should clarify that, where it has found that a public utility with a transmission stated rate does not need to revise such rate to reflect the reduced federal income tax rate following the Tax Rate-Related Orders to Show Cause, those public utilities are not required to make a filing in compliance with the final rule.[114]

79. EEI argues that, if the Commission does require public utilities with transmission stated rates to make compliance filings, it should establish a threshold such that the final rule only applies to agreements with annual revenues/charges per agreement above $100,000 to $500,000 per year. EEI asserts that, below that threshold, the cost of preparing a compliance filing would exceed the amount returned to customers.[115]

80. EEI asserts that, its arguments regarding compliance filings and public utilities with transmission stated rates notwithstanding, addressing compliance with the final rule on a single-issue basis is appropriate and efficient. Industrial Customers agree that such a single-issue ratemaking approach is warranted.[116] EEI notes that the Commission has historically demonstrated a willingness to allow single-issue filings to address tax-related changes to rates.[117]

81. Separately, EEI argues that the five categories of information the NOPR proposes as necessary to support the compliance filings of public utilities with transmission stated rates are duplicative of the additional disclosures required in their FERC Form No. 1 filings following issuance of the ADIT Treatment Following Asset Sales and Retirements Policy Statement. EEI asserts that the Commission should clarify that the ADIT Treatment Following Asset Sales and Retirements Policy Statement's required disclosures obviate the need for this information to be presented in compliance filings to the final rule. Alternatively, EEI requests that the Commission should confirm that a compliance filing is not necessary for public utilities with transmission stated rates that included the ADIT Treatment Following Asset Sales and Retirements Policy Statement's required information in their FERC Form No. 1s.[118]

82. On the other hand, AMP argues that the Commission should require public utilities with transmission stated rates to file the same worksheet proposed for public utilities with transmission formula rates. AMP states that such a worksheet, which would be filed annually, would be used to track and defer, for future return or recovery, changes in the annual amortization of excess and deficient ADIT. AMP states that, alternatively, transmission stated rates could be adjusted each year to reflect required changes to annual excess and deficient ADIT amortization.[119]

83. APPA requests that the Commission clarify that the full amount of any excess or deficient ADIT be returned to or collected from customers based on the actual level of excess or deficient ADIT on that public utility's books.[120] APPA asserts, and Six Cities agree, that the mechanism to return excess ADIT to or recover deficient ADIT from customers proposed in the NOPR should not prevent customers from receiving the full benefit of the Tax Cuts and Jobs Act and that the Commission should specify that any difference between the actual amounts on a public utility's books and the amount determined by ADIT values used in the last rate case must be reconciled in the next rate case.[121]

84. APPA contends, and Six Cities agree, that to the extent the Commission intends for a public utility to provide information on excess or deficient ADIT relative to the ADIT balance in its last rate case rather than its current ADIT balance, the final rule should require public utilities with transmission stated rates to provide the latter.[122]

85. Six Cities request that the Commission direct public utilities with transmission stated rates subject to a moratorium to delay amortization of excess or deficient ADIT until their next rate cases (*i.e.,* the end of the moratorium period). Six Cities contend that customers may otherwise lose the benefits of the Tax Cuts and Jobs Act because the required amortization schedule might begin or occur during the moratorium period.[123] Six Cities argue that this delay would be consistent with the Commission's statement that ''public utilities should not amortize an excess ADIT regulatory liability for accounting purposes until it is included in ratemaking.'' [124] Six Cities contend that this requirement would not upset any moratorium as public utilities would only be placing excess ADIT in a deferred account. Six Cities request that, in conjunction with this deferral requirement, the Commission require that any affected public utilities submit a single-issue compliance filing coinciding with the end of the moratorium period.[125]

3. Commission Determination

86. We do not adopt the NOPR proposal to require public utilities with transmission stated rates to (1) determine the excess and deficient income tax caused by the Tax Cuts and Jobs Act's reduction to the federal corporate income tax rate and (2) return this amount to or recover this amount from customers. Instead, we maintain the status quo under Order No. 144, Order No. 475 and 18 CFR 35.24, under which public utilities with transmission stated rates should address any excess or deficient ADIT caused by the Tax Cuts and Jobs Act in their next rate case.[126] We also do not adopt any of the other proposals in the NOPR related to public utilities with transmission stated rates.[127]

87. In Order No. 144, the Commission stated that the cost of service adjustments for excess and deficient ADIT are required to be made in a public utility's next rate case.[128] Thus, Order No. 144 stands for the proposition that it is appropriate for a public utility

[110] EEI Comments at 8–11 (citing NOPR, 165 FERC ¶ 61,117 at P 29).

[111] *Id.;* Avista Comments at 2–3.

[112] FirstEnergy Comments at 2.

[113] EEI Comments at 8–11.

[114] *Id.* at 11–12; Avista Comments at 3–4.

[115] EEI Comments at 13.

[116] Industrial Customers Comments at 6.

[117] EEI Comments at 14–15.

[118] *Id.* at 12–13.

[119] AMP Comments at 13.

[120] APPA Comments at 5–6.

[121] *Id.* at 6; Six Cities Comments at 2.

[122] APPA Comments at 6; Six Cities Comments at 2.

[123] Six Cities Comments at 3–5.

[124] *Id.* at 5 (citing NOPR, 165 FERC ¶ 61,117 at P 39).

[125] *Id.* at 5–6.

[126] *See* Order No. 144, FERC Stats. & Regs. ¶ 30,254, at 31,519, 31,560.

[127] NOPR, 165 FERC ¶ 61,117 at P 40.

[128] Order No. 144, FERC Stats. & Regs. ¶ 30,254 at 31,519.

with transmission stated rates to address excess and deficient ADIT in its next rate case, as opposed to on a generic basis. Order No. 475, which the Commission issued following the last reduction in the federal corporate income tax rate, also supports our decision to not adopt the requirements in the NOPR for public utilities with transmission stated rates. In Order No. 475, the Commission declined to act on excess and deficient ADIT for public utilities with transmission stated rates on a generic basis and instead stated that determination would be made in a public utility's next rate case. The Commission reasoned that the potentially complex questions involving the return of excess ADIT were best dealt with in individual FPA section 205 or 206 proceedings where all interested parties could weigh in.[129] We find that this rationale still applies. The question of how to properly handle excess and deficient ADIT for public utilities with transmission stated rates following a tax rate change continues to raise complex questions that are more properly addressed in a rate case.

88. We agree with EEI's comments that addressing excess and deficient ADIT in the next rate case for a public utility with transmission stated rates is more reasonable, efficient, and accurate than the proposal in the NOPR. Although APPA supported requiring public utilities with transmission stated rates to address excess or deficient ADIT on a single-issue basis at a general level, it noted that the approach proposed in the NOPR to accomplish this goal would still require a reconciliation in a public utility's next rate proceeding.[130] APPA's comments highlight the inefficiency and inaccuracy of addressing excess and deficient ADIT on a single-issue basis because such an approach would offer only a temporary, imperfect solution that would need to be revisited in the public utility's next rate proceeding.

89. We therefore find that it is inappropriate to address excess and deficient ADIT resulting from the Tax Cuts and Jobs Act on a single-issue basis for public utilities with transmission stated rates. Like the Commission's finding in Order No. 475 following the tax rate changes in 1986, we determine that for the Tax Cuts and Jobs Act, a public utility's next rate proceeding is the appropriate time to address excess and deficient ADIT in the context of transmission stated rates.

90. We decline to adopt Six Cities' proposal for the Commission to direct public utilities with transmission stated rates subject to a moratorium to delay amortization of excess or deficient ADIT until the next rate case. As explained above, excess or deficient ADIT resulting from the Tax Cuts and Jobs Act for a public utility with transmission stated rates will be addressed in that public utility's next rate case. This outcome is consistent with Order No. 144, 18 CFR 35.24, and the approach adopted by the Commission in Order No. 475.[131]

91. Although we plan to address excess and deficient ADIT issues for public utilities with transmission stated rates to their future rate cases, we clarify our intentions. First, we emphasize that to the extent public utilities with transmission stated rates have a Commission-approved ratemaking method made specifically applicable to them for returning excess ADIT, they should have begun reducing excess ADIT pursuant to that previously approved method.[132]

92. In the absence of a prior Commission-approved methodology, the Commission's regulations require that public utilities ''use some ratemaking method'' for making a provision for returning excess ADIT. The regulations further state that ''the appropriateness of such method will be subject to a case-by-case determination'' by the Commission.[133]

93. In applying this ''case-by-case'' analysis, we recognize there are differences between formula rates (as discussed elsewhere in this order) and stated rates. For stated rates, we will generally apply a policy that public utilities begin reducing excess ADIT immediately upon a tax rate change and not at a later date, such as at the time of a future rate case.[134] This guidance addresses when the amortization of excess ADIT should begin, rather than other issues related to the reasonableness of a public utility's amortization methodology (*e.g.,* ARAM or South Georgia). Moreover, this discussion regarding when amortization of excess ADIT begins for public utilities with stated transmission rates is merely intended to provide guidance regarding the general course of action the Commission intends to follow in future adjudications. The Commission will address issues related to a utility's method for amortizing excess ADIT in stated rates (including timing) based on the specific facts and circumstances in each proceeding. For example, nothing here precludes a public utility with transmission stated rates from proposing to delay amortization of excess ADIT to its next rate case.

94. We believe it is reasonable to treat transmission formula rates differently than transmission stated rates given the unique circumstances surrounding formula rates at the time the Tax Cuts and Jobs Act became law. First as discussed above and in the NOPR, most electric transmission formula rates lack a mechanism to make provision for excess ADIT in computing the income tax component of the cost of service.[135] It is inappropriate to treat excess ADIT as reducing immediately as of the Tax Cuts and Jobs Act when the formula itself lacks a mechanism to accomplish this task. We further emphasize that, upon enactment of the Tax Cuts and Jobs Act, the rates of public utilities with transmission formula rates (unlike those with stated rates) actually increased because the formula rates lacked an input for excess ADIT. Thus, the excess ADIT no longer served as a reduction from rate base as it did prior to the tax rate change when it was part of ADIT.[136] Because the transmission formula rate excluded excess ADIT from the calculation of the rate, it is appropriate to treat excess ADIT as being wholly preserved in Account 254 until it can be addressed and reinserted into the transmission formula rate as required by this final rule.[137]

95. For these reasons, we believe the policy discussed above regarding transmission stated rates and their treatment of excess ADIT is reasonable. Therefore, we reject Six Cities' proposal for public utilities with transmission

[129] Order No. 475, FERC Stats. & Regs. ¶ 30,752 at 30,736.

[130] APPA Comments at 6.

[131] Order No. 475, FERC Stats. & Regs. ¶ 30,752, at 30,736.

[132] 18 CFR 35.24(c)(3). The same regulations apply to interstate natural gas pipelines under 18 CFR 154.305.

[133] *Id.*

[134] *See, e.g., Interstate and Intrastate Natural Gas Pipelines; Rate Changes Relating to Federal Income Tax Rate,* Order No. 849, 164 FERC ¶ 61,031, at PP 136–150 (2018) (providing guidance that natural gas pipelines should begin amortizing excess ADIT resulting from the Tax Cuts and Jobs Act immediately for purposes of the FERC Form No. 501–G informational filing, consistent with section 154.305 of the Commission's regulations).

[135] ADIT NOPR, 165 FERC ¶ 61,117 at P 16.

[136] Previously, the excess ADIT had been included in regular ADIT (Accounts 190, 281, 282 and 283) and served as a reduction to rate base. While the excess ADIT in Account 254 should have also served as a reduction to rate base, the formula rates did not include the appropriate mechanism for this to occur.

[137] Further distinguishing transmission formula rates from stated rates, even where a public utility's formula rate included provisions for excess ADIT, the Commission's policy prior to this final rule required the public utility to seek Commission approval prior to returning excess ADIT. *See PJM,* 165 FERC ¶ 61,275 at P 28. Accordingly, public utilities with formula rates could not return excess ADIT under this prior policy. This provides another way to distinguish transmission formula rates from stated rates.

stated rates to delay amortization of excess or deficient ADIT until the next rate case.

C. Compliance Filings

1. NOPR

96. The Commission proposed to require each public utility with transmission stated or formula rates to submit a compliance filing within 90 days of the effective date of this final rule to revise its transmission stated or formula rates, as necessary, to demonstrate that it meets the requirements set forth in this final rule.[138]

97. The Commission noted that some public utilities with transmission formula rates already had mechanisms in place in their rates that address the requirements discussed in this final rule. Where existing mechanisms would be modified by this final rule, the Commission proposed that the public utility must either comply with the requirements of this final rule or demonstrate that these previously approved mechanisms continue to be consistent with or superior to the requirements of this final rule.[139]

2. Comments

98. Some commenters support the Commission's 90-day compliance filing proposal.[140] EEI requests that the Commission modify the compliance timeline for public utilities with transmission formula rates so that those utilities must submit compliance filings within the later of (1) 90 days of issuance of a final rule or (2) the public utility's next informational or true-up filing. EEI contends that the complexity and time-consuming nature of the annual update and true-up processes support such flexibility.[141] Conversely, Industrial Customers argue that the compliance period should be shortened for the final rule.[142]

99. EEI also requests that the Commission provide guidance in the final rule as to the timing of compliance filings for public utilities transitioning from transmission stated to transmission formula rates. EEI argues that these public utilities should be allowed to address compliance with the final rule in the proceeding addressing this transition. EEI asserts this would reduce burden and increase efficiency for the Commission and all interested parties. EEI contends that, so long as these public utilities are not amortizing ADIT balances prior to the proceeding addressing this transition, customers will see the benefits in reduction of the federal income tax rate.[143]

3. Commission Determination

100. We adopt a modified version of EEI's proposal in its comments to the NOPR and require each public utility with transmission formula rates to submit a filing to demonstrate compliance with the final rule including revisions to its transmission formula rates, as necessary, within the later of (1) 30 days of the effective date of this final rule[144] or (2) the public utility's next annual informational filing following the issuance of this final rule. We find that this schedule for compliance filings will reduce the burden on public utilities by allowing them flexibility to align the compliance requirement with their annual informational filing deadlines. However, we note that this compliance filing schedule represents the deadline to submit a compliance filing and that public utilities may choose to make their compliance filings earlier. Additionally, on compliance, we expect public utilities with transmission formula rates to make their proposed tariff sheets effective on the effective date of this final rule.

101. We adopt the proposal that, if a public utility believes that its existing transmission formula rate already meets the requirements of this final rule, the public utility must demonstrate that these previously approved mechanisms are consistent with or superior to the requirements of this final rule; otherwise, such a public utility must modify their transmission formula rate to comply with the requirements of this final rule.

102. Regarding Industrial Customers' request for a shortened compliance period, we find that the compliance period adopted by this final rule appropriately balances the time necessary for public utilities to develop and implement the changes required by this final rule, including the ADIT Worksheet, while still ensuring that compliance occurs in a timely manner.

103. As for a public utility transitioning from transmission stated rates to transmission formula rates, because we decline to adopt the NOPR requirements for public utilities with transmission stated rates, a public utility transitioning from stated rates to formula rates will not need to make a compliance filing. Accordingly, when the public utility makes a filing under section 205 to adopt transmission formula rates, the Commission at that time will consider whether the utility's proposal appropriately reflects the excess or deficient ADIT resulting from the Tax Cuts and Jobs Act.

104. As discussed above, this final rule requires that each public utility with a transmission formula rate populate the ADIT Worksheet submitted in compliance with the requirements of this final rule with excess and deficient ADIT resulting from the Tax Cuts and Jobs Act and any interested party will have an opportunity to comment on this information. Consistent with past practice, we will also determine whether the proposed amortization periods for any excess and deficient ADIT are just and reasonable.[145] To aid in our review and provide greater clarity to customers, we also require that public utilities clearly indicate the date such inputs were populated with excess and deficient ADIT data.

D. Other Comments Relating to Issues Not Addressed in the NOPR

1. Comments

105. EEI argues that the Commission should affirm in the final rule that the proposed requirements apply only to jurisdictional transmission rates and that ADIT-related issues in all other rates, particularly negotiated rates, will be addressed on a case-by-case basis.[146] EEI proposes that the Commission clarify that a ''transmission rate'' is a rate for transmission delivery service, and therefore does not include ancillary services that are provided under OATTs or other tariffs. MISO Transmission Owners request a similar clarification and state that they do not support the proposal to the extent it would apply to non-transmission rates in the Commission-jurisdictional OATTs of public utilities with transmission formula rates.[147] EEI requests that the Commission reiterate that customers who choose to challenge rates other than transmission rates continue to bear the burden of demonstrating that the Tax Cuts and Jobs Act has rendered

[138] NOPR, 165 FERC ¶ 61,117 at P 51.

[139] *Id.* P 52.

[140] *See* Eversource Comments at 15; AMP Comments at 13–14.

[141] EEI Comments at 7–8.

[142] Industrial Customers Comments at 5–6.

[143] EEI Comments at 15–16.

[144] The final rule becomes effective 60 days after publication in the **Federal Register**. With the first set of compliance filings due 30 days after the effective date of the final rule, public utilities will have a minimum of 90 days from the date of publication in the **Federal Register** to make compliance filings.

[145] *See, e.g., Emera Me.,* 165 FERC ¶ 61,086, at PP 44–45 (2018); *So. Cal. Edison Co.,* 166 FERC ¶ 61,006 at PP 23–24.

[146] EEI Comments at 16–17.

[147] MISO Transmission Owners Comments at 16–17.

such rates unjust, unreasonable, unduly discriminatory, or preferential.[148]

106. APPA argues that the Commission should reconsider its position and act affirmatively to ensure non-transmission, cost-based rates are adjusted to reflect the effects of the Tax Cuts and Jobs Act. APPA points to its previous comments submitted in response to the NOI, noting over-collection in revenues from the non-transmission rates. APPA argues that the ability to file a complaint under FPA section 206 does not provide adequate protections as customers are unlikely to have sufficient information to judge whether the Tax Cuts and Jobs Act has rendered an existing non-transmission rate unjust and unreasonable. APPA contends that the Commission should direct jurisdictional public utilities to file adjustments to their non-transmission cost-based rates to reflect Tax Cuts and Jobs Act-related changes or show cause why they should not be required to do so. APPA asserts that, at minimum, any public utilities with non-transmission cost-based rates not addressed in the NOPR or the Tax Rate-Related Orders to Show Cause should be required to file an informational filing describing the effect of the Tax Cuts and Jobs Act on their income tax costs and ADIT.[149]

107. NRECA supports the Commission's proposal to not address the rates of non-public utilities.[150]

108. DEMEC and Industrial Customers argue that refunds of excess ADIT resulting from the Tax Cuts and Jobs Act should include interest.[151] Industrial Customers argue that interest would compensate ratepayers for the loss of benefit of the partial rate base reduction for the period until the adjustment is implemented.[152]

109. EEI states that the Commission should consider accepting comments about the ADIT Treatment Following Asset Sales and Retirements Policy Statement in the context of this NOPR to allow for clarification. EEI contends that the Commission should clarify whether the ADIT Treatment Following Asset Sales and Retirements Policy Statement applies in the case of all ordinary retirements or excludes all ordinary retirements. EEI also argues that the Commission should clarify that the ADIT Treatment Following Asset Sales and Retirements Policy Statement does not apply to retirements and sales that are closed after November 23, 2018, the ADIT Treatment Following Asset Sales and Retirements Policy Statement's effective date, where transmission stated rate cases have addressed accounting and ratemaking treatment prior to the effective date as evidenced by a final state commission order.[153]

110. DEMEC notes that the ADIT Treatment Following Asset Sales and Retirements Policy Statement did not address transmission facilities transferred to other functions (*e.g.,* from transmission to distribution). DEMEC argues that the Commission should ensure the refund of excess ADIT associated with retired, sold, and transferred facilities to customers.[154]

111. AMP argues that the Commission should take immediate action to stop further charges based on pre-Tax Cuts and Jobs Act federal income tax rates by initiating ''show cause'' proceedings for each public utility that has transmission stated rates not yet reflecting post-Tax Cuts and Jobs Act income tax rates.[155] Similarly, AMP and Industrial Customers request that the Commission act immediately to issue the final rule to prevent those public utilities that still have transmission rates based on a 35 percent federal income tax rate from collecting excessive federal income tax revenue allowances until their next rate cases.[156] AMP further argues that the final rule should be expanded to require the return of any incremental charges collected after December 31, 2017 that relate to utilizing the pre-Tax Cuts and Jobs Act tax rate in jurisdictional ratemaking. AMP contends that these incremental charges will not necessarily be returned as a component of excess ADIT under the NOPR because the re-measurement of excess and deficient ADIT took place on December 31, 2017 and accounts only for incremental tax charges occurring until the date of re-measurement. AMP asserts that, absent Commission action, public utilities will have no obligation to return these charges collected after re-measurement.[157] AMP argues that the Commission should issue a directive requiring refunds for rates charged after December 31, 2017, to the extent those rates were based on the 35 percent federal income tax rate.[158]

2. Commission Determination

112. We affirm that this final rule applies only to public utilities with transmission formula rates that are contained in an OATT, a transmission owner tariff, or a rate schedule. This final rule does not address ancillary services or non-transmission rates for services provided under an OATT or other tariff. We find the arguments requesting that the Commission address non-transmission rates to be beyond the scope of this proceeding.

113. Additionally, we find that AMP's requests for the Commission to initiate ''show cause'' orders for public utilities not yet reflecting the Tax Cuts and Jobs Act's change in tax rates[159] and to issue a directive requiring refunds for rates charged after December 31, 2017, to the extent those rates were based on the 35 percent federal income tax rate, are beyond the scope of this proceeding. In this final rule, we focus only on ensuring that transmission formula rates properly address excess and deficient ADIT resulting from the Tax Cuts and Jobs Act and any future tax rate changes in a transparent manner and consistent with Order No. 144 and 18 CFR 35.24.

114. We are unpersuaded by DEMEC's and Industrial Customers' request for public utilities to include interest when returning excess ADIT. The Commission has chosen not to require interest in prior proceedings involving the return of excess ADIT, including proceedings addressing the return of excess ADIT following the Tax Cuts and Jobs Act.[160] Furthermore, the requirements in this final rule will ensure that the full regulatory liability for excess ADIT is returned to transmission formula rate customers and that rate base neutrality is preserved going forward. Accordingly, we find that transmission formula rate customers will receive the full benefit of the Tax Cuts and Jobs Act, and therefore, we do not find it appropriate to require public utilities to include interest when returning excess ADIT as a result of the Tax Cuts and Jobs Act to customers.

115. We find requests to clarify the ADIT Treatment Following Asset Sales and Retirements Policy Statement to be beyond the scope of this proceeding.

[148] EEI Comments at 17.

[149] APPA Comments at 11–13.

[150] NRECA Comments at 5.

[151] DEMEC Comments at 11; Industrial Customers Comments at 5.

[152] Industrial Customers Comments at 6.

[153] EEI Comments at 17–18.

[154] DEMEC Comments at 16.

[155] AMP Comments at 13.

[156] *Id.* at 13–14; Industrial Comments at 5–6.

[157] AMP Comments at 13.

[158] *Id.* at 14.

[159] *See supra* n.23.

[160] *See, e.g.,* Order No. 475, FERC Stats. & Regs. ¶ 30,752, at 30,737; *Emera Me.,* 165 FERC ¶ 61,086; *So. Cal. Edison Co.,* 166 FERC ¶ 61,006.

IV. Information Collection Statement

116. The Paperwork Reduction Act (PRA) [161] requires each federal agency to seek and obtain the Office of Management and Budget's (OMB) approval before undertaking a collection of information (including reporting, record keeping, and public disclosure requirements) directed to ten or more persons or contained in a rule of general applicability. OMB regulations require approval of certain information collection requirements imposed by rules (including deletion, revision, or implementation of new requirements).[162] Upon approval of a collection of information, OMB will assign an OMB control number and an expiration date. Respondents subject to the filing requirements of a rule will not be penalized for failing to respond to the collection of information unless the collection of information displays a valid OMB control number.

117. The Commission is submitting these reporting and recordkeeping requirements to OMB for its review and approval under section 3507(d) of the PRA. Comments are solicited on the Commission's need for this information, whether the information will have practical utility, the accuracy of the provided burden estimate, ways to enhance the quality, utility, and clarity of the information to be collected, and any suggested methods for minimizing the respondent's burden, including the use of automated information techniques.

118. *Public Reporting Burden:* The Commission initially identified 106 public utilities with transmission formula rates that will each be required to revise its rate so that any excess or deficient ADIT is properly reflected in its revenue requirement following a change in tax rates, such as those established by the Tax Cuts and Jobs Act. Additionally, each public utility with a transmission formula rate will be required to incorporate the ADIT Worksheet into its transmission formula rate to increase transparency. Public utilities will be required to populate this worksheet in their compliance filings. We also note the Commission's reliance on the ADIT Worksheet in lieu of an FPA section 205 filing each time a local, state, or federal tax rate changes will result in an overall reduction in burden in the long run to public utilities with transmission formula rates.

119. The Commission also initially identified 31 public utilities with transmission stated rates that it proposed to require to calculate the excess and deficient ADIT caused by the Tax Cuts and Jobs Act and to return to or recover from customers those amounts. However, the Commission decided not to adopt the proposed requirements for public utilities with transmission stated rates in this proceeding, and therefore public utilities with transmission stated rates will have no future burden or cost associated with this final rule.

120. Based on these assumptions, we estimate the burden and cost [163] for the information collection requirements as follows.

CHANGES DUE TO THE FINAL RULE IN DOCKET NO. RM19–5–000

	Number of respondents (1)	Annual number of responses per respondent (2)	Total number of responses (1) * (2) = (3)	Average burden hours & cost ($) per response (4)	Total annual burden hours & total annual cost ($) (3) * (4) = (5)	Cost per respondent ($) (5) ÷ (1)
Revising transmission formula rates so that excess ADIT is deducted and/or deficient ADIT is added to rate base (one-time) [164].	106	1	106	8 hours; $672	848 hours; $71,232	$672
Revising transmission formula rates so that any excess and/or deficient ADIT is amortized (one-time).	106	1	106	8 hours; $672	848 hours; $71,232	672
Revising transmission stated rates to return or recover excess or deficient ADIT (one-time).	0	0	0	0; $0	0 hours; $0	0
Requiring public utilities with transmission formula rates to incorporate a new permanent worksheet that will annually track ADIT information (one-time).	106	1	106	44 hours; $3,696	4,664 hours; $391,776	3,696
Requiring public utilities with transmission formula rates to update their ADIT worksheet (annual, starting in Year 2).	106	1	106	4 hours; $336	424 hours; $35,616	336
Total (Stated Rates) [165]			0		0 hours; $0	
Total (Formula Rates), one-time in Year 1 [166].			318		6,360 hours; $534,240	
Total (Formula Rates (annual, starting in Year 2)).			106		424 hours; $35,616	

[161] 44 U.S.C. 3501–21.

[162] 5 CFR 1320.11.

[163] The loaded hourly wage figure (including benefits) is based on the average of the occupational categories for 2018 found on the Bureau of Labor Statistics website (*http://www.bls.gov/oes/current/naics2_22.htm* and *http://www.bls.gov/news.release/ecec.nr0.htm*):

—Accountant and Auditor (Occupation Code: 13–2011): $56.09.

—Management (Occupation Code: 11–0000): $95.24.

—Legal (Occupation Code: 23–0000): $142.86.

—Office and Administrative Support (Occupation Code: 43–0000): $42.11.

These various occupational categories' wage (and benefits) figures are averaged and weighted equally, giving an average of $84.08/hour. The resulting wage figure is rounded to $84.00/hour for use in calculating wage figures in the final rule in Docket No. RM19–5–000.

[164] One-time burdens apply in Year 1 only. The ongoing annual burden starting in Year 2 covers the annual requirement to update the worksheet, mentioned below.

[165] Total for Public Utilities with Transmission Stated Rates.

[166] Total for Public Utilities with Transmission Formula Rates.

Cost to Comply: We have projected the total cost of compliance as follows: [167]

- Year 1: $534,240 ($5,040/utility) for public utilities with transmission formula rates.
- Year 2 and continuing annually: $35,616 ($336/utility) for public utilities with transmission formula rates.

Title: FERC–516, Electric Rate Schedules and Tariff Filings.

Action: Proposed revisions to an information collection.

OMB Control No.: 1902–0096.

Respondents for this Proposal: Businesses or other for profit and/or not-for-profit institutions.

Frequency of Information: One-time implementation burden during Year 1, and ongoing annual burden starting in Year 2.

Necessity of Information: The Commission requires information in order to ensure for public utilities with transmission formula rates that (1) rate base neutrality is preserved following enactment of the Tax Cuts and Jobs Act; (2) the reduction in ADIT on the books of public utilities with transmission formula rates that was collected from customers but is no longer payable to the IRS due to the Tax Cuts and Jobs Act is returned to or recovered from customers consistent with general ratemaking principles; and (3) there is increased transparency for the process of excess and deficient ADIT calculation and amortization.

Internal Review: We have reviewed the proposed changes and have determined that such changes are necessary. These requirements conform to the Commission's need for efficient information collection, communication, and management within the electric industry. We have specific, objective support for the burden estimates associated with the information collection requirements.

121. Interested persons may obtain information on the reporting requirements by contacting the following: Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426 [Attention: Ellen Brown, Office of the Executive Director], email: *DataClearance@ferc.gov,* phone: (202) 502–8663, fax: (202) 273–0873. Comments concerning the collection of information and the associated burden estimate(s), may also be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 [Attention: Desk Officer for the Federal Energy Regulatory Commission]. Due to security concerns, comments should be sent electronically to the following email address: *oira_submission@omb.eop.gov.* Comments submitted to OMB should include FERC–516 and OMB Control No. 1902–0096.

V. Environmental Analysis

122. The Commission is required to prepare an Environmental Assessment or an Environmental Impact Statement for any action that may have a significant adverse effect on the human environment.[168] The actions taken here fall within categorical exclusions in the Commission's regulations for approval of actions under sections 205 and 206 of the FPA relating to the filing of schedules containing all rates and charges for the transmission or sale of electric energy subject to the Commission's jurisdiction, plus the classification, practices, contracts and regulations that affect rates, charges, classification, and services.[169] Therefore, an environmental review is unnecessary and has not been prepared in this rulemaking.

VI. Regulatory Flexibility Act

123. The Regulatory Flexibility Act of 1980 (RFA) [170] generally requires a description and analysis of final rules that will have significant economic impact on a substantial number of small entities.

124. The Small Business Administration (SBA) revised its size standards (effective January 22, 2014) for electric utilities from a standard based on megawatt hours to a standard based on the number of employees, including affiliates. Under SBA's standards, some transmission owners will fall under the following category and associated size threshold: electric bulk power transmission and control, at 500 employees.[171]

125. As noted in the above Information Collection Statement, we estimate that 106 public utilities with transmission formula rates, both large and small, are subject to the requirements adopted by this rule. Of these, we estimate that approximately 43 percent are small entities (approximately 46 entities). We estimate the average total cost to each of these entities will be $5,040 in Year 1 and $336 in subsequent years.

126. According to SBA guidance, the determination of significance of impact ''should be seen as relative to the size of the business, the size of the competitor's business, and the impact the regulation has on larger competitors.'' [172] We do not consider the estimated burden to be a significant economic impact. As a result, we certify that the revisions proposed in this final rule will not have a significant economic impact on a substantial number of small entities.

VII. Document Availability

127. In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the internet through FERC's Home Page (*http://www.ferc.gov*) and in FERC's Public Reference Room during normal business hours (8:30 a.m. to 5:00 p.m. Eastern time) at 888 First Street NE, Room 2A, Washington, DC 20426.

128. From FERC's Home Page on the internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

129. User assistance is available for eLibrary and the FERC's website during normal business hours from FERC Online Support at 202–502–6652 (toll free at 1–866–208–3676) or email at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202) 502–8659. Email the Public Reference Room at *public.referenceroom@ferc.gov.*

[167] For a public utility with a transmission formula rate, the costs for Year 1 would consist of filing proposed changes to its transmission formula rate, including the addition of the ADIT Worksheet, with the Commission based on the compliance schedule laid out in this final rule plus the initial implementation. The annual ongoing cost starting in Year 2 relates to updating the worksheet.

[168] *Regulations Implementing the National Environmental Policy Act,* Order No. 486, FERC Stats. & Regs. ¶ 30,783 (1987) (cross-referenced at 41 FERC ¶ 61,284).

[169] 18 CFR 380.4(a)(15).

[170] 5 U.S.C. 601–612.

[171] 13 CFR 121.201, Sector 22 (Utilities), NAICS code 221121 (Electric Bulk Power Transmission and Control).

[172] U.S. Small Business Administration, *A Guide for Government Agencies How to Comply with the Regulatory Flexibility Act,* at 18 (May 2012), *https://www.sba.gov/sites/default/files/advocacy/rfaguide_0512_0.pdf.*

VIII. Effective Date and Congressional Notification

130. These regulations are effective January 27, 2020. The Commission has determined, with the concurrence of the Administrator of the Office of Information and Regulatory Affairs of OMB, that this rule is not a ''major rule'' as defined in section 351 of the Small Business Regulatory Enforcement Fairness Act of 1996.

By the Commission.

Issued: November 21, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

Note: Appendix A will not be published in the **Federal Register**.

Appendix A—List of Commenters

Short name	Commenter
APPA	American Public Power Association.
AMP	American Municipal Power, Inc.
Avista	Avista Corporation.
DEMEC	Delaware Municipal Electric Corporation, Inc.
EEI	Edison Electric Institute.
Eversource	Eversource Energy Service Company.
FirstEnergy	FirstEnergy Service Company filing on behalf of its affiliates American Transmission Systems, Incorporated, Jersey Central Power & Light Company, Mid-Atlantic Interstate Transmission LLC, West Penn Power Company, the Potomac Edison Company, Monongahela Power Company, and Trans-Allegheny Interstate Line Company.
Industrial Customers	Electricity Consumers Resource Council, the American Forest & Paper Association, and the American Chemistry Council.
MISO Transmission Owners	Ameren Services Company, as agent for Union Electric Company and Ameren Illinois Company; American Transmission Company LLC; Central Minnesota Municipal Power Agency; City Water, Light & Power (Springfield, IL); Cleco Power LLC; Cooperative Energy; Dairyland Power Cooperative; Duke Energy Business Services, LLC for Duke Energy Indiana, LLC; East Texas Electric Cooperative; Entergy Arkansas, Inc.; Entergy Louisiana, LLC; Entergy Mississippi, Inc.; Entergy New Orleans, LLC; Entergy Texas, Inc.; Great River Energy; Indiana Municipal Power Agency; Indianapolis Power & Light Company; International Transmission Company; ITC Midwest LLC; Lafayette Utilities System; Michigan Electric Transmission Company, LLC; MidAmerican Energy Company; Minnesota Power (and its subsidiary Superior Water, L&P); Missouri River Energy Services; Montana-Dakota Utilities Co.; Northern Indiana Public Service Company LLC; Northern States Power Company, a Minnesota corporation, and Northern States Power Company, a Wisconsin corporation, subsidiaries of Xcel Energy Inc.; Northwestern Wisconsin Electric Company; Otter Tail Power Company; Prairie Power Inc.; Southern Indiana Gas & Electric Company; Southern Minnesota Municipal Power Agency; Wabash Valley Power Association, Inc.; and Wolverine Power Supply Cooperative, Inc.
NRECA	National Rural Electric Cooperative Association.
PSEG	Public Service Electric and Gas Company.
Six Cities	The Cities of Anaheim, Azusa, Banning, Colton, Pasadena, and Riverside, CA.
TAPS	Transmission Access Policy Study Group.
Xcel	Xcel Energy Services Inc., on behalf of the Xcel Energy Operating Companies including Northern States Power Company; Northern States Power Company; Public Service Company of Colorado; and Southwestern Public Service Company.

[FR Doc. 2019–25724 Filed 11–26–19; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2019–0823]

RIN 1625–AA09

Drawbridge Operation Regulation; Wolf River, Winneconne, WI

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is removing the existing drawbridge operation regulation for the Winneconne Highway Bridge, mile 2.4, at Winneconne, WI. The drawbridge was replaced with a fixed bridge through the Coast Guard Bridge Permitting and Public Notice Process in 2018 and the operating regulation is no longer applicable or necessary.

DATES: This rule is effective November 27, 2019.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov.* Type USCG–2019–0823 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 Mr. Lee Soule, Bridge Management Specialist, Ninth Coast Guard District; telephone (216) 902–6085, email *lee.d.soule@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations [Delete/add any Abbreviations not Used/Used in This Document]

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register
OMB Office of Management and Budget
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this final 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), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because because on December 13, 2016, we published PUBLIC NOTICE 09–04–16 and mailed out an availability of public notice addressed to all adjacent ZIP codes and

interested parties as part of the bridge permit public notice and comment process. The comment process was open for 30-days. We did not receive any negative comments on this rule.

We are issuing this rule under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective in less than 30 days after publication in the **Federal Register**. The fixed bridge is inplace and the drawbridge has been removed to the satisfaction of the District Commander. This is an administrative action to update the CFR.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority 33 U.S.C. 499.

Winneconne Highway Bridge, mile 2.4, at Winneconne, WI was a vertical lift drawbridge that provided 23 feet vertical clearance in the open position. The new Fixed Bridge provides the same 23 feet vertical clearance the drawbridge provided.

IV. Discussion of Final Rule

The Coast Guard is removing the operational schedule of the former drawbridge because it has been replaced by a new fixed bridge that allow vessels to pass under the bridge without the need to wait for an opening.

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 protesters.

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 was supported by a public notice process and the public was given the opportunity to participate in the planning of the bridge replacement. We are now updating the CFR to reflect the current condition of the waterway.

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. This regulatory action determination is based on the ability that vessels can still transit the bridge and that the public was engaged in this decision through the Coast Guard Bridge Permit process and public notice procedures. The Coast Guard received no comments from the Small Business Administration durring the bridge permitting process. 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 bridge may be small entities, for the reasons stated in section IV.A above this final rule would 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**, 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 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.

The public was engaged in this decision through the Coast Guard Bridge Permit process and public notice procedures.

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 Management Directive 023–01, U.S. Coast Guard Environmental Planning Policy COMDTINST 5090.1 (series) and U.S. Coast Guard Environmental Planning Implementation Procedures (series) which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f). We have made a determination 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 is removing the operating regulations or procedures for drawbridges. This action is categorically excluded from further review, under paragraph L49, of Chapter 3, Table3–1 of the U.S. Coast Guard Environmental Planning Implementation Procedures.

Neither a Record of Environmental Consideration nor a Memorandum for the Record are 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; Department of Homeland Security Delegation No. 0170.1.

§ 117.1107 [Amended]

■ 2. In § 117.1107, remove paragraph (a), and remove the paragraph (b) designation.

Dated: November 19, 2019.

D.L. Cottrell,

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

[FR Doc. 2019–25616 Filed 11–26–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF EDUCATION

34 CFR Chapter II

[Docket ID ED–2019–OPEPD–0019]

RIN 1875–AA12

Final Priority for Discretionary Grant Programs

AGENCY: Department of Education.

ACTION: Final priority.

SUMMARY: The Secretary of Education announces a priority for discretionary grant programs that supports alignment between the Department of Education's (the Department's) discretionary grant investments and the Administration's Opportunity Zones initiative, which aims to spur economic development and job creation in distressed communities.

DATES: This priority is effective December 27, 2019.

FOR FURTHER INFORMATION CONTACT: Allison Holte, U.S. Department of Education, 400 Maryland Avenue SW, Room 4W211, Washington, DC 20202. Telephone: (202) 205–7726.

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:

Program Authority: 20 U.S.C. 1221e–3.

We published a notice of proposed priority in the **Federal Register** on July 29, 2019 (84 FR 36504) (NPP). The NPP contained background information and our reasons for proposing the priority.

There are no differences between the proposed priority and the final priority.

Public Comment: In response to our invitation in the NPP, 11 parties submitted comments on the proposed priority.

We group major issues according to subject. Generally, we do not address comments that raised concerns not directly related to the proposed priority.

Analysis of Comments

Comment: Two commenters expressed general support for the priority, and shared information about the needs of specific Qualified Opportunity Zones. A third commenter expressed support and recommended that we revise the language to prioritize applicants who propose to strengthen the workforce talent pipeline within the Qualified Opportunity Zone, promote partnerships with other local stakeholders, and build capacity among local leaders and practitioners.

Discussion: We appreciate these comments and encourage all eligible organizations—located in or serving a Qualified Opportunity Zone—to apply for grants under competitions that use this priority in the future. This document does not solicit grants.

In addition, we appreciate the commenter's suggestion to revise the priority to include a focus on specific policy goals. We agree that the commenter's suggested policies are important but decline to revise this priority to include them. Our intent for this priority is to drive grant funds toward Qualified Opportunity Zones and to encourage applicants to think creatively about how to make use of Qualified Opportunity Funds, where possible, to support their proposed projects. The goals and content of an applicant's proposed project will depend in large part on the statute and regulations governing the grant program to which it is applying, as well as any of the Secretary's Supplemental Priorities (83 FR 9096) we may choose to include in the grant competition. For that reason, including additional requirements in this priority is neither necessary nor appropriate.

Changes: None.

Comment: Several commenters raised concerns about how the Department would practically apply the priority in a grant competition. One commenter cautioned the Department not to require applicants to be physically located in a Qualified Opportunity Zone, because many organizations provide services in a Qualified Opportunity Zone but have offices in a nearby community. Another commenter expressed concern that the priority would not require applicants to explain the work they propose to do in a Qualified Opportunity Zone, where they would conduct their work, or why. A third commenter expressed general support for the broad Opportunity Zones initiative but urged the Department to exercise caution when determining whether to use the priority as an absolute, competitive preference, or invitational priority. The commenter recommended specifically that we not use the priority as an absolute priority, and only use it as a competitive preference priority after very careful consideration of its potential impact.

Discussion: The priority's flexible structure is specifically designed to allow the Department to address, in the broader context of specific discretionary grant competitions in which the priority may be used, each of the concerns raised by the commenters. In particular, the Department may choose to use all or a subset of the provisions contained in the priority in any discretionary grant competition. For example, the Department may choose not to use paragraph (b) (for applicants that can demonstrate that they are physically located in a Qualified Opportunity Zone) in a grant competition if we determine that physical co-location of an applicant within a Qualified Opportunity Zone is not necessary for achieving the goals of that competition.

In addition, while each of the subparts do not specifically require applicants to explain the work they propose to do, and paragraph (b) does not specifically require applicants to tell us where they will conduct their projects, we remind commenters that this priority will be used in the context of our discretionary grant programs. The activities an applicant proposes to carry out, either directly or through a contract or subgrant, in response to this priority would still be limited to those permitted by that grant program's statute and regulations. In addition to any applicable statutory and regulatory requirements, we include in each notice

inviting applications for new awards a set of selection criteria that applicants must address in order for peer reviewers to score their applications. We include these selection criteria to better understand the details of an applicant's proposal, including why it proposes the project in the first place. For these reasons, we do not think it is necessary to revise the priority in order to ensure that we award high-quality grants.

Finally, we agree with the commenter that the decision to include any priority—be it absolute, competitive preference, or invitational—should be made judiciously. We intend to include this priority in a grant competition only after careful consideration.

Changes: None.

Comment: One commenter expressed concerns about the general structure of Qualified Opportunity Zones and Qualified Opportunity Funds, noting that investors are more likely to create a Qualified Opportunity Fund in areas with the highest potential return on investment, not necessarily the areas that are most distressed. The commenter also cited research that indicates that States did not always designate the most economically distressed census tracts as Opportunity Zones. Finally, the commenter cautioned that the proposed priority could distort the statutory intent of programs authorized by the Elementary and Secondary Education Act, as amended (ESEA), recommending that the Department instead focus funds on existing ESEA programs as authorized by Congress.

Discussion: We recognize that some Qualified Opportunity Zones may be more attractive to investors than others. The priority includes three subparts that can be used separately or in combination, and only one of the subparts requires an applicant to demonstrate that its project will benefit from a Qualified Opportunity Fund. When deciding to use this priority in future grant competitions, we will carefully consider whether and how the priority fits appropriately within the existing statutory and regulatory framework of each program. In some cases, for example, it may be more appropriate to only focus on subpart (a) or (b) of the priority, which require that either the applicant's work is conducted in a Qualified Opportunity Zone or the applicant itself is located in a Qualified Opportunity Zone. For both subparts, whether the Qualified Opportunity Zone has received an investment from a Qualified Opportunity Fund is irrelevant.

In addition, we remind the commenter that an applicant addressing this priority in a grant competition would still need to address all statutory and regulatory requirements for the program to which it is applying. Many of the Department's discretionary programs are targeted to high-need populations in some way. Therefore, even in cases where we determine that it is appropriate to use subpart (c) (which asks applicants to demonstrate that they have received or will receive an investment from a Qualified Opportunity Fund), we believe that grant funds will still benefit communities that need them most.

We agree with the commenter that State governors had wide latitude in determining which census tracts to designate as Opportunity Zones. As a result, some Qualified Opportunity Zones are less economically distressed than others. Despite this fact, research shows that governors generally selected census tracts that are relatively disadvantaged compared to national averages and to averages among communities in eligible, non-designated census tracts. According to the Urban Institute's analysis of the 2012–2016 Census Bureau data, the average poverty rate in Qualified Opportunity Zones was 31.75 percent, compared to an average neighborhood poverty rate of 21.12 percent across all eligible non-designated census tracts and an average poverty rate of 16.6 percent nationwide. In addition, compared to all census tracts nationwide and to all eligible non-designated census tracts, Qualified Opportunity Zones had lower median household incomes, higher unemployment rates, and lower levels of educational attainment.[1] Additionally, with over 8,700 census tracts designated as Qualified Opportunity Zones nationwide, significantly more distressed communities will benefit from Opportunity Zone status than under previous place-based initiatives. For example, only 22 communities received the designation of ''Promise Zone,'' a place-based initiative created in 2014.[2]

Finally, we disagree with the commenter that use of this priority would distort the statutory purpose of ESEA programs. As discussed above, applicants addressing this priority in a grant competition would still be required to meet all statutory and regulatory requirements of the program to which they are applying, including any requirements concerning the demographics or location of the population to be served by the grant. For example, if a grant program using this priority also required that funds support projects in schools with a majority of students who receive free- or reduced-price lunch, grants would only support Qualified Opportunity Zones that also met those other requirements. We believe that including this priority in grant competitions may result in more grant funds going to Qualified Opportunity Zones; however, those grant funds still must be used for purposes that meet all applicable statutory and regulatory requirements.

Changes: None.

Comment: Two commenters expressed concern that this priority is unconstitutional because it violates 20 U.S.C. 1232a, which prohibits, among other things, Federal control over the curriculum, program of instruction, administration, or personnel of any educational institution, school, or school system.

Discussion: This priority does not violate 20 U.S.C. 1232a because it does not establish any requirement involving Federal control over the curriculum, program of instruction, administration, or personnel of any educational institution, school, or school system. Moreover, any prospective applicant that does not wish to work in a Qualified Opportunity Zone, is not located in a Qualified Opportunity Zone, or does not wish to work with a Qualified Opportunity Fund, depending on how the priority is used in a given competition, may choose not to address the priority.

Changes: None.

Comment: One commenter supported the priority and suggested that the Department create and publicly post a list of elementary and secondary schools located in Qualified Opportunity Zones to aid applicants in preparing their applications.

Discussion: We appreciate this suggestion and are exploring ways to assist potential applicants in aligning their projects with Qualified Opportunity Zones. We also note that the Treasury Department has created a website of Opportunity Zones Resources that includes a searchable map: *https://www.cdfifund.gov/Pages/Opportunity-Zones.aspx.*

Changes: None.

Final Priority

Priority—Spurring Investment in Qualified Opportunity Zones.

Under this priority, an applicant must demonstrate one or more of the following:

[1] Brett Theodos, Brady Meixell, and Carl Hedman, ''Did States Maximize Their Opportunity Zones Selections?'' (Urban Institute), 2018, available at: *https://www.urban.org/sites/default/files/publication/98445/did_states_maximize_their_opportunity_zone_selections_7.pdf.*

[2] *See: https://www.hudexchange.info/programs/promise-zones/promise-zones-overview/.*

(a) The area in which the applicant proposes to provide services overlaps with a Qualified Opportunity Zone, as designated by the Secretary of the Treasury under section 1400Z–1 of the Internal Revenue Code (IRC). An applicant must—

(i) Provide the census tract number of the Qualified Opportunity Zone(s) in which it proposes to provide services; and

(ii) Describe how the applicant will provide services in the Qualified Opportunity Zone(s).

(b) The applicant is located in a Qualified Opportunity Zone. The applicant is located in a Qualified Opportunity Zone if the applicant has multiple locations, at least one of which is within a Qualified Opportunity Zone, or if the applicant's location overlaps with a Qualified Opportunity Zone. The applicant must provide the census tract number of the Qualified Opportunity Zone in which it is located.

(c) The applicant has received, or will receive by a date specified by the Department, an investment, including access to real property, from a Qualified Opportunity Fund under section 1400Z–2 of the IRC for a purpose directly related to its proposed project. An applicant must—

(i) Identify the Qualified Opportunity Fund from which it has received or will receive an investment; and

(ii) Describe how the investment is or will be directly related to its proposed project.

Types of Priorities

When inviting applications for a competition using one or more priorities, we designate the type of each priority as absolute, competitive preference, or invitational through a notice in the **Federal Register**. The effect of each type of priority follows:

Absolute priority: Under an absolute priority, we consider only applications that meet the priority (34 CFR 75.105(c)(3)).

Competitive preference priority: Under a competitive preference priority, we give competitive preference to an application by (1) awarding additional points, depending on the extent to which the application meets the priority (34 CFR 75.105(c)(2)(i)); or (2) selecting an application that meets the priority over an application of comparable merit that does not meet the priority (34 CFR 75.105(c)(2)(ii)).

Invitational priority: Under an invitational priority, we are particularly interested in applications that meet the priority. However, we do not give an application that meets the priority a preference over other applications (34 CFR 75.105(c)(1)).

This document does not preclude us from proposing additional priorities, requirements, definitions, or selection criteria, subject to meeting applicable rulemaking requirements.

Note: This document does *not* solicit applications. In any year in which we choose to use this priority, we invite applications through a notice in the **Federal Register**.

Executive Orders 12866, 13563, and 13771

Regulatory Impact Analysis

Under Executive Order 12866, it must be determined whether this regulatory action is ''significant'' and, therefore, subject to the requirements of the Executive order and subject to review by the Office of Management and Budget (OMB). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action likely to result in a rule that may—

(1) Have an annual effect on the economy of $100 million or more, or adversely affect a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities in a material way (also referred to as an ''economically significant'' rule);

(2) Create serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles stated in the Executive order.

This final regulatory action is a significant regulatory action subject to review by OMB under section 3(f) of Executive Order 12866.

Under Executive Order 13771, for each new rule that the Department proposes for notice and comment or otherwise promulgates that is a significant regulatory action under Executive Order 12866, and that imposes total costs greater than zero, it must identify two deregulatory actions. For FY 2020, any new incremental costs associated with a new regulation must be fully offset by the elimination of existing costs through deregulatory actions. Although this regulatory action is a significant regulatory action, the requirements of Executive Order 13771 do not apply because this regulatory action is a ''transfer rule'' not covered by the Executive order.

We have also reviewed this final regulatory action under Executive Order 13563, which supplements and explicitly reaffirms the principles, structures, and definitions governing regulatory review established in Executive Order 12866. To the extent permitted by law, Executive Order 13563 requires that an agency—

(1) Propose or adopt regulations only upon a reasoned determination that their benefits justify their costs (recognizing that some benefits and costs are difficult to quantify);

(2) Tailor its regulations to impose the least burden on society, consistent with obtaining regulatory objectives and taking into account—among other things and to the extent practicable—the costs of cumulative regulations;

(3) In choosing among alternative regulatory approaches, select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity);

(4) To the extent feasible, specify performance objectives, rather than the behavior or manner of compliance a regulated entity must adopt; and

(5) Identify and assess available alternatives to direct regulation, including economic incentives—such as user fees or marketable permits—to encourage the desired behavior, or provide information that enables the public to make choices.

Executive Order 13563 also requires an agency ''to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible.'' The Office of Information and Regulatory Affairs of OMB has emphasized that these techniques may include ''identifying changing future compliance costs that might result from technological innovation or anticipated behavioral changes.''

We are issuing this final priority only on a reasoned determination that its benefits justify its costs. In choosing among alternative regulatory approaches, we selected those approaches that maximize net benefits. Based on the analysis that follows, the Department believes that this regulatory action is consistent with the principles in Executive Order 13563.

We also have determined that this regulatory action does not unduly interfere with State, local, and Tribal governments in the exercise of their governmental functions.

In accordance with these Executive orders, the Department has assessed the potential costs and benefits, both quantitative and qualitative, of this

regulatory action. The potential costs are those resulting from statutory requirements and those we have determined as necessary for administering the Department's programs and activities.

Discussion of Potential Costs and Benefits

The Department believes that this regulatory action does not impose significant costs on eligible entities, whose participation in discretionary grant programs is voluntary. Additionally, the benefits of the priority outweigh any associated costs because it would result in the Department's discretionary grant programs selecting high-quality applications to implement activities that are designed to increase education opportunities and improve education outcomes while also targeting investment in our Nation's most economically distressed communities.

The Secretary believes that the costs imposed on applicants by the priority would be limited to paperwork burden related to preparing an application for a discretionary grant program that is using the priority in its competition. The priority would likely result in some Federal funds that would have been awarded to grantees in areas that are not designated as Qualified Opportunity Zones going instead to grantees in areas that have received that designation. We believe that the results of recently completed FY 2019 competitions provide some helpful descriptive data on the extent to which this priority may increase the number of applications from, and grantees ultimately funded in, Qualified Opportunity Zones. In FY 2019, the Department included a priority for projects in Qualified Opportunity Zones in nine competitions; five of these competitions included only an invitational priority and, in the remaining four competitions, programs created and used a program-specific absolute or competitive preference priority. In the five competitions that included only an invitational priority, 41 percent of total applications and 47 percent of funded applications addressed the priority. In the four competitions that included a competitive preference or absolute priority, 53 percent of total applications and 60 percent of funded applications addressed the priority. Of the approximately $55 million awarded to new grantees in these four competitions, over $30 million went to applicants that addressed an absolute or competitive preference priority for projects in Qualified Opportunity Zones. While these data provide some information about the impact of including the priority announced in this NFP in future competitions, it is important to note that the universe of FY 2019 competitions that used the priority is small, unrepresentative of the Department's overall grant portfolio, and includes programs that made a relatively small number of awards. Further the awards to projects in Qualified Opportunity Zones did not change the total amount of awards made by the Department under these competitions.

Regulatory Flexibility Act Certification: The Secretary certifies that the final priority will not have a significant economic impact on a substantial number of small entities. The U.S. Small Business Administration (SBA) Size Standards define proprietary institutions as small businesses if they are independently owned and operated, are not dominant in their field of operation, and have total annual revenue below $7,000,000. Nonprofit institutions are defined as small entities if they are independently owned and operated and not dominant in their field of operation. Public institutions are defined as small organizations if they are operated by a government overseeing a population below 50,000.

The Secretary certifies that this regulatory action will not have a significant economic impact on small entities. The priority will be used in a limited number of the Department's discretionary grant competitions annually, would not change the basic eligibility requirements for those competitions, was designed to minimize the paperwork burden added to the normal application process, and would not impose any costs on small entities because the decision to apply for a discretionary grant is entirely voluntary. In the case of small entities that choose to apply for funding under a discretionary grant competition that uses the priority, the increased costs would be limited to the marginally increased paperwork burden of demonstrating an applicant's relationship to a Qualified Opportunity Zone, which generally involves identifying and reporting census tract numbers. For example, we estimate that it would take an entity applying for a discretionary grant under this priority less than one hour to identify the census tract number(s) for the area they intend to serve, or for their own location. The Department expects to provide resources in the coming months to further expedite this process for applicants. Further, any marginal increase in paperwork burden associated with the regular application process for small entities would be more than offset by the benefits of the priority, including the increased likelihood that small entities in or serving Qualified Opportunity Zones will be successful in competing for Federal education funds and that funded projects will improve educational opportunities and outcomes and thereby contribute materially to the success of other small entities in our Nation's most economically distressed communities.

Intergovernmental Review: This program is subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for this program.

Accessible Format: Individuals with disabilities can obtain this document 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 the 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 the 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: November 22, 2019.

Betsy DeVos,

Secretary of Education.

[FR Doc. 2019–25819 Filed 11–26–19; 8:45 am]

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DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 202, 216, 217, 225, 234, and 235

[Docket DARS–2019–0008]

RIN 0750–AJ32

Defense Federal Acquisition Regulation Supplement: Use of Fixed-Price Contracts (DFARS Case 2017–D024)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is issuing a final rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to implement a section of the National Defense Authorization Act for Fiscal Year 2017 that requires a preference for fixed-price contracts, review and approval for certain cost-reimbursement contract types, and the use of firm-fixed-price contract types for foreign military sales unless an exception or waiver applies.

DATES: Effective November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Ms. Kimberly Bass, telephone 571–372–6174.

SUPPLEMENTARY INFORMATION:

I. Background

DoD published a proposed rule in the **Federal Register** at 84 FR 12179 on April 1, 2019, to implement sections 829 and 830 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Pub. L. 114–328). On May 29, 2019, a document was published in the **Federal Register** at 84 FR 24734 to extend the comment period for 14 days until June 14, 2019.

Section 829 of the NDAA for FY 2017 requires contracting officers to first consider fixed-price contracts, including fixed-price incentive contracts, when determining contract type and to obtain approval from the head of the contracting activity (HCA) for—

- Cost-reimbursement contracts in excess of $50 million to be awarded after October 1, 2018, and before October 1, 2019; and
- Cost-reimbursement contracts in excess of $25 million to be awarded on or after October 1, 2019.

Section 830 provides requirements, exceptions, and waiver authority for the use of firm-fixed-price contracts for foreign military sales (FMS). It requires contracting officers to use firm fixed-price contracts, unless an exception or a waiver applies.

Seven respondents submitted public comments in response to the proposed rule.

II. Discussion and Analysis

DoD reviewed the public comments in the development of the final rule. A discussion of the comments received and changes from the proposed rule made in the final rule are provided as follows:

A. Summary of Significant Changes From the Proposed Rule

There is one change from the proposed rule made in the final rule in response to the public comments. In order to properly align with the Federal Acquisition Regulation (FAR) requirements for approval of the determination and findings for use of incentive- and award-fee contracts, the content of DFARS Procedures, Guidance, and Information (PGI) 216.401(e)(iii) is relocated to DFARS 216.401(d)(i).

B. Analysis of Public Comments

1. Section 829 of the NDAA for FY 2017

a. Increased Administrative Burden

Comment: A respondent recommended that approval requests to use other than firm-fixed-price or fixed-price incentive contracts be included in the acquisition strategy, rather than in a separate approval document.

Response: This rule does not create a requirement for a separate approval document; rather, this rule instructs contracting officers to obtain HCA approval of their decision to use a cost-reimbursement type contract when the value of the contract is in excess of $25 million (on or after October 1, 2019). In accordance with FAR 7.105(b)(3), contracting officers are already required to include in an acquisition plan a discussion of the rationale for the selection of contract type, to include details regarding the complexity of the requirements and the associated reasoning essential to support the contract type selection. Departments and agencies have the latitude to establish the internal procedures for obtaining HCA approval of the use of cost-reimbursement contracts, which may include HCA approval of the acquisition plan.

Comment: Respondents expressed concern with increased administrative burdens in the acquisition process, to include the timeliness of required approvals for contract type selection as a result of the rule. The respondents believed the rule will create difficulty for contracting officers when determining contract types based on risk.

Response: The proposed rule implements the statutory requirement to obtain higher-level approval of the use of cost- reimbursement contracts at the specified thresholds. Section 829 of the NDAA for FY 2017 does not prohibit redelegation and FAR 1.102–4(b) authorizes decision making and the accountability for the decisions made to be delegated to the lowest level. As such, this rule delegates the section 829 approval authority to the head of the contracting activity, which should reduce any perceived impacts on administrative lead times. In addition, the Under Secretary of Defense for Acquisition and Sustainment (USD(A&S)) has already determined that the use of cost-reimbursement contracts for research and development in excess of $25 million is approved, subject to a written determination by the contracting officer, as specified at DFARS 235.006(b)(i). This upfront approval should alleviate unnecessary burden associated with research and development contracts, which are frequently and appropriately awarded as cost-reimbursement contracts.

b. Contract Type Selection

Comment: A respondent expressed concerns that established programs may require cost-reimbursement and time-and-materials contracts when the program does not have a relevant or appropriate cost history, and that defense contractors use firm-fixed-price contracts to obtain high profits and do not disclose actual costs.

Response: The proposed rule is consistent with DoD's current policies for the selection of contract type, which should balance risk fairly between the contractor and the Government, providing the opportunity to earn a reasonable profit/fee for successful delivery of products and services. Per DFARS 216.104, contracting officers are required to consider the principles and procedures in Director, Defense Procurement and Acquisition Policy (DPAP) (now Defense Pricing and Contracting (DPC)), memorandum dated April 1, 2016, entitled ''Guidance on Using Incentive and Other Contract Types,'' when selecting and negotiating the most appropriate contract type for a given procurement. As stated in the memorandum, ''Profit should not be targeted as a cost-cutting measure, but should instead be reflective of actual performance, with higher profit levels tied to better performance and lower levels to poorer performance.''

c. Congressional Intent

Comment: A respondent expressed concern that section 829 of the NDAA for FY 2017 requirements permit risks to be placed on the contractor, rather than on the Government.

Response: Section 829 specifically established a preference for fixed-price contracts, including fixed-price incentive fee contracts, in the determination of contract type, and mandated approval of the use of cost-reimbursement contracts at established thresholds and time periods.

Comment: A respondent was concerned that contracting officers would no longer have the flexibility during contract type determination to use tradeoffs (cost, schedule, and performance).

Response: DFARS 216.104, Factors in selecting contract type, requires contracting officers to follow the principles and procedures in the DPAP (now DPC) memorandum, ''Guidance on Using Incentive and Other Contract Types,'' dated April 1, 2016, when selecting and negotiating the most appropriate contract type for a given procurement. Section 829 requirements will in no way impede the requirement for contracting officers to consider the factors associated with cost, schedule, and performance, as required by FAR 16.104 in the determination of contract type.

d. Location of Approval Requirements

Comment: A respondent recommended that all DoD approval requirements for incentive and award-fee contracts be located in the DFARS instead of the PGI for coherency.

Response: DoD agrees with the respondent's comment. In order to properly align with the FAR requirements for approval of the determination and findings for use of incentive- and award-fee contracts, the content of DFARS PGI 216.401(e)(iii) has been relocated to DFARS 216.401(d). The relocated text in DFARS 216.401(d) has been revised to reflect that approval of the HCA is required for cost-reimbursement incentive- or award-fee contracts valued in excess of $50 million or above to align with the section 829 implementation.

2. Section 830 of the NDAA for FY 2017

a. Foreign Military Sales

Comment: A respondent recommended the waiver authority be revised to the Service Acquisition Executive, Combatant Commander, or USD(A&S). The respondent also stated the Secretary of Defense justification delegating authority to the chief of contracting office should have been included in the proposed rule; to ensure only a DoD official appointed and confirmed by the Senate made the best interest determination applicable to the FMS.

Response: FAR 1.102–4(b), authorizes decision making and the accountability for the decisions made to be delegated to the lowest level. Section 830 does not prohibit redelegation. Therefore, DoD has the discretion to delegate approval authority associated with section 830 waiver approval authority to the chief of the contracting office.

Comment: A respondent recommended deletion of DFARS 225.7301–2, which requires the contracting officer to coordinate through agency channels with the Principal Director of DPC prior to issuance of an FMS solicitation exceeding $500 million. The respondent expressed concern that the requirement created an extension of the peer review process, beyond service contracts in excess of $1 billion, without any statutory basis and without public comment.

Response: The policy guidance at DFARS 225.7301–2 implements internal procedures for contracting officers negotiating sole source major system requirements for U.S. and U.S./FMS procurements contained in the DPAP (now DPC) policy memorandum, Negotiations of Sole Source Major Systems for U.S. and U.S/FMS Combined Procurements, dated June 28, 2018. Internal operating procedures of the Government are not subject to the requirements of the Office of Federal Procurement Policy statute (see section 41 U.S.C. 1707).

Comment: A respondent asked if the changes in the rule associated with FMS are indicative of a Department-wide shift for all contracting. And, if not, the respondent further asked how the proposed rule aligns with DoD's commitment to buy for the foreign customer as it would for itself.

Response: This policy requirement implements section 830 and the DPAP (now DPC) policy memorandum, Negotiations of Sole Source Major Systems for U.S. and U.S./FMS Combined Procurements, dated June 28, 2018. This policy requirement is not applicable to all DoD procurements. Section 830 does not limit DoD's use of established defense acquisition regulations and procedures for FMS.

Comment: A respondent asked if DoD will utilize firm-fixed-price contracts for FMS cases if a more effective acquisition approach is available.

Response: Section 830 specifically requires the use of firm-fixed-price contracts for FMS. This requirement may be waived if the chief of the contracting office determines, on a case-by-case basis, that a different contract type is in the best interest of the United States and American taxpayers.

Comment: A respondent asked what discretion the contracting authority will have to deviate from this default approach or advise the foreign purchaser that different contractual terms would better satisfy their requirement.

Response: The Letter of Offer and Acceptance facilitates the Government and the foreign country's agreement to specified terms and conditions on the FMS. Section 830 specifically requires the use of firm-fixed-price contracts for FMS unless an exception or a waiver applies.

The exception applies only if the foreign country (that is a counterparty to a FMS) has established a preference for a different contract type or requests in writing that a different contract type be used for a specific FMS.

The waiver is determined on a case-by-case basis that a different contract type is in the best interest of the United States and American taxpayers.

Comment: A respondent asked whether the foreign customer will no longer have access to the full DoD purchasing options, but rather just a portion of them given the default contract option being proposed.

Response: Under FMS, the foreign customer is assured that the acquisition process will be subject to DoD standards through every step of the process. DoD standards dictate the defense acquisition system process, which includes the primary guiding principle that acquisitions must be in the best interest of the Government. In accordance with DFARS 225.7301(a) and (b), the Government sells defense articles and services to foreign governments or international organizations through FMS agreements and conducts FMS acquisitions under the same acquisition and contract management procedures used for other defense acquisitions. The agreement is documented in a Letter of Offer and Acceptance as required by the Defense Security Cooperation Agency (DSCA) Security Assistance Management Manual (DSCA 5105.38–M). Section 830 requirements will in no way impede the requirement for contracting officers to consider the factors associated with the FMS requirement process required by the defense acquisition system.

Comment: Two respondents requested DoD provide clarity on the exemption language regarding the ''in the best interest of the U.S. and U.S. taxpayer.''

Response: FMS procurements are funded using both foreign funds (which become appropriated funds when deposited into the Department of the Treasury) and appropriated funding for FMS requirements. In both instances they are considered Federal Government funds. This may also include funds expended for Government administrative costs associated with execution of the acquisition process. In accordance with FAR 1.102(d), Statement of guiding principles for the Federal Acquisition System, contracting officers are required to use sound business judgement as a member of the acquisition team to ensure decisions are made ensuring it is in the best interest of the Government, and ultimately the U.S. taxpayer. This rule does not remove the requirement for contracting officers to consider risk when determining the appropriate contract type for FMS. Inherently, a firm-fixed-price contract is used when the requirement is well defined, market conditions are stable, and when financial risks are otherwise insignificant; an example being commercial items. A cost-reimbursement contract is used when a requirement is unable to be adequately defined and uncertainty exists, increasing financial risks. Cost-reimbursement contracts may be used in research and development efforts, major system development, and prototype development, testing or low rate initial production efforts.

b. Congressional Intent

Comment: A respondent stated that the use of fixed-price incentive contracts for FMS was not in line with the intent of Congress for section 830 of the NDAA for 2017.

Response: The rule implements the section 830 requirement to use of firm-fixed-price contracts for foreign military sales, unless an exception or a waiver applies. The exception applies only if the foreign country (that is a counterparty to a foreign military sale) has established a preference for a different contract type or requests in writing that a different contract type be used for a specific FMS. The waiver is determined on a case-by-case basis that a different contract type is in the best interest of the United States and American taxpayers.

Comment: A respondent expressed concern that section 830 of the NDAA for 2017 permits risks to be placed on the contractor, rather than the Government.

Response: Section 830 specifically requires the use of firm-fixed-price contracts for foreign military sales, unless an exception or a waiver applies. Inherently, a firm-fixed-price contract is used when the requirement is well defined, market conditions are stable, and when financial risks are otherwise insignificant. Typical use would be for commercial supplies and services. The contractor is required to provide an acceptable deliverable at the time, place, and total price specified in the contract.

c. Increased Administrative Burden

Comment: A respondent recommended deletion of 225.7301–2, ''Solicitation approval for sole source contracts'', because contracting officers should not have to seek approval to follow the law.

Response: This internal operating procedural policy is established in accordance with the DPAP (now DPC) memorandum, ''Negotiations of Sole Source Major Systems for U.S. and U.S./FMS Combined Procurements,'' dated June 28, 2018.

d. Out of Scope

Comment: A respondent inquired about a future legislative proposal for the potential repeal of section 830 of the NDAA for FY 2017.

Response: The respondent's inquiry regarding a potential legislative proposal is out of scope of the requirement for the implementation of section 830 of the NDAA for FY 2017.

C. Other Changes

The following additional changes from the proposed rule are made in the final rule:

1. The requirement to obtain head of contracting activity approval prior to awarding cost-reimbursement contracts in excess of $50 million awarded after October 1, 2018, and before October 1, 2019, is removed from DFARS 216.301–3. This requirement applies to contracts awarded prior to the effective date of this rule.

2. The requirement for HCA approval of cost-reimbursement incentive- or award fee contracts valued in excess of $25 million is relocated to DFARS 216.401(d)(ii).

3. The statement ''for contracts entered into on or after October 1, 2014'' is removed from DFARS 234.004.

III. Applicability to Contracts at or Below the Simplified Acquisition Threshold and for Commercial Items, Including Commercially Available Off-the-Shelf Items

This rule does not propose to create any new DFARS clauses or amend any existing DFARS clauses.

IV. Executive Orders 12866 and 13563

Executive Orders (E.O.s) 12866 and 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This is not a significant regulatory action and, therefore, was not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. This rule is not a major rule under 5 U.S.C. 804.

V. Executive Order 13771

This final rule is not subject to E.O. 13771, because this rule is not a significant regulatory action under E.O. 12866.

VI. Regulatory Flexibility Act

A final regulatory flexibility analysis (FRFA) has been prepared consistent with the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.* The FRFA is summarized as follows:

This final rule is necessary to implement section 829 and 830 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017.

Section 829 requires contracting officers to first consider fixed-price contracts when determining contract type and to obtain approval from the head of the contracting activity (HCA) for cost-reimbursement contracts in excess of $25 million to be awarded on or after October 1, 2019. Section 830 directs DoD to prescribe regulations requiring the use of firm-fixed-price (FFP) contracts for foreign military sales (FMS).

The objective of the final rule is to implement the statutory requirements in section 829 and 830 of the NDAA for FY 2017 to: (1) Establish a preference for the use of fixed-price contracts in the determination of contract price; and (2) accelerate the contracting and pricing process of FMS by basing price reasonableness determinations on actual cost and pricing data for purchases of the same product for DoD.

There were no issues raised by the public in response to the initial regulatory flexibility analysis provided in the proposed rule.

The final rule will apply to small entities competing on cost-reimbursement contracts. According to

data obtained from the Federal Procurement Data System (FPDS) for FY 2017, DoD awarded 1,674 cost-reimbursement contracts, task orders, and delivery orders, valued over $50 million. Only 58 awards, approximately five percent, were made to unique small businesses.

The rule does not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35) or other compliance requirements for small entities.

DoD has not identified any alternatives that would meet the requirements of the applicable statutes.

VII. Paperwork Reduction Act

The rule does not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

List of Subjects in 48 CFR Parts 202, 216, 217, 225, 234, and 235

Government procurement.

Jennifer Lee Hawes,

Regulatory Control Officer, Defense Acquisition Regulations System.

Therefore, 48 CFR parts 202, 216, 217, 225, 234, and 235 are amended as follows:

■ 1. The authority citation for 48 CFR parts 202, 216, 217, 225, 234, and 235 continues to read as follows:

Authority: 41 U.S.C. 1303 and 48 CFR chapter 1.

PART 202—DEFINITION OF WORDS AND TERMS

■ 2. Amend section 202.101 by adding in alphabetical order a definition for ''Milestone decision authority'' to read as follows:

202.101 Definitions.

* * * * *

Milestone decision authority, with respect to a major defense acquisition program, major automated information system, or major system, means the official within the Department of Defense designated with the overall responsibility and authority for acquisition decisions for the program or system, including authority to approve entry of the program or system into the next phase of the acquisition process (10 U.S.C. 2431a).

* * * * *

PART 216—TYPES OF CONTRACTS

■ 3. Amend section 216.102 by—

■ a. Designating the text as paragraph (2); and

■ b. Adding paragraphs (1) and (3).

The additions read as follows:

216.102 Policies.

(1) In accordance with section 829 of the National Defense Authorization Act for Fiscal Year 2017 (Pub. L. 114–328), the contracting officer shall first consider the use of fixed-price contracts, including fixed-price incentive contracts, in the determination of contract type. See 216.301–3(2) for approval requirements for certain cost-reimbursement contracts.

* * * * *

(3) See 225.7301–1 for the requirement to use fixed-price contracts for acquisitions for foreign military sales.

216.104–70 [Amended]

■ 4. Amend section 216.104–70 by removing ''contract type'' and adding ''contract type, and see 235.006(b) for additional approval requirements'' in its place.

■ 5. Amend section 216.301–3 by—

■ a. Designating the text as paragraph (1); and

■ b. Adding paragraph (2).

The addition reads as follows:

216.301–3 Limitations.

* * * * *

(2) Except as provided in 235.006(b), in accordance with section 829 of the National Defense Authorization Act for Fiscal Year 2017 (Pub. L. 114–328), approval of the head of the contracting activity is required prior to awarding cost-reimbursement contracts in excess of $25 million.

■ 6. Amend section 216.401 by adding paragraph (d) to read as follows:

216.401 General.

* * * * *

(d)(i) Except as provided in paragraph (d)(ii), the determination and findings justifying that the use of an incentive- or award-fee contract is in the best interest of the Government, may be signed by the head of contracting activity or a designee—

(A) No lower than one level below the head of the contracting activity for award fee contracts; or

(B) One level above the contracting officer for incentive fee contracts.

(ii) For cost-reimbursement incentive- or award fee contracts valued in excess of $25 million, the determination and findings justifying that the use of this type of contract is in the best interest of the Government shall be signed by the head of the contracting activity. See DFARS 216.301–3(2).

* * * * *

PART 217—SPECIAL CONTRACTING METHODS

■ 7. Amend section 217.202 by adding paragraphs (1)(i) and (ii) to read as follows:

217.202 Use of options.

(1) * * *

(i) See PGI 217.202(1) for guidance on the use of options with foreign military sales (FMS).

(ii) See PGI 217.202(2) for the use options with sole source major systems for U.S. and U.S./FMS combined procurements.

* * * * *

PART 225—FOREIGN ACQUISITION

■ 8. Add section 225.7301–1 to read as follows:

225.7301–1 Requirement to use firm-fixed-price contracts.

(a) *Requirement.* In accordance with section 830 of the National Defense Authorization Act for Fiscal Year 2017 (Pub. L. 114–328), a firm-fixed-price contract shall be used for FMS, unless the foreign country that is the counterparty to FMS—

(1) Has established in writing a preference for a different contract type; or

(2) Requests in writing that a different contract type be used for a specific FMS. See PGI 217.202(2) on the use of priced options for FMS requirements.

(b) *Waiver.* The requirement in paragraph (a) of this section may be waived, if the chief of the contracting office determines, on a case-by-case basis, that a different contract type is in the best interest of the United States and American taxpayers.

■ 9. Add section 225.7301–2 to read as follows:

225.7301–2 Solicitation approval for sole source contracts.

The contracting officer shall coordinate through agency channels with the Principal Director, Defense Pricing and Contracting, prior to issuing a solicitation for a sole source contract for U.S./FMS combined requirements for a major system that has an estimated contract value that exceeds $500 million. See also 201.170 and PGI 216.403–1(1)(ii)(B) and (C).

PART 234—MAJOR SYSTEM ACQUISITION

■ 10. Amend section 234.004 by—

■ a. In paragraph (2)(i)(A), removing ''Milestone Decision Authority'' and adding ''milestone decision authority'' in its place;
■ b. In paragraph (2)(i)(C) introductory text, removing ''Milestone Decision Authority's'' and adding ''milestone decision authority's'' in its place;
■ c. Revising paragraphs (2)(ii) introductory text and (2)(ii)(A) introductory text;
■ d. In paragraph (2)(ii)(A)(*2*), removing the word ''when''; and
■ e. Adding paragraphs (2)(iii) and (2)(iv).

The revision and addition read as follows:

234.004 Acquisition strategy.

* * * * *

(2) * * *

(ii) In accordance with section 811 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112–239), the contracting officer shall—

(A) Not use cost-reimbursement line items for the acquisition of production of major defense acquisition programs, unless the Under Secretary of Defense for Acquisition and Sustainment (USD(A&S)), or the milestone decision authority when the milestone decision authority is the service acquisition executive of the military department that is managing the program, submits to the congressional defense committees—

* * * * *

(iii) See 216.301–3 for additional contract type approval requirements for cost-reimbursement contracts.

(iv) For fixed-price incentive (firm target) contracts, contracting officers shall comply with the guidance provided at PGI 216.403–1(1)(ii)(B) and (C).

PART 235—RESEARCH AND DEVELOPMENT CONTRACTING

■ 11. Amend section 235.006 by—
■ a. Redesignating paragraphs (b)(i) and (ii) as paragraphs (b)(ii) and (iii);
■ b. In newly redesignated paragraph (b)(ii)(B) introductory text, removing ''Under Secretary of Defense (Acquisition, Technology, and Logistics) (USD(AT&L))'' and adding ''milestone decision authority'' in its place;
■ c. In newly redesignated paragraph (b)(iii)(A)(*3*) introductory text, removing ''(b)(ii)(A)(*1*)'' and adding ''(b)(iii)(A)(*1*)'' in its place;
■ d. In newly redesignated paragraph (b)(iii)(A)(*3*)(*i*), removing ''USD(AT&L)'' and adding ''USD(A&S)'' in its place;
■ e. In newly redesignated paragraph (b)(iii)(A)(*3*)(*ii*), removing ''(b)(ii)(A)(*3*)(*i*)'' and adding ''(b)(iii)(A)(*3*)(*i*)'' in its place;
■ f. In the newly redesignated paragraph (b)(iii)(B) introductory text, removing ''USD(AT&L)'' and adding ''USD(A&S)'' in two places; and
■ g. Adding new paragraph (b)(i).

The addition reads as follows:

235.006 Contracting methods and contract type.

(b)(i) Consistent with section 829 of the National Defense Authorization Act for Fiscal Year 2017 (Pub. L. 114–328), the Under Secretary of Defense for Acquisition and Sustainment (USD(A&S)) has determined that the use of cost-reimbursement contracts for research and development in excess of $25 million is approved, if the contracting officer executes a written determination and findings that—

(A) The level of program risk does not permit realistic pricing; and

(B) It is not possible to provide an equitable and sensible allocation of program risk between the Government and the contractor.

* * * * *

[FR Doc. 2019–25658 Filed 11–26–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 215 and 252

[Docket DARS–2019–0038]

RIN 0750–AJ78

Defense Federal Acquisition Regulation Supplement: Management of Should-Cost Review Process (DFARS Case 2018–D015)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is issuing a final rule to amend the Defense Federal Acquisition Regulation Supplement (DFARS) to implement a section of the National Defense Authorization Act for Fiscal Year 2018, which requires an amendment to the DFARS to provide for the appropriate use of the should-cost review process of a major weapon system.

DATES: Effective November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Ms. Amy G. Williams, telephone 571–372–6106.

SUPPLEMENTARY INFORMATION:

I. Background

DoD published a proposed rule in the **Federal Register** at 84 FR 39254 on August 9, 2019, to implement section 837 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018 (Pub. L. 115–91). Section 837 requires an amendment to the DFARS to provide for the appropriate use of the should-cost review process of a major weapon system in a manner that is transparent, objective, and provides for the efficiency of the systems acquisition process in the Department of Defense. There were no public comments submitted in response to the proposed rule. There are no changes from the proposed rule made in the final rule.

II. Applicability to Contracts at or Below the Simplified Acquisition Threshold and for Commercial Items, Including Commercially Available Off-the-Shelf Items

This rule create a new clause at DFARS 252.215–7015, Program Should-Cost Review, but this clause is not applicable to contracts valued at or below the simplified acquisition threshold or for the acquisition of commercial items, including commercially available off-the-shelf items. Contracts for the development and or production of a major weapon system do not include contracts valued at or below the simplified acquisition threshold and are unlikely to include contracts for commercial items.

III. Executive Orders 12866 and 13563

Executive Order (E.O.s) 12866 and 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This is not a significant regulatory and, therefore, was not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. This is not a major rule under 5 U.S.C. 804.

IV. Executive Order 13771

This rule is not subject to E.O. 13771, because this rule is not a significant regulatory action under E.O. 12866.

V. Regulatory Flexibility Act

A final regulatory flexibility analysis (FRFA) has been prepared consistent with the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.* The FRFA is summarized as follows:

This action is necessary to implement section 837 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018. Section 837 requires an amendment to the DFARS to provide for the appropriate use of the should-cost review process of a major weapon system in a manner that is transparent, objective and provides for the efficiency of the systems acquisition process in the Department of Defense.

The objective of this rule is to amend the DFARS to include six elements, at a minimum, regarding the appropriate use of the should-cost review of a major weapon system: (1) A description of the features of the should-cost review process, (2) establishment of a process for communicating with the prime contractor on the program the elements of a proposed should-cost review, (3) a method for ensuring that identified should-cost savings opportunities are based on accurate, complete, and current information and can be quantified and tracked, (4) a description of the training, skills, and experience that Department of Defense and contractor officials carrying out a should-cost review should possess, (5) a method for ensuring appropriate collaboration with the contractor throughout the review process, and (6) establishment of review process requirements that provide for sufficient analysis and minimize any impact on program schedule. The legal basis for these changes is section 837 of the NDAA for FY 2018.

No public comments were received in response to the proposed rule.

This rule only applies to contracts for the development and or production of a major systems, as defined in FAR 2.101. DoD estimates that there are 150 major systems, which include major weapon systems. DoD estimates that the prime contractors for major systems are other than small business and only one program should-cost review occurs per year for major systems, so this rule will have minimal impact on small businesses.

This final rule does not include any new reporting, recordkeeping, or other compliance requirements for small businesses.

There are no known significant alternative approaches to the rule that would meet the objectives. There is no significant economic impact on small entities.

VI. Paperwork Reduction Act

The rule does not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

List of Subjects in 48 CFR Parts 215 and 252

Government procurement.

Jennifer Lee Hawes,
Regulatory Control Officer, Defense Acquisition Regulations System.

Therefore, 48 CFR parts 215 and 252 are amended as follows:

■ 1. The authority citation for 48 CFR parts 215 and 252 continues to read as follows:

Authority: 41 U.S.C. 1303 and 48 CFR chapter 1.

PART 215—CONTRACTING BY NEGOTIATION

■ 2. Amend section 215.407–4 by designating the text as paragraph (a), adding a heading to newly designated paragraph (a), and adding paragraph (b) to read as follows:

215.407–4 Should-cost review.

(a) *General.* * * *

(b) *Program should-cost review.* Major weapon system should-cost program reviews shall be conducted in a manner that is transparent, objective, and provides for the efficiency of the DoD systems acquisition process (section 837 of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115–91)).

(i) Major weapon system should-cost reviews may include the following features:

(A) A thorough review of each contributing element of the program cost and the justification for each cost.

(B) An analysis of non-value added overhead and unnecessary reporting requirements.

(C) Benchmarking against similar DoD programs, similar commercial programs (where appropriate), and other programs by the same contractor at the same facility.

(D) An analysis of supply chain management to encourage competition and incentive cost performance at lower tiers.

(E) A review of how to restructure the program (Government and contractor) team in a streamlined manner, if necessary.

(F) Identification of opportunities to break out Government-furnished equipment versus prime contractor-furnished materials.

(G) Identification of items or services contracted through third parties that result in unnecessary pass-through costs.

(H) Evaluation of ability to use integrated developmental and operational testing and modeling and simulation to reduce overall costs.

(I) Identification of alternative technology and materials to reduce developmental or lifecycle costs for a program.

(J) Identification and prioritization of cost savings opportunities.

(K) Establishment of measurable targets and ongoing tracking systems.

(ii) The should-cost review shall provide for sufficient analysis while minimizing the impact on program schedule by engaging stakeholders early, relying on information already available before requesting additional data, and establishing a team with the relevant expertise early.

(iii) The should-cost review team shall be comprised of members, including third-party experts if necessary, with the training, skills, and experience in analysis of cost elements, production or sustainment processes, and technologies relevant to the program under review. The review team may include members from the Defense Contract Management Agency, the department or agency's cost analysis center, and appropriate functional organizations, as necessary.

(iv) The should-cost review team shall establish a process for communicating and collaborating with the contractor throughout the should-cost review, including notification to the contractor regarding which elements of the contractor's operations will be reviewed and what information will be necessary to perform the review, as soon as practicable, both prior to and during the review.

(v) The should-cost review team report shall ensure, to the maximum extent practicable, review of current, accurate, and complete data, and shall identify cost savings opportunities associated with specific engineering or business changes that can be quantified and tracked.

■ 3. Amend section 215.408 by adding paragraph (8) to read as follows:

215.408 Solicitation provisions and contract clauses.

* * * * *

(8) Use the clause at 252.215–7015, Program Should-Cost Review, in all solicitations and contracts for the development or production of a major weapon system, as defined in 234.7001.

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

■ 4. Add section 252.215–7015 to read as follows:

252.215–7015 Program Should-Cost Review.

As prescribed in 215.408(8), use the following clause:

Program Should-Cost Review (Nov 2019)

(a) The Government has the right to perform a program should-cost review, as described in Federal Acquisition Regulation (FAR) 15.407–4(b). The review may be conducted in support of a particular contract proposal or during contract performance to find opportunities to reduce program costs. The Government will communicate the elements of the proposed should-cost review to the prime contractor (Pub. L. 115–91).

(b) If the Government performs a program should-cost review, upon the Government's request, the Contractor shall provide access to accurate and complete cost data and Contractor facilities and personnel necessary to permit the Government to perform the program should-cost review.

(c) The Government has the right to use third-party experts to supplement the program should-cost review team. The Contractor shall provide access to the Contractor's facilities and information necessary to support the program should-cost review to any third-party experts who have signed non-disclosure agreements in accordance with the FAR 52.203–16.

(End of clause)

[FR Doc. 2019–25655 Filed 11–26–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 225 and 237

[Docket DARS–2019–0066]

RIN 0750–AK86

Defense Federal Acquisition Regulation Supplement: Repeal of Temporary Statutory Authorities (DFARS Case 2019–D040)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is issuing a final rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to implement a section of the National Defense Authorization Act for Fiscal Year 2019.

DATES: Effective November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Ms. Kimberly R. Ziegler, telephone 571–372–6095.

SUPPLEMENTARY INFORMATION:

I. Background

DoD is amending the DFARS to partially implement section 812 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Pub. L. 115–232). Section 812 repealed more than 60 obsolete Defense acquisition laws, most of which have been completed, have expired, or do not impact the contracting regulations. DoD published a final rule to repeal one statute identified in section 812 at 84 FR 12137 on April 1, 2019. This rule repeals two additional statutes, section 842(b) of the NDAA for FY 2007 (Pub. L. 109–364) and section 1010 of the USA Patriot Act of 2001 (Pub. L. 107–56).

To implement section 842(b) of the NDAA for FY 2007, DoD published a final rule at 74 FR 37626 on July 29, 2009 (DFARS Case 2008–D003). The rule established a one-time waiver authority for contracts under which specialty metals were incorporated into items produced, manufactured, or assembled in the United States prior to October 17, 2006, and where final acceptance by the Government took place after that date, but before September 30, 2010.

To implement section 1010 of the USA Patriot Act of 2001, DoD published a final rule at 67 FR 55730 on August 30, 2002 (DFARS Case 2001–D018). The rule provided an exception to the prohibition on contracting for security functions at a military installation or facility. The exception authorized DoD to award contracts to proximately located local and State governments during the period of time that United States armed forces were engaged in Operation Enduring Freedom and 180 days thereafter. Operation Enduring Freedom officially ended on December 29, 2014; therefore, this authority expired on June 26, 2015.

II. Discussion and Analysis

This rule removes the obsolete language at DFARS 225.7003–4 and 237.102–70(c) that implemented sections 842(b) and 1010, respectively.

III. Publication of This Final Rule for Public Comment Is Not Required by Statute

The statute that applies to the publication of the Federal Acquisition Regulation is Office of Federal Procurement Policy statute (codified at title 41 of the United States Code). Specifically, 41 U.S.C. 1707(a)(1) requires that a procurement policy, regulation, procedure, or form (including an amendment or modification thereof) must be published for public comment if it relates to the expenditure of appropriated funds, and has either a significant effect beyond the internal operating procedures of the agency issuing the policy, regulation, procedure or form, or has a significant cost or administrative impact on contractors or offerors. This final rule is not required to be published for public comment, because the rule merely removes two expired authorities from the DFARS.

IV. Applicability to Contracts at or Below the Simplified Acquisition Threshold and for Commercial Items, Including Commercially Available Off-the-Shelf Items

This rule removes expired authorities for contracted security functions at a military installation or facility at DFARS 237.102–70(c) and a one-time waiver of the specialty metals clause under certain circumstances at DFARS 225.7003–4. This rule does not create or revise any solicitation provisions or contract clauses.

V. Executive Orders 12866 and 13563

Executive Orders (E.O.) 12866 and E.O. 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This is not a significant regulatory action and, therefore, was not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. This rule is not a major rule under 5 U.S.C. 804.

VI. Executive Order 13771

This rule is not subject to E.O. 13771, because this rule is not a significant regulatory action under E.O. 12866.

VII. Regulatory Flexibility Act

Because a notice of proposed rulemaking and an opportunity for public comment are not required to be given for this rule under 41 U.S.C. 1707(a)(1) (see section III. of this preamble), the analytical requirement of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) are not applicable. Accordingly, no regulatory flexibility analysis is required, and none has been prepared.

VIII. Paperwork Reduction Act

The rule does not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

List of Subjects in 48 CFR Parts 225 and 237

Government procurement.

Jennifer Lee Hawes,

Regulatory Control Officer, Defense Acquisition Regulations System.

Therefore, 48 CFR parts 225 and 237 are amended as follows:

■ 1. The authority citation for 48 CFR parts 225 and 237 continues to read as follows:

Authority: 41 U.S.C. 1303 and 48 CFR chapter 1.

PART 225—FOREIGN ACQUISITION

225.7003–4 [Removed and Reserved]

■ 2. Remove and reserve section 225.7003–4.

PART 237—SERVICE CONTRACTING

■ 3. Amend section 237.102–70 by—

■ a. Removing paragraph (c);

■ b. Redesignating paragraph (d) as paragraph (c);

■ c. Revising newly redesignated paragraph (c)(1) introductory text; and

■ d. In newly redesignated paragraph (c)(2), removing ''PGI 237.102–70(d)'' and ''(d)(1)(iv) of this subsection'' and adding ''PGI 237.102–70(c)'' and ''(c)(1)(iv) of this section'' it their place, respectively.

The revision reads as follows:

237.102–70 Prohibition on contracting for firefighting or security-guard functions.

* * * * *

(c)(1) Under section 332 of Public Law 107–314, as amended by section 333 of Public Law 109–364 and section 343 of Public Law 110–181, this prohibition does not apply to any contract that is entered into for any increased performance of security-guard functions at a military installation or facility undertaken in response to the terrorist attacks on the United States on September 11, 2001, if—

* * * * *

[FR Doc. 2019–25659 Filed 11–26–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 228 and 252

[Docket DARS–2019–0030]

RIN 0750–AK12

Defense Federal Acquisition Regulation Supplement: Modification of DFARS Clause ''Accident Reporting and Investigation Involving Aircraft, Missiles, and Space Launch Vehicles'' (DFARS Case 2018–D047)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is issuing a final rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to modify the text of an existing clause prescription to require, instead of permit, the clause be included in applicable solicitations and contracts, pursuant to action taken by the Regulatory Reform Task Force.

DATES: Effective November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Ms. Carrie Moore, telephone 571–372–6093.

SUPPLEMENTARY INFORMATION:

I. Background

DoD published a proposed rule in the **Federal Register** at 84 FR 30986 on June 28, 2019, to modify the clause prescription at DFARS 228.370 to require that DFARS clause 252.228–7005, Accident Reporting and Investigation Involving Aircraft, Missiles, and Space Launch Vehicles, be included in all solicitations and contracts, when applicable. The rule also updates the text of the clause to follow current DFARS convention regarding the use of the word ''shall'' to indicate a mandatory requirement or action. One respondent provided a public comment on the proposed rule.

II. Discussion and Analysis

A discussion of the comment received and the change made to the rule as a result of the comment is provided as follows:

Comment: The respondent suggested replacing the word ''accident'' with ''mishap'' throughout the clause to align with the terminology used in DoD Instruction 6055.07, ''Mishap Notification, Investigation, Reporting, and Recordkeeping.''

Response: As the use of the term ''mishap'' has become more prevalent throughout DoD in lieu of ''accident'' since the creation of the clause, and the clause is closely associated with the guidance in DoDI 6055.07, the clause title and text is updated to include the word ''mishap'' instead of ''accident'' in the final rule.

III. Applicability to Contracts at or Below the Simplified Acquisition Threshold and for Commercial Items, Including Commercially Available Off-the-Shelf Items

This rule does not create any new provisions or clauses, nor does it change the applicability of the affected clause to contracts at or below the simplified acquisition threshold or to the acquisition of commercial items, including those for commercially available off-the-shelf items.

IV. Executive Orders 12866 and 13563

Executive Orders (E.O.s) 12866 and E.O. 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This is not a significant regulatory action and, therefore, was not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. This rule is not a major rule under 5 U.S.C. 804.

V. Executive Order 13771

This rule is not subject to E.O. 13771, because this rule is not a significant regulatory action under E.O. 12866.

VI. Regulatory Flexibility Act

A final regulatory flexibility analysis (FRFA) has been prepared consistent with the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.* The FRFA is summarized as follows:

The Department of Defense is amending the Defense Federal Acquisition Regulation Supplement (DFARS) to amend the clause prescription at DFARS 228.370 to require that DFARS clause 252.228–7005, Accident Reporting and Investigation Involving Aircraft, Missiles, and Space Launch Vehicles, be included in all solicitations and contracts involving the manufacture, modification, overhaul, or repair of these items; update the text of the clause to follow current DFARS convention regarding the use of the word ''shall'' to

indicate a mandatory requirement or action; and update the clause title by removing ''Accident'' and replacing it with ''Mishap''.

The objective of this rule is to ensure contractor cooperation: In the early reporting of accidents that involve an aircraft, missile, or space launch vehicle being manufactured, modified, repaired, or overhauled by the contractor in connection with the contract; and, with the Government investigation of such accidents. The modification of this DFARS clause supports a recommendation from the DoD Regulatory Reform Task Force. No public comments were received in response to the initial regulatory flexibility analysis.

This rule requires, instead of permits, the inclusion of the clause in all applicable contracts, and updates the text of the clause to clarify its intent. It is presumed that the clause is already being included in all applicable contracts. The rule simply clarifies the Government's expectation on the usage of the clause.

Based on fiscal year 2018 data from the Federal Procurement Data System (FPDS), the Government awarded approximately 960 noncommercial contracts and orders for services under the following product service codes:

- AC16—R&D—Defense System: Aircraft (Management/Support);
- AC26—Defense System: Missile/Space Systems (Management/Support);
- AR96—R&D—Space: Other (Management/Support);
- J014—Repair, and Rebuilding of Equipment—Guided Missiles;
- J015—Maintenance, Repair, and Rebuilding of Equipment—Aircraft and Airframe Structural Components;
- J018—Maintenance, Repair, and Rebuilding of Equipment—Space Vehicles;
- K014—Modification of Equipment—Guided Missiles;
- K015—Modification of Equipment—Aircraft and Airframe Structural Components; and,
- K018—Modification of Equipment—Space Vehicles.

Of the 960 contracts and orders awarded, approximately 16% of the awards were made to 54 unique small businesses entities. FPDS does not provide additional information on the types of support services provided under the contract, which can include manufacture, modification, overhaul, or repair work; therefore, the number of small business contractors impacted by this rule is expected to be less than the number of entities identified by the data.

This rule does not include any new reporting, recordkeeping, or other compliance requirements for small businesses. This rule does not duplicate, overlap, or conflict with any other Federal rules. There are no known significant alternative approaches to the rule that would meet the stated objectives.

VII. Paperwork Reduction Act

The rule does not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

List of Subjects in 48 CFR Parts 228 and 252

Government procurement.

Jennifer Lee Hawes,

Regulatory Control Officer, Defense Acquisition Regulations System.

Therefore, 48 CFR parts 228 and 252 are amended as follows:

■ 1. The authority citation for 48 CFR parts 228 and 252 continues to read as follows:

Authority: 41 U.S.C. 1303 and 48 CFR chapter 1.

PART 228—BONDS AND INSURANCE

■ 2. Amend section 228.370 by revising paragraph (d) to read as follows:

228.370 Additional clauses.

* * * * *

(d) Use the clause at 252.228–7005, Mishap Reporting and Investigation Involving Aircraft, Missiles, and Space Launch Vehicles, in solicitations and contracts that involve the manufacture, modification, overhaul, or repair of aircraft, missiles, and space launch vehicles.

* * * * *

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

252.228–7005 [Amended]

■ 3. Amend section 252.228–7005 by—

■ a. In the section heading and the clause title, removing ''Accident'' and adding ''Mishap'' in both places;

■ b. Removing the clause date ''(DEC 1991)'' and adding ''(NOV 2019)'' in its place;

■ c. In paragraph (a), removing ''accident'' and adding ''mishap'' in its place; and

■ d. In paragraph (b), removing ''accident'' and ''will'' and adding ''mishap'' and ''shall'' in their place, respectively; and

■ e. In paragraph (c), removing ''will'' and ''accident'' and adding ''shall'' and ''mishap'' in their place, respectively.

[FR Doc. 2019–25656 Filed 11–26–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 181218999–9402–02]

RIN 0648–XW015

Magnuson-Stevens Act Provisions; Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; 2019 Tribal Fishery Allocations for Pacific Whiting; Reapportionment Between Tribal and Non-Tribal Sectors

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Inseason reapportionment of tribal Pacific whiting allocation.

SUMMARY: This document announces the reapportionment of 40,000 metric tons of Pacific whiting from the tribal allocation to the non-tribal commercial fishery sectors via automatic action on September 13, 2019. This reapportionment is to allow full utilization of the Pacific whiting resource.

DATES: The reapportionment of Pacific whiting was applicable from 12 p.m. local time, September 13, 2019, through December 31, 2019. Comments will be accepted through December 12, 2019.

ADDRESSES: You may submit comments, identified by NOAA–NMFS–2019–0001 by any of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal eRulemaking Portal at *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2019-0001*. Click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Barry A. Thom, Regional Administrator, West Coast Region, NMFS, 1201 NE Lloyd Center Blvd. Suite #1100, Portland, OR 97232, Attn: Stacey Miller.

Instructions: Comments sent by any other method to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record. All personal identifying information

(*e.g.,* name, address, *etc.*), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Electronic Access

This document is accessible online at the Office of the Federal Register's website at *http://www.gpo.gov/fdsys/search/home.action.* Background information and documents are available at NMFS' West Coast Region website at *https://www.fisheries.noaa.gov/species/pacific-whiting#management.*

FOR FURTHER INFORMATION CONTACT: Stacey Miller (West Coast Region, NMFS), phone: 503–231–6290 or email: *Stacey.Miller@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Background

Pacific Whiting

Pacific whiting (*Merluccius productus*) is a very productive species with highly variable recruitment (the biomass of fish that mature and enter the fishery each year) and a relatively short life span compared to other groundfish species. Pacific whiting has the largest annual allowable harvest levels (by volume) of the more than 90 groundfish species managed under the Pacific Coast Groundfish Fishery Management Plan (FMP), which governs the groundfish fishery off Washington, Oregon, and California. The coastwide Pacific whiting stock is managed jointly by the United States and Canada, and mature Pacific whiting are commonly available to vessels operating in U.S. waters from April through December. Background on the stock assessment, and the establishment of the 2019 Total Allowable Catch (TAC), for Pacific whiting was provided in the final rule for the 2019 Pacific whiting harvest specifications, published May 10, 2019 (84 FR 20578). Pacific whiting is allocated to the Pacific Coast treaty tribes (tribal fishery) and to three non-tribal commercial sectors: The catcher/processor cooperative (C/P Coop), the mothership cooperative (MS Coop), and the Shorebased Individual Fishery Quota (IFQ) Program.

This document announces the reapportionment of 40,000 metric tons (mt) of Pacific whiting from the tribal allocation to the non-tribal commercial sectors on September 13, 2019. Regulations at 50 CFR 660.131(h) contain provisions that allow the Regional Administrator to reapportion Pacific whiting from the tribal allocation, specified at 50 CFR 660.50, that will not be harvested by the end of the fishing year to other sectors.

Pacific Whiting Reapportionment

For 2019, the Pacific Coast treaty tribes were allocated 77,251 mt of Pacific whiting. The best available information on September 13, 2019, indicated that less than 5,000 mt of the 2019 allocation had been harvested, and at least 40,000 mt of the tribal allocation would not be harvested by December 31, 2019. As required under the 2017 Endangered Species Act (ESA) Section 7(a)(2) biological opinion on the effects of the Pacific Coast Groundfish Fishery Management Plan on listed salmonids, NMFS considered the number and bycatch rate of Chinook salmon taken by the Pacific whiting fishery sectors prior to reapportionment. Based on the best available information in early September 2019, NMFS determined there was little risk that the reapportionment would cause the Pacific whiting sector fisheries to exceed the guideline limit of 11,000 Chinook salmon under current regulations and practices. In early September, incidental take of Chinook salmon by the non-tribal sector was 12 percent of the guideline limit. While the incidental take of Chinook salmon was higher compared to the same period in the previous two years, the total take this year is still well below the guideline limit.

To allow for increased utilization of the resource, on September 13, 2019, NMFS reapportioned 40,000 mt from the Tribal sector to the Shorebased IFQ Program, C/P Coop, and MS Coop in proportion to each sector's original allocation. Reapportioning this amount is expected to allow for greater attainment of the TAC while not limiting tribal harvest opportunities for the remainder of the year. NMFS provided notice of the reapportionment on September 13, 2019, via emails sent directly to fishing businesses and individuals, and postings on the NMFS West Coast Region website. Reapportionment was effective the same day as the notice.

The amounts of Pacific whiting available for 2019 before and after the reapportionment are described in the table below.

TABLE 1—2019 PACIFIC WHITING ALLOCATIONS

Sector	Initial 2019 allocation (mt)	Final 2019 allocation (mt)
Tribal	77,251	37,251
C/P Coop	123,312	136,912
MS Coop	87,044	96,644
Shorebased IFQ Program	152,326.5	169,126

Classification

NOAA's Assistant Administrator for Fisheries (AA) finds that good cause exists for this notification to be issued without affording prior notice and opportunity for public comment pursuant to 5 U.S.C. 553(b)(B), because such notification would be impracticable and contrary to the public interest. As previously noted, NMFS provided actual notice of the reapportionment to fishery participants at the time of the action. Prior notice and opportunity for public comment on this reapportionment was impracticable because NMFS had insufficient time to provide prior notice between the time the information about the progress of the fishery needed to make this determination became available and the time at which fishery modifications had to be implemented in order to allow fishery participants access to the available fish during the remainder of the fishing season. For the same reasons, the AA also finds good cause to waive the 30-day delay in effectiveness for these actions, required under 5 U.S.C. 553(d)(3).

These actions are authorized by §§ 660.55 (i), 660.60(d), and 660.131(h) and are exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.* and 16 U.S.C. 7001 *et seq.*

Dated: November 21, 2019.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2019–25737 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 180713633–9174–02; RTID 0648–XY055]

Fisheries of the Exclusive Economic Zone Off Alaska; Several Groundfish Species in the Bering Sea and Aleutian Islands Management Area

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; apportionment of reserves; request for comments.

SUMMARY: NMFS apportions amounts of the non-specified reserve, to the initial total allowable catch (ITAC) of Bering Sea and Aleutian Islands (BSAI) sculpins and to the total allowable catch (TAC) of Aleutian Islands (AI) Greenland turbot, Bering Sea (BS) ''other rockfish,'' BSAI arrowtooth flounder, BSAI sharks, BSAI shortraker rockfish, and Bering Sea and Eastern Aleutian Islands (BS/EAI) blackspotted/rougheye rockfish. This action is necessary to allow the fisheries to continue operating. It is intended to promote the goals and objectives of the fishery management plan for the BSAI management area.

DATES: Effective November 26, 2019, through 2400 hrs, Alaska local time, December 31, 2019. Comments must be received at the following address no later than 4:30 p.m., Alaska local time, December 11, 2019.

ADDRESSES: Submit your comments, identified by docket number NOAA–NMFS–2018–0089, by either of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *https://www.regulations.gov/docket?D=NOAA-NMFS-2018-0089,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS. Mail comments to P.O. Box 21668, Juneau, AK 99802–1668.

Instructions: NMFS may not consider comments if they are sent by any other method, to any other address or individual, or received after the comment period ends. All comments received are a part of the public record and NMFS will post the comments for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, *etc.*), confidential business information, or otherwise sensitive information submitted voluntarily by the sender is publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

FOR FURTHER INFORMATION CONTACT: Steve Whitney, 907–586–7228.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the BSAI exclusive economic zone according to the Fishery Management Plan for Groundfish of the Bering Sea and Aleutian Islands Management Area (FMP) prepared by the North Pacific Fishery Management Council under authority of the Magnuson-Stevens Fishery Conservation and Management Act. Regulations governing fishing by U.S. vessels in accordance with the FMP appear at subpart H of 50 CFR part 600 and 50 CFR part 679.

The 2019 ITAC BSAI sculpins was established as 4,250 mt, the 2019 TAC of AI Greenland turbot was established as 169 mt, the 2019 TAC of BS ''other rockfish'' was established as 684, the 2019 TAC of BSAI arrowtooth flounder was established as 10,200 mt, the 2019 TAC of BSAI sharks was established as 145 mt, the 2019 TAC of BSAI shortraker rockfish was established as 358 mt, and the 2019 TAC of BS/EAI blackspotted/rougheye rockfish was established as 95 mt by the final 2019 and 2020 harvest specifications for groundfish of the BSAI (84 FR 9000, March 13, 2019) and reserve releases (84 FR 49678, September 23, 2019 and 84 FR 57653, October 28, 2019). In accordance with § 679.20(a)(3) the Regional Administrator, Alaska Region, NMFS, has reviewed the most current available data and finds that the ITACs and TACS for AI Greenland turbot, BS ''other rockfish'', BSAI arrowtooth flounder, BSAI sculpins, BSAI sharks, BSAI shortraker rockfish, and BS/EAI blackspotted/rougheye rockfish need to be supplemented from the non-specified reserve to promote efficiency in the utilization of fishery resources in the BSAI and allow fishing operations to continue.

Therefore, in accordance with § 679.20(b)(3), NMFS apportions from the non-specified reserve of groundfish to ITACs and TACs in the BSAI management area as follows: 10 mt to AI Greenland turbot, 100 mt to BS ''other rockfish'', 1,252 mt to BSAI arrowtooth flounder, 1,358 mt to BSAI sculpins, 10 mt to BSAI sharks, 42 mt to BSAI shortraker rockfish, and 10 mt to BS/EAI blackspotted/rougheye rockfish. These apportionments are consistent with § 679.20(b)(1)(i) and do not result in overfishing of any target species because the revised ITACs and TACs are equal to or less than the specifications of the acceptable biological catch in the final 2019 and 2020 harvest specifications for groundfish in the BSAI (84 FR 9000, March 13, 2019).

The harvest specification for the 2019 ITACs and TACs included in the harvest specifications for groundfish in the BSAI are revised as follows: 179 mt for AI Greenland turbot, 784 mt for BS ''other rockfish'', 11,452 mt for BSAI arrowtooth flounder, 5,608 mt for BSAI sculpins, 155 mt for BSAI sharks, 400 mt for BSAI shortraker rockfish, and 105 mt for BS/EAI blackspotted/rougheye rockfish.

Classification

This action responds to the best available information recently obtained from the fishery. The Assistant Administrator for Fisheries, NOAA, (AA) finds good cause to waive the requirement to provide prior notice and opportunity for public comment pursuant to the authority set forth at 5 U.S.C. 553(b)(B) and § 679.20(b)(3)(iii)(A) as such a requirement is impracticable and contrary to the public interest. This requirement is impracticable and contrary to the public interest as it would prevent NMFS from responding to the most recent fisheries data in a timely fashion and would delay the apportionment of the non-specified reserves of groundfish to the AI Greenland turbot, BS ''other rockfish'', BSAI arrowtooth flounder, BSAI sculpins, BSAI sharks, BSAI shortraker rockfish, and BS/EAI blackspotted/rougheye rockfish ITACs and TACs. Immediate notification is necessary to allow for the orderly conduct and efficient operation of this fishery, to allow the industry to plan for the fishing season, and to avoid potential disruption to the fishing fleet and processors. NMFS was unable to publish a notice providing time for public comment because the most recent, relevant data only became available as of November 19, 2019.

The AA also finds good cause to waive the 30-day delay in the effective date of this action under 5 U.S.C. 553(d)(3). This finding is based upon the reasons provided above for waiver of prior notice and opportunity for public comment.

Under § 679.20(b)(3)(iii), interested persons are invited to submit written comments on this action (see **ADDRESSES**) until December 11, 2019.

This action is required by § 679.20 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 22, 2019.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2019–25816 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 84, No. 229
Wednesday, November 27, 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 COMMERCE

15 CFR Part 7

[Docket No. 191119–0084]

RIN 0605–AA51

Securing the Information and Communications Technology and Services Supply Chain

AGENCY: U.S. Department of Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: Pursuant to an Executive order of May 15, 2019, entitled ''Securing the Information and Communications Technology and Services Supply Chain,'' the Department of Commerce (the Department) proposes to implement regulations that would govern the process and procedures that the Secretary of Commerce (Secretary) will use to identify, assess, and address certain information and communications technology and services transactions that pose an undue risk to critical infrastructure or the digital economy in the United States, or an unacceptable risk to U.S. national security or the safety of United States persons.

DATES: Written comments must be received on or before December 27, 2019.

ADDRESSES: All comments must be submitted by one of the following methods:

- *By the Federal eRulemaking Portal: http://www.regulations.gov* at docket number DOC–2019–0005.
- *By email directly to: ICTsupplychain@doc.gov.* Include ''RIN 0605–AA51'' in the subject line.
- *By mail or hand delivery to:* Henry Young, U.S. Department of Commerce, ATTN: RIN 0605–AA51, 1401 Constitution Avenue NW, Washington, DC 20230.
- *Instructions:* Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered. For those seeking to submit confidential business information (CBI), please submit such information by email or mail or hand delivery as instructed above. Each CBI submission must also contain a summary of the CBI in sufficient detail to permit a reasonable understanding of the substance of the information for public consumption. Such summary information will be posted on *regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Henry Young, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: 202–482–0224. For media inquiries: Rebecca Glover, Director, Office of Public Affairs, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–4883.

SUPPLEMENTARY INFORMATION:

I. Background

The information and communications technology and services (ICTS) supply chain is critical to nearly every aspect of U.S. national security. It underpins our economy; supports critical infrastructure and emergency services; and facilitates the nation's ability to store, process, and transmit vast amounts of data, including sensitive information, that is used for personal, commercial, government, and national security purposes. The ICTS supply chain must be secure to protect our national security, including the economic strength that is an essential element of our national security. However, the ICTS supply chain has become increasingly vulnerable to exploitation and is an attractive target for espionage, sabotage, and foreign interference activity. ICTS that are designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary augment our adversaries' ability to create or exploit vulnerabilities in ICTS to potentially catastrophic effect. The President has determined that the unrestricted acquisition or use of such ICTS causes an unusual and extraordinary threat to the national security, foreign policy, and economy of the United States.

Executive Order 13873 of May 15, 2019, ''Securing the Information and Communications Technology and Services Supply Chain'' (84 FR 22689) (Executive order), was issued pursuant to the President's authority under the Constitution and the laws of the United States, including the International Emergency Economic Powers Act (50 U.S.C. 1701 *et seq.*) (IEEPA), the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and section 301 of Title 3, United States Code. The Executive order grants the Secretary of Commerce (Secretary) the authority to prohibit any acquisition, importation, transfer, installation, dealing in, or use of any information and communications technology or service (a ''transaction'') subject to United States' jurisdiction where the Secretary, in consultation with other relevant agency heads, determines that the transaction: (i) Involves property in which a foreign country or national has an interest; (ii) includes information and communications technology or services designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary; and (iii) poses certain undue risks to critical infrastructure or the digital economy in the United States or certain unacceptable risk to U.S. national security or U.S. persons. (84 FR 22689).

The Department is proposing regulations that would implement the terms of the Executive order by establishing a process by which the Secretary will determine whether a particular transaction should be prohibited. A transaction that meets the following conditions will be subject to review by the Secretary and may require mitigation, prohibition, or an unwinding of the transaction if determined to be prohibited: (1) The transaction is conducted by any person subject to the jurisdiction of the United States or involves property subject to the jurisdiction of the United States; (2) the transaction involves any property in which any foreign country or a national thereof has an interest (including through an interest in a contract for the provision of the technology or service); and (3) the transaction was initiated, pending, or completed after May 15, 2019, regardless of when any contract applicable to the transaction was entered into, dated or signed, or when any license, permit, or authorization applicable to such transaction was

granted. Transactions involving certain ongoing activities, including but not limited to managed services, software updates, or repairs, would constitute transactions that was completed on or after May 15, 2019 even if a contract was entered into prior to May 15, 2019.

To assist the Department in the execution and implementation of the Executive order, Section 5 of the Executive order requires the Office of the Director of National Intelligence (ODNI) and the Department of Homeland Security (DHS) to produce an initial threat assessment and vulnerability assessment, respectively. Pursuant to Section 5(a) of the Executive order, the Director of National Intelligence produced an initial, classified threat assessment setting forth the threats to the United States and its people from ICTS designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary.

Pursuant to Section 5(b) of the Executive order, DHS provided to the Department an initial vulnerabilities assessment identifying and assessing ICTS hardware, software, and services that present vulnerabilities in the United States. The Department will use this vulnerability assessment as one of the available sources of information to inform its analysis of risks and will use the categories of ICTS identified in the assessment as an analytical tool to assist in evaluating transactions within the Executive order's scope.

The Secretary herein adopts a case-by-case, fact-specific approach to determine those transactions that meet the requirements set forth in the Executive order and are therefore prohibited or must be mitigated. A case-by-case process allows for the deliberative application of the authority granted to the Secretary by the President in the Executive order as the Secretary seeks to calibrate properly the application of this new authority. A case-by-case application of this authority would allow the Secretary to target and prohibit transactions that meet the Executive order criteria, without unintentionally prohibiting other transactions involving similar ICTS that may not rise to the level of presenting an undue risk to critical infrastructure or the digital economy in the United States or an unacceptable risk to national security or the safety of U.S. persons. This approach would also ensure that the Department does not inadvertently preclude innovation or access to technology in the United States.

II. Prohibited Transactions

The Executive order proscribes transactions, which involve the acquisition, importation, transfer, installation, dealing in or use of ICTS by any person where the transaction (i) involves any property in which a foreign country or a national thereof has any interest, (ii) involves any ICTS ''designed, developed, manufactured, or supplied'' by entities ''owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary,'' and (iii) poses ''an undue risk'' of several specified adverse consequences, or ''an unacceptable risk'' to national security or the safety of U.S. persons.

In implementing the Executive order, the Secretary will decide whether the particular circumstances of a potentially prohibited transaction may meet this standard. The Secretary, upon the Secretary's own motion or upon referral of a particular transaction from another Federal agency, will evaluate transactions the Secretary believes may be covered by the Executive order and determine, in consultation with the heads of other agencies as appropriate, whether any such transaction should be prohibited or mitigated.

Under the procedures set forth in the proposed rule the Secretary would provide, as appropriate, direct notice to the parties of a transaction that an evaluation of a transaction is being conducted and that he has reached a preliminary determination regarding a transaction. In making determinations, the Secretary, in consultation with other Federal agencies, would assess, for example, whether a party to a transaction is owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary, and whether the use of a certain class of ICTS or transactions by particular classes of users present an undue or unacceptable risk. Parties notified of an evaluation and preliminary determination would have an opportunity to submit an opposition and information in support of their opposition, which may include proposed measures for mitigation, prior to the Secretary issuing a final determination.

Upon completion of the evaluation, the Secretary would issue an unclassified, written final determination to the parties engaged in the transaction, and, as appropriate, to the public, that would summarize the elements of the evaluation and explain how the Secretary's determination is consistent with the terms of the Executive order and its implementing regulations. In the event that classified or any other protected information is used or relied upon by the Secretary in making a determination, such information would not be made available except as required by law. If the Secretary determines that a transaction presents an undue or unacceptable risk, the Secretary may require measures to mitigate the transaction's identified risks or may prohibit the transaction, including by requiring that the parties engaged in the transaction immediately cease the use of the ICTS that poses the undue or unacceptable risk, even if such ICTS has been installed or was in operation prior to the Secretary's determination. The Secretary will not issue an advisory opinion or a declaratory ruling with respect to any particular transaction.

The Executive order also authorizes the Secretary to exempt certain classes of transactions from the Executive order's restrictions if the Secretary determines (for example, because of the nature or capabilities of the ICTS involved or the characteristics of the purchaser or ultimate user) that such transactions do not present an undue or unacceptable risk or are outside the scope of the Executive order. The Executive order also authorizes the Secretary to prohibit transactions as a class if the Secretary determines that such class of transactions pose an undue or unacceptable risk. The proposed rule does not recognize particular technologies or particular participants in the market for ICTS as categorically included or excluded from the prohibitions established by the Executive order. If, in the future, the Secretary determines that it is appropriate to designate classes of transactions for categorical inclusion or exclusion, further guidance will be issued at that time.

It is expected that parties engaging in any transaction subject to the Executive order will maintain records related to such transaction in a manner consistent with the recordkeeping practices used in their ordinary course of business for such a transaction. Any parties notified that a transaction is being evaluated will be advised by that notice to immediately take steps to retain any and all records relating to such transaction.

III. Request for Comment

The Department invites comment on all aspects of the proposed regulation but notes that the determination of a ''foreign adversary'' for purposes of implementing the Executive order is a matter of executive branch discretion and will be made by the Secretary in consultation with the Secretary of the Treasury, the Secretary of State, the Secretary of Defense, the Attorney

General, the Secretary of Homeland Security, the United States Trade Representative, the Director of National Intelligence, the Administrator of General Services, the Chairman of the Federal Communications Commission, and, as appropriate, the heads of other executive departments and agencies (agencies).

- As noted above, the Secretary would initially engage in a case-by-case analysis of specific transactions, as facts become known to the Secretary to determine if they are prohibited by the Executive order. Are there instances where the Secretary should consider categorical exclusions? Are there classes of persons whose use of ICTS can never violate the Executive order? If so, please provide a detailed explanation of why the commenter believes a particular transaction can never meet the requirements of the Executive order.
- Are there transactions involving types or classes of ICTS where the acquisition or use in the United States or by U.S. parties would fall within the terms of the Executive order's prohibited transactions because the transaction could present an undue or unacceptable risk, but that risk could be reliably and adequately mitigated to prevent the undue or unacceptable risk? If the commenter believes the risks of a prohibited transaction can be mitigated, what form could such mitigation measures take?
- If mitigation measures are adopted for a transaction otherwise prohibited by the Executive order, how should the Secretary ensure that parties to such transaction consistently execute and comply with the agreed-upon mitigation measures that make an otherwise prohibited transaction permissible? How best could the Secretary be made aware of changes in factual circumstances, including technology developments, that could render mitigation measures obsolete, no longer effective, or newly applicable?
- Section 1(a) of the Executive order and the definition of ''transaction'' that the proposed rule would implement refer to ''acquisition, importation, transfer, installation, dealing in, or use of any information and communications technology or service.'' How are these terms, in particular ''dealing in'' and ''use of,'' best interpreted?
- As discussed above, the Secretary expects persons engaged in transactions will maintain records of those transactions in the ordinary course of business. Should the Department require additional recordkeeping requirements for information related to transactions? Any non-public oral communication to Department officials regarding the substance of the proposed rule would be considered an ex parte presentation, and a summary of the substance of the ex parte presentation will be placed on the public record and become part of this docket. No later than two (2) business days after an oral communication or meeting, the party which engaged in such communication or meeting must submit a memorandum to the Department summarizing the substance of the communication. The Department reserves the right to supplement the memorandum with additional information as necessary, or to request that the party making the filing do so, if a Department official believes that important information was omitted or characterized incorrectly. Any written presentation provided in support of the oral communication or meeting will also be placed on the public record and become part of this docket. Such ex parte communications must be submitted to this docket as provided in the **ADDRESSES** section above and clearly labeled as an ex parte presentation. Federal entities are not subject to these procedures.

IV. Classification

A. Executive Order 12866 (Regulatory Policies and Procedures)

This rulemaking has been determined to be a significant action under Executive Order 12866.

B. Executive Order 13771 (Reducing Regulation and Controlling Regulatory Costs)

This rulemaking is exempt from the requirements of Executive Order 13771 because it involves a national security matter.

C. Regulatory Flexibility Act

In compliance with section 603 of the Regulatory Flexibility Act (RFA), the Department has prepared the below initial regulatory flexibility analysis (IRFA) for this proposed rule. The IRFA describes the economic impacts the proposed action may have on small entities. The Department seeks comment on all aspects of the IRFA, including the categories and numbers of small entities that may be directly impacted by this proposed rule.

(1) A statement of the need for, objectives, and the legal basis of the proposed rule. The description of the action, why it is being considered, and the legal basis for the proposed rule are contained in the preamble.

(2) A description of, and where feasible, an estimate of the number of small entities to which the proposed rule will apply. The proposed rule defines ''information and communications technology or services'' as ''any hardware, software, or other product or service primarily intended to fulfill or enable the function of information or data processing, storage, retrieval, or communication by electronic means, including through transmission, storage, or display.'' A majority of entities today, large or small, utilize some manner of ICTS, therefore it is extremely difficult to obtain a determination of the kind and number of small entities impacted by the proposed rule. The Department acknowledges that actions taken pursuant to this proposed rule may affect small entities or groups that are not easily categorized at present. We therefore describe here, at the outset, three broad groups of small entities that utilize ICTS that could be directly affected herein. The Department understands that the groups set forth here do not encompass all of the small entities or groups that utilize ICTS and could potentially be impacted by the proposed rule. The Department invites comment on other small entities or groups that should be identified as potentially impacted by the proposed rule.

1. Telecommunications and Information Technology Equipment and Service Providers

i. Telecommunications Service Providers
   1. Incumbent Local Exchange Carriers (LECs)
   2. Interchange Carriers (IXCs)
   3. Competitive Access Providers
   4. Operator Service Providers (OSPs)
   5. Local Resellers
   6. Toll Resellers
   7. Wired Telecommunications Carriers
   8. Wireless Telecommunications Carrier (except Satellite)
   9. Common Carrier Paging
   10. Wireless Telephony
   11. Satellite Telecommunications
   12. All Other Telecommunications

ii. Internet and Digital Service Providers
   1. Internet Service Providers (Broadband)
   2. Internet Service Providers (Non-Broadband)
   3. Cloud Providers
   4. Data Center Service Providers
   5. Managed Security Service Providers
   6. Internet Application Operators/Developers
   7. Software Providers (platform as a service, software as a service, etc.)

iii. Vendors and Equipment Manufacturers
   1. Vendors of Infrastructure

Development or ''Network Buildout''
2. Telephone Apparatus Manufacturing
3. Radio and Television Broadcasting and Wireless Communications Equipment
4. Information Technology Equipment Manufacturers
5. Connected Device Manufacturers (*e.g.,* connected video cameras, health monitoring devices)
6. Other Communications Equipment Manufacturing

(3) A description of the projected reporting, recordkeeping and other compliance requirements of the proposed rule, including an estimate of the classes of small entities that will be subject to the requirement and the type of professional skills necessary for preparation of the report or record. This proposed rule would not mandate any reporting, recordkeeping, or other compliance requirements unless an entity receives direct notice that an evaluation into a transaction to which such entity is a party is being conducted. If a small entity receives such notice, the entity will need to retain and provide requested information. The Department does not anticipate that any specific professional skills will be required to retain and provide such information. As discussed above, the Department anticipates a broad range of small entities or groups involved in ICTS that may be impacted by the proposed rule, thus making it difficult to determine the kind and number of small entities that may be impacted. However, as a part of the initial analysis to determine the kind and number of small entities that may be impacted by the proposed rule, the Department has identified the three broad groups of small entities listed above that utilize ICTS and may be subject under the proposed rule to an evaluation of a transaction to which such small entities may be a party.

(4) An identification, to the extent practicable, of all relevant Federal rules that may duplicate, overlap or conflict with the proposed rule. This rule does not duplicate or conflict with any Federal rules.

(5) A description of any significant alternatives to the proposed rule that accomplish the stated objectives of Executive Order 13873 and applicable statutes and that would minimize any significant economic impact of the proposed rule on small entities.

• *No-action alternative:* Not implementing a rule under the Executive order is not a viable alternative because of the national security concerns associated with transactions involving information and communications technology or services designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary.

• *Alternative that would categorically exclude small entities or groups of small entities:* This alternative would also not achieve the objectives of Executive Order 13873 of alleviating the national security concerns associated with certain transactions because, due to the nature of ICTS networks, transactions by small entities or groups of information and communications technology or services designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary may pose an undue risk to critical infrastructure or the digital economy in the United States or an unacceptable risk to national security or U.S. persons, and as such, should be evaluated in order to determine whether they should be mitigated, prohibited, or require an unwinding of the transaction.

• *Preferred alternative:* The proposed rule is the preferred alternative. It would achieve the objectives of Executive Order 13873 by implementing a procedure that would allow the Secretary to apply a case-by-case, fact-specific process to identify, assess, and address any and all transactions that pose an undue risk to critical infrastructure or the digital economy in the United States or an unacceptable risk to national security or U.S. persons.

D. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (PRA) provides that an agency generally cannot conduct or sponsor a collection of information, and no person is required to respond to nor be subject to a penalty for failure to comply with a collection of information, unless that collection has obtained Office of Management and Budget (OMB) approval and displays a currently valid OMB Control Number. This rulemaking does not contain a collection of information requirement subject to review and approval by OMB under the PRA; the rule would require only that parties engaging in any transaction subject to Executive Order 13873 shall maintain records related to such transaction in a manner consistent with the recordkeeping practices used in their ordinary course of business.

E. Unfunded Mandates Reform Act of 1995

This proposed rule would not produce a Federal mandate (under the regulatory provisions of Title II of the Unfunded Mandates Reform Act of 1995) for State, local, and tribal governments or the private sector.

F. Executive Order 13132 (Federalism)

This proposed rule does not contain policies having federalism implications requiring preparations of a Federalism Summary Impact Statement.

G. Executive Order 12630 (Governmental Actions and Interference With Constitutionally Protected Property Rights)

This proposed rule does not contain policies that have takings implications.

H. Executive Order 13175 (Consultation and Coordination With Indian Tribes)

The Department has analyzed this proposed rule under Executive Order 13175 and has determined that the action would not have a substantial direct effect on one or more Indian tribes, would not impose substantial direct compliance costs on Indian tribal governments, and would not preempt tribal law.

I. National Environmental Policy Act

The Department has reviewed this rulemaking action for the purposes of the National Environmental Policy Act (42 U.S.C. 4321 *et seq.*). It has determined that this proposed rule would not have a significant impact on the quality of the human environment.

List of Subjects in 15 CFR Part 7

Administrative practice and procedure, Business and industry, Communications, Computer technology, Critical infrastructure, Executive orders, Foreign persons, Investigations, National security, Penalties, Technology, Telecommunications.

For the reasons set out in the preamble, 15 CFR part 7 is proposed to be added to read as follows:

PART 7—SECURING THE INFORMATION AND COMMUNICATIONS TECHNOLOGY AND SERVICES SUPPLY CHAIN

Subpart A—General

Sec.
7.1 Scope.
7.2 Definitions.
7.3 Purpose.
7.4 Effect on other law.
7.5 Amendment, modification, or revocation.
7.6 Public disclosure of records.

7.7 No advisory opinions or declaratory rulings.
7.8 No categorical inclusions or exclusions.

Subpart B—Implementation for Evaluations

7.100 Commencement of an evaluation of a transaction.
7.101 Criteria to assess the effect of a transaction.
7.102 Conduct of an evaluation.
7.103 Written determinations; adjustment of transactions; signature, date, and public availability.
7.104 Emergency action.

Subpart C—Enforcement

7.200 Penalties.

Authority: 50 U.S.C. 1701 *et seq.;* 50 U.S.C. U.S.C. 1601 *et seq.;* E.O. 13873, 84 FR 22689.

Subpart A—General

§ 7.1 Scope.

(a) Except as provided in paragraph (b) of this section, this part applies only to any acquisition, importation, transfer, installation, dealing in, or use of any information and communications technology or service (a ''transaction''), that meets each of the following conditions:

(1) The transaction is conducted by any person subject to the jurisdiction of the United States or involves property subject to the jurisdiction of the United States;

(2) The transaction involves any property in which any foreign country or a national thereof has an interest (including through an interest in a contract for the provision of the technology or service); and

(3) The transaction was initiated, is pending, or will be completed after May 15, 2019, regardless of when any contract applicable to the transaction was entered into, dated, or signed or when any license, permit, or authorization applicable to such transaction was granted. Transactions involving certain ongoing activities, including but not limited to managed services, software updates, or repairs, constitute transactions that ''will be completed'' on or after May 15, 2019 even if a contract was entered into prior to May 15, 2019. Such transactions are subject to review by the Secretary and may require mitigation or an unwinding of the transaction if determined to be prohibited.

(b) This part does not apply to any other acquisition, importation, transfer, installation, dealing in or use of information communications technology and services or any other goods or services.

§ 7.2 Definitions.

Entity means a partnership, association, trust, joint venture, corporation, group, subgroup, or other organization.

Executive order means Executive Order 13873 of May 15, 2019.

Foreign adversary means any foreign government or foreign non-government person determined by the Secretary to have engaged in a long-term pattern or serious instances of conduct significantly adverse to the national security of the United States or security and safety of United States persons for the purposes of Executive Order 13783.

Information and communications technology or services means any hardware, software, or other product or service primarily intended to fulfill or enable the function of information or data processing, storage, retrieval, or communication by electronic means, including through transmission, storage, or display.

Person means an individual or entity.

Secretary means the Secretary of Commerce or the Secretary's designee.

Transaction means any acquisition, importation, transfer, installation, dealing in, or use of any information and communications technology or service. Use of the term *transaction* in this part includes a class of transactions.

United States person means any United States citizen, permanent resident alien, entity organized under the laws of the United States or any jurisdiction within the United States (including foreign branches), or any person in the United States.

§ 7.3 Purpose.

The regulations in this part set forth the procedures by which the Secretary shall commence and conduct evaluations to determine the effect that any acquisition, importation, transfer, installation, dealing in, or use of an information and communications technology or service that has been designed, developed, manufactured, or supplied by persons owned by, controlled by, or subject to the jurisdiction or direction of foreign adversaries have on the national security, foreign policy, and economy of the United States. The evaluations will address transactions on a case-by-case, fact-specific basis. Based on the evaluation findings, the Secretary, in consultation with relevant agency heads specified in the Executive order and other relevant governmental bodies, as appropriate shall make a decision for action or inaction regarding adjustment of a transaction. Action regarding adjustment of a transaction may include a prohibition or approval of an otherwise prohibited transaction due to adoption of mitigation measures determined by the Secretary to sufficiently mitigate the risks associated with the transaction. The Secretary shall also engage in coordination and information sharing, as appropriate, with international partners on the application of the regulations in this part.

§ 7.4 Effect on other law.

Nothing in this part shall be construed as altering or affecting any other authority, process, regulation, investigation, enforcement measure, or review provided by or established under any other provision of Federal law, including prohibitions under the National Defense Authorization Act of 2019, the Federal Acquisition Regulations, or the International Emergency Economic Powers Act (IEEPA) (50 U.S.C. 1701 *et seq.*), or any other authority of the President or the Congress under the Constitution of the United States.

§ 7.5 Amendment, modification, or revocation.

Except as otherwise provided by law, the provisions of this part and any determinations, orders, or decisions issued thereunder may be amended, modified, or revoked, in whole or in part, at any time.

§ 7.6 Public disclosure of records.

Public requests for agency records related to this part will be processed in accordance with the Department of Commerce's Freedom of Information Act regulations, 15 CFR part 4, or other applicable law and regulation.

§ 7.7 No advisory opinions or declaratory rulings.

The Secretary will not issue an advisory opinion or a declaratory ruling with respect to any particular transaction.

§ 7.8 No categorical inclusions or exclusions.

The Secretary has declined to identify classes of transactions that are subject to prohibition or are excluded from prohibition. Determination of transactions prohibited by the Executive order will be made on a case-by-case basis. Should the Secretary determine based on a particular case that a class of transactions should be prohibited or excluded, the Secretary will publish such determination and further guidance or request for comment (if needed) in the **Federal Register**.

Subpart B—Implementation for Evaluations

§ 7.100 Commencement of an evaluation of a transaction.

The Secretary may commence an evaluation of a transaction in one of three ways:

(a) At the Secretary's discretion;

(b) Upon request of the Secretary of the Treasury, the Secretary of State, the Secretary of Defense, the Attorney General, the Secretary of Homeland Security, the United States Trade Representative, the Director of National Intelligence, the Administrator of General Services, or the Chairman of the Federal Communications Commission, or, as appropriate, the head of any other Government department, agency, governmental body, or the Federal Acquisition Security Council (FASC). A request from other Government departments, agencies, governmental body, or FASC for an evaluation shall be in writing provided from the head of the requesting agency, or their designee, to the Secretary; or

(c) Based on information submitted to the Secretary by private parties that the Secretary determines to be credible. Information from private parties may be submitted to the Secretary via a web portal to be made available on *https://www.commerce.gov/issues/ict-supply-chain.*

§ 7.101 Criteria to assess the effect of a transaction.

(a) To determine the effect of a transaction subject to evaluation, the Secretary, in consultation with the Secretary of the Treasury, the Secretary of State, the Secretary of Defense, the Attorney General, the Secretary of Homeland Security, the United States Trade Representative, the Director of National Intelligence, the Administrator of General Services, the Chairman of the Federal Communications Commission, and, as appropriate, the heads of other executive departments and agencies, shall consider whether:

(1) The transaction is subject to the jurisdiction of the United States;

(2) The transaction involves any property in which any foreign country or a national thereof has an interest (including through an interest in a contract for the provision of the technology or service);

(3) The transaction was initiated, is pending, or will be completed after May 15, 2019, regardless of when any contract applicable to the transaction was entered into, dated, or signed or when any license, permit, or authorization applicable to such transaction was granted;

(4) The transaction involves information and communications technology or services designed, developed, manufactured, or supplied, by persons owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary; and

(5) The transaction:

(i) Poses an undue risk of sabotage to or subversion of the design, integrity, manufacturing, production, distribution, installation, operation, or maintenance of information and communications technology or services in the United States;

(ii) Poses an undue risk of catastrophic effects on the security or resiliency of United States critical infrastructure or the digital economy of the United States; or

(iii) Otherwise poses an unacceptable risk to the national security of the United States or the security and safety of United States persons.

(b) In determining whether a transaction involves an information and communications technology or service designed, developed, manufactured, or supplied, by persons ''owned by, controlled by, or subject to the jurisdiction or direction of a foreign adversary,'' the Department will consider a number of factors, including, but not limited to the laws and practices of the foreign adversary; equity interest, access rights, seats on a board of directors or other governing body, contractual arrangements, voting rights, and control over design plans, operations, hiring decisions, or business plan development.

§ 7.102 Conduct of an evaluation.

In conducting an evaluation of whether a transaction meets the criteria described in § 7.101, the Secretary:

(a) Shall, as appropriate, seek information and advice from, and consult with, appropriate officers of the United States or their designees. Information received from agencies of the U.S. Government, state, local, tribal, or territorial governments, or business confidential or other trade secret information will not be made available for public inspection except as otherwise required by law;

(b) May use all appropriate tools available to collect information, including but not limited to the following:

(1) Relevant publicly available, business confidential or proprietary information, and classified information as part of an evaluation;

(2) Information from foreign governments as a part of an evaluation; and

(3) Information from parties to a transaction as part of an evaluation, including records related to such transaction that any party keeps or uses, or would be expected to keep or use, in their ordinary course of business for such a transaction. Parties notified that one of their transactions is being evaluated must immediately take steps to retain any and all records relating to such transaction, regardless of whether those records would normally be retained prior to receiving such notice; and

(c) May consolidate any referral, or materials that are filed while an evaluation is in progress, concerning transactions of the same or related class and raising similar issues.

§ 7.103 Written determinations; adjustment of transactions; signature, date, and public availability.

(a) Upon a preliminary determination by the Secretary that a transaction meets the criteria set forth in § 7.101, the Secretary shall, when consistent with national security, provide written notice to the parties of the transaction advising that:

(1) The Secretary has reached a preliminary determination;

(2) An explanation of the basis for such preliminary determination to the extent such explanation can be provided consistent with national security; and

(3) Within 30 days after receipt of the notice, the specific party may submit an opposition and information in support of such opposition to the preliminary determination or information on proposed measures for mitigation.

(b) The Secretary shall take into consideration any comments received pursuant to the process set forth in paragraph (a) of this section in making a final determination. Within 30 days of receipt of any information received pursuant to paragraph (a)(3) of this section, the Secretary will issue a final determination.

(c) In making a final determination, the Secretary may:

(1) Determine the transaction is prohibited;

(2) Determine the transaction is not prohibited; or

(3) At the Secretary's discretion and in consultation with the heads of other agencies as appropriate, require measures and specific timeframes to mitigate risks identified during an evaluation as a precondition of approving a transaction that may otherwise be prohibited.

(d) A final determination shall be in writing and shall describe whether the transaction is prohibited; the transaction is not prohibited; or an otherwise

prohibited transaction is permitted pursuant to the adoption of mitigation measures. Any determination to permit an otherwise prohibited transaction based on mitigation measures shall also provide a description of the mitigation measures adopted. A final determination shall be sent to the parties of the transaction by registered U.S. mail.

(e) Any determination to either prohibit a transaction or permit an otherwise prohibited transaction based on mitigation measures shall also provide a clear statement of the penalties set forth in § 7.200 that parties will face if they fail to comply fully with either the prohibition or those mitigation measures.

(f) The Secretary may commence an evaluation and make a new determination of any transaction, subject to this part, if circumstances, technology, or available information has materially changed.

(g) All determinations by the Secretary shall be signed and dated.

(h) Such final determination with respect to a transaction shall constitute final agency action.

(i) A summary of the Secretary's final determination will be made public through posting on *https://www.commerce.gov/issues/ict-supply-chain* and publication in the **Federal Register**.

(j) Deadlines set forth in this section may be extended at the Secretary discretion.

§ 7.104 Emergency action.

It is the intent of the Secretary to follow the procedures set forth in this part unless, when public harm is likely to occur if the procedures are followed or national security interests require it, then the Secretary may vary or dispense with any or all of the procedures set forth in this part. In such an instance, in a manner consistent with national security interests, the Secretary shall provide as part of the final written determination the basis for the decision to engage in emergency action under this section.

Subpart C—Enforcement

§ 7.200 Penalties.

(a) Subject to IEEPA, 50 U.S.C. 1705, any person who, after [effective date of final rule], violates, attempts to violate, conspires to violate, or causes a violation of any determination, regulation, prohibition, or other action issued under this part, or makes any false or misleading representation, statement, or certification, or falsifies or conceals any material fact, either directly to the Department of Commerce, the Bureau of Industry and Security, United States Customs and Border Protection, or an official of any other United States agency, or indirectly through any other person in the course of any action under this part may be liable to the United States for a civil penalty up to $302,584, as adjusted annually for inflation under 15 CFR 6.5, or an amount that is twice the amount of the transaction that is the basis of the violation with respect to which the penalty is imposed. The amount of the penalty assessed for a violation shall be based on the nature of the violation.

(b) Any person who, after [effective date of final rule], violates a material provision of a mitigation measure or a material condition imposed by the United States under § 7.103 or § 7.104 may be liable to the United States for a civil penalty under 50 U.S.C. 1705, not to exceed $302,584, as adjusted annually for inflation under 15 CFR 6.5, per violation or the value of the transaction. Any penalty assessed under this paragraph (b) shall be based on the nature of the violation and shall be separate and apart from any damages sought pursuant to a mitigation measure or any action taken under § 7.103.

(c) A determination to impose penalties under paragraph (a) or (b) of this section will be made by the Secretary. Notice of the penalty, including a written explanation of the penalized conduct and the amount of the penalty, shall be sent to the penalized party by registered U.S. mail.

(d) Upon receiving notice of the imposition of a penalty under paragraph (a) or (b) of this section, the penalized party may, within 15 days of receipt of the notice of the penalty, submit a petition for reconsideration to the Secretary, including a defense, justification, or explanation for the penalized conduct. The Secretary will review the petition and issue a final decision within 30 days of receipt of the petition.

(e) The penalties authorized in paragraphs (a) and (b) of this section may be recovered in a civil action brought by the United States in Federal district court.

(f) The penalties available under this section are without prejudice to other penalties, civil or criminal, available under law.

(g) Section 1001 of title 18, United States Code, shall apply to all information provided to the Secretary under this part by any party to a transaction.

Dated: November 19, 2019.

Wilbur L. Ross,

Secretary of Commerce.

[FR Doc. 2019–25554 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–20–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 212, 244, and 252

[Docket DARS–2019–0052]

RIN 0750–AK66

Defense Federal Acquisition Regulation Supplement: Treatment of Certain Items as Commercial Items (DFARS Case 2019–D029)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Proposed rule.

SUMMARY: DoD is proposing to amend the Defense Federal Acquisition Regulation Supplement (DFARS) to implement several sections of the National Defense Authorization Act for Fiscal Year 2017 that address treatment of commingled items purchased by contractors and services provided by nontraditional defense contractors as commercial items. DoD is also proposing to further implement a section of the National Defense Authorization Act for Fiscal Year 2018 that provides that a contract for an item using FAR part 12 procedures shall serve as a prior commercial item determination.

DATES: Comments on the proposed rule should be submitted in writing to the address shown below on or before January 27, 2020, to be considered in the formation of a final rule.

ADDRESSES: Submit comments identified by DFARS Case 2019–D029, using any of the following methods:

○ *Regulations.gov: http://www.regulations.gov.* Search for ''DFARS Case 2019–D029'' under the heading ''Enter keyword or ID'' and selecting ''Search.'' Select ''Comment Now'' and follow the instructions provided to submit a comment. Please include ''DFARS Case 2019–D029'' on any attached documents.

○ *Email: osd.dfars@mail.mil.* Include DFARS Case 2019–D029 in the subject line of the message.

○ *Fax:* 571–372–6094.

○ *Mail:* Defense Acquisition Regulations System, Attn: Ms. Amy Williams, OUSD(A&S)DPC/DARS,

Room 3B941, 3060 Defense Pentagon, Washington, DC 20301–3060.

Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal 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. Amy G. Williams, telephone 571–372–6106.

SUPPLEMENTARY INFORMATION:

I. Background

DoD is proposing to revise the DFARS to implement sections 877 and 878 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Pub. L. 114–328) and further implement section 848 of the NDAA for FY 2018 (Pub. L. 115–91). Section 877, Treatment of Commingled Items purchased by Contractors as Commercial Items, adds 10 U.S.C. 2380B. Section 878, Treatment of Services Provided by Nontraditional Contractors as Commercial Items, amends 10 U.S.C. 2380a. Section 848 modifies 10 U.S.C. 2380(b) to provide that a contract for an item using FAR part 12 procedures shall serve as a prior commercial item determination, unless the appropriate official determines in writing that the use of such procedures was improper or that it is no longer appropriate to acquire the item using commercial item acquisition procedures.

II. Discussion and Analysis

A. Section 848. This rule proposes to amend DFARS 212.102(a) in order to further implement section 848 of the NDAA for FY 2017, which was partially implemented in the final rule under DFARS Case 2018–D006, published in the **Federal Register** on January 31, 2018 (83 FR 4431). This rule—

- Adds a new paragraph at (a)(i) to clarify that the use of FAR part 12 procedures is not only for the acquisition of items that have been determined to be commercial items, as defined in FAR 2.101, but also for the acquisition of items that do not meet than FAR definition of ''commercial item'' and do not require a commercial item determination, but are to be treated as commercial items due to the applicability of 41 U.S.C. 1908 or 10 U.S.C. 2380a;
- Redesignates paragraph (a)(ii) on prior commercial item determinations as (a)(iii) and expands it to cover other prior use of FAR part 12 procedures;
- Adds a paragraph at (a)(iii)(A)*(2)* to state that a contract for an item acquired using commercial item acquisition procedures under FAR part 12 shall serve as a prior commercial item determination, unless the item was acquired pursuant to one of those statutes and therefore did not require a commercial item determination.
- Adds a clarification at (a)(iii)(B) with regard to when DFARS subpart 212.70 is applicable.

B. Section 878. This rule also proposes to add a new DFARS 212.102(a)(iv)(B) to implement section 878 of the NDAA for FY 2017, with regard to the requirement to treat services provided by a business unit that is a nontraditional defense contractor as commercial services, to the extent that such services use the same pool of employees as used for commercial customers and are priced using methodology similar to methodology used for commercial pricing. This is an exception to the general rule of granting agency discretion to treat supplies and services provided by nontraditional defense contractors as commercial items.

C. Section 877. Lastly, this rule proposes to implement section 877 of the NDAA for FY 2018 at DFARS 244.402 and 252.244.7000, Subcontracts for Commercial Items. The policy is established at DFARS 244.403(S–70), and the requirement is imposed on the contractor in a new paragraph (c) of the clause at DFARS 252.244–7000, to treat as commercial items any items valued at less than $10,000 per item that were purchased by the contractor for use in the performance of multiple contracts with the Department of Defense and other parties and are not identifiable to any particular contract when purchased. This does not apply to items that were purchased specifically for a DoD contract but were subsequently commingled with similar items purchased for other contracts. The clause also requires that the contractor shall ensure that any such items to be used in performance of a DoD contract meet all applicable terms and conditions of the DoD contract, because issues may arise with regard to the compliance of commingled parts that were not purchases specifically for use in performance of a DoD contract.

III. Applicability to Contracts at or Below the Simplified Acquisition Threshold and for Commercial Items, Including Commercially Available Off-the-Shelf Items

This rule proposes to modify the clause at DFARS 252.244,7000, Subcontracts for Commercial Items, but does not modify its applicability. The clause is applicable to all solicitations and contracts, including solicitations and contracts using FAR part 12 procedures for the acquisition of commercial items and solicitations and contracts valued at or below the simplified acquisition procedures. However, the amendment to DFARS 252.244–7000 proposed by this rule does not add or impose any burdens on contractors, but allows treatment of certain items as commercial items that do not otherwise meet the definition of ''commercial item'' in FAR part 2.

IV. Executive Orders 12866 and 13563

Executive Orders (E.O.s) 12866 and 13563 direct 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This is not a significant regulatory action and, therefore, was not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. This rule is not a major rule under 5 U.S.C. 804.

V. Executive Order 13771

This rule is not expected to be an E.O. 13771 regulatory action, because this rule is not significant under E.O. 12866.

VI. Regulatory Flexibility Act

DoD does not expect this proposed rule to have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.* However, an initial regulatory flexibility analysis has been performed and is summarized as follows:

This proposed rule is issued in order to implement sections 877 and 878 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (10 U.S.C. 2380a and 10 U.S.C. 2380b) and further implements section 848 of the NDAA for FY 2018 (10 U.S.C. 2380(b)).

The objective of this rule is to address the use of FAR part 12 procedures, prior

commercial item determinations, and the treatment as commercial items of services provided by nontraditional defense contractors and certain items purchased by a contractor for use in the performance of multiple contracts. The legal basis for the rule is the NDAA section cited as the reasons for the action.

Based on FY 2018 data from the Federal Procurement Data System (FPDS), awards of commercial contracts were made to 15,231 nontraditional defense contractors that were also small entities. It is unknown how many of those entities might provide services that use the same pool of employees used for commercial customers and are priced using methodology similar to the methodology used for commercial pricing.

Also based on FPDS data for FY 2018, DoD awarded 110,000 contracts for the purchase of supplies, commercial or noncommercial, exceeding $10,000, to 13,892 unique small entities. This rule will affect an unknown number of those 13,892 small entities, if such small entities purchase noncommercial items valued at less than $10,000 per item that are not identifiable to any particular contract when purchased and are for use in the performance of multiple contracts with DoD and other parties.

This rule does not impose any new reporting, recordkeeping, or other compliance requirements. The rule does remind the contractor of the responsibility to ensure that items treated as commercial items pursuant to section 877 of the NDAA for FY 2017 that are to be used in the performance of the DoD contract meet all terms and conditions of the contract that are applicable to commercial items.

The rule does not duplicate, overlap, or conflict with any other Federal rules.

DoD did not identify any significant alternatives that would minimize or reduce the significant economic impact on small entities, because there is no significant impact on small entities. Any impact is expected to be beneficial.

DoD invites comments from small business concerns and other interested parties on the expected impact of this rule on small entities.

DoD will also consider comments from small entities concerning the existing regulations in subparts affected by this rule in accordance with 5 U.S.C. 610. Interested parties must submit such comments separately and should cite 5 U.S.C 610 (DFARS Case 2019–D027), in correspondence.

VII. Paperwork Reduction Act

The rule does not contain any new information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

List of Subjects in 48 CFR Parts 212, 244, and 252

Government procurement.

Jennifer Lee Hawes,

Regulatory Control Officer, Defense Acquisition Regulations System.

Therefore, 48 CFR parts 212, 244, and 252 are proposed to be amended as follows:

■ 1. The authority citation for 48 CFR parts 212, 244, and 252 continues to read as follows:

Authority: 41 U.S.C. 1303 and 48 CFR chapter 1.

PART 212—ACQUISITION OF COMMERCIAL ITEMS

■ 2. Revise section 212.102 to read as follows:

212.102 Applicability.

(a)(i) *Use of FAR part 12 procedures.* Use of FAR part 12 procedures is based on—

(A) A determination that an item is a commercial item, as defined in FAR 2.101; or

(B) Applicability of the following statutes that provide for treatment as a commercial item and use of part 12 procedures, even though the item does not meet the definition of ''commercial item'' at FAR 2.101 and does not require a commercial item determination:

(*1*) 41 U.S.C. 1903, when used to procure supplies or services to be used to facilitate defense against or recovery from cyber, nuclear, biological, chemical, or radiological attack pursuant to FAR 12.102(f).

(*2*) 10 U.S.C. 2380a, when used to procure supplies or services from nontraditional defense contractors pursuant to 212.102(a)(iv).

(ii) *Commercial item determination.* (A) When using FAR part 12 procedures for acquisitions of commercial items pursuant to 212.102(a)(i)(A) exceeding $1 million in value, the contracting officer shall—

(*1*) Determine in writing that the acquisition meets the commercial item definition in FAR 2.101;

(*2*) Include the written determination in the contract file;

(*3*) Obtain approval at one level above the contracting officer when a commercial item determination relies on paragraph (1)(ii), (3), (4), or (6) of the ''commercial item'' definition at FAR 2.101; and

(*4*) Follow the procedures and guidance at PGI 212.102(a)(ii)(A) regarding file documentation and commercial item determinations.

(B) See PGI 212.102(a)(ii)(B) for information about items that DoD has historically acquired as military-unique, noncommercial items.

(iii) *Prior commercial item determination or other use of FAR part 12 procedures.* (A)(*1*) Pursuant to 10 U.S.C. 2306a(b)(4)(A), the contracting officer may presume that a prior commercial item determination made by a military department, a defense agency, or another component of DoD shall serve as a determination for subsequent procurements of such item.

(*2*) Pursuant to 10 U.S.C. 2380(b), except as provided in paragraph (a)(iii)(B)(*2*) of this section, a contract for an item acquired using commercial item acquisition procedures under FAR part 12 shall serve as a prior commercial item determination, unless the item was acquired pursuant to paragraph (a)(i)(B) of this section.

(B)(*1*) Until November 15, 2020, prior to converting a procurement of commercial items valued at more than $1 million from commercial acquisition procedures to noncommercial acquisition procedures under FAR part 15, follow the procedures at subpart 212.70 in lieu of the procedures in paragraph (a)(iii)(B)(*2*) of this section.

(*2*) Pursuant to 10 U.S.C. 2306a(b)(4)(B) and (C) and 10 U.S.C. 2380(b), except as provided in paragraph (a)(iii)(B)(*1*) of this section, if the contracting officer does not make the presumption that a prior commercial item determination is valid, or that the continued use of FAR part 12 procedures for other statutory reasons is still appropriate, and instead chooses to proceed with a procurement of an item using procedures other than FAR part 12 procedures, the contracting officer shall request a review by the head of the contracting activity that will conduct the procurement. Not later than 30 days after receiving a request for review, the head of a contracting activity shall—

(*i*) Confirm that the prior use of FAR part 12 procedures was appropriate and still applicable; or

(*ii*) Issue a determination that the prior use of FAR part 12 procedures was improper or that it is no longer appropriate to acquire the item using FAR part 12 procedures, with a written explanation of the basis for the determination.

(iv) *Nontraditional defense contractors.* In accordance with 10 U.S.C. 2380a, contracting officers—

(A) Except as provided in paragraph (a)(iv)(B) of this section, may treat supplies and services provided by nontraditional defense contractors as

commercial items. This permissive authority is intended to enhance defense innovation and investment, enable DoD to acquire items that otherwise might not have been available, and create incentives for nontraditional defense contractors to do business with DoD. It is not intended to recategorize current noncommercial items, however, when appropriate, contracting officers may consider applying commercial item procedures to the procurement of supplies and services from business segments that meet the definition of ''nontraditional defense contractor'' even though they have been established under traditional defense contractors;

(B) Shall treat services provided by a business unit that is a nontraditional defense contractor as commercial items, to the extent that such services use the same pool of employees as used for commercial customers and are priced using methodology similar to methodology used for commercial pricing; and

(C) Shall document the file when treating supplies or services from a nontraditional defense contractor as commercial items in accordance with paragraph (a)(iv)(A) or (B) of this section.

212.7001 [Amended]

■ 3. Amend section 212.7001(a)(2) by removing ''Acquisition, Technology, and Logistics'' and adding ''Acquisition and Sustainment'' in its place.

PART 244—SUBCONTRACTING POLICIES AND PROCEDURES

■ 4. Amend section 244.402 by–

■ a. In paragraph (a), removing ''Contractors shall'' and adding ''Contractors are required to'' in its place; and

■ b. Adding paragraph S–70.

The addition reads as follows:

244.402 Policy requirements.

* * * * *

(S–70) In accordance with 10 U.S.C. 2380B, items that are valued at less than $10,000 per item that are purchased by a contractor for use in the performance of multiple contracts with the Department of Defense and other parties and are not identifiable to any particular contract when purchased shall be treated as commercial items.

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

■ 5. Amend section 252.244–7000 by–

■ a. In the clause heading, removing the date ''(JUN 2013)'' and adding ''(ABBREVIATED MONTH AND YEAR OF FINAL RULE EFFECTIVE DATE)'' in its place;

■ b. Redesignating paragraph (c) as paragraph (d);

■ c. Adding a new paragraph (c); and

■ d. In the newly redesignated paragraph (d), removing ''paragraph (c)'' and adding ''paragraph (d)'' in its place.

The addition reads as follows:

252.244–7000 Subcontracts for Commercial Items.

* * * * *

(c) The Contractor shall treat as commercial items any items valued at less than $10,000 per item that were purchased by the Contractor for use in the performance of multiple contracts with the Department of Defense and other parties and are not identifiable to any particular contract when purchased. The Contractor shall ensure that any such items to be used in performance of this contract meet all terms and conditions of this contract that are applicable to commercial items.

* * * * *

[FR Doc. 2019–25663 Filed 11–26–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–R4–ES–2019–0059; 4500030114]

RIN 1018–BD09

Endangered and Threatened Wildlife and Plants; Designation of Critical Habitat for Suwannee Moccasinshell

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), propose to designate critical habitat for the Suwannee moccasinshell (*Medionidus walkeri*) under the Endangered Species Act (Act). The Suwannee moccasinshell is a freshwater mussel species from the Suwannee River Basin in Florida and Georgia. In total, approximately 306 kilometers (190 miles) of stream channels in Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Madison, Suwannee, and Union Counties, Florida, and Brooks and Lowndes Counties, Georgia, fall within the boundaries of the proposed critical habitat designation. If we finalize this rule as proposed, it would extend the Act's protections to this species' critical habitat. The effect of this regulation is to designate critical habitat for the Suwannee moccasinshell under the Act. We also announce the availability of a draft economic analysis of the proposed designation.

DATES: We will accept comments on the proposed rule or draft economic analysis that are received or postmarked on or before January 27, 2020. Comments submitted electronically using the Federal eRulemaking Portal (see **ADDRESSES** below) must be received by 11:59 p.m. Eastern Time on the closing date. We must receive requests for public hearings, in writing, at the address shown in **ADDRESSES** by January 13, 2020.

ADDRESSES: You may submit comments on the proposed rule or draft economic analysis by one of the following methods:

(1) *Electronically:* Go to the Federal eRulemaking Portal: *http://www.regulations.gov.* In the Keyword box, enter FWS–R4–ES–2019–0059, which is the docket number for this rulemaking. Then, in the Search panel on the left side of the screen, under the Document Type heading, click on the Proposed Rules link to locate this document. You may submit a comment by clicking on ''Comment Now!''

(2) *By hard copy:* Submit by U.S. mail or hand-delivery to: Public Comments Processing, Attn: FWS–R4–ES–2019–0059; U.S. Fish and Wildlife Service Headquarters, MS: JAO/1N, 5275 Leesburg Pike, Falls Church, VA 22041–3803.

We request that you send comments only by the methods described above. We will post all comments on *http://www.regulations.gov.* This generally means that we will also include any personal information you provide during the comment period (see the Information Requested section below for more information).

Document availability: The DEA is available at *http://www.fws.gov/PanamaCity* and at *http://www.regulations.gov* at Docket No. FWS–R4–ES–2019–0059, and at the Panama City Ecological Services Field Office (see **FOR FURTHER INFORMATION CONTACT**).

The coordinates from which the maps are generated are included in the critical habitat unit descriptions of this document and are available at *http://www.fws.gov/PanamaCity,* and at *http://www.regulations.gov* at Docket No. FWS–R4–ES–2019–0059 and at the Panama City Ecological Services Field Office (see **FOR FURTHER INFORMATION CONTACT**). Additional tools or supporting information that we may

develop for this critical habitat designation will be available at the Fish and Wildlife Service website and Field Office set out above, and may also be included in the preamble and/or at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Sean M. Blomquist, Acting Field Supervisor, U.S. Fish and Wildlife Service, Panama City Ecological Services Field Office, 1601 Balboa Avenue, Panama City, FL 32405; by telephone 850–769–0552; or by facsimile at 850–763–2177. If you use a telecommunications device for the deaf, call the Federal Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION:

Executive Summary

Why we need to publish a rule. Under the Endangered Species Act, when we list any species as threatened or endangered we must designate critical habitat to the maximum extent prudent and determinable. Designation of critical habitat can only be completed by issuing a rule.

What this document does. This document is a proposed rule for designation of critical habitat for the Suwannee moccasinshell in the Suwannee River Basin in Florida and Georgia. It provides our rationale for pursuing this rulemaking action.

The basis for our action. Under the Endangered Species Act, when we determine that a species is threatened or endangered, we must, to the maximum extent prudent and determinable, designate critical habitat. Section 4(b)(2) of the Endangered Species Act states that the Secretary shall designate critical habitat on the basis of the best available scientific data after taking into consideration the economic impact, national security impact, and any other relevant impact of specifying any particular area as critical habitat. The Secretary may exclude an area from critical habitat if he determines that the benefits of such exclusion outweigh the benefits of specifying such area as part of the critical habitat, unless he determines, based on the best scientific data available, that the failure to designate such area as critical habitat will result in the extinction of the species.

Economic impacts. We have prepared an analysis of the economic impacts of the proposed critical habitat designation and related factors. We hereby announce the availability of the draft economic analysis and seek additional public review and comment.

We will seek peer review. We are seeking comments from independent specialists to ensure that our listing proposal is based on scientifically sound data and analyses. We have invited these peer reviewers to comment on our specific assumptions and conclusions in this listing proposal.

Information Requested

We intend that any final action resulting from this proposed rule will be based on the best scientific and commercial data available and be as accurate and as effective as possible. Therefore, we request comments or information from other concerned government agencies, the scientific community, industry, or any other interested party concerning this proposed rule. We particularly seek comments concerning:

(1) The reasons why we should or should not designate habitat as ''critical habitat'' under section 4 of the Act (16 U.S.C. 1531 *et seq.*) including information to inform the following factors such that a designation of critical habitat may be determined to be not prudent:

(a) The species is threatened by taking or other human activity and identification of critical habitat can be expected to increase the degree of such threat to the species;

(b) The present or threatened destruction, modification, or curtailment of a species' habitat or range is not a threat to the species, or threats to the species' habitat stem solely from causes that cannot be addressed through management actions resulting from consultations under section 7(a)(2) of the Act;

(c) Areas within the jurisdiction of the United States provide no more than negligible conservation value, if any, for a species occurring primarily outside the jurisdiction of the United States; or

(d) No areas meet the definition of critical habitat.

(2) Specific information on:

(a) The amount and distribution of Suwannee moccasinshell habitat,

(b) What areas, that were occupied at the time of listing and that contain the physical or biological features essential to the conservation of the species, should be included in the designation and why,

(c) Special management considerations or protection that may be needed in critical habitat areas we are proposing, including managing for the potential effects of climate change, and

(d) What areas not occupied at the time of listing are essential for the conservation of the species. We particularly seek comments regarding:

(i) Whether occupied areas are inadequate for the conservation of the species; and,

(ii) Specific information that supports the determination that unoccupied areas will, with reasonable certainty, contribute to the conservation of the species and, contain at least one physical or biological feature essential to the conservation of the species.

(3) Land use designations and current or planned activities in the subject areas and their possible impacts on proposed critical habitat.

(4) Information on the projected and reasonably likely impacts of climate change on the Suwannee moccasinshell and proposed critical habitat.

(5) Any probable economic, national security, or other relevant impacts of designating any area that may be included in the final designation and the benefits of including or excluding areas that exhibit these impacts.

(6) Information on the extent to which the description of economic impacts in the draft economic analysis is a reasonable estimate of the likely economic impacts.

(7) Whether we could improve or modify our approach to designating critical habitat in any way to provide for greater public participation and understanding, or to better accommodate public concerns and comments.

You may submit your comments and materials concerning this proposed rule by one of the methods listed in **ADDRESSES**. We request that you send comments only by the methods described in **ADDRESSES**.

All comments submitted electronically via *http://www.regulations.gov* will be presented on the website in their entirety as submitted. For comments submitted via hard copy, we will post your entire comment—including your personal identifying information—on *http://www.regulations.gov.* You may request at the top of your document that we withhold personal information such as your street address, phone number, or email address from public review; however, we cannot guarantee that we will be able to do so.

Comments and materials we receive, as well as supporting documentation we used in preparing this proposed rule, will be available for public inspection on *http://www.regulations.gov,* or by appointment, during normal business hours, at the U.S. Fish and Wildlife Service, Panama City Ecological Services Office, Panama City, FL (see **FOR FURTHER INFORMATION CONTACT**). Because we will consider all comments and information received during the

comment period, our final determinations may differ from this proposal.

Previous Federal Actions

On October 6, 2015, we published a proposed rule to list the Suwannee moccasinshell as threatened (80 FR 60335) under the Endangered Species Act of 1973, as amended (ESA or Act; 16 U.S.C. 1531 *et seq.*). Publication of the proposed rule opened a 60-day comment period, which closed on December 7, 2015. On October 6, 2016, we published the final rule listing the species as threatened (81 FR 69417). Federal actions prior to October 6, 2016, affecting the species are outlined in the proposed listing rule.

Critical Habitat

Background

Critical habitat is defined in section 3 of the Act as:

(1) The specific areas within the geographical area occupied by the species, at the time it is listed in accordance with the Act, on which are found those physical or biological features.

(a) Essential to the conservation of the species, and

(b) Which may require special management considerations or protection; and

(2) Specific areas outside the geographical area occupied by the species at the time it is listed, upon a determination that such areas are essential for the conservation of the species.

Our regulations at 50 CFR 424.02 define the geographical area occupied by the species as: An area that may generally be delineated around species' occurrences, as determined by the Secretary (*i.e.,* range). Such areas may include those areas used throughout all or part of the species' life cycle, even if not used on a regular basis (*e.g.,* migratory corridors, seasonal habitats, and habitats used periodically, but not solely by vagrant individuals).

Conservation, as defined under section 3 of the Act, means to use and the use of all methods and procedures that are necessary to bring an endangered or threatened species to the point at which the measures provided pursuant to the Act are no longer necessary. Such methods and procedures include, but are not limited to, all activities associated with scientific resources management such as research, census, law enforcement, habitat acquisition and maintenance, propagation, live trapping, and transplantation, and, in the extraordinary case where population pressures within a given ecosystem cannot be otherwise relieved, may include regulated taking.

Critical habitat receives protection under section 7 of the Act through the requirement that Federal agencies ensure, in consultation with the Service, that any action they authorize, fund, or carry out is not likely to result in the destruction or adverse modification of critical habitat. The designation of critical habitat does not affect land ownership or establish a refuge, wilderness, reserve, preserve, or other conservation area. Such designation does not allow the government or public to access private lands. Such designation does not require implementation of restoration, recovery, or enhancement measures by non-Federal landowners. Where a landowner requests Federal agency funding or authorization for an action that may affect a listed species or critical habitat, the consultation requirements of section 7(a)(2) of the Act would apply, but even in the event of a destruction or adverse modification finding, the obligation of the Federal action agency and the landowner is not to restore or recover the species, but to implement reasonable and prudent alternatives to avoid destruction or adverse modification of critical habitat.

Under the first prong of the Act's definition of critical habitat, areas within the geographical area occupied by the species at the time it was listed are included in a critical habitat designation if they contain physical or biological features (1) which are essential to the conservation of the species and (2) which may require special management considerations or protection. For these areas, critical habitat designations identify, to the extent known using the best scientific and commercial data available, those physical or biological features that are essential to the conservation of the species (such as space, food, cover, and protected habitat). In identifying those physical or biological features that occur in specific areas, we focus on the specific features that are essential to support the life-history needs of the species, including but not limited to, water characteristics, soil type, geological features, prey, vegetation, symbiotic species, or other features. A feature may be a single habitat characteristic, or a more complex combination of habitat characteristics. Features may include habitat characteristics that support ephemeral or dynamic habitat conditions. Features may also be expressed in terms relating to principles of conservation biology, such as patch size, distribution distances, and connectivity.

Under the second prong of the Act's definition of critical habitat, we can designate critical habitat in areas outside the geographical area occupied by the species at the time it is listed, upon a determination that such areas are essential for the conservation of the species. When designating critical habitat, the Secretary will first evaluate areas occupied by the species. The Secretary will only consider unoccupied areas to be essential where a critical habitat designation limited to geographical areas occupied by the species would be inadequate to ensure the conservation of the species. In addition, for an unoccupied area to be considered essential, the Secretary must determine that there is a reasonable certainty both that the area will contribute to the conservation of the species and that the area contains one or more of those physical or biological features essential to the conservation of the species.

Section 4 of the Act requires that we designate critical habitat on the basis of the best scientific data available. Further, our Policy on Information Standards Under the Endangered Species Act (published in the **Federal Register** on July 1, 1994 (59 FR 34271)), the Information Quality Act (section 515 of the Treasury and General Government Appropriations Act for Fiscal Year 2001 (Pub. L. 106–554; H.R. 5658)), and our associated Information Quality Guidelines, provide criteria, establish procedures, and provide guidance to ensure that our decisions are based on the best scientific data available. They require our biologists, to the extent consistent with the Act and with the use of the best scientific data available, to use primary and original sources of information as the basis for recommendations to designate critical habitat.

When we are determining which areas should be designated as critical habitat, our primary source of information is generally the information developed during the listing process for the species. Additional information sources may include the recovery plan for the species, articles in peer-reviewed journals, conservation plans developed by States and counties, scientific status surveys and studies, biological assessments, other unpublished materials, or experts' opinions or personal knowledge.

Habitat is dynamic, and species may move from one area to another over time. We recognize that critical habitat designated at a particular point in time may not include all of the habitat areas

that we may later determine are necessary for the recovery of the species. For these reasons, a critical habitat designation does not signal that habitat outside the designated area is unimportant or may not be needed for recovery of the species. Areas that are important to the conservation of the species, both inside and outside the critical habitat designation, will continue to be subject to: (1) Conservation actions implemented under section 7(a)(1) of the Act, (2) regulatory protections afforded by the requirement in section 7(a)(2) of the Act for Federal agencies to ensure their actions are not likely to jeopardize the continued existence of any endangered or threatened species, and (3) section 9 of the Act's prohibitions on taking any individual of the species, including taking caused by actions that affect habitat. Federally funded or permitted projects affecting listed species outside their designated critical habitat areas may still result in jeopardy findings in some cases. These protections and conservation tools will continue to contribute to recovery of this species. Similarly, critical habitat designations made on the basis of the best available information at the time of designation will not control the direction and substance of future recovery plans, habitat conservation plans (HCPs), or other species conservation planning efforts if new information available at the time of these planning efforts calls for a different outcome.

Prudency Determination

Section 4(a)(3) of the Act, as amended, and implementing regulations (50 CFR 424.12), require that the Secretary shall designate critical habitat at the time the species is determined to be an endangered or threatened species to the maximum extent prudent and determinable. Our regulations (50 CFR 424.12(a)(1)) state that the Secretary may, but is not required to, determine that a designation would not be prudent in the following circumstances:

(i) The species is threatened by taking or other human activity and identification of critical habitat can be expected to increase the degree of such threat to the species;

(ii) The present or threatened destruction, modification, or curtailment of a species' habitat or range is not a threat to the species, or threats to the species' habitat stem solely from causes that cannot be addressed through management actions resulting from consultations under section 7(a)(2) of the Act;

(iii) Areas within the jurisdiction of the United States provide no more than negligible conservation value, if any, for a species occurring primarily outside the jurisdiction of the United States;

(iv) No areas meet the definition of critical habitat; or

(v) The Secretary otherwise determines that designation of critical habitat would not be prudent based on the best scientific data available.

As discussed in the final rule listing this species as threatened, at the time of listing, there was no imminent threat of take attributed to collection or vandalism of this species; and in the years since listing, no threat of taking or vandalism have emerged. Identification and mapping of critical habitat is not expected to initiate any such threat. In our final listing rule, we determined that the present or threatened destruction, modification, or curtailment of habitat or range is a threat to the Suwannee moccasinshell and those threats may be addressed by section 7(a)(2) consultation measures. The species occurs wholly in the jurisdiction of the United States and we are able to identify areas that meet the definition of critical habitat. Therefore, because none of the circumstances enumerated in our regulations at 50 CFR 424.12(a)(1) have been met and because there are no other circumstances the Secretary has identified for which this designation of critical habitat would be not prudent we have determined that the designation of critical habitat is prudent for the Suwannee moccasinshell.

Critical Habitat Determinability

Having determined that designation is prudent, under section 4(a)(3) of the Act we must find whether critical habitat for the Suwannee moccasinshell is determinable. Our regulations at 50 CFR 424.12(a)(2) state that critical habitat is not determinable when one or both of the following situations exist:

(i) Data sufficient to perform required analyses are lacking, or

(ii) The biological needs of the species are not sufficiently well known to identify any area that meets the definition of ''critical habitat.''

We reviewed the available information pertaining to the biological needs of the species and habitat characteristics where the species is located. This and other information represent the best scientific data available and lead us to conclude that the designation of critical habitat is determinable for the Suwannee moccasinshell.

Physical or Biological Features Essential to the Conservation of the Species

In accordance with section 3(5)(A)(i) of the Act and regulations at 50 CFR 424.12(b), in determining which areas we will designate as critical habitat from within the geographical area occupied by the species at the time of listing, we consider the physical or biological features that are essential to the conservation of the species and that may require special management considerations or protection. We have defined physical or biological features essential to the conservation of the species in 50 CFR 424.02. Categories of physical or biological features include, but are not limited to:

(1) Space for individual and population growth and for normal behavior;

(2) Food, water, air, light, minerals, or other nutritional or physiological requirements;

(3) Cover or shelter;

(4) Sites for breeding, reproduction, or rearing (or development) of offspring; and

(5) Habitats that are protected from disturbance or are representative of the historic geographical and ecological distributions of a species.

Summary of Essential Physical or Biological Features

We derive the specific physical or biological features essential for the Suwannee moccasinshell from studies of its habitat, ecology, and life history as described below. Additional information can be found in the final listing rule published in the **Federal Register** on October 6, 2016 (81 FR 69417).

Space for Individual and Population Growth and for Normal Behavior

Mussels generally live embedded in the bottom of stable streams and other bodies of water, in areas where flow velocities are sufficient to remove finer sediments and provide well-oxygenated waters. The Suwannee moccasinshell inhabits creeks and rivers where it is found in substrates of sand or a mixture of sand and gravel, and in areas with slow to moderate current (Williams 2015, p. 2). The Suwannee moccasinshell, similar to other mussels, is dependent on areas with flow refuges, where shear stress is relatively low and sediments remain stable during high flow events (Strayer 1999, pp. 468, 472; Hastie *et al.* 2001, pp. 111–114; Gangloff and Feminella 2007, p. 71). The species is often associated with large woody material embedded in the substrate, which may help stabilize substrates and

act as a flow refuge. Substrates that remain stable in high flows conceivably allow these relatively sedentary animals to remain in the same general location throughout their entire lives. These habitat conditions not only provide space for Suwannee moccasinshell populations, but also provide cover and shelter and sites for breeding, reproduction, and growth of offspring.

Food, Water, Air, Light, Minerals, or Other Nutritional or Physiological Requirements

Freshwater mussels, such as the Suwannee moccasinshell, siphon water into their shells and across four gills that are specialized for respiration, food collection, and brooding larvae in females. Food items include fine detritus (particles of organic debris), algae, diatoms, and bacteria (Strayer *et al.* 2004, pp. 430–431, Vaughn *et al.* 2008, p. 410). Adult mussels obtain food items both from the water column and from the sediment, either by taking water in through the incurrent siphon or by moving material extracted from sediments into their shell using cilia (hair-like structures) on their foot. For the first several months, juvenile mussels feed primarily with their foot, although they also may filter interstitial (pore) water (Yeager *et al.* 1994, pp. 217–221). Food availability and quality for the Suwannee moccasinshell is affected by habitat stability, floodplain connectivity, flow, and water and sediment quality. Adequate food availability and quality is essential for normal behavior, growth, and viability during all life stages of this species.

The Suwannee moccasinshell is a riverine species that depends upon adequate amounts of flowing water. Flowing water transports food items to the sedentary juvenile and adult life stages, provides oxygen for respiration, removes wastes, transports sperm to females, and maintains the stream bottom habitats where the species is found (the effects of flow alteration on habitat is discussed below under *Habitats Protected from Disturbance*). A sufficient amount of continuously flowing water is a feature essential to this species.

The ranges of standard water quality characteristics (such as temperature, dissolved oxygen, pH, and conductivity) required by the Suwannee moccasinshell for normal behavior, growth, and viability of all life stages have not been investigated or are poorly understood. However, as relatively sedentary animals, mussels must tolerate the full range of physical and chemical conditions that occur naturally within the streams where they persist. The physical and chemical conditions (water quality) within the Suwannee moccasinshell's historical range may vary according to season, geology, climate events, and human activities within the watershed. The combined effects of groundwater pumping and drought can lower groundwater levels in the basin, which can result in severely reduced stream flows for extended periods (Grubbs and Crandall 2007, p. 78; Torak *et al.* 2010, pp. 46–47). Moreover, increased stream temperatures and decreased dissolved oxygen concentrations are important secondary effects associated with flow reduction and cessation. Sensitive mussel species like the Suwannee moccasinshell may suffer lethal and non-lethal effects to low dissolved oxygen levels and elevated stream temperatures (Johnson *et al.* 2001, pp. 5–8; Golladay *et al.* 2004, p. 501; Haag and Warren 2008, pp. 1174–1176), and is particularly susceptible to these conditions during its early life stages (Sparks and Strayer 1998, pp. 132–133; Pandolfo *et al.* 2010, p. 965; Archambault *et al.* 2013, p. 247). Although specific physical and chemical tolerance ranges are not known for the Suwannee moccasinshell, we believe that current numeric standards for water quality criteria that have been adopted by the States under the Clean Water Act (CWA) represent levels that are essential to the conservation of the species.

Sites for Breeding, Reproduction, or Rearing (or Development) of Offspring

Sites for breeding, reproduction, and development are tied to areas in stable rivers and creeks where flow velocities are sufficient to maintain habitats, and bottom substrates are composed of sand or a mixture of sand and gravel (see *Space for Individual and Population Growth and for Normal Behavior* above). Juvenile mussels depend upon areas where substrates remain stable during high flow events. The presence of large embedded logs may contribute to substrate stability and act as flow refuges. The larvae of most freshwater mussels are parasitic, requiring a period of encystment on a fish host in order to transform into juvenile mussels. Thus, the presence of appropriate host fishes to complete its reproductive life cycle is essential to the Suwannee moccasinshell. In laboratory host trials, Suwannee moccasinshell larvae transformed primarily on the blackbanded darter (*Percina nigrofasciata*) and to a lesser extent on the brown darter (*Etheostoma edwini*) (Johnson *et al.* 2016, p. 171). The blackbanded darter is one of the most abundant darter species in coastal plain streams, and the distribution of both fish species overlap with the historical distribution of the Suwannee moccasinshell (Kuehne and Barbour 1983, pp. 29–30; Robins *et al.* 2018, pp. 317, 336).

Habitats Protected From Disturbance

The Suwannee moccasinshell's habitat has been impacted by pollution and reduced flows throughout its range, and by channel instability and excessive sedimentation in portions of its range (see *Factor A. The Present or Threatened Destruction, Modification, or Curtailment of Its Habitat or Range* of the proposed listing rule).

An environment free from toxic levels of pollutants is essential to the Suwannee moccasinshell, especially to its early life stages. There is no specific information on the sensitivity of the species to common municipal, agricultural, and industrial pollutants. However, as a group, freshwater mussels are more sensitive to pollution than many other aquatic organisms, and are one of the first species to respond to water quality impacts (Haag 2012, p. 355) (see Pollution discussion under Factor A of the final listing rule). We currently believe that most numeric standards for pollutants that have been adopted by the States under the CWA represent levels that are essential to the conservation of the Suwannee moccasinshell. However, some standards may not adequately protect sensitive mollusks like the Suwannee moccasinshell, or are not being appropriately measured, monitored, or achieved in some reaches (see *Factor D. The Inadequacy of Existing Regulatory Mechanisms* section of the final listing rule).

The Suwannee moccasinshell is a riverine species that depends upon a natural flow regime to maintain the benthic habitats where it lives. A natural hydrologic regime is critical for the exchange of nutrients, movement and spawning activities of potential fish hosts, and maintenance of habitats. Altered flow regimes (including higher peak flows, lower base flows, and changes to seasonal flow pulses) can physically alter stream habitats. For example, increases in the amount and rate at which stormwater runoff enters stream channels can erode the stream bed and banks and cause sedimentation in downstream areas. Reductions in stream flow can alter hydraulically mediated sediment sorting throughout the river, which may displace or otherwise alter habitat for the Suwannee moccasinshell and its host fishes. Changes in flow regimes are attributable

to factors such as lowering of the groundwater table due to pumping, changes in land use, and impoundments.

The Suwannee moccasinshell requires geomorphically stable stream channels to maintain its habitats. Channel instability occurs when the natural erosion process is accelerated leading to erosion (degradation) and sediment deposition (aggradation), and can eventually lead to channel incision (lowering of the streambed). Channel instability can lead to profound changes to mussel habitats due to scouring and sediment deposition (Hartfield 1993, p. 138). Stream channels can become destabilized as a result of physical alterations to the channel (such as dredging, straightening, impounding, and hardening), altered stormwater runoff patterns, and disturbance to riparian areas. Natural stream channel stability is achieved by allowing the river or creek to develop a stable dimension, pattern, and profile such that, over time, channel features are maintained and the stream channel neither degrades nor aggrades. Stable rivers and creeks consistently transport their sediment load, both in size and type, associated with local deposition and scour (Rosgen 1996, pp. 1–3). These habitats are dynamic and are formed and maintained by water quantity, channel features (dimension, pattern, and profile), and natural sediment input to the system through periodic flooding, which maintains connectivity and interaction with the floodplain.

The Suwannee moccasinshell requires habitats that are free from excessive sedimentation. Although sediment deposition is a normal stream process, habitat may be degraded or destroyed in areas where excessive amounts of sediment accumulate and smother habitat. Sediments that enter via stormwater runoff, may also serve to transport pollutants (like pesticides and surfactants) into streams (Haag 2012, p. 378). Heavy accumulations of unconsolidated sediments can alter bottom substrates to such a degree that it becomes uninhabitable for mussels, particularly juveniles.

In conclusion, based on the analysis above, we have determined that the following physical or biological features are essential to support the Suwannee moccasinshell:

(1) Geomorphically stable stream channels (channels that maintain lateral dimensions, longitudinal profiles, and sinuosity patterns over time without an aggrading or degrading bed elevation).

(2) Stable substrates of muddy sand or mixtures of sand and gravel, and with little to no accumulation of unconsolidated sediments and low amounts of filamentous algae.

(3) A natural hydrologic flow regime (magnitude, frequency, duration, and seasonality of discharge over time) necessary to maintain benthic habitats where the species is found, and connectivity of stream channels with the floodplain, allowing the exchange of nutrients and sediment for habitat maintenance, food availability, and spawning habitat for native fishes.

(4) Water quality conditions needed to sustain healthy Suwannee moccasinshell populations, including low pollutant levels (not less than State criteria), a natural temperature regime, pH (between 6.0 to 8.5), adequate oxygen content (not less than State criteria), hardness, turbidity, and other chemical characteristics necessary for normal behavior, growth, and viability of all life stages.

(5) The presence of abundant fish hosts necessary for recruitment of the Suwannee moccasinshell. The presence of blackbanded darters (*Percina nigrofasciata*) and brown darters (*Etheostoma edwini*) will serve as an indication of fish host presence.

Special Management Considerations or Protection

When designating critical habitat, we assess whether the specific areas within the geographical area occupied by the species at the time of listing contain features that are essential to the conservation of the species and which may require special management considerations or protection. All three units that we are proposing for designation, including the unit that was occupied by the species at the time of listing, have mixed ownership of adjacent riparian lands with mainly private (72 percent) and State (27 percent) lands (table 1). All State-owned riparian lands are in Florida, and the majority are managed by Florida's Suwannee River Water Management District (SRWMD). Tracts are managed to maintain adequate water supply and water quality for natural systems by preserving riparian habitats and restricting development (SRWMD 2014, p. 3). The SRWMD also established minimum flows and levels for the river channel in the lower basin, downstream of Fanning Springs. Minimum flow and level criteria establish a limit at which further withdrawals would be detrimental to water resources, taking into consideration fish and wildlife habitats, the passage of fish, sediment loads, and water quality, among others (SRWMD 2005, pp. 6–8). In addition, the Suwannee River and Santa Fe River system have been designated Outstanding Florida Waters (OFW), which prevents the permitted discharge of pollutants that would lower existing water quality of, or significantly degrade, the OFW. While these programs may indirectly alleviate some detrimental impacts on aquatic habitats, there currently are no plans or agreements designed specifically for the conservation of the Suwannee moccasinshell or for freshwater mussels in general.

The features essential to the conservation of the Suwannee moccasinshell may require special management considerations or protection to ameliorate the following threats: Reduced flows, nonpoint source pollution (from stormwater runoff or infiltration), point source pollution (from wastewater discharges or accidental releases), and physical alterations to the stream channel (for example, dredging, straightening, impounding, etc.). Special management considerations or protection are required within critical habitat areas to ameliorate these threats, and include (but are not limited to): (1) Moderation of surface and ground water withdrawals; (2) improvement of the treatment of wastewater discharged from permitted facilities and the operation of those facilities; (3) reductions in pesticide and fertilizer use especially in groundwater recharge areas and near stream channels; (4) use of best management practices (BMPs) designed to reduce sedimentation, erosion, and stream bank alteration; (5) protection and restoration of riparian buffers; and (6) avoidance of physical alternations to the stream channel. This only applies to federal actions (see the Application of the ''Adverse Modification'' Standard below for more information).

Criteria Used To Identify Critical Habitat

As required by section 4(b)(2) of the Act, we use the best scientific data available to designate critical habitat. In accordance with the Act and our implementing regulations at 50 CFR 424.12(b), we review available information pertaining to the habitat requirements of the species and identify specific areas within the geographical area occupied by the species at the time of listing and any specific areas outside the geographical area occupied by the species to be considered for designation as critical habitat.

The current distribution of the species is much reduced from its historical range. We anticipate that recovery will require continued protection of the existing population and its habitat, as

well as reintroduction of Suwannee moccasinshell into historically occupied areas, ensuring there are viable populations and that they occur over a wide geographic area. Rangewide recovery considerations, such as maintaining existing genetic diversity and striving for representation of all major portions of the species' current range, were considered in formulating this proposed critical habitat.

For this proposed rule, we completed the following steps to delineate critical habitat (specific methods follow below):

(1) We compiled all available occurrence data records.

(2) We used confirmed presences from June 2001–March 2016 as the foundation for identifying areas currently occupied.

(3) We evaluated habitat suitability of stream segments currently occupied by the species, and retained all occupied stream segments.

(4) We evaluated unoccupied stream segments for suitability, connectivity, and expansion, and identified areas containing the components comprising the physical or biological features that may require special management considerations or protection.

(5) We omitted some unoccupied areas that are highly degraded and are not likely restorable (*e.g.,* insufficient flowing water, channel destabilized), and, therefore, are not considered essential for the conservation of the species.

(6) We delineated boundaries of potential proposed critical habitat units based on the above information.

Specific criteria and methodology used to determine proposed critical habitat unit boundaries are discussed below.

Sources of data for this proposed critical habitat designation include multiple databases maintained by Florida Fish and Wildlife Conservation Commission, Dr. James D. Williams, Florida Museum of Natural History, and U.S. Geological Survey; verified museum records from multiple institutions (see *Methods* in Johnson *et al.* 2016, pp. 164–165); and a status report by Blalock–Herod and Williams (2001, entire). Occurrence data included records collected from May 1916 to March 2016. A large number of surveys were conducted throughout the Suwannee River basin by Florida Fish and Wildlife Conservation Commission biologists during 2012–2016, and all sites with historical occurrences of Suwannee moccasinshell were sampled during this period. Sources of information pertaining to habitat requirements of the Suwannee moccasinshell include observations recorded during surveys and information contained in Blalock–Herod and Williams (2001, entire) and Williams *et al.* (2014, pp. 278–280).

Areas Occupied at the Time of Listing

We define ''currently occupied'' as river reaches with positive surveys from 2000 to 2016. In making these determinations, we recognized that known occurrences for some mussel species are extremely localized, and rare mussels can be difficult to locate. In addition, stream habitats are highly dependent upon upstream and downstream channel habitat conditions for their maintenance. Therefore, we considered the entire reach between the uppermost and lowermost currently occupied locations to delineate the probable upstream and downstream extent of the Suwannee moccasinshell's distribution. Within the current range of the species, some habitats may or may not be actively utilized by individuals, but we consider these areas to be occupied at the scale of the geographic range of the species.

We propose to designate one occupied unit as critical habitat for the Suwannee moccasinshell in the Suwannee River and lower Santa Fe River. This area contains one or more of the physical or biological features to support life-history processes essential to the conservation of the Suwannee moccasinshell, and those physical or biological features require special management conditions or protections. This remaining population provides little redundancy for the species, and a series of back-to-back stochastic events or a single catastrophic event could significantly reduce or extirpate the remaining population. Consequently, we have determined that the occupied area is inadequate to ensure the conservation of the species. Therefore, we have also identified, and are proposing for designation of critical habitat, unoccupied areas that are essential for the conservation of the species.

Areas Unoccupied at the Time of Listing

Because we have determined occupied areas alone are not adequate for the conservation of the species, we have evaluated whether any unoccupied areas are essential for the conservation of the species. We are proposing as critical habitat two units that are currently unoccupied. The units have at least one of the physical or biological features essential to the conservation of the species and we are reasonably certain that each will contribute to the conservation of the species. Our specific rationale for each unit can be found below in the unit descriptions below.

An examination of all available collection data shows that the Suwannee moccasinshell's range and numbers have declined over time (see ''Distribution and Abundance'' discussion in the final listing rule). For example, despite considerable survey effort, the species has not been collected in the lower Suwannee River or Withlacoochee River subbasins since the 1960s, and was last collected in the upper Santa Fe River subbasin in 1996 (Johnson *et al.* 2016, p. 170). There has also been a reduction in numbers, with fewer individuals encountered during recent surveys than were collected historically (Johnson *et al.* 2016, pp. 166, 170).

The Suwannee moccasinshell's reduced range and small population size may increase its vulnerability to many threats. Aquatic species with small ranges, few populations, and small or declining population sizes are the most vulnerable to extinction (Primack 2008, p. 137; Haag 2012, p. 336). The effects of certain environmental pressures, particularly habitat degradation and loss, catastrophic weather events, and introduced species, are greater when population size is small (Soulé 1980, pp. 33, 71; Primack 2008, pp. 133–137, 152). Threats to the Suwannee moccasinshell are compounded by its reduced and linear distribution, with nearly the entire population presently distributed within the Suwannee River mainstem. A small population also occurs in the lower Santa Fe River, however, only 5 recent collections (3 of which are relic shell) have been reported in this subbasin (Johnson *et al.* 2016, p. 171).

A larger population of Suwannee moccasinshell occurring over a wide geographic area can have higher resilience. A large population is better able to return to pre–disturbance numbers after stochastic events, and also has increased availability of mates and reduced risk of genetic drift and inbreeding depression. The minimum viable population size needed to withstand stochastic events is not known for mussels. However, for species with complex life histories like freshwater mussels, maximizing the chances of persistence over the long–term, likely requires a population of considerable size (Haag 2012, p. 371). Reestablishing viable populations in the Withlacoochee and upper Santa Fe River subbasins increases Suwannee moccasinshell resiliency by expanding its range into historically occupied areas, potentially increasing population size, and providing refuge from

catastrophic events (for example, flooding and spills) in the Suwannee River.

We determined the Withlacoochee and upper Santa Fe River subbasins have the potential for future reoccupation by the species, provided that stressors are managed and mitigated. These specific areas encompass the minimum area of the species' historical range within the proposed critical habitat designation, while still providing ecological diversity so that the species has the ability to evolve and adapt over time (representation) to ensure that the species has an adequate level of redundancy to guard against future catastrophic events. These areas also represent the stream reaches within the historical range with the best potential for recovery of the species due to their current conditions and likely suitability for reintroductions. Accordingly, we propose to designate one unoccupied unit in the upper Santa Fe River and one unoccupied unit in the Withlacoochee River. As described below in the individual unit descriptions, each unit contains one or more of the physical or biological features and are reasonably certain to contribute to the conservation of the species.

General Information on the Maps of the Proposed Critical Habitat Designation

The critical habitat streams were mapped with USGS National Hydrography Dataset GIS data. The high-resolution 1:24,000 flowlines were used to delineate the upstream and downstream boundaries of the proposed critical habitat units and to calculate river kilometers and miles, according to the criteria explained below. The downstream boundary of a unit is the confluence of a named tributary stream or spring, below the farthest downstream occurrence record. The upstream boundary is the confluence of the first major tributary, road-crossing bridge, or a permanent barrier to fish passage above the farthest upstream occurrence record. The confluence of a large tributary typically marks a significant change in the size of the stream and is a logical and recognizable upstream terminus. Likewise, a dam or other barrier to fish passage marks the upstream extent to which mussels may disperse via their fish hosts. In the unit descriptions, distances between landmarks marking the upstream or downstream extent of a stream segment are given in river kilometers (km) and equivalent miles (mi), as measured tracing the course of the stream, not straight-line distance.

The areas proposed as critical habitat include only stream channels within the ordinary high-water line. There are no developed areas within the critical habitat boundaries except for transportation crossings, which do not remove the suitability of these areas for this species. The scale of the maps we prepared under the parameters for publication within the Code of Federal Regulations may not reflect the exclusion of such developed lands. Any such lands inadvertently left inside critical habitat boundaries shown on the maps of this proposed rule have been excluded by text in the proposed rule and are not proposed for designation as critical habitat. Therefore, if the critical habitat is finalized as proposed, a Federal action involving these lands would not trigger section 7 consultation with respect to critical habitat and the requirement of no adverse modification unless the specific action would affect the physical or biological features in the adjacent critical habitat.

The critical habitat designation is defined by the maps, as modified by any accompanying regulatory text, presented at the end of this document in the rule portion. We include more detailed information on the boundaries of the critical habitat designation in the preamble of this document. The coordinates on which each map is based are provided in the critical habitat unit descriptions at the end of this document, and are available at the Service's internet site, (*http://www.fws.gov/panamacity*), (*http://www.regulations.gov*) at Docket No. FWS–R4–ES–2019–0059, and at the field office responsible for this designation (see **FOR FURTHER INFORMATION CONTACT** above).

Proposed Critical Habitat Designation

We are proposing to designate approximately 306 km (190 mi) of stream channel in three units as critical habitat for the Suwannee moccasinshell. The three units we propose as critical habitat are: Unit 1: Suwannee River, Unit 2: Upper Santa Fe River, and Unit 3: Withlacoochee River. Overall, about 81 percent of critical habitat proposed for the Suwannee moccasinshell is already designated as critical habitat for either of two ESA-listed species: The oval pigtoe (*Pleurobema pyriforme*) or Gulf sturgeon *(Acipenser oxyrinchus desotoi).* Table 1 shows the proposed critical habitat units for the Suwannee moccasinshell and ownership of riparian lands adjacent to the units.

TABLE 1—PROPOSED CRITICAL HABITAT UNITS FOR THE SUWANNEE MOCCASINSHELL

[Ownership of riparian lands adjacent to the units is given for each streambank in kilometers (km) and miles (mi). Lengths greater than 10 kilometers are rounded to the nearest whole kilometer and mile]

Bank	Private km (mi)	State km (mi)	County km (mi)	Unit length km (mi)
Unit 1: Suwannee River, FL				187 (116.2)
Right descending bank *	133 (83)	51 (31)	3.1 (1.9)	
Left descending bank *	133 (83)	53 (33)	1.5 (0.9)	
Total	*266 (165)*	*103 (64)*	*4.6 (2.9)*	
Unit 2: Upper Santa Fe River, FL				43 (26.7)
Right descending bank	34 (21)	8.4 (5.2)	0.4 (0.3)	
Left descending bank	26 (16)	13 (8)	3.6 (2.2)	
Total	*61 (38)*	*22 (13)*	*4 (2.5)*	
Unit 3: Withlacoochee River, FL and GA				75.5 (46.9)
Right descending bank	58 (36)	17 (11)	0	
Left descending bank	53 (33)	22 (14)	0	
Total	*112 (69)*	*39 (25)*	*0*	

Note: Totals may not sum due to rounding.

* Right and left descending bank is that bank of a stream when facing in the direction of flow or downstream.

We present brief descriptions of all units, and reasons why they meet the definition of critical habitat for the Suwannee moccasinshell, below.

Unit 1: Suwannee River, Florida

Unit 1 consists of approximately 187 km (116 mi) of the Suwannee River and lower Santa Fe River in Alachua, Columbia, Dixie, Gilchrist, Lafayette, Madison, and Suwannee Counties, Florida. The unit includes the Suwannee River mainstem from the confluence of Hart Springs (near river kilometer 71) in Dixie-Gilchrist Counties, upstream 137 km (85 mi) to the confluence of the Withlacoochee River in Madison-Suwannee Counties; and the Santa Fe River from its confluence with the Suwannee River in Suwannee-Gilchrist Counties, upstream 50 km (31 mi) to the river's rise in Alachua County. The Santa Fe River flows underground for about 5 km (3.1 mi), ''sinking'' at O'Leno State Park and ''rising'' at River Rise Preserve State Park. The lower and upper portions of the Santa Fe are intermittently connected during high flow event. The riparian lands along stream reaches in this unit are generally privately owned agricultural or silvicultural lands, or State-owned or -managed conservation lands (Table 1). The Suwannee moccasinshell occupies all stream reaches in this unit, which contains most of the physical or biological features essential to the conservation of the Suwannee moccasinshell. However, in the Santa Fe River, flow levels have declined over time, and excessive sedimentation and algae growth are a problem; therefore, physical or biological features 1 and 3 are not consistently present in this portion of the unit. Currently, 73 percent of Unit 1 is designated critical habitat for the Gulf sturgeon (a migratory fish). Some small urban areas also exist near the two rivers. Special management considerations and protections that may be required to address threats within the unit include: Minimizing ground and surface water withdrawals or other actions that alter stream hydrology; reducing the use of fertilizers and pesticides, especially in spring recharge areas and near stream channels; improving treatment of wastewater discharged from permitted facilities and the operation of those facilities; implementing practices that protect or restore riparian buffer areas along stream corridors; prohibiting the removal of pre-cut submerged timber (deadhead logs); establishing and enforcing restrictions on boat speed and length, especially in the lower Santa Fe River. Many of these measures must also be implemented in areas upstream of the unit to adequately protect habitat within the unit.

Unit 2: Upper Santa Fe River, Florida

Unit 2 consists of approximately 43 km (27 mi) of the Santa Fe River and New River in Alachua, Bradford, Columbia, and Union Counties, Florida. The unit includes the Santa Fe River from the river's sink in Alachua County, upstream 36.5 km (23 mi) to the confluence of Rocky Creek in Bradford-Alachua Counties; and the New River from its confluence with the Santa Fe River, upstream 6.5 km (4 mi) to the confluence of Five Mile Creek in Union-Bradford Counties. Unit 2 is within the historical range of the Suwannee moccasinshell but is not currently occupied by the species. The riparian lands along stream channels in this unit are generally privately owned agricultural or silvicultural lands, or are State-owned or -managed conservation lands (Table 1). All of Unit 2 is already designated critical habitat for the oval pigtoe (a freshwater mussel). The Suwannee moccasinshell was routinely represented in historical collections in the upper Santa Fe subbasin, however, it is the only mussel species not detected in contemporary surveys. Currently, the unit supports a diverse mussel fauna, including several species that ordinarily co-occur with the Suwannee moccasinshell. This unit has at least one of the physical or biological features essential to the conservation of the species and we are reasonably certain that this area will contribute to the conservation of the species. Our specific rationale for this unit can be found below.

This area is essential to the conservation of the species because it would improve the resiliency and redundancy of the species, which is necessary to conserve and recover the Suwannee moccasinshell. For species resiliency and redundancy, it is important to reestablish Suwannee moccasinshell populations in Unit 2. Presently, nearly the entire population is linearly distributed within the mainstem Suwannee River and vulnerable to catastrophic events (for example, contaminant spills or severe floods) as well as to random fluctuations in population size or environmental conditions (Haag and Williams 2014, p. 48). Reestablishing viable populations in the Santa Fe River subbasin would reduce its extinction risk by expanding its current range into areas beyond the mainstem by providing connectivity to already occupied areas, space for growth and population expansion in portions of historical habitat, and refugia areas from threats in the Suwannee River mainstem.

Although it is considered unoccupied, portions of this unit contain some or all of the physical or biological features essential for the conservation of the species. Unit 2 possesses those characteristics as described by physical or biological features 1 and 2 and stable stream channels and suitable substrates are present throughout much of the unit. Unit 2 retains the features of a natural stream channel and presently supports a diverse mussel fauna, including several mussel species that ordinarily co-occur with the Suwannee moccasinshell. Both fish species found to serve as larval hosts for the Suwannee moccasinshell occur within the unit (Robins *et al.* 2018, pp. 317, 336).

Physical or biological features 3 and 4 are degraded in the unit during some times of the year. Flow levels in the upper Santa Fe River have declined over time, and the river has ceased to flow multiple times since 2000 (Johnson *et al.* 2016, p. 170). An important effect of reduced flows is altered water quality, especially depressed dissolved oxygen levels and elevated water temperatures (discussed above under ''Physical or Biological Features''). In 2007, the SRWMD developed minimum flow levels to establish flows protective of ''fish and wildlife habitats and the passage of fish'' in the upper Santa Fe River (SRWMD 2007, entire). The restoration of natural flow levels is a complex issue that will require considerable involvement and collaboration of Federal, State, and local governments and private landowners to implement projects that reduce groundwater pumping in order to recover aquifer levels and sustain base flows in the upper Santa Fe River subbasin. However, if implemented, water management strategies would improve physical or biological features 3 and 4.

The need for conservation efforts is recognized by our conservation partners, and methods for restoring and reintroducing the species into unoccupied habitat are being developed. The Florida Fish and Wildlife Conservation Commission has expressed support for including this area in a critical habitat designation (Florida Fish and Wildlife Conservation Commission 2019). Accordingly, we are reasonably certain this unit will contribute to the conservation of the species.

Unit 3: Withlacoochee River, Georgia and Florida

Unit 3 consists of approximately 75.5 km (47 mi) of the Withlacoochee River

in Madison and Hamilton Counties, Florida, and Brooks and Lowndes Counties, Georgia. The unit includes the Withlacoochee River from its confluence with the Suwannee River in Madison-Hamilton Counties, FL, upstream 75.5 km (47 mi) to the confluence of Okapilco Creek in Brooks-Lowndes Counties, GA. Unit 3 is within the historical range of the Suwannee moccasinshell but is not currently occupied by the species. The riparian lands along stream channels in this unit are generally agricultural or silvicultural lands (Table 1). Upstream of the unit, urban areas associated with the City of Valdosta, GA are present near the Withlacoochee River. Twenty-five percent of Unit 3 is already designated critical habitat for the Gulf sturgeon. Currently, the unit supports a diverse mussel fauna, however, the Suwannee moccasinshell is the only species not detected in contemporary surveys. This unit has at least one of the physical or biological features essential to the conservation of the species and we are reasonably certain that this area will contribute to the conservation of the species. Our specific rationale for this unit can be found below.

This area is essential to the conservation of the species because it would improve the resiliency and redundancy of the species, which is necessary to conserve and recover the Suwannee moccasinshell. For species resiliency and redundancy, it is important to reestablish Suwannee moccasinshell populations in Unit 3. Presently, nearly the entire population is linearly distributed within the mainstem Suwannee River and vulnerable to catastrophic events (for example, contaminant spills or severe floods) as well as to random fluctuations in population size or environmental conditions (Haag and Williams 2014, p. 48). Reestablishing viable populations in the Withlacoochee River subbasin would reduce its extinction risk by expanding its current range into areas beyond the mainstem by providing connectivity to already occupied areas, space for growth and population expansion in portions of historical habitat, and refugia areas from threats in the Suwannee River mainstem.

Although it is considered unoccupied, portions of this unit contain some or all of the physical or biological features essential for the conservation of the species. Unit 3 possesses those characteristics as described by physical or biological features 1 and 2, and long reaches of stable stream channel with suitable substrates are present within the unit. Unit 3 retains the features of a natural stream channel and supports a diverse mussel fauna, including several mussel species that ordinarily co-occur with the Suwannee moccasinshell. Both fish species found to serve as larval hosts for the Suwannee moccasinshell occur within the unit (Robins *et al.* 2018, pp. 317, 336). Therefore, we believe the unit has the potential to support the species' life-history functions.

Physical or biological feature 4 is in degraded condition, and pollution may have contributed to the Suwannee moccasinshell's decline in Unit 3. The domestic wastewater treatment plant for the city of Valdosta, GA is approximately 14 river miles upstream of the unit, and has a history of untreated sewage releases to the Withlacoochee River after heavy rain events. However, major renovations to the city's sewer system were completed in June 2016 with the construction of a new treatment plant. Additional projects to address continued problems with sewage spills are ongoing, and the construction of a large retention basin is planned. If these improvements are realized, water quality could be restored to levels necessary to support the species.

The need for conservation efforts is recognized by our conservation partners, and methods for restoring and reintroducing the species into unoccupied habitat are being developed. The Florida Fish and Wildlife Conservation Commission and Georgia Department of Natural Resources have expressed support for including this area in a critical habitat designation (Florida Fish and Wildlife Conservation Commission 2019; Georgia Department of Natural Resources 2018). Accordingly, we are reasonably certain this unit will contribute to the conservation of the species.

Effects of Critical Habitat Designation

Section 7 Consultation

Section 7(a)(2) of the Act requires Federal agencies, including the Service, to ensure that any action they fund, authorize, or carry out is not likely to jeopardize the continued existence of any endangered species or threatened species or result in the destruction or adverse modification of designated critical habitat of such species. In addition, section 7(a)(4) of the Act requires Federal agencies to confer with the Service on any agency action that is likely to jeopardize the continued existence of any species proposed to be listed under the Act or result in the destruction or adverse modification of proposed critical habitat.

We published a final regulation with a revised definition of destruction or adverse modification on August 27, 2019 (84 FR 44976). Destruction or adverse modification means a direct or indirect alteration that appreciably diminishes the value of critical habitat as a whole for the conservation of a listed species.

If a Federal action may affect a listed species or its critical habitat, the responsible Federal agency (action agency) must enter into consultation with us. Examples of actions that are subject to the section 7 consultation process are actions on State, tribal, local, or private lands that require a Federal permit (such as a permit from the U.S. Army Corps of Engineers under section 404 of the CWA or a permit from the Service under section 10 of the Act) or that involve some other Federal action (such as funding from the Federal Highway Administration, Federal Aviation Administration, or the Federal Emergency Management Agency). Federal actions not affecting listed species or critical habitat, and actions on State, tribal, local, or private lands that are not federally funded, or authorized or carried out by a Federal agency, do not require section 7 consultation.

Compliance with the requirements of section 7(a)(2), is documented through our issuance of:

(1) A concurrence letter for Federal actions that may affect, but are not likely to adversely affect, listed species or critical habitat; or

(2) A biological opinion for Federal actions that may affect and are likely to adversely affect, listed species or critical habitat.

When we issue a biological opinion concluding that a project is likely to jeopardize the continued existence of a listed species and/or destroy or adversely modify critical habitat, we provide reasonable and prudent alternatives to the project, if any are identifiable, that would avoid the likelihood of jeopardy and/or destruction or adverse modification of critical habitat. We define ''reasonable and prudent alternatives'' (at 50 CFR 402.02) as alternative actions identified during consultation that:

(1) Can be implemented in a manner consistent with the intended purpose of the action,

(2) Can be implemented consistent with the scope of the Federal agency's legal authority and jurisdiction,

(3) Are economically and technologically feasible, and

(4) Would, in the Director's opinion, avoid the likelihood of jeopardizing the continued existence of the listed species

and/or avoid the likelihood of destroying or adversely modifying critical habitat.

Reasonable and prudent alternatives can vary from slight project modifications to extensive redesign or relocation of the project. Costs associated with implementing a reasonable and prudent alternative are similarly variable.

Regulations at 50 CFR 402.16 require Federal agencies to reinitiate consultation on previously reviewed actions in instances where we have listed a new species or subsequently designated critical habitat that may be affected and the Federal agency has retained discretionary involvement or control over the action (or the agency's discretionary involvement or control is authorized by law). Consequently, Federal agencies sometimes may need to request reinitiation of consultation with us on actions for which formal consultation has been completed, if those actions with discretionary involvement or control may affect subsequently listed species or designated critical habitat. The regulations also specify some exceptions to this requirement for specific land management plans. See the regulations for a description of those exceptions.

Overall, about 81 percent of critical habitat proposed for the Suwannee moccasinshell is already designated as critical habitat for either the oval pigtoe or Gulf sturgeon. For Federal actions within areas already designated as critical habitat for these species, conservation measures we would recommend for the Suwannee moccasinshell are likely to be the same or very similar to those we already recommend for the oval pigtoe and Gulf sturgeon. New additional conservation measures will, however, likely be needed within that portion of Unit 3 that is unoccupied by the Suwannee moccasinshell but not currently designated critical habitat for the Gulf sturgeon.

Application of the ''Destruction or Adverse Modification'' Standard

The key factor related to the destruction or adverse modification determination is whether, with implementation of the proposed Federal action, the critical habitat affected by the action is altered in way that appreciably diminishes the value of the designated critical habitat as a whole for the conservation of the listed species. As discussed above, the role of critical habitat is to support the physical or biological features essential to the conservation of a listed species and provide for the conservation of the species.

Section 4(b)(8) of the Act requires us to briefly evaluate and describe, in any proposed or final regulation that designates critical habitat, activities involving a Federal action that may violate section 7(a)(2) of the Act by destroying or adversely modifying such habitat, or that may be affected by such designation.

Activities that may be found likely to destroy or adversely modify critical habitat under 7(a)(2) of the Act include, but are not limited to:

(1) Actions that would introduce contaminants or alter water chemistry or temperature. Such activities could include, but are not limited to, release of chemical or biological pollutants, or heated effluents into the surface water or connected groundwater at a point source or by dispersed release (nonpoint source). These activities could alter water quality conditions to levels that are beyond the tolerances of the mussel or its fish host.

(2) Actions that would reduce flow levels or alter flow regimes. This could include, but are not limited to, activities that lower groundwater levels including groundwater pumping and surface water withdrawal or diversion. These activities can result in long-term reduced stream flows, which may cause channels to stop flowing or dry up; and also may decrease oxygen levels, elevate water temperatures, degrade water quality, and cause sediments to accumulate. These activities could alter flow levels beyond the tolerances of the mussel or its fish host.

(3) Actions that would significantly increase the filamentous algal community within the stream channel. Such activities could include, but are not limited to, release of nutrients into the surface water or connected groundwater at a point source or by dispersed release (nonpoint source). These activities can result in excessive filamentous algae filling streams and reducing habitat for the mussel and its fish host, degrading water quality during their decay, and decreasing oxygen levels at night from their respiration. Thick algal mats can also entrain young mussels and prevent juveniles from settling into the sediment. These activities could degrade the habitat and reduce oxygen levels below the tolerances of the mussel or its fish host.

(4) Actions that would significantly alter channel morphology or cause channel instability. Such activities could include but are not limited to channelization, impoundment, road and bridge construction, mining, dredging, destruction of riparian vegetation, and land clearing. These activities may lead to changes in flow regimes, erosion of the streambed and banks, and excessive sedimentation that could degrade the habitat of the mussel or its fish host.

(5) Actions that would cause significant amounts of sediments to enter the stream channel. Such activities could include, but are not limited to livestock grazing, road and bridge construction, channel alteration, timber harvest, commercial and residential development, and other watershed and floodplain disturbances. These activities could eliminate or degrade the habitat necessary for the growth and reproduction of the mussel or its fish host.

Exemptions

Application of Section 4(a)(3) of the Act

Section 4(a)(3)(B)(i) of the Act (16 U.S.C. 1533(a)(3)(B)(i)) provides that: ''The Secretary shall not designate as critical habitat any lands or other geographic areas owned or controlled by the Department of Defense, or designated for its use, that are subject to an integrated natural resources management plan [INRMP] prepared under section 101 of the Sikes Act (16 U.S.C. 670a), if the Secretary determines in writing that such plan provides a benefit to the species for which critical habitat is proposed for designation.'' There are no Department of Defense lands with a completed INRMP within the proposed critical habitat designation.

Consideration of Impacts Under Section 4(b)(2) of the Act

Section 4(b)(2) of the Act states that the Secretary shall designate and make revisions to critical habitat on the basis of the best available scientific data after taking into consideration the economic impact, national security impact, and any other relevant impact of specifying any particular area as critical habitat. The Secretary may exclude an area from critical habitat if he determines that the benefits of such exclusion outweigh the benefits of specifying such area as part of the critical habitat, unless he determines, based on the best scientific data available, that the failure to designate such area as critical habitat will result in the extinction of the species. In making that determination, the statute on its face, as well as the legislative history, are clear that the Secretary has broad discretion regarding which factor(s) to use and how much weight to give to any factor.

When considering the benefits of exclusion, we consider, among other

things, whether exclusion of a specific area is likely to result in conservation; the continuation, strengthening, or encouragement of partnerships; or implementation of a management plan. In the case of the Suwannee moccasinshell, the benefits of critical habitat include public awareness of the presence of the species and the importance of habitat protection, and, where a Federal nexus exists, increased habitat protection for the Suwannee moccasinshell due to protection from adverse modification or destruction of critical habitat. In practice, situations with a Federal nexus exist primarily on Federal lands or for projects undertaken by Federal agencies. Additionally, continued implementation of an ongoing management plan that provides equal to or more conservation than a critical habitat designation would reduce the benefits of including that specific area in the critical habitat designation.

We have not considered any areas for exclusion from critical habitat. However, the final decision on whether to exclude any areas will be based on the best scientific data available at the time of the final designation, including information obtained during the comment period and information about the economic impact of designation. Accordingly, we have prepared a draft economic analysis concerning the proposed critical habitat designation, which is available for review and comment (see **ADDRESSES**).

Consideration of Economic Impacts

Section 4(b)(2) of the Act and its implementing regulations require that we consider the economic impact that may result from a designation of critical habitat. To assess the probable economic impacts of a designation, we must first evaluate specific land uses or activities and projects that may occur in the area of the critical habitat. We then must evaluate the impacts that a specific critical habitat designation may have on restricting or modifying specific land uses or activities for the benefit of the species and its habitat within the areas proposed. We then identify which conservation efforts may be the result of the species being listed under the Act versus those attributed solely to the designation of critical habitat for this particular species. The probable economic impact of a proposed critical habitat designation is analyzed by comparing scenarios both ''with critical habitat'' and ''without critical habitat.'' The ''without critical habitat'' scenario represents the baseline for the analysis, which includes the existing regulatory and socio-economic burden imposed on landowners, managers, or other resource users potentially affected by the designation of critical habitat (*e.g.,* under the Federal listing as well as other Federal, State, and local regulations). The baseline, therefore, represents the costs of all efforts attributable to the listing of the species under the Act (*i.e.,* conservation of the species and its habitat incurred regardless of whether critical habitat is designated). The ''with critical habitat'' scenario describes the incremental impacts associated specifically with the designation of critical habitat for the species. The incremental conservation efforts and associated impacts would not be expected without the designation of critical habitat for the species. In other words, the incremental costs are those attributable solely to the designation of critical habitat, above and beyond the baseline costs. These are the costs we use when evaluating the benefits of inclusion and exclusion of particular areas from the final designation of critical habitat should we choose to conduct an optional section 4(b)(2) exclusion analysis.

For this designation, we developed an incremental effects memorandum (IEM) considering the probable incremental economic impacts that may result from this proposed designation of critical habitat. The information contained in our IEM was then used to develop a screening analysis of the probable effects of the designation (Industrial Economics 2017). The purpose of the screening analysis is to filter out the geographic areas in which the critical habitat designation is unlikely to result in probable incremental economic impacts. In particular, the screening analysis considers baseline costs (*i.e.,* absent critical habitat designation) and includes probable economic impacts where land and water use may be subject to conservation plans, land management plans, best management practices, or regulations that protect the habitat area as a result of the Federal listing status of the species. The screening analysis filters out particular areas of critical habitat that are already subject to such protections and are, therefore, unlikely to incur incremental economic impacts. Ultimately, the screening analysis allows us to focus our analysis on evaluating the specific areas or sectors that may incur probable incremental economic impacts as a result of the designation. The screening analysis also assesses whether units unoccupied by the species may require additional management or conservation efforts as a result of the critical habitat designation, and thus may incur incremental economic impacts. This screening analysis, combined with the information contained in our IEM, constitute our draft economic analysis (DEA) of the proposed critical habitat designation for the Suwannee moccasinshell and is summarized in the narrative below.

Executive Orders 12866 and 13563 direct Federal agencies to assess the costs and benefits of available regulatory alternatives in quantitative (to the extent feasible) and qualitative terms. Consistent with the E.O. regulatory analysis requirements, our effects analysis under the Act may take into consideration impacts to both directly and indirectly affected entities, where practicable and reasonable. If sufficient data are available, we assess to the extent practicable the probable impacts to both directly and indirectly affected entities. As part of our screening analysis, we considered the types of economic activities that are likely to occur within the areas likely affected by the critical habitat designation. In our evaluation of the probable incremental economic impacts that may result from the proposed designation of critical habitat for the Suwannee moccasinshell, first we identified, in the IEM dated June 30, 2016, probable incremental economic impacts associated with the following categories of activities: (1) Groundwater pumping; (2) agriculture; (3) mining; (4) grazing; (5) discharge of chemical pollutants; (6) roadway and bridge construction; (7) in-stream dams and diversions; (8) dredging; (9) commercial or residential development; (10) timber harvest; and (11) removal of large in-channel logs. We considered each industry or category individually. Additionally, we considered whether these activities would have any Federal involvement.

Critical habitat designation generally will not affect activities that do not have any Federal involvement; under the ESA, the designation of critical habitat only affects activities conducted, funded, permitted, or authorized by Federal agencies. In areas where the Suwannee moccasinshell is present, Federal agencies already are required to consult with the Service under section 7 of the Act on activities they fund, permit, or implement that may affect the species. If we finalize this proposed critical habitat designation, consultations to avoid the destruction or adverse modification of critical habitat would be incorporated into the existing consultation process.

In our IEM, we attempted to clarify the distinction between the effects that will result from the species being listed and those attributable to the critical

habitat designation (*i.e.,* difference between the jeopardy and adverse modification standards) for the Suwannee moccasinshell's critical habitat. The following specific circumstances in this case help to inform our evaluation: (1) The physical or biological features identified for occupied critical habitat are the same features essential for the life requisites of the species and (2) any actions that would result in sufficient harm or harassment to constitute jeopardy to the Suwannee moccasinshell would also likely adversely affect the essential physical or biological features of occupied critical habitat. The IEM outlines our rationale concerning this limited distinction between baseline conservation efforts and incremental impacts of the designation of critical habitat for this species.

The proposed critical habitat designation for the Suwannee moccasinshell totals approximately 306 kilometers (190 miles) of stream channels in three units. The riparian lands adjacent to critical habitat are under private (72 percent), State (27 percent), and county (1 percent) ownership. Unit 1 is the only occupied unit and is 61 percent of the total proposed critical habitat designation. As discussed above, in this occupied area, any actions that may affect the species or its habitat would also affect designated critical habitat and it is unlikely that any additional conservation efforts would be recommended to address the adverse modification standard over and above those recommended as necessary to avoid jeopardizing the continued existence of the Suwannee moccasinshell. Therefore, only administrative costs are expected in actions affecting this unit. While this additional analysis will require time and resources by both the Federal action agency and the Service, it is believed that, in most circumstances, these costs, because they are predominantly administrative in nature, would not be significant.

Units 2 and 3 are currently unoccupied by the species but are essential for the conservation of the species. These units total 119 km (78 mi) and comprise 39 percent of the total proposed critical habitat designation. In these unoccupied areas, any conservation efforts or associated probable impacts would be considered incremental effects attributed to the critical habitat designation.

The screening analysis finds that the total annual incremental costs of critical habitat designation for the Suwannee moccasinshell are anticipated to be less than $100,000 per year. The highest costs are anticipated in Unit 3 because it is unoccupied by the species and is not already designated critical habitat for another mussel species (for comparison, see discussion for Unit 2 below). In this unit, the designation is anticipated to result in a small number of additional section 7 consultations (approximately three per year), primarily related to planned transportation projects that intersect the unit. Anticipated project modifications may include minimizing the extent of in-channel maintenance activities, relocation of discharge outfalls, or requiring strict adherence of water quality and habitat protections. Total annual costs to the Service and action agencies for consultations and project modifications in Unit 3 are anticipated to be less than $80,000 annually (Industrial Economics 2017, pp. 9–12).

In Units 1 and 2, the economic costs of implementing the rule will most likely be limited to additional administrative efforts by the Service and action agencies to consider adverse modification. Unit 1 is occupied by the Suwannee moccasinshell, and conservation actions taken in order to be protective of the species would also be sufficient to protect its critical habitat. Unit 2 is also designated as critical habitat for the oval pigtoe, a freshwater mussel with nearly identical physical or biological features to the Suwannee moccasinshell. Conservation efforts taken to protect oval pigtoe critical habitat would also be sufficient to protect Suwannee moccasinshell critical habitat. Thus, additional project modifications are not anticipated in Units 1 and 2. In total, up to six section 7 consultations per year are anticipated to occur in Units 1 and 2, with total costs of less than $20,000 annually (Industrial Economics 2017, pp. 7–9).

Exclusions

Exclusions Based on Economic Impacts

We are soliciting data and comments from the public on the DEA discussed above, as well as all aspects of the proposed rule. During the development of a final designation, we will consider the information presented in the DEA and any additional information on economic impacts received through the public comment period to determine whether any specific areas should be excluded from the final critical habitat designation under authority of section 4(b)(2) and our implementing regulations at 50 CFR 424.19.

Exclusions Based on National Security Impacts

In preparing this proposal, we have determined that none of the lands within the proposed designation of critical habitat for the Suwannee moccasinshell are owned or managed by the Department of Defense or Department of Homeland Security, and, therefore, we anticipate no impact on national security or homeland security. However, during the development of a final designation we will consider any additional information received through the public comment period on the impacts of the proposed designation on national security or homeland security to determine whether any specific areas should be excluded from the final critical habitat designation under authority of section 4(b)(2) and our implementing regulations at 50 CFR 424.19.

Exclusions Based on Other Relevant Impacts

Under section 4(b)(2) of the Act, we consider any other relevant impacts, in addition to economic impacts and impacts on national security. We consider a number of factors, including whether the landowners have developed any HCPs or other management plans for the area, or whether there are conservation partnerships that would be encouraged by designation of, or exclusion from, critical habitat. In addition, we look at any tribal issues, and consider the government-to-government relationship of the United States with tribal entities. We also consider any social impacts that might occur because of the designation.

In preparing this proposal, we have determined that there are currently no HCPs or other management plans for the Suwannee moccasinshell, and the proposed designation does not include any tribal lands or trust resources. Therefore, we anticipate no impact on tribal lands, partnerships, or HCPs from this proposed critical habitat designation. During the development of a final designation, we will consider any additional information received through the public comment period regarding other relevant impacts to determine whether any specific areas should be excluded from the final critical habitat designation under authority of section 4(b)(2) and our implementing regulations at 50 CFR 424.19.

Peer Review

In accordance with our joint policy on peer review published in the **Federal Register** on July 1, 1994 (59 FR 34270), we will seek the expert opinions of at

least three appropriate and independent specialists regarding this proposed rule. The purpose of peer review is to ensure that our critical habitat designation is based on scientifically sound data and analyses. We have invited these peer reviewers to comment during this public comment period.

Public Hearings

Section 4(b)(5) of the Act provides for one or more public hearings on this proposal, if requested. Requests must be received within 45 days after the date of publication of this proposed rule in the **Federal Register**. Such requests must be sent to the address shown in **ADDRESSES**. We will schedule public hearings on this proposal, if any are requested, and announce the dates, times, and places of those hearings, as well as how to obtain reasonable accommodations, in the **Federal Register** and local newspapers at least 15 days before the hearing.

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. The Office of Information and Regulatory Affairs has determined that this rule is not significant.

E.O. 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 have developed this rule in a manner consistent with these requirements.

Regulatory Flexibility Act (5 U.S.C. 601 et seq.)

Under the Regulatory Flexibility Act (RFA; 5 U.S.C. 601 *et seq.*), as amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA; 5 U.S.C. 801 *et seq.*), 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 entities (*i.e.,* small businesses, small organizations, and small government jurisdictions). However, no regulatory flexibility analysis is required if the head of the agency certifies the rule will not have a significant economic impact on a substantial number of small entities. The SBREFA amended the RFA to require Federal agencies to provide a certification statement of the factual basis for certifying that the rule will not have a significant economic impact on a substantial number of small entities.

According to the Small Business Administration, small entities include small organizations such as independent nonprofit organizations; small governmental jurisdictions, including school boards and city and town governments that serve fewer than 50,000 residents; and small businesses (13 CFR 121.201). Small businesses include manufacturing and mining concerns with fewer than 500 employees, wholesale trade entities with fewer than 100 employees, retail and service businesses with less than $5 million in annual sales, general and heavy construction businesses with less than $27.5 million in annual business, special trade contractors doing less than $11.5 million in annual business, and agricultural businesses with annual sales less than $750,000. To determine if potential economic impacts to these small entities are significant, we considered the types of activities that might trigger regulatory impacts under this designation as well as types of project modifications that may result. In general, the term ''significant economic impact'' is meant to apply to a typical small business firm's business operations.

The Service's current understanding of the requirements under the RFA, as amended, and following recent court decisions, is that Federal agencies are only required to evaluate the potential incremental impacts of rulemaking on those entities directly regulated by the rulemaking itself and, therefore, not required to evaluate the potential impacts to indirectly regulated entities. The regulatory mechanism through which critical habitat protections are realized is section 7 of the Act, which requires Federal agencies, in consultation with the Service, to ensure that any action authorized, funded, or carried out by the Agency is not likely to destroy or adversely modify critical habitat. Therefore, under section 7, only Federal action agencies are directly subject to the specific regulatory requirement (avoiding destruction and adverse modification) imposed by critical habitat designation. Consequently, it is our position that only Federal action agencies will be directly regulated by this designation. Moreover, Federal agencies are not small entities. Therefore, because no small entities are directly regulated by this rulemaking, the Service certifies that, if promulgated, the proposed critical habitat designation will not have a significant economic impact on a substantial number of small entities.

In summary, we have considered whether the proposed designation would result in a significant economic impact on a substantial number of small entities. For the above reasons and based on currently available information, we certify that, if promulgated, the proposed critical habitat designation would not have a significant economic impact on a substantial number of small business entities. Therefore, an initial regulatory flexibility analysis is not required.

Energy Supply, Distribution, or Use—Executive Order 13211

Executive Order 13211 (Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use) requires agencies to prepare Statements of Energy Effects when undertaking certain actions. In our economic analysis, we did not find that the designation of this proposed critical habitat will significantly affect energy supplies, distribution, or use. Therefore, this action is not a significant energy action, and no Statement of Energy Effects is required. We will further evaluate this issue if relevant comments are received during the comment period.

Unfunded Mandates Reform Act (2 U.S.C. 1501 et seq.)

In accordance with the Unfunded Mandates Reform Act (2 U.S.C. 1501 *et seq.*), we make the following findings:

(1) This rule will not produce a Federal mandate. In general, a Federal mandate is a provision in legislation, statute, or regulation that would impose an enforceable duty upon State, local, or tribal governments, or the private sector, and includes both ''Federal intergovernmental mandates'' and ''Federal private sector mandates.'' These terms are defined in 2 U.S.C. 658(5)–(7). ''Federal intergovernmental mandate'' includes a regulation that ''would impose an enforceable duty upon State, local, or tribal governments'' with two exceptions. It excludes ''a condition of Federal assistance.'' It also excludes ''a duty arising from participation in a voluntary Federal

program,'' unless the regulation ''relates to a then-existing Federal program under which $500,000,000 or more is provided annually to State, local, and tribal governments under entitlement authority,'' if the provision would ''increase the stringency of conditions of assistance'' or ''place caps upon, or otherwise decrease, the Federal Government's responsibility to provide funding,'' and the State, local, or tribal governments ''lack authority'' to adjust accordingly. At the time of enactment, these entitlement programs were: Medicaid; Aid to Families with Dependent Children work programs; Child Nutrition; Food Stamps; Social Services Block Grants; Vocational Rehabilitation State Grants; Foster Care, Adoption Assistance, and Independent Living; Family Support Welfare Services; and Child Support Enforcement. ''Federal private sector mandate'' includes a regulation that ''would impose an enforceable duty upon the private sector, except (i) a condition of Federal assistance or (ii) a duty arising from participation in a voluntary Federal program.''

The designation of critical habitat does not impose a legally binding duty on non-Federal Government entities or private parties. Under the Act, the only regulatory effect is that Federal agencies must ensure that their actions do not destroy or adversely modify critical habitat under section 7. While non-Federal entities that receive Federal funding, assistance, or permits, or that otherwise require approval or authorization from a Federal agency for an action, may be indirectly impacted by the designation of critical habitat, the legally binding duty to avoid destruction or adverse modification of critical habitat rests squarely on the Federal agency. Furthermore, to the extent that non-Federal entities are indirectly impacted because they receive Federal assistance or participate in a voluntary Federal aid program, the Unfunded Mandates Reform Act would not apply, nor would critical habitat shift the costs of the large entitlement programs listed above onto State governments.

(2) We do not believe that this rule would significantly or uniquely affect small governments because it will not produce a Federal mandate of $100 million or greater in any year, that is, it is not a ''significant regulatory action'' under the Unfunded Mandates Reform Act. The designation of critical habitat imposes no obligations on State or local governments and, as such, a Small Government Agency Plan is not required.

Takings—Executive Order 12630

In accordance with E.O. 12630 (Government Actions and Interference with Constitutionally Protected Private Property Rights), we have analyzed the potential takings implications of designating critical habitat for the Suwannee moccasinshell in a takings implications assessment. The Act does not authorize the Service to regulate private actions on private lands or confiscate private property as a result of critical habitat designation. Designation of critical habitat does not affect land ownership, or establish any closures, or restrictions on use of or access to the designated areas. Furthermore, the designation of critical habitat does not affect landowner actions that do not require Federal funding or permits, nor does it preclude development of habitat conservation programs or issuance of incidental take permits to permit actions that do require Federal funding or permits to go forward. However, Federal agencies are prohibited from carrying out, funding, or authorizing actions that would destroy or adversely modify critical habitat. A takings implications assessment has been completed and concludes that this designation of critical habitat for Suwannee moccasinshell does not pose significant takings implications for lands within or affected by the designation.

Federalism—Executive Order 13132

In accordance with E.O. 13132 (Federalism), this proposed rule does not have significant Federalism effects. A Federalism assessment is not required. In keeping with Department of the Interior and Department of Commerce policy, we requested information from, and coordinated development of this proposed critical habitat designation with, appropriate State resource agencies in Florida and Georgia. From a federalism perspective, the designation of critical habitat directly affects only the responsibilities of Federal agencies. The Act imposes no other duties with respect to critical habitat, either for States and local governments, or for anyone else. As a result, the rule does not have substantial direct effects either on the States, or on the relationship between the national government and the States, or on the distribution of powers and responsibilities among the various levels of government. The designation may have some benefit to these governments because the areas that contain the features essential to the conservation of the species are more clearly defined, and the physical or biological features of the habitat necessary to the conservation of the species are specifically identified. This information does not alter where and what federally sponsored activities may occur. However, it may assist these local governments in long-range planning (because these local governments no longer have to wait for case-by-case section 7 consultations to occur).

Where State and local governments require approval or authorization from a Federal agency for actions that may affect critical habitat, consultation under section 7(a)(2) would be required. While non-Federal entities that receive Federal funding, assistance, or permits, or that otherwise require approval or authorization from a Federal agency for an action, may be indirectly impacted by the designation of critical habitat, the legally binding duty to avoid destruction or adverse modification of critical habitat rests squarely on the Federal agency.

Civil Justice Reform—Executive Order 12988

In accordance with Executive Order 12988 (Civil Justice Reform), the Office of the Solicitor has determined that the rule does not unduly burden the judicial system and that it meets the requirements of sections 3(a) and 3(b)(2) of the Order. We have proposed designating critical habitat in accordance with the provisions of the Act. To assist the public in understanding the habitat needs of the species, the rule identifies the elements of physical or biological features essential to the conservation of the species. The designated areas of critical habitat are presented on maps, and the rule provides several options for the interested public to obtain more detailed location information, if desired.

Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.)

This rule does not contain any new collections of information that require approval by OMB under 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 currently valid OMB control number.

National Environmental Policy Act (42 U.S.C. 4321 et seq.)

It is our position that, outside the jurisdiction of the U.S. Court of Appeals for the Tenth Circuit, we do not need to prepare environmental analyses pursuant to the National Environmental Policy Act in connection with designating critical habitat under the Act. We published a notice outlining

our reasons for this determination in the **Federal Register** on October 25, 1983 (48 FR 49244). This position was upheld by the U.S. Court of Appeals for the Ninth Circuit (*Douglas County* v. *Babbitt,* 48 F.3d 1495 (9th Cir. 1995), cert. denied 516 U.S. 1042 (1996)).

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), Executive Order 13175 (Consultation and Coordination With Indian Tribal Governments), and the Department of the Interior's manual at 512 DM 2, we readily acknowledge our responsibility to communicate meaningfully with recognized Federal Tribes on a government-to-government basis. In accordance with Secretarial Order 3206 of June 5, 1997 (American Indian Tribal Rights, Federal-Tribal Trust Responsibilities, and the Endangered Species Act), we readily acknowledge our responsibilities to work directly with tribes in developing programs for healthy ecosystems, to acknowledge that tribal lands are not subject to the same controls as Federal public lands, to remain sensitive to Indian culture, and to make information available to tribes.

As stated above (see *Exclusions Based on Other Relevant Impacts,* above), we have determined that no tribal lands or interests are affected by this proposed designation.

Clarity of the Rule

We are required by Executive Orders 12866 and 12988 and by the Presidential Memorandum of June 1, 1998, to write all rules in plain language. This means that each rule we publish must:

(1) Be logically organized;

(2) Use the active voice to address readers directly;

(3) Use clear language rather than jargon;

(4) Be divided into short sections and sentences; and

(5) Use lists and tables wherever possible.

If you feel that we have not met these requirements, send us comments by one of the methods listed in **ADDRESSES**. To better help us revise the rule, your comments should be as specific as possible. For example, you should tell us the numbers of the sections or paragraphs that are unclearly written, which sections or sentences are too long, the sections where you feel lists or tables would be useful, etc.

References Cited

A complete list of references cited in this rulemaking is available on the internet at *http://www.regulations.gov* and upon request from the Panama City Ecological Services Field Office (see **FOR FURTHER INFORMATION CONTACT**).

Authors

The primary authors of this proposed rulemaking are the staff members of the Panama City Ecological Services Field Office.

List of Subjects in 50 CFR Part 17

Endangered and threatened species, Exports, Imports, Reporting and recordkeeping requirements, Transportation.

Proposed Regulation Promulgation

Accordingly, we propose to amend part 17, subchapter B of chapter I, title 50 of the Code of Federal Regulations, as set forth below:

PART 17—ENDANGERED AND THREATENED WILDLIFE AND PLANTS

■ 1. The authority citation for part 17 continues to read as follows:

Authority: 16 U.S.C. 1361–1407; 1531–1544; and 4201–4245; unless otherwise noted.

■ 2. In § 17.11(h), revise the entry for ''Moccasinshell, Suwannee'' under ''CLAMS'' in the List of Endangered and Threatened Wildlife to read as follows:

§ 17.11 Endangered and threatened wildlife.

* * * * *

(h) * * *

Common name	Scientific name	Where listed	Status	Listing citations and applicable rules
*	*	*	*	*
CLAMS				
*	*	*	*	*
Moccasinshell, Suwannee	*Medionidus walkeri*	Wherever found	T	81 FR 69417, 10/6/2016; 50 CFR 17.95(f).CH
*	*	*	*	*

■ 3. In § 17.95, amend paragraph (f) by adding an entry for ''Suwannee moccasinshell (*Medionidus walkeri*),'' in the same alphabetical order that the species appears in the table at § 17.11(h), to read as follows:

§ 17.95 Critical habitat—fish and wildlife.

* * * * *

(f) *Clams and Snails.*

* * * * *

Suwannee Moccasinshell (*Medionidus walkeri*)

(1) Critical habitat units are depicted on the maps below for Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Madison, Suwannee, and Union Counties, Florida; and Brooks and Lowndes Counties, Georgia.

(2) Within these areas, the physical or biological features essential to the conservation of Suwannee moccasinshell consist of the following components:

(i) Geomorphically stable stream channels (channels that maintain lateral dimensions, longitudinal profiles, and sinuosity patterns over time without an aggrading or degrading bed elevation).

(ii) Stable substrates of muddy sand or mixtures of sand and gravel, and with little to no accumulation of unconsolidated sediments and low amounts of filamentous algae.

(iii) A natural hydrologic flow regime (magnitude, frequency, duration, and seasonality of discharge over time) necessary to maintain benthic habitats where the species is found, and connectivity of stream channels with the floodplain, allowing the exchange of nutrients and sediment for habitat maintenance, food availability, and spawning habitat for native fishes.

(iv) Water quality conditions needed to sustain healthy Suwannee moccasinshell populations, including low pollutant levels (not less than State criteria), a natural temperature regime, pH (between 6.0 to 8.5), adequate oxygen content (not less than State criteria), hardness, turbidity, and other

chemical characteristics necessary for normal behavior, growth, and viability of all life stages.

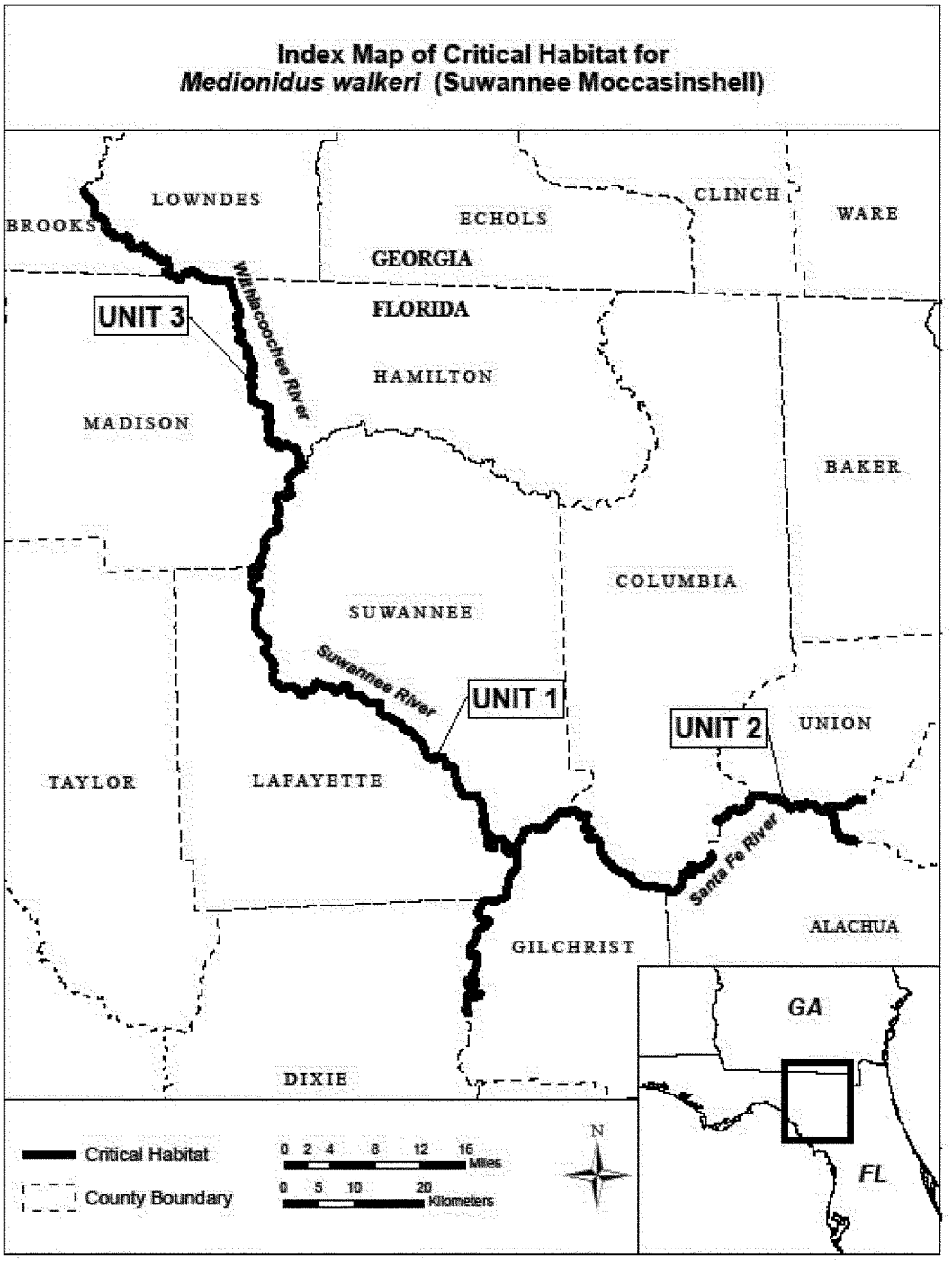
(v) The presence of fish hosts necessary for recruitment of the Suwannee moccasinshell. The presence of blackbanded darters (*Percina nigrofasciata*) and brown darters (*Etheostoma edwini*) will serve as an indication of fish host presence.

(3) Critical habitat does not include manmade structures (such as buildings, aqueducts, dams, roads, and other paved areas) and the land on which they are located existing within the legal boundaries on [EFFECTIVE DATE OF THE FINAL RULE].

(4) *Critical habitat map units.* Data layers defining map units were created with USGS National Hydrography Dataset GIS data. The high-resolution 1:24,000 flowlines were used to calculate river kilometers and miles. ESRIs ArcGIS 10.2.2 software was used to determine longitude and latitude coordinates using decimal degrees. The projection used in mapping all units was Universal Transverse Mercator, NAD 83, Zone 16 North. The maps in this entry, as modified by any accompanying regulatory text, establish the boundaries of the critical habitat designation. The coordinates on which each map is based are provided in the critical habitat unit descriptions and are available at the Service's internet site, (*http://www.fws.gov/panamacity*), (*http://www.regulations.gov*) at Docket No. FWS–R4–ES–2019–0059, and at the field office responsible for this designation. You may obtain field office location by contacting one of the Service regional offices, the addresses of which are listed at 50 CFR 2.2.

(5) *Note:* Index map of critical habitat units for the Suwannee moccasinshell in Florida and Georgia follows:

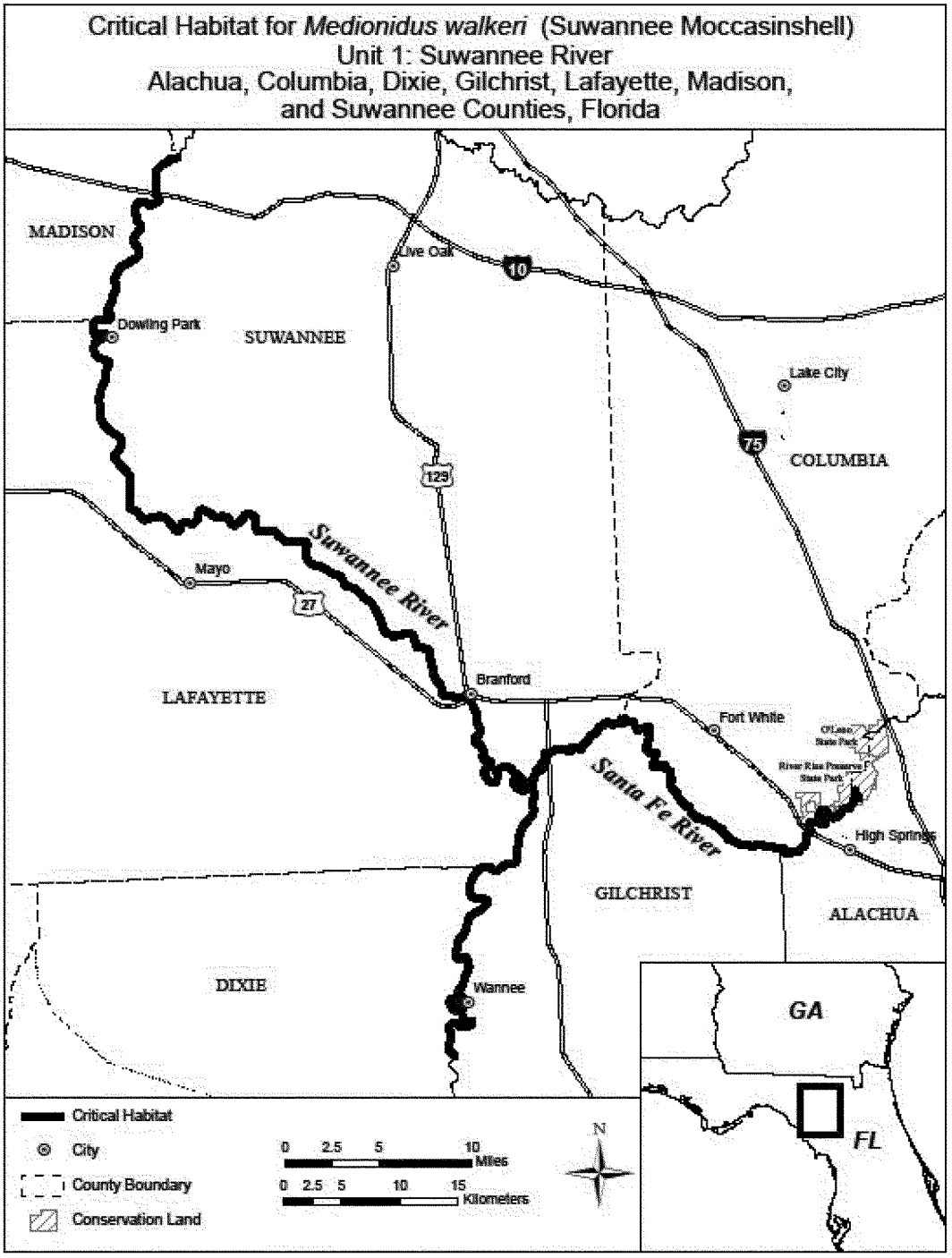
BILLING CODE 4333–15–P



(6) Unit 1: Suwannee River in Alachua, Columbia, Dixie, Gilchrist, Lafayette, Madison, and Suwannee Counties, Florida.

(i) *General description:* Unit 1 consists of approximately 187 kilometers (km) (116 miles (mi)) of the Suwannee River and lower Santa Fe River in Alachua, Columbia, Dixie, Gilchrist, Lafayette, Madison, and Suwannee Counties, Florida. The unit includes the Suwannee River mainstem from the confluence of Hart Springs (−82.954, 29.676) in Dixie-Gilchrist Counties, upstream 137 km (85 mi) to the confluence of the Withlacoochee River (−83.171, 30.385) in Madison-Suwannee Counties; and the Santa Fe River from its confluence with the Suwannee River in Suwannee-Gilchrist Counties (−82.879, 29.886), upstream 50 km (31 mi) to the river's rise (the Santa Fe River runs underground for more than 3 miles, emerging at River Rise Preserve State Park) in Alachua County (−82.591, 29.873).

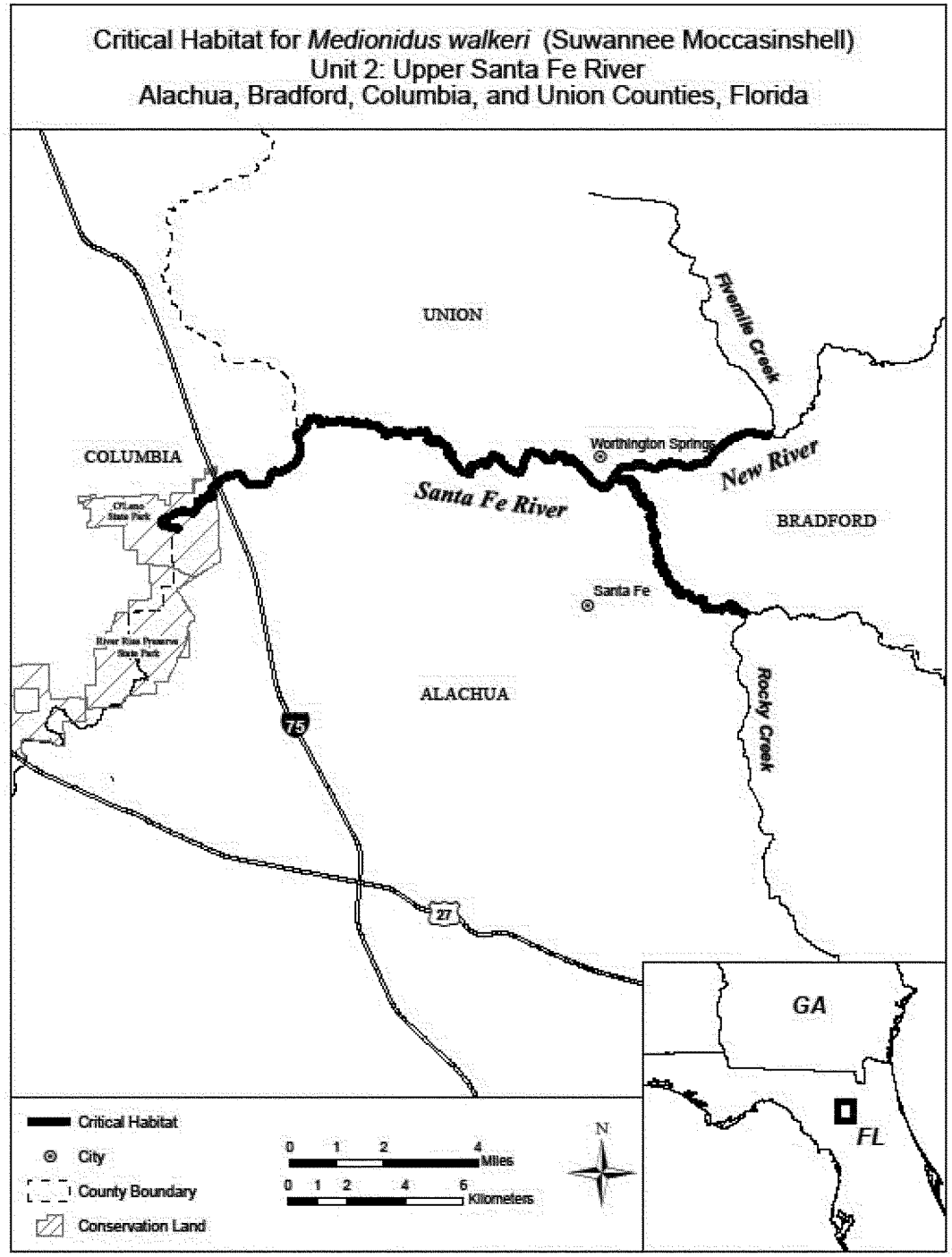
(ii) Map of Unit 1, Suwannee River, follows:



(7) Unit 2: Upper Santa Fe River in Alachua, Bradford, Columbia, and Union, Counties, Florida.

(i) The Upper Santa Fe River Unit consists of approximately 43 km (27 mi) of the Santa Fe River and New River in Alachua, Bradford, Columbia, and Union Counties, Florida. The unit includes the Santa Fe River from the river's sink (−82.572, 29.912) in Alachua County, upstream 36.5 km (23 mi) to the confluence of Rocky Creek (−82.373, 29.879) in Bradford-Alachua Counties; and the New River from its confluence with the Santa Fe River (−82.418, 29.923), upstream 6.5 km (4 mi) to the confluence of Five Mile Creek (−82.362, 29.934) in Union-Bradford Counties.

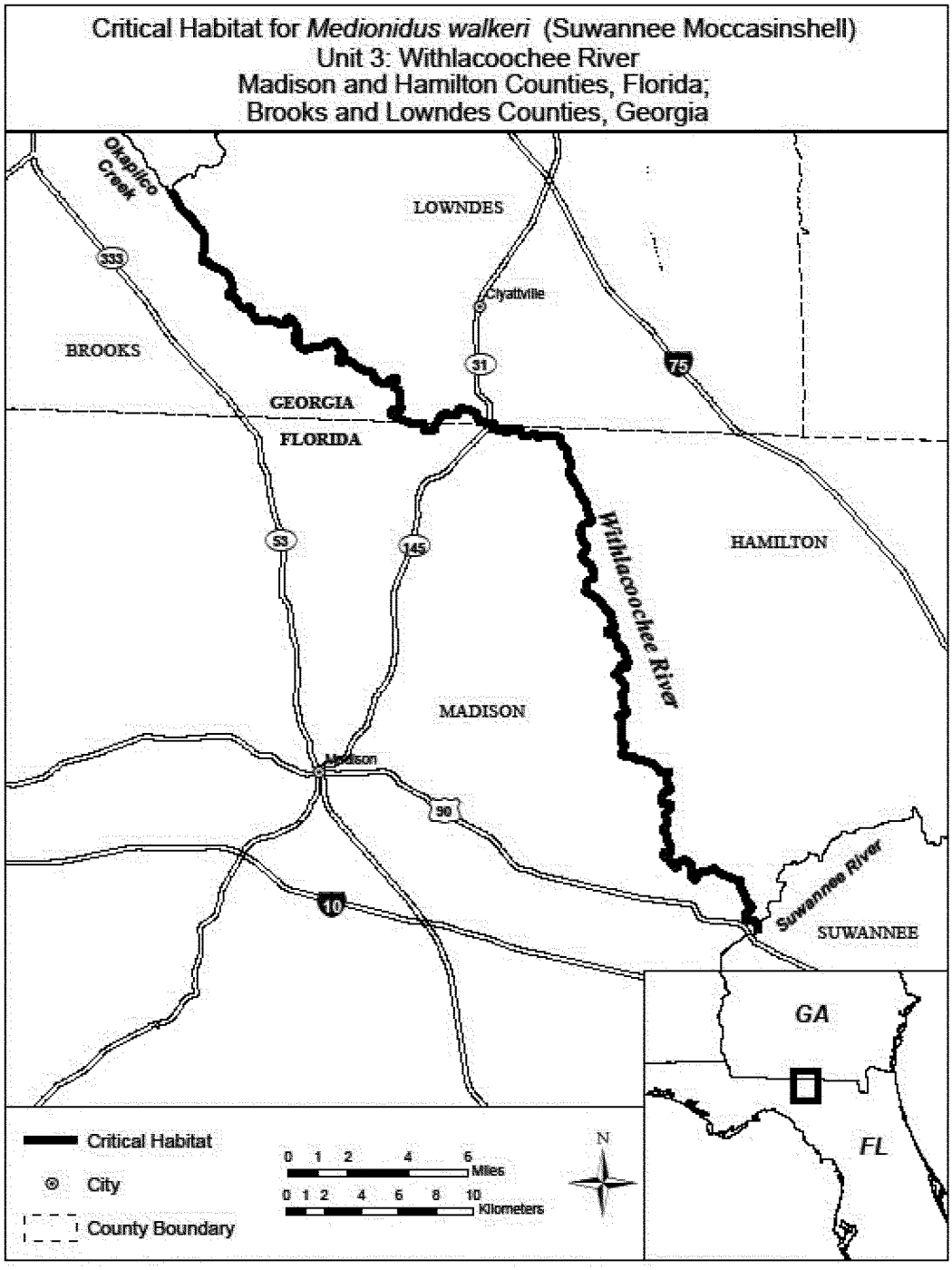
(ii) Map of Unit 2, Upper Santa Fe River, follows:



(8) Unit 3: Withlacoochee River in Hamilton and Madison Counties, Florida; Brooks and Lowndes Counties, Georgia.

(i) The Withlacoochee River Unit consists of approximately 75.5 km (47 mi) of the Withlacoochee River in Hamilton and Madison Counties, Florida, and Brooks and Lowndes Counties, Georgia. The unit includes the Withlacoochee River from its confluence with the Suwannee River (−83.171, 30.385) in Madison-Hamilton Counties, FL, upstream 75.5 km (47 mi) to the confluence of Okapilco Creek (−83.484, 30.752) in Brooks–Lowndes Counties, GA.

(ii) Map of Unit 3, Withlacoochee River, follows:



* * * * *

Dated: November 18, 2019.

Margaret E. Everson,

Principal Deputy Director, U.S. Fish and Wildlife Service, Exercising the authority of the Director, U.S. Fish and Wildlife Service.

[FR Doc. 2019–25598 Filed 11–26–19; 8:45 am]

BILLING CODE 4333–15–C

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Parts 223, 224, and 226

[Docket No. 191121–0087]

RIN 0648–BI06

Endangered and Threatened Wildlife and Plants: Proposed Rule To Designate Critical Habitat for the Central America, Mexico, and Western North Pacific Distinct Population Segments of Humpback Whales

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Extension of public comment period; notice of public hearing.

SUMMARY: NMFS announces the extension of the public comment period on the proposed rule to designate critical habitat for the Central America, Mexico, and Western North Pacific distinct population segments (DPSs) of humpback whales (*Megaptera novaeangliae*). We also announce that an additional public hearing will be held on this proposed rule.

DATES: The deadline for receipt of comments is extended to January 31, 2020. A public hearing will be held on January 6, 2020, from 4 p.m. to 7 p.m. (local time) in Petersburg, Alaska.

ADDRESSES: You may submit data, information, or written comments on the proposed rule, identified by NOAA–NMFS–2019–0066, and on the supplemental documents by the following methods:

Electronic Submission: Submit all electronic comments via the Federal eRulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2019-0066,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.

Mail: Submit written comments to Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service, 1315 East West Highway (SSMC3), Silver Spring, MD 20910, Attn: Humpback Whale Critical Habitat Proposed Rule.

Instructions: Comments sent by any other method than the above (except if provided during a public hearing), to any other address or individual, or received after the end of the comment period, might not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. We will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Public Hearing: A public hearing will be held on January 6, 2020, in the Petersburg Borough Assembly Chambers, 12 South Nordic Drive, Petersburg, Alaska 99833.

Supporting Documents: Documents supporting this proposed rule, which include a Draft Biological Report (NMFS 2019a), a Draft Economic Analysis (IEc 2019a), and a Draft Section 4(b)(2) Report (NMFS 2019b), are available on the Federal e-Rulemaking Portal, *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2019-0066.*

FOR FURTHER INFORMATION CONTACT: Lisa Manning, NMFS, Office of Protected Resources, 301–427–8466.

SUPPLEMENTARY INFORMATION:

Background

On October 9, 2019, we published a proposed rule to designate critical habitat for the endangered Western North Pacific DPS, the endangered Central America DPS, and the threatened Mexico DPS of humpback whales under the ESA (84 FR 54354). Areas proposed as critical habitat include specific marine areas located off the coasts of California, Oregon, Washington, and Alaska. Based on consideration of national security and economic impacts, we also have proposed to exclude multiple areas from the designation for each DPS. The deadline for submission of public comments on this proposed rule and the supporting documents was originally scheduled for December 9, 2019. Following receipt of several requests, we are extending the deadline for submission of public comments to January 31, 2020. This extension will help ensure that the proposed rule and supporting documents undergo thorough and robust review.

Public Hearings

A series of five public hearings was announced in the **Federal Register** on October 17, 2019 (84 FR 55530). In response to several requests, we are scheduling a sixth public hearing in Petersburg, Alaska, on January 6, 2020. See **DATES** and **ADDRESSES** sections for further details. We will be offering remote access to this hearing via a webinar. For instructions on how to access this hearing remotely, please contact Lisa Manning (see **FOR FURTHER INFORMATION CONTACT**).

The public hearing will begin with a brief presentation by NMFS to provide an overview of critical habitat under the ESA and a summary of the proposed critical habitat designations for humpback whales. Following the presentation, members of the public will have the opportunity to provide oral comments on the record regarding the proposed designations. Members of the public will also have the opportunity to submit written comments at the hearing. Written comments may also be submitted at any time during the public comment period; see **ADDRESSES** section for more details. Note that all comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, *etc.*), confidential business information, or otherwise sensitive information submitted voluntarily by the commenter will be publicly accessible.

Reasonable Accommodations

People needing accommodations so that they may attend and participate at the public hearing should submit a request for reasonable accommodations as soon as possible, and no later than 7 business days prior to the hearing date, by contacting Lisa Manning (see **FOR FURTHER INFORMATION CONTACT**).

Authority: 16 U.S.C. 1531 *et seq.*

Dated: November 21, 2019.

Samuel D. Rauch III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

[FR Doc. 2019–25759 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

Notices

Federal Register

Vol. 84, No. 229

Wednesday, November 27, 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.

ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

Notice of Public Meeting of the Assembly of the Administrative Conference of the United States

AGENCY: Administrative Conference of the United States.

ACTION: Notice.

SUMMARY: Pursuant to the Federal Advisory Committee Act (5 U.S.C. App.), the Assembly of the Administrative Conference of the United States will hold a meeting to consider five proposed recommendations and to conduct other business. This meeting will be open to the public.

DATES: The meeting will take place on Thursday, December 12, 2019, 9:30 a.m. to 5:30 p.m. The meeting may adjourn early if all business is finished.

ADDRESSES: The meeting will be held at The George Washington University Law School (GW Law), 2000 H Street NW, Washington, DC 20052 (Jacob Burns Moot Court Room).

FOR FURTHER INFORMATION CONTACT: Shawne McGibbon, General Counsel (Designated Federal Officer), Administrative Conference of the United States, Suite 706 South, 1120 20th Street NW, Washington, DC 20036; Telephone 202–480–2088; email *smcgibbon@acus.gov.*

SUPPLEMENTARY INFORMATION: The Administrative Conference of the United States makes recommendations to federal agencies, the President, Congress, and the Judicial Conference of the United States regarding the improvement of administrative procedures (5 U.S.C. 594). The membership of the Conference, when meeting in plenary session, constitutes the Assembly of the Conference (5 U.S.C. 595).

Agenda: The Assembly will consider five proposed recommendations as described below:

Agency Economists. This proposed recommendation addresses the placement of economists within rule-writing agencies (*e.g.,* centralized v. dispersed throughout the agency) and explores methods for promoting high-quality economic analysis within each of the possible organizational structures. Each possible structure has strengths and weaknesses that can affect the flow of information between economists and decision-makers. The proposed recommendation does not endorse any one organizational structure over another but identifies steps agencies can take to remove structural barriers that can impede the communication of objective, consistent, and high-quality economic analysis during the rulemaking process.

Internet Evidence in Agency Adjudication. This proposed recommendation addresses agency adjudicators' increasing reliance on their own factual research—especially internet research—when conducting hearings and deciding cases. Though such independent research can be an efficient means to acquire facts, it can also raise concerns regarding the accuracy of information uncovered and fairness to the litigants. The proposed recommendation urges agencies to develop publicly available policies on independent research that, among other things, identify sources of information that are reliable in all cases, set forth standards for adjudicators to apply when assessing the reliability of other sources, and ensure that litigants have ready access to all sources.

Acting Agency Officials and Delegations of Authority. This proposed recommendation offers agencies best practices for promoting greater transparency and compliance with the Federal Vacancies Reform Act of 1998 when a Senate-confirmed position sits vacant. It also addresses the use of delegations of authority in the face of staffing vacancies. It urges agencies to determine whether the agency is subject to the Vacancies Act and, if so, establish compliance processes; improve transparency by disclosing on their websites information about acting officials and delegations of authority; and provide additional support and training to agency officials responsible for Vacancies Act compliance.

Listing Agency Officials. This proposed recommendation promotes the public availability of real-time information about high-level officials leading federal agencies. It encourages agencies to publish on their websites basic information about high-level agency leaders and identify vacant leadership positions and acting officials. It also recommends that the Office of Personnel Management publish on its website a monthly list of high-level agency leaders, as well as an archival list of former Senate-confirmed presidential appointees.

Recruiting and Hiring Agency Attorneys. This proposed recommendation offers best practices for agencies to recruit and hire attorneys. First, it notes that agencies are not bound by certain procedural requirements that apply to the hiring of other kinds of employees. Then, among other suggestions, it advises agencies to post and disseminate announcements widely when they seek broad applicant pools; write announcements clearly and concisely; communicate to applicants any limitations on the number of applicants the agency will consider; establish policies for reviewing applications and interviewing candidates; and decide, in the period before an attorney's adverse action rights accrue, whether to retain the attorney after the period elapses.

Additional information about the proposed recommendations and the order of the agenda, as well as other materials related to the meeting, can be found at the 72nd Plenary Session page on the Conference's website: *https://www.acus.gov/meetings-and-events/plenary-meeting/72nd-plenary-session.*

Public Participation: The Conference welcomes the attendance of the public at the meeting, subject to space limitations, and will make every effort to accommodate persons with disabilities or special needs. Members of the public who wish to attend in person are asked to RSVP online at the 72nd Plenary Session web page shown above, no later than two days before the meeting, in order to facilitate entry and to ensure adequate seating. Members of the public who attend the meeting may be permitted to speak only with the consent of the Chairman and the unanimous approval of the members of

the Assembly. If you need special accommodations due to disability, please inform the Designated Federal Officer noted above at least seven days in advance of the meeting. The public may also view the meeting on GW Law's YouTube Channel: *https://youtube.com/user/gwlawschool.* Alternatively, an archived video recording of the meeting will be available on the Conference's website shortly after the conclusion of the event: *https://livestream.com/ACUS.*

Written Comments: Persons who wish to comment on any of the proposed recommendations may do so by submitting a written statement either online by clicking ''Submit a comment'' on the 72nd Plenary Session web page shown above or by mail addressed to: December 2019 Plenary Session Comments, Administrative Conference of the United States, Suite 706 South, 1120 20th Street NW, Washington, DC 20036. Written submissions must be received no later than 10:00 a.m. (EDT), Thursday, December 5, 2019, to ensure consideration by the Assembly.

Dated: November 22, 2019.

Shawne McGibbon,

General Counsel.

[FR Doc. 2019–25777 Filed 11–26–19; 8:45 am]

BILLING CODE 6110–01–P

DEPARTMENT OF AGRICULTURE

Submission for OMB Review; Comment Request

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments are requested regarding: 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; the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; ways to enhance the quality, utility and clarity of the information to be collected; and ways to 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 and other forms of information technology.

Comments regarding this information collection received by December 27, 2019 will be considered. Written comments should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), New Executive Office Building, 725 17th Street NW, Washington, DC 20503. Commentors are encouraged to submit their comments to OMB via email to: *OIRA_Submission@omb.eop.gov* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Copies of the submission(s) may be obtained by calling (202) 720–8681.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Forest Service

Title: Application and Permit for Non-Federal Commercial Use of Roads, Trails and Areas Restricted by Regulation or Order.

OMB Control Number: 0596–0016.

Summary of Collection: Authority for permits for use of National Forest System (NFS) roads, trails, and areas on NFS lands restricted by order or regulation drives from the National Forest Roads and Trails Act (16 U.S.C. 532–538). This statute authorizes the Secretary of Agriculture to promulgate regulations regarding use of NFS roads, NFS trails, and areas on NFS lands; established procedures for sharing investments in NFS roads; and require commercial users to perform road maintenance commensurate with their use of NFS roads. Forest Service regulations implementing this authority are found in 36 CFR 212.5, 212.9, 212.51, 261.10, 261.12, 261.13, 261.54, and 261.55.

Need and Use of the Information: Information is collected from individuals, corporations, or organizations who want to use a NFS Road, Trail or Area for purposes that are restricted. Form FS–7700–40 ''Application for a Permit for Use of Roads, Trails and Areas Restricted by Regulation or Order'' along with FS–7700–40a ''Commercial Use Attachment'' or FS–7700–40b ''Oversize Vehicle Attachment'' if applicable. The forms provide identifying information about the applicant such as, the name; address; and telephone number; description of mileage of roads; purpose of use; use schedule; and plans for future use. FS will use the information to prepare the applicant's permit, FS–7700–41 or FS–7700–48, to identify the road maintenance that is the direct result of the applicant's traffic, to calculate any applicable collections for recovery of past Federal investments in roads and assure that the requirements are met. Without the information FS would not be able to issue permits for moving oversize vehicles on FNS roads, permits to enter areas subject to areas for closures, or permits for motorized use of roads, trails, or areas not designated for such use on a motor vehicle use map.

Description of Respondents: Business or other for-profit; Individuals or households; State, Local or Tribal Government; Not-for-profit institutions.

Number of Respondents: 1,100.

Frequency of Responses: Reporting: On occasion.

Total Burden Hours: 275.

Kimble Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2019–25811 Filed 11–26–19; 8:45 am]

BILLING CODE 3411–15–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B–47–2019]

Foreign-Trade Zone (FTZ) 201—Holyoke, Massachusetts; Authorization of Production Activity; ProAmpac Holdings, Inc. (Flexible Packaging Applications); Westfield, Massachusetts

On July 25, 2019, The Holyoke Economic Development and Industrial Corporation, grantee of FTZ 201, submitted a notification of proposed production activity to the FTZ Board on behalf of ProAmpac Holdings, Inc., within FTZ 201, in Westfield, Massachusetts.

The notification was processed in accordance with the regulations of the FTZ Board (15 CFR part 400), including notice in the **Federal Register** inviting public comment (84 FR 37831, August 2, 2019). On November 22, 2019, the applicant was notified of the FTZ Board's decision that no further review of the activity is warranted at this time. The production activity described in the notification was authorized, subject to the FTZ Act and the FTZ Board's regulations, including Section 400.14.

Dated: November 22, 2019.

Elizabeth Whiteman,

Acting Executive Secretary.

[FR Doc. 2019–25771 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–433–813 and A–427–830]

Strontium Chromate From Austria and France: Antidumping Duty Orders

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: Based on affirmative final determinations by the Department of Commerce (Commerce) and the International Trade Commission (ITC), Commerce is issuing antidumping duty orders on strontium chromate from Austria and France.

DATES: Applicable November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Joshua Simonidis or Dennis McClure, AD/CVD Operations, Office VIII, Enforcement and Compliance, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone (202) 482–0608 or (202) 482–5973, respectively.

SUPPLEMENTARY INFORMATION:

Background

In accordance with sections 735(d) and 777(i)(1) of the Tariff Act of 1930, as amended (the Act), and 19 CFR 351.210(c), on October 8, 2019, Commerce published its affirmative final determinations in the less-than-fair-value (LTFV) investigations of strontium chromate from Austria and France.[1] On November 21, 2019, the ITC notified Commerce of its affirmative determinations, pursuant to section 735(d) of the Act, that an industry in the United States is materially injured within the meaning of section 735(b)(1)(A)(i) of the Act, by reason of the LTFV imports of strontium chromate from Austria and France.[2]

Scope of the Orders

The merchandise covered by these orders is strontium chromate from Austria and France. For a complete description of the scope of the orders, *see* the Appendix to this notice.

Antidumping Duty Orders

As stated above, on November 21, 2019, in accordance with sections 735(b)(1)(A)(i) and 735(d) of the Act, the ITC notified Commerce of its determination that the industry in the United States producing strontium chromate is materially injured with respect to strontium chromate from Austria and France.[3] Therefore, in accordance with section 735(c)(2) of the Act, we are issuing these antidumping duty orders. Because the ITC determined that imports of strontium chromate from Austria and France are materially injuring a U.S. industry, unliquidated entries of such merchandise from Austria and France, entered or withdrawn from warehouse for consumption, are subject to the assessment of antidumping duties.

Therefore, in accordance with section 736(a)(1) of the Act, Commerce will direct U.S. Customs and Border Protection (CBP) to assess, upon further instruction by Commerce, antidumping duties equal to the amount by which the normal value of the merchandise exceeds the export price (or constructed export price) of the merchandise, for all relevant entries of strontium chromate from Austria and France. Antidumping duties will be assessed on unliquidated entries of strontium chromate from France entered, or withdrawn from warehouse, for consumption on or after May 17, 2019, the date of publication of the preliminary determination,[4] and on unliquidated entries of strontium chromate from Austria entered or withdrawn from warehouse, for consumption on or after June 18, 2019, the date of publication of the amended preliminary determination,[5] but will not include entries occurring after the expiration of the provisional measures period and before publication in the **Federal Register** of the ITC's injury determinations.

Suspension of Liquidation

In accordance with section 735(c)(1)(B) of the Act, we will instruct CBP to continue to suspend liquidation, and resume suspension of liquidation, on all relevant entries of strontium chromate from Austria and France, respectively, which are entered, or withdrawn from warehouse, for consumption on or after the date of publication of the ITC's notice of final determination in the **Federal Register**. These instructions suspending liquidation will remain in effect until further notice.

We will also instruct CBP to require cash deposits for estimated antidumping duties equal to the amounts as indicated below. Accordingly, effective on the date of publication in the **Federal Register** of the ITC's affirmative injury determinations, CBP will require, at the same time as importers would normally deposit estimated normal customs duties on this subject merchandise, a cash deposit equal to the estimated weighted-average dumping margins listed below.[6] The relevant all-others rates apply to all producers or exporters not specifically listed, as appropriate.

Provisional Measures

Section 733(d) of the Act states that instructions issued pursuant to an affirmative preliminary determination may not remain in effect for more than four months, except where exporters representing a significant proportion of exports of the subject merchandise request Commerce to extend that four-month period to no more than six months. At the request of exporters that account for a significant proportion of exports of strontium chromate from Austria and France, we extended the four-month period to six months in each proceeding.[7] In the France investigation, Commerce published the preliminary determinations on May 17, 2019.[8] Therefore, the extended period, beginning on the date of publication of the preliminary determination, ended on November 13, 2019.

In accordance with section 733(d) of the Act and our practice, we will instruct CBP to terminate the suspension of liquidation and to liquidate, without regard to antidumping duties, unliquidated entries of strontium chromate from France entered, or withdrawn from warehouse, for consumption after November 13, 2019, the date on which the provisional measures expired, until and through the day preceding the date of publication of the ITC's injury determinations in the **Federal Register**. Suspension of liquidation will resume on the date of publication of the ITC's determination in the **Federal Register**, as discussed above.

[1] *See Strontium Chromate From Austria: Final Affirmative Determination of Sales at Less Than Fair Value,* 84 FR 53676 (October 8, 2019) (*Austria Final Determination*); *see also Strontium Chromate From France: Final Affirmative Determination of Sales at Less Than Fair Value and Final Negative Determination of Critical Circumstances,* 84 FR 53678 (October 8, 2019) *(France Final Determination*).

[2] *See* Notification Letter from the ITC, dated November 21, 2019.

[3] *Id.*

[4] *See Strontium Chromate From France: Preliminary Affirmative Determination of Sales at Less Than Fair Value, Preliminary Negative Determination of Critical Circumstances, Postponement of Final Determination, and Extension of Provisional Measures,* 84 FR 22438 (May 17, 2019) (*France Preliminary Determination*).

[5] *See Strontium Chromate From Austria: Amended Preliminary Determination of Sales at Less Than Fair Value,* 84 FR 28272 (June 18, 2019) (*Austria Amended Preliminary Determination*). *See also Strontium Chromate from Austria: Preliminary Determination of Sales at Not Less Than Fair Value and Postponement of Final Determination,* 84 FR 22443 (May 17, 2019) (*Austria Preliminary Determination*).

[6] *See* section 736(a)(3) of the Act.

[7] *See France Preliminary Determination; see also Austria Amended Preliminary Determination.*

[8] *See France Preliminary Determination.*

In the Austria investigation, Commerce published the amended preliminary determination on June 18, 2019.[9] Therefore, the extended provisional measures period for Austria, beginning on the date of publication of the amended preliminary determination, expires on December 15, 2019. Accordingly, provisional measures for Austria will likely continue until and through the day preceding the date of publication of the ITC's injury determinations in the **Federal Register**. Suspension of liquidation will continue on the date of publication of the ITC's determination in the **Federal Register**, as discussed above.

Estimated Weighted-Average Dumping Margins

The weighted-average dumping margins are as follows:

	Producer/exporter	Estimated weighted-average dumping margin (percent)
Austria	Habich GmbH	25.90
	All Others	25.90
France	Société Nouvelle des Couleurs Zinciques.	32.16
	All Others	32.16

Notifications to Interested Parties

This notice constitutes the antidumping duty orders with respect to strontium chromate from Austria and France pursuant to section 736(a) of the Act. Interested parties can find a list of antidumping duty orders currently in effect at *http://enforcement.trade.gov/stats/iastats1.html.*

These orders are issued and published in accordance with section 736(a) of the Act and 19 CFR 351.211(b).

Dated: November 22, 2019.

Jeffrey I. Kessler,

Assistant Secretary for Enforcement and Compliance.

Appendix

Scope of the Orders

The merchandise covered by these orders is strontium chromate, regardless of form (including but not limited to, powder (sometimes known as granular), dispersions (sometimes known as paste), or in any solution). The chemical formula for strontium chromate is SrCrO4 and the Chemical Abstracts Service (CAS) registry number is 7789–06–2.

Strontium chromate that has been blended with another product or products is included in the scope if the resulting mix contains 15 percent or more of strontium chromate by total formula weight. Products with which strontium chromate may be blended include, but are not limited to, water and solvents such as Aromatic 100 Methyl Amyl Ketone (MAK)/2-Heptanone, Acetone, Glycol Ether EB, Naphtha Leicht, and Xylene. Subject merchandise includes strontium chromate that has been processed in a third country into a product that otherwise would be within the scope of these orders if processed in the country of manufacture of the in-scope strontium chromate.

The merchandise subject to these orders is currently classified in the Harmonized Tariff Schedule of the United States (HTSUS) under subheading 2841.50.9100. Subject merchandise may also enter under HTSUS subheading 3212.90.0050. While the HTSUS subheadings and CAS registry number are provided for convenience and customs purposes, the written description of the scope is dispositive.

[FR Doc. 2019–25776 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–DS–P

[9] *See Austria Amended Preliminary Determination.*

DEPARTMENT OF COMMERCE

International Trade Administration

[A–580–867]

Large Power Transformers From the Republic of Korea: Correction to the Preliminary Results of Antidumping Duty Administrative Review; 2017–2018

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

FOR FURTHER INFORMATION CONTACT: Joshua DeMoss or John Drury, AD/CVD Operations, Office VI, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–3362 or (202) 482–0195, respectively.

SUPPLEMENTARY INFORMATION: On October 17, 2019, the Department of Commerce (Commerce) published the preliminary results of the 2017–2018 administrative review of the antidumping order for large power transformers from the Republic of Korea. Commerce inadvertently stated that a weight-average dumping margin exists for LSIS Co., Ltd (LSIS). LSIS timely notified Commerce that it had no exports, sales, or entries during the period of review (POR), August 1, 2017 to July 31, 2018.[1] Commerce issued a no-shipment inquiry to U.S. Customs and Border Protection (CBP), and CBP responded that it found no evidence of shipments from LSIS during the POR.[2] Specifically, CBP indicated that it found no shipments by LSIS during the POR.[3] Thus, based on record evidence, we preliminary determine that LSIS had no shipments during the POR. Consistent with Commerce's practice, we find that it is not appropriate to rescind the review with respect to LSIS but, rather, to complete the review and issue appropriate instructions to CBP based on the final results of this review.[4] This notice serves as a correction notice.

Dated: November 21, 2019.

Christian Marsh,

Deputy Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2019–25774 Filed 11–26–19; 8:45 a.m.]

BILLING CODE 3510–DS–P

[1] *See* LSIS's Letter, ''Large Power Transformers from the Republic of Korea: LSIS Co., Ltd.'s No Shipment Letter,'' dated November 1, 2018.

[2] *See* Memorandum, ''Large Power Transformers from the Republic of Korea; 2018–2018 Administrative Review: No Shipment Inquiry with Respect to LSIS,'' dated October 16, 2019.

[3] *Id.*

[4] *See, e.g., Certain Frozen Warmwater Shrimp From Thailand; Preliminary Results of Antidumping Duty Administrative Review, Partial Rescission of Review, Preliminary Determination of No Shipments; 2012–2013,* 79 FR 15951, 15952 (March 24, 2014), unchanged in *Certain Frozen Warmwater Shrimp From Thailand: Final Results of Antidumping Duty Administrative Review, Final Determination of No Shipments, and Partial Rescission of Review; 2012–2013,* 79 FR 51306 (August 28, 2014); *Magnesium Metal From the Russian Federation: Preliminary Results of Antidumping Duty Administrative Review,* 75 FR 26922, 26923 (May 13, 2010), unchanged in *Magnesium Metal From the Russian Federation: Final Results of Antidumping Duty Administrative Review,* 75 FR 56989 (September 17, 2010).

DEPARTMENT OF COMMERCE

International Trade Administration

[A–580–893]

Fine Denier Polyester Staple Fiber From the Republic of Korea: Amended Final Results of Antidumping Duty Changed Circumstances Review

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce (Commerce) is amending the *Final Results* of a changed circumstances review (CCR) of the antidumping duty (AD) order on fine denier polyester staple fiber (PSF) from the Republic of Korea (Korea) to correct certain ministerial errors.

DATES: Applicable November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Thomas Hanna, AD/CVD Operations, Office IV, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401

Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–0835.

SUPPLEMENTARY INFORMATION:

Background

On October 2, 2019, Commerce published the *Final Results* of a changed circumstances review (CCR) of the AD order on PSF from Korea.[1] In those *Final Results,* Commerce determined, based on its successor-in-interest analysis and evidence that Toray Chemical Korea, Inc. (TCK) merged into Toray Advanced Materials Korea, Inc. (TAK), that TAK is the successor-in-interest to TCK. On October 1, 2019, TAK alleged that Commerce made certain ministerial errors in the *CCR Final Results.*[2]

Legal Framework

A ministerial error, as defined in section 751(h) of the Tariff Act of 1930, as amended (the Act), includes ''errors in addition, subtraction, or other arithmetic function, clerical errors resulting from inaccurate copying, duplication, or the like, and any other type of unintentional error which the administering authority considers ministerial.'' [3] Commerce's regulations (19 CFR 351.224(e)) provide that Commerce ''will analyze any comments received and, if appropriate, correct any ministerial error by amending . . . the final results of review . . . .''

TAK's Comments

According to TAK, Commerce erred by stating that it would ''instruct U.S. Customs and Border Protection to suspend entries of subject merchandise produced or exported by TAK at TCK current cash deposit rate of 0.00 percent'' because TCK was excluded from the AD order on PSF from Korea if it both produced and exported PSF and entries of such merchandise were not subject to suspension of liquidation or cash deposit requirements.[4] TAK also alleges that Commerce erred in making its successor-in-interest determination effective upon publication of the final results of the CCR and not effective April 1, 2019, the date TCK merged into TAK.[5]

Analysis

We agree with TAK. Thus, Commerce's determination that TAK is the successor-in-interest to TCK means that as of the effective date of Commerce's successor-in-interest determination, subject merchandise produced and exported by TAK is not subject to the antidumping duty order on PSF from Korea. Therefore, entries of such merchandise should not be subject to suspension of liquidation, but should be liquidated without regard to antidumping duties. For those entries, we should not have indicated in the *CCR Final Results* that we would ''instruct U.S. Customs and Border Protection to suspend entries of subject merchandise produced *or* exported by TAK at TCK's current cash deposit rate of 0.00 percent'' (emphasis added) because: (1) PSF produced *and* exported by TAK is entitled to the exclusion that applies to PSF produced *and* exported by TCK; and (2) in the underlying investigation, Commerce instructed CBP not to suspend liquidation of entries of PSF produced and exported by TCK.

On the other hand, for PSF produced by TCK but exported by another entity to the United States, or merchandise produced by another entity, and exported by TCK to the United States, TAK is the successor-in-interest to TCK, but like TCK, TAK's merchandise would not be excluded from the AD order on PSF from Korea.

In the *CCR Final Results,* we also indicated that our successor-in-interest determination would take effect upon publication of the final results of the CCR.[6] This approach is consistent with the position taken by Commerce in other CCRs, including two CCRs covering the same merger but different AD orders.[7] However, we overlooked the fact that the instant CCR involved a company that had merchandise which it had both produced and exported that was excluded from the AD order on PSF from Korea, whereas the other CCRs that used the publication date as the effective date involved companies whose merchandise was subject to an AD order and had a cash deposit rate, no matter if they produced and/or exported their own merchandise to the United States.

In *Hot-Rolled Lead and Bismuth Carbon Steel Products,* an interested party argued that ''the Department's determination to apply Glynwed's antidumping duty deposit rate to Niagara prospectively from the publication date of the final results, is contrary to the Department's finding that Niagara is the successor-in-interest to Glynwed as of May 21, 1999, and inconsistent with the retroactive application of Glynwed's countervailing duty deposit rate to Niagara.'' [8] In response, Commerce explained that the effective date was applied retroactively in the countervailing duty case, because merchandise produced and exported by the predecessor company to a successor-in-interest was excluded from the order:

> The basis for Niagara's apparent misunderstanding is that it fails to recognize that Glenwed, the predecessor company to Niagara, was excluded, *ab initio,* from the countervailing duty order, but has always been subject to the antidumping duty order. As such, Glenwed, and now its successor-in-interest Niagara, was never liable for any estimated cash deposits under the countervailing duty order. Thus, with the Department's determination that Niagara is the successor-in-interest to Glenwed, Niagara (like Glenwed) is not now, and never was subject to the . . . order. Therefore, with respect to the countervailing duty order, it is appropriate to apply the changed circumstances-determination retroactively to May 21, 1999, the date Glenwed became Niagara . . . However, with respect to the antidumping duty order, it is appropriate to change the estimated cash deposit rate for Niagara only as of the effective date of the Department's final changed-circumstances determination. Because Glenwed was always subject to the antidumping duty order, it was always potentially liable for estimated cash deposits . . . However, because cash deposits are only estimates of the amount of antidumping duties that will be due, changes in cash deposit rates are not made retroactive.[9]

The record shows that TCK merged into TAK on April 1, 2019.[10] Because there is no other information on the record calling into question the merger date, and no parties commented on this matter, consistent with previous practice as shown, it is appropriate to apply the effective date retroactively to April 1, 2019.

Accordingly, we determine, in accordance with section 751(h) of the

[1] *See Fine Denier Polyester Staple Fiber (PSF) from the Republic of Korea: Notice of Final Results of Antidumping Duty Changed Circumstances Review,* 84 FR 52457 (October 2, 2019) (*CCR Final Results*).

[2] *See* TAK's Letter, ''Fine Denier Polyester Staple Fiber from the Republic of Korea: Request to Correct Error in Final Results Notice of Changed Circumstances Review,'' dated October 1, 2019 (*TAK's Letter*).

[3] *See* 19 CFR 351.224(f).

[4] *See Fine Denier Polyester Staple Fiber From the People's Republic of China, India, the Republic of Korea, and Taiwan: Antidumping Duty Orders,* 83 FR 34545 (July 20, 2018).

[5] *See TAK's Letter.*

[6] *See Final Results.*

[7] *See Certain Polyester Staple Fiber From the Republic of Korea: Notice of Final Results of Antidumping Duty Changed Circumstances Review,* 84 FR 45124 (August 28, 2019); *Low Melt Polyester Staple Fiber From the Republic of Korea: Notice of Final Results of Antidumping Duty Changed Circumstances Review,* 84 FR 45129 (August 28, 2019).

[8] *Certain Hot-Rolled Lead and Bismuth Carbon Steel Products From the United Kingdom: Final Results of Changed-Circumstances Antidumping and Countervailing Duty Administrative Reviews,* 64 FR 66880–66881 (November 30, 1999) (*Hot-Rolled Lead and Bismuth Carbon Steel Products*).

[9] *Id.*

[10] See TAK's Letter, ''Changed Circumstances Review Request,'' dated May 23, 2019 at Exhibit 2.

Act and 19 CFR 351.224(f), that we made a ministerial error in the *CCR Final Results* by stating that we would instruct CBP to suspend entries of subject merchandise produced or exported by TAK at a 0.00 percent cash deposit rate. In fact, for merchandise both produced and exported by TAK, we will instruct CBP not to suspend liquidation of entries of subject merchandise because that merchandise is excluded from the AD order on PSF from Korea. For those entries, we will also instruct CBP to liquidate such entries without regard to antidumping duties. For entries of merchandise produced, but not exported, or exported, but not produced, by TAK, the all-others rate determined in the underlying investigation [11] will continue to be applicable.

With respect to the effective date of these results of a CCR, also in accordance with section 751(h) of the Act and 19 CFR 351.224(f), we determine further that we made a ministerial error in the *CCR Final Results* when we indicated that the results would be effective upon publication of the final results notice, rather than the date of the merger. Because some of the merchandise exported by TAK will be excluded from the AD order on PSF from Korea, the effective date should be the date of the merger. Accordingly, pursuant to 19 CFR 351.224(e), we are amending the *Final Results* to correct these errors.

Commerce intends to issue liquidation instructions to CBP 15 days after publication of these amended final results of this CCR instructing CBP to not suspend liquidation of, and to liquidate without regarding to antidumping duties, subject merchandise produced and exported by TCK's successor-in-interest, TAK, entered, or withdrawn from warehouse, for consumption on or after April 1, 2019.

Notification to Importers

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of doubled antidumping duties.

[11] *PSF from Korea* Final, 83 FR at 24743.

Notification to Interested Parties

We are issuing this determination and publishing these final results and notice in accordance with sections 751(h) and 777(i) of the Act and 19 CFR 351.224(e).

Dated: November 20, 2019.

Christian Marsh,

Deputy Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2019–25775 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

Meeting of the Civil Nuclear Trade Advisory Committee

AGENCY: International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of Federal Advisory Committee meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda for a meeting of the Civil Nuclear Trade Advisory Committee (CINTAC).

DATES: The meeting is scheduled for Thursday, December 19, 2019, from 2:00 p.m. to 4:00 p.m. Eastern Standard Time (EST). The deadline for members of the public to register to participate, including requests to make comments during the meeting and for auxiliary aids, or to submit written comments for dissemination prior to the meeting, is 5:00 p.m. EST on Monday, December 16, 2019.

ADDRESSES: The meeting will be held via conference call. The call-in number and passcode will be provided by email to registrants. Requests to register to participate (including to speak or for auxiliary aids) and any written comments should be submitted to: Mr. Devin Horne, Office of Energy & Environmental Industries, International Trade Administration, Room 28018, 1401 Constitution Ave. NW, Washington, DC 20230. (Fax: 202–482–5665; email: *devin.horne@trade.gov*). Members of the public are encouraged to submit registration requests and written comments via email to ensure timely receipt.

FOR FURTHER INFORMATION CONTACT: Mr. Devin Horne, Office of Energy & Environmental Industries, International Trade Administration, Room 28018, 1401 Constitution Ave. NW, Washington, DC 20230. (Phone: 202–482–0775; Fax: 202–482–5665; email: *devin.horne@trade.gov*).

SUPPLEMENTARY INFORMATION:

Background: The CINTAC was established under the discretionary authority of the Secretary of Commerce and in accordance with the Federal Advisory Committee Act, as amended, 5 U.S.C. App., in response to an identified need for consensus advice from U.S. industry to the U.S. Government regarding the development and administration of programs to expand United States exports of civil nuclear goods and services in accordance with applicable U.S. laws and regulations, including advice on how U.S. civil nuclear goods and services export policies, programs, and activities will affect the U.S. civil nuclear industry's competitiveness and ability to participate in the international market.

The Department of Commerce renewed the CINTAC charter on August 10, 2018. This meeting is being convened under the sixth charter of the CINTAC.

Topics to be considered: The agenda for the meeting on Thursday, December 19, 2019, CINTAC is as follows: Discussion of activities related to the U.S. Department of Commerce's Civil Nuclear Trade Initiative.

Members of the public wishing to attend the meeting must notify Mr. Devin Horne at the contact information above by 5:00 p.m. EST on Monday, December 16, 2019 in order to pre-register to participate. Please specify any requests for reasonable accommodation at least five business days in advance of the meeting. Last minute requests will be accepted but may not receive a timely response. A limited amount of time will be available for brief oral comments from members of the public attending the meeting. To accommodate as many speakers as possible, the time for public comments will be limited to two (2) minutes per person, with a total public comment period of 20 minutes. Individuals wishing to reserve speaking time during the meeting must contact Mr. Horne and submit a brief statement of the general nature of the comments and the name and address of the proposed participant by 5:00 p.m. EST on Monday, December 16, 2019. If the number of registrants requesting to make statements is greater than can be reasonably accommodated during the meeting, ITA may conduct a lottery to determine the speakers.

Any member of the public may submit written comments concerning the CINTAC's affairs at any time before and after the meeting. Comments may be submitted to the Civil Nuclear Trade Advisory Committee, Office of Energy & Environmental Industries, Room 28018, 1401 Constitution Ave. NW, Washington, DC 20230. For

consideration during the meeting, and to ensure transmission to the Committee prior to the meeting, comments must be received no later than 5:00 p.m. EST on Monday, December 16, 2019. Comments received after that date will be distributed to the members but may not be considered at the meeting.

Copies of CINTAC meeting minutes will be available within 90 days of the meeting.

Dated: November 14, 2019.

Devin Horne,

Designated Federal Officer, Office of Energy and Environmental Industries.

[FR Doc. 2019–25786 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–DR–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XV011]

Draft 2019 Marine Mammal Stock Assessment Reports

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; request for comments and new information.

SUMMARY: NMFS reviewed the Alaska, Atlantic, and Pacific regional marine mammal stock assessment reports (SARs) in accordance with the Marine Mammal Protection Act (MMPA). SARs for marine mammals in the Alaska, Atlantic, and Pacific regions were revised according to new information. NMFS solicits public comments on the draft 2019 SARs. In addition to releasing draft 2019 Pacific SARs for public comment, NMFS is also providing an opportunity to comment on the final 2018 Western North Pacific (WNP) gray whale SAR previously published in the **Federal Register** on June 19, 2019 (84 FR 28489). NMFS is also requesting new information for strategic stocks that were not updated in 2019.

DATES: Comments must be received by February 25, 2020.

ADDRESSES: The 2019 draft SARs are available in electronic form via the internet at *https://www.fisheries.noaa.gov/national/marine-mammal-protection/draft-marine-mammal-stock-assessment-reports.* The 2018 final Gray Whale Western North Pacific SAR is available at *https://www.fisheries.noaa.gov/national/marine-mammal-protection/marine-mammal-stock-assessment-reports-species-stock#cetaceans---large-whales.*

Copies of the Alaska Regional SARs may be requested from Marcia Muto, Alaska Fisheries Science Center, NMFS, 7600 Sand Point Way NE, Seattle, WA 98115–6349.

Copies of the Atlantic, Gulf of Mexico, and Caribbean Regional SARs may be requested from Elizabeth Josephson, Northeast Fisheries Science Center, 166 Water St., Woods Hole, MA 02543.

Copies of the Pacific Regional SARs may be requested from Jim Carretta, Southwest Fisheries Science Center, 8604 La Jolla Shores Drive, La Jolla, CA 92037–1508.

You may submit comments or new information, identified by NOAA–NMFS–2019–0090, by either of the following methods:

Federal e-Rulemaking Portal: Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2019-0090,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.

Mail: Send comments, new information, or requests for copies of reports to: Dr. Zachary Schakner, Protected Species Science Branch, Office of Science and Technology, National Marine Fisheries Service, 1315 East-West Highway, Silver Spring, MD 20910–3226, Attn: Stock Assessments.

Instructions: NMFS may not consider comments if they are sent by any other method, to any other address or individual, or received after the end of the comment period. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

FOR FURTHER INFORMATION CONTACT: Dr. Zachary Schakner, Office of Science and Technology, 301–427–8106, *Zachary.Schakner@noaa.gov;* Marcia Muto, 206–526–4026, *Marcia.Muto@noaa.gov,* regarding Alaska regional stock assessments; Elizabeth Josephson, 508–495–2362, *Elizabeth.Josephson@noaa.gov,* regarding Atlantic, Gulf of Mexico, and Caribbean regional stock assessments; or Jim Carretta, 858–546–7171, *Jim.Carretta@noaa.gov,* regarding Pacific regional stock assessments.

SUPPLEMENTARY INFORMATION:

Background

Section 117 of the MMPA (16 U.S.C. 1361 *et seq.*) requires NMFS and the U.S. Fish and Wildlife Service (FWS) to prepare stock assessments for each stock of marine mammals occurring in waters under the jurisdiction of the United States, including the U.S. Exclusive Economic Zone. These reports must contain information regarding the distribution and abundance of the stock, population growth rates and trends, estimates of annual human-caused mortality and serious injury (M/SI) from all sources, descriptions of the fisheries with which the stock interacts, and the status of the stock. Initial reports were completed in 1995.

The MMPA requires NMFS and FWS to review the SARs at least annually for strategic stocks and stocks for which significant new information is available, and at least once every three years for non-strategic stocks. The term ''strategic stock'' means a marine mammal stock: (A) For which the level of direct human-caused mortality exceeds the potential biological removal level or PBR (defined by the MMPA as the maximum number of animals, not including natural mortalities, that may be removed from a marine mammal stock while allowing that stock to reach or maintain its optimum sustainable population); (B) which, based on the best available scientific information, is declining and is likely to be listed as a threatened species under the Endangered Species Act (ESA) within the foreseeable future; or (C) which is listed as a threatened species or endangered species under the ESA. NMFS and the FWS are required to revise a SAR if the status of the stock has changed or can be more accurately determined.

Prior to public review, the updated SARs under NMFS' jurisdiction are peer-reviewed within NMFS Fisheries Science Centers and by members of three regional independent Scientific Review Groups, established under the MMPA to independently advise NMFS on information and uncertainties related to the status of marine mammals.

The period covered by the 2019 draft SARs is 2013–2017. NMFS reviewed the status of all marine mammal strategic stocks as required and considered whether significant new information was available for all other stocks under NMFS' jurisdiction. As a result of this review, NMFS revised a total of 65 reports representing 76 stocks in the Alaska, Atlantic, and Pacific regions to incorporate new information. The 2019 revisions consist primarily of updated or revised M/SI estimate, updated abundance estimates, including the

application of an established capture-mark-recapture method to estimate the abundance of Gulf of Maine humpback whales, and the introduction of a new method for estimating cryptic mortality for Gulf of Maine humpback whales and North Atlantic right whales. One stock (Alaska ringed seal) changed in status from non-strategic to strategic, and four stocks (Western North Atlantic false killer whale and St. Andrew Bay, St. Joseph Bay, and West Bay common bottlenose dolphin stocks) changed in status from strategic to non-strategic. Substantive revisions to the SARs are discussed below.

NMFS solicits public comments on the draft 2019 SARs. In addition to releasing draft 2019 Pacific SARs for public comment, NMFS is also providing an opportunity to comment on the final 2018 WNP gray whale SAR previously published in the **Federal Register** on June 19, 2019 (84 FR 28489). NMFS is providing this opportunity because of the difference in abundance reported in the draft and final reports. To ensure NMFS is aware of new information relevant to all strategic stocks, NMFS requests new information for strategic stocks that were not updated in 2019. Specifically, new relevant information could include peer-reviewed information on human-caused serious injury and mortality, fishery interactions, abundance, distribution, stock structure and habitat concerns, which could be incorporated into the SARs, and other information on emerging concerns for a strategic stock.

Alaska Reports

In 2019, NMFS reviewed all 45 stocks in the Alaska region for new information, and revised 18 SARs under NMFS jurisdiction representing 29 stocks (15 strategic and 14 non-strategic). The Alaska ringed seal stock changed from non-strategic to strategic status because the stock is now considered threatened under the ESA (see below). A list of the 29 stocks revised in 2019 for the Alaska region (contained in 18 reports) is presented in Table 1. Information on the remaining Alaska region stocks can be found in the final 2018 reports (Muto *et al.,* 2019).

TABLE 1—LIST OF MARINE MAMMAL STOCKS IN THE ALASKA REGION REVISED IN 2019

Strategic stocks	Non-strategic stocks
• Steller sea lion, Western U.S	• Steller sea lion, Eastern U.S.
• Northern fur seal, Eastern Pacific	• Harbor seals (12 stocks):
• Bearded seal, Alaska	○ Aleutian Islands.
• Ringed seal, Alaska	○ Pribilof Islands.
• Beluga whale, Cook Inlet	○ Bristol Bay.
• Killer whale, AT1 Transient	○ N Kodiak.
• Harbor porpoise, Southeast Alaska	○ S Kodiak.
• Harbor porpoise, Gulf of Alaska	○ Prince William Sound.
• Harbor porpoise, Bering Sea	○ Cook Inlet/Shelikof Strait.
• Sperm whale, North Pacific	○ Glacier Bay/Icy Strait.
• Humpback whale, Western North Pacific	○ Lynn Canal/Stephens Passage.
• Humpback whale, Central North Pacific	○ Sitka/Chatham Strait.
• Fin whale, Northeast Pacific	○ Dixon/Cape Decision.
• North Pacific right whale, Eastern North Pacific	○ Clarence Strait.
• Bowhead whale, Western Arctic	• Killer whale, Eastern North Pacific Northern Resident.

Revisions to the Alaska SARs included updates of abundance and/or M/SI estimates. New abundance estimates are available for the Western and Eastern U.S. Steller sea lion, harbor seal (12 stocks), Alaska ringed seal, AT1 Transient and Eastern North Pacific Northern Resident killer whale, Southeast Alaska and Gulf of Alaska harbor porpoise, North Pacific sperm whale, Northeast Pacific fin whale, and Western Arctic bowhead whale stocks.

Alaska Ringed Seal

In 2012, NMFS listed the Arctic ringed seals (*Pusa hispida hispida*), and thus the Alaska stock of ringed seals, as threatened under the ESA (77 FR 76706, December 28, 2012). The primary concern for this population is the ongoing and projected loss of sea-ice and snow cover stemming from climate change, which is expected to pose a significant threat to the persistence of these seals in the foreseeable future. On March 11, 2016, the U.S. District Court for the District of Alaska issued a decision vacating NMFS' listing in a lawsuit that challenged listing ringed seals under the ESA (*Alaska Oil and Gas Association* v. *Pritzker, Case No. 4:14–cv–00029–RPB*). Consequently, it was also no longer designated as depleted or classified as a strategic stock. In 2018, the 9th Circuit Court of Appeals overturned the decision and approved the agency's protection of the seals, and the ESA listing was reinstated. Because of its threatened status under the ESA, this ringed seal stock is considered depleted under the MMPA and is now classified as a strategic stock. NMFS did not revise the Alaska ringed seal report in 2018 because at the time the draft 2018 SARs were prepared, this stock was not considered to be depleted or strategic under the MMPA. The change in status from non-strategic to strategic was notated in the final 2018 Alaska Marine Mammal Stock Assessments stock summary table (Appendix 2, Muto *et al.,* 2019).

Atlantic Reports

In 2019, NMFS reviewed all 116 stocks in the Atlantic region for new information (including the Atlantic Ocean, Gulf of Mexico, and U.S. territories in the Caribbean) under NMFS jurisdiction. This year, NMFS revised 35 reports, created 1 new common bottlenose dolphin report (St. Andrew Bay) and resubmitted 1 new common bottlenose dolphin report (West Bay). These updated reports represent 37 stocks (5 strategic and 32 non-strategic). The Western North Atlantic (WNA) false killer whale stock and three common bottlenose dolphin stocks (St. Andrew Bay, St. Joseph Bay, and West Bay) changed from strategic to non-strategic status because they do not meet the criteria to qualify as strategic. A list of the 37 stocks in the Atlantic region is presented in Table 2. Information on the remaining Atlantic region stocks can be found in the final 2018 reports (Hayes *et al.,* 2019).

TABLE 2—LIST OF MARINE MAMMAL STOCKS IN THE ATLANTIC REGION REVISED IN 2019

Strategic stocks	Non-strategic stocks
• North Atlantic right whale, Western Atlantic	• Humpback whale, Gulf of Maine.
• Fin whale, WNA	• Minke whale, Canadian East Coast.
• Sei whale, Nova Scotia	• Dwarf sperm whale, WNA.
• Blue whale, WNA	• Pygmy sperm whale, WNA.
• Sperm whale	• Pygmy killer whale, WNA.
	• False killer whale, WNA.
	• Cuvier's beaked whale, WNA.
	• Blainville's beaked whale, WNA.
	• Gervais beaked whale, WNA.
	• Sowerby's beaked whale, WNA.
	• True's beaked whale, WNA.
	• Melon-headed whale, WNA.
	• Risso's dolphin, WNA.
	• Pilot whale, long-finned, WNA.
	• Pilot whale, short-finned, WNA.
	• Atlantic white-sided dolphin, WNA.
	• White-beaked dolphin, WNA.
	• Common dolphin, WNA.
	• Atlantic spotted dolphin, WNA.
	• Pantropical spotted dolphin, WNA.
	• Striped dolphin, WNA.
	• Fraser's dolphin, WNA.
	• Clymene dolphin, WNA.
	• Spinner dolphin, WNA.
	• Common bottlenose dolphin, WNA offshore.
	• Harbor porpoise, Gulf of Maine/Bay of Fundy.
	• Harbor seal, WNA.
	• Gray seal, WNA.
	• Harp seal, WNA.
	• Bottlenose dolphin, West Bay.
	• Bottlenose dolphin, St. Andrew Bay.
	• Bottlenose dolphin, St. Joseph Bay.

Revisions to the Atlantic SARs included updates of abundance and/or M/SI estimates. New abundance estimates are available for the North Atlantic right whale, WNA fin whale, Nova Scotia sei whale, WNA blue whale, North Atlantic sperm whale, Gulf of Maine humpback whale, Canadian East Coast minke whale, WNA dwarf and pygmy sperm whale (*Kogia* spp.), WNA false killer whale, WNA beaked whale (*Ziphius* and *Mesoplodon* spp.), WNA Risso's dolphin, Long-finned pilot whale, WNA Atlantic white-sided dolphin, WNA White-beaked dolphin, WNA common dolphin, WNA Atlantic spotted dolphin, WNA pantropical spotted dolphin, WNA striped dolphin, WNA Clymene dolphin, WNA spinner dolphin, WNA common bottlenose dolphin, Gulf of Maine/Bay of Fundy harbor porpoise, and the West Bay, St. Andrew Bay, and St. Joseph Bay common bottlenose dolphin stocks.

Estimating Cryptic Mortality for North Atlantic Right Whale and Gulf of Maine Humpback Whale

The North Atlantic right whale and Gulf of Maine humpback whale reports include the presentation of cryptic mortality estimates and attempt to apportion unseen mortality to various sources while considering detection bias. The cryptic mortality estimate is calculated by taking the annual population estimate generated from the Pace *et al.* (2017) approach and applying a basic population dynamic formula. A method to assign cause to these unseen mortalities is still being established, as such these additions are not counted towards PBR at this time.

North Atlantic Right Whale, Western Atlantic

The western North Atlantic right whale stock size is based on a state-space model of the sighting histories of individual whales identified using photo-identification techniques (Pace et al. 2017). Using a hierarchical, state-space Bayesian open population model of these histories produced a median abundance value. The best abundance estimate available for the North Atlantic right whale stock is 428 individuals (95% credible intervals 406 to 447). The previous best abundance estimate in the 2018 SAR was 451 (95% credible intervals 434 to 464). As a result of the lower abundance estimate, the PBR decreased from 0.9 (in the 2018 SAR) to 0.8. Only 5 and 0 calves were detected in 2017 and 2018, respectively. Therefore, it is estimated the decline in the right whale population will continue for at least an additional 2 years.

Humpback Whale, Gulf of Maine

For the Gulf of Maine humpback whale report, two new independent abundance estimates are available from different methods—one based upon ship and aerial line-transect surveys, and a second from applying mark and recapture methods to photo identification records from the J. Robbins studies (Robbins and Pace 2018). The best abundance estimate for the Gulf of Maine humpback whale stock is 1,396 (based upon the mark and recapture method). The minimum abundance estimate is 1,380 (previously 896 in 2018 SAR) and PBR for the Gulf of Maine humpback whale stock is 22 whales (previously 14.6). This stock is not considered strategic, but if the newly estimated cryptic mortality were included, the estimated annual anthropogenic mortality would be over PBR.

False Killer Whale, Western North Atlantic

The WNA false killer whale WNA stock changed from strategic to non-

strategic because it does not meet the criteria to qualify as strategic. When this stock was last revised in 2014, it was considered strategic because the abundance of the stock is small and NMFS was concerned that relatively few mortalities and serious injuries would exceed PBR. While no fishery-related mortality or serious injury has been observed in the last five years, there was a recorded interaction with the pelagic longline fishery in 2011. False killer whale interactions with longline fisheries in the Pacific are of considerable concern, but little is known about interactions in the Atlantic.

Common Bottlenose Dolphins

NMFS is in the process of writing individual stock assessment reports for each of the 31 bay, sound, and estuary stocks of common bottlenose dolphins in the northern Gulf of Mexico. Two new individual reports, for St. Andrew Bay and West Bay Estuarine System stocks, were completed for the draft 2019 SARs. The West Bay report was originally submitted with the draft 2018 SARs but was withdrawn because the updated abundance estimate for this stock was based on a publication that was still under review at the time the 2018 SARs were finalized. That publication is now ''in press,'' so NMFS is resubmitting the West Bay stock as a new draft 2019 report. The reader will not see tracked changes in the West Bay or St. Andrew Bay reports because these are new reports. To date, NMFS has completed seven individual bottlenose dolphin stocks reports (St. Andrew Bay, West Bay, Terrebonne-Timbalier Bay Estuarine System, Barataria Bay Estuarine System, Mississippi Sound/Lake Borgne/Bay Boudreau, Choctawhatchee Bay, and St. Joseph Bay), and the remaining 24 stocks are included in the Northern Gulf of Mexico Bay, Sound, and Estuary Stocks report.

The West Bay, St. Andrew Bay, and St. Joseph Bay common bottlenose dolphin stocks changed from strategic to non-strategic. These stocks were previously considered strategic in part due to an Unusual Mortality Event (UME) of unprecedented size and duration (2010 through 2014) among common bottlenose dolphins along the northern Gulf of Mexico coast. Although these stocks do not meet the criteria to qualify as strategic under the GAMMS (NMFS 2016), NMFS continues to have concerns regarding these stocks due to their small stock size and the high number of common bottlenose dolphin deaths associated with UMEs in the Florida panhandle since 1999.

Pacific Reports

In 2019, NMFS reviewed all 85 stocks in the Pacific region (waters along the west coast of the United States, within waters surrounding the main and Northwestern Hawaiian Islands, and within waters surrounding U.S. territories in the Western Pacific) for new information, and revised SARs for 10 stocks (6 strategic and 4 non-strategic). A list of the 10 reports revised in 2019 is presented in Table 3. Information on the remaining Pacific region stocks can be found in the final 2018 reports (Carretta *et al.,* 2019).

TABLE 3—LIST OF MARINE MAMMAL STOCKS IN THE PACIFIC REGION REVISED IN 2019

Strategic stocks	Non-strategic stocks
• Guadalupe fur seal • Hawaiian monk seal • Killer whale, Eastern N Pacific Southern Resident • Sperm whale, CA/OR/WA • Humpback whale, CA/OR/WA • Blue whale, Eastern N Pacific	• Harbor porpoise, Morro Bay. • Harbor porpoise, Monterey Bay. • Harbor porpoise, San Francisco-Russian River. • Harbor porpoise, Northern CA/Southern OR.

New abundance estimates are available for 8 stocks: Guadalupe fur seals, Hawaiian monk seals, four harbor porpoise stocks (Morro Bay, Monterey Bay, San Francisco-Russian River, and Northern California/Southern Oregon), Southern Resident killer whales, and Eastern North Pacific blue whales.

2018 Final Western North Pacific Gray Whale SAR

In addition to releasing draft 2019 Pacific SARs for public comment, NMFS is also providing an opportunity to comment on the final 2018 WNP gray whale SAR previously published in the **Federal Register** on June 19, 2019 (84 FR 28489). NMFS is providing this opportunity because of the difference in abundance reported in the draft and final reports.

The draft 2018 WNP gray whale stock assessment was prepared during autumn 2017/winter 2018 in advance of the Pacific Scientific Review Group meeting in February 2018. The draft 2018 report included an abundance estimate and calculated PBR based on results from Cooke *et al.* (2016), who estimated WNP gray whale stock abundance at 175 whales (95% credible intervals 158 to 193). Following the publication of the draft report, the SAR authors reviewed abundance estimates by Cooke (2017) and Cooke *et al.* (2018) published in November 2017 and January 2018, respectively. Those publications estimate WNP abundance to be 290 individuals (90% credible intervals 271 to 311) due to differences in the data analyzed. Cooke *et al.* (2016) estimated abundance based on Sakhalin Island whales only, while Cooke (2017) and Cooke *et al.* (2018) estimates included whales from both Sakhalin and Kamchatka regions. After considering public comments on the draft 2018 SAR regarding open versus closed population assumptions on the combined Sakhalin-Kamchatka feeding aggregation (84 FR 28489, June 19, 2019), the SAR authors updated the abundance estimate in the final 2018 report using the values from Cooke 2017 and Cooke *et al.* 2018. The WNP abundance estimates in the final 2018 report are higher than the draft report because the final estimates included Kamchatka whales. As a result, PBR values changed from 0.07 in the draft report to 0.12 whales in the final 2018 WNP SAR. In light of these changes, NMFS is now accepting public comment on the abundance estimates that appear in the final 2018 Western North Pacific Gray Whale SAR.

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Dated: November 22, 2019.

Chris Oliver,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 2019–25809 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XY048]

Fisheries of the Exclusive Economic Zone Off Alaska; Bering Sea and Aleutian Islands Management Area; Cost Recovery Programs

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of standard prices and fee percentages.

SUMMARY: NMFS publishes standard prices and fee percentages for cost recovery for the Amendment 80 Program, the American Fisheries Act (AFA) Program, the Aleutian Islands Pollock (AIP) Program, and the Western Alaska Community Development Quota (CDQ) groundfish and halibut Programs. The fee percentage for 2019 is 0.94 percent for the Amendment 80 Program, 0.23 percent for the AFA inshore cooperatives, 3.0 percent for the AIP program, and 0.70 percent for the CDQ groundfish and halibut Programs. This action is intended to provide the 2019 standard prices and fee percentages to calculate the required payment for cost recovery fees due by December 31, 2019.

DATES: The standard prices and fee percentages are valid on November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Carl Greene, Fee Coordinator, 907–586–7105.

SUPPLEMENTARY INFORMATION:

Background

Section 304(d) of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) authorizes and requires the collection of cost recovery fees for limited access privilege programs and the CDQ Program. Cost recovery fees recover the actual costs directly related to the management, data collection, and enforcement of the programs. Section 304(d) of the Magnuson-Stevens Act mandates that cost recovery fees not exceed three percent of the annual ex-vessel value of fish harvested by a program subject to a cost recovery fee, and that the fee be collected either at the time of landing, filing of a landing report, or sale of such fish during a fishing season or in the last quarter of the calendar year in which the fish is harvested.

NMFS manages the Amendment 80 Program, AFA Program, and AIP Program as limited access privilege programs. On January 5, 2016, NMFS published a final rule to implement cost recovery for these three limited access privilege programs and the CDQ groundfish and halibut programs (81 FR 150). The designated representative (for the purposes of cost recovery) for each program is responsible for submitting the fee payment to NMFS on or before the due date of December 31 of the year in which the landings were made. The total dollar amount of the fee due is determined by multiplying the NMFS published fee percentage by the ex-vessel value of all landings under the program made during the fishing year. NMFS publishes this notice of the fee percentages for the Amendment 80, AFA, AIP, and CDQ groundfish and halibut fisheries in the **Federal Register** by December 1 each year.

Standard Prices

The fee liability is based on the ex-vessel value of fish harvested in each program. For purposes of calculating cost recovery fees, NMFS calculates a standard ex-vessel price (standard price) for each species. A standard price is determined using information on landings purchased (volume) and ex-vessel value paid (value). For most groundfish species, NMFS annually summarizes volume and value information for landings of all fishery species subject to cost recovery in order to estimate a standard price for each species. The standard prices are described in U.S. dollars per pound for landings made during the year. The standard prices for all species in the Amendment 80, AFA, AIP, and CDQ groundfish and halibut programs are listed in Table 1. Each landing made under each program is multiplied by the appropriate standard price to arrive at an ex-vessel value for each landing. These values are summed together to arrive at the ex-vessel value of each program (fishery value).

TABLE 1—STANDARD EX-VESSEL PRICES BY SPECIES FOR THE 2019 FISHING YEAR

Species	Gear type	Reporting period	Standard ex-vessel price per pound ($)
Arrowtooth flounder	All	January 1, 2019–October 31, 2019	0.21
Atka mackerel	All	January 1, 2019–October 31, 2019	0.26
Flathead sole	All	January 1, 2019–October 31, 2019	0.22
Greenland turbot	All	January 1, 2019–October 31, 2019	0.67
CDQ halibut	Fixed gear	October 1, 2019–September 30, 2019	4.30
Pacific cod	Fixed gear	January 1, 2019–October 31, 2019	0.45
	Trawl gear	January 1, 2019–October 31, 2019	0.39
Pacific ocean perch	All	January 1, 2019–October 31, 2019	0.16
Pollock	All	January 1, 2018–December 31, 2018	0.14
Rock sole	All	January 1, 2019–March 31, 2019	0.28
	All	April 1, 2019–October 31, 2019	0.19
Sablefish	Fixed gear	October 1, 2018–September 30, 2019	1.98
	Trawl gear	January 1, 2019–October 31, 2019	0.72
Yellowfin sole	All	January 1, 2019–October 31, 2019	0.20

Fee Percentage

NMFS calculates the fee percentage each year according to the factors and methods described in Federal regulations at 50 CFR 679.33(c)(2), 679.66(c)(2), 679.67(c)(2), and 679.95(c)(2). NMFS determines the fee percentage that applies to landings made during the year by dividing the total costs directly related to the management, data collection, and enforcement of each program (direct program costs) during the year by the fishery value. NMFS captures direct program costs through an established accounting system that allows staff to track labor, travel, contracts, rent, and procurement. For 2019, the direct program costs were tracked from October 1, 2018, to September 30, 2019 (the end of the fiscal year). The individual 2019 fee percentages for the Amendment 80 Program and the Western Alaska Community Development Quota (CDQ) groundfish and halibut Programs are higher relative to percentages calculated for the programs in 2018. The 2019 percentage for the American Fisheries Act (AFA) Program was slightly less than the 2018 percentage, and the 2019 percentage for the Aleutian Islands Pollock Program remained the same as 2018.

NMFS will provide an annual report that summarizes direct program costs for each of the programs in early 2020. NMFS calculates the fishery value as described under the section ''Standard Prices.''

Amendment 80 Program Standard Prices and Fee Percentage

The Amendment 80 Program allocates total allowable catches (TACs) of groundfish species, other than Bering Sea pollock, to identified trawl catcher/processors in the Bering Sea and Aleutian Islands (BSAI). The Amendment 80 Program allocates a portion of the BSAI TACs of six species: Atka mackerel, Pacific cod, flathead sole, rock sole, yellowfin sole, and Aleutian Islands Pacific ocean perch. Participants in the Amendment 80 sector have established cooperatives to harvest these allocations. Each Amendment 80 cooperative is responsible for payment of the cost recovery fee for fish landed under the Amendment 80 Program. Cost recovery requirements for the Amendment 80 Program are at 50 CFR 679.95.

For most Amendment 80 species, NMFS annually summarizes volume and value information for landings of all fishery species subject to cost recovery in order to estimate a standard price for each fishery species. Regulations specify that for rock sole, NMFS shall calculate a separate standard price for two periods—January 1 through March 31, and April 1 through October 31, which accounts for a substantial difference in estimated rock sole prices during the first quarter of the year relative to the remainder of the year. The volume and value information is obtained from the First Wholesale Volume and Value Report, and the Pacific Cod Ex-Vessel Volume and Value Report.

Using the fee percentage formula described above, the estimated percentage of direct program costs to fishery value for the 2019 calendar year is 0.94 percent for the Amendment 80 Program. For 2019, NMFS applied the fee percentage to each Amendment 80 species landing that was debited from an Amendment 80 cooperative quota allocation between January 1 and December 31 to calculate the Amendment 80 fee liability for each Amendment 80 cooperative. The 2019 fee payments must be submitted to NMFS on or before December 31, 2019. Payment must be made in accordance with the payment methods set forth in 50 CFR 679.95(a)(3)(iv).

AFA Standard Price and Fee Percentages

The AFA allocates the Bering Sea directed pollock fishery TAC to three sectors—catcher/processor, mothership, and inshore. Each sector has established cooperatives to harvest the sector's exclusive allocation. In 2019, the cooperative for the inshore sector is responsible for paying the fee for Bering Sea pollock landed under the AFA. Cost recovery requirements for the AFA sectors are at 50 CFR 679.66.

NMFS calculates the standard price for pollock using the most recent annual value information reported to the Alaska Department of Fish & Game for the Commercial Operator's Annual Report and compiled in the Alaska Commercial Fisheries Entry Commission Gross Earnings data for Bering Sea pollock. Due to the time required to compile the data, there is a one-year delay between the gross earnings data year and the fishing year to which it is applied. For example, NMFS used 2018 gross earnings data to calculate the standard price for 2019 pollock landings.

Under the fee percentage formula described above, the estimated percentage of direct program costs to fishery value for the 2019 calendar year is 0.23 percent for the AFA inshore sector. To calculate the 2019 fee liabilities, NMFS applied the respective fee percentages to the landings of Bering Sea pollock debited from each cooperative's fishery allocation that occurred between January 1 and December 31. The 2019 fee payments must be submitted to NMFS on or before December 31, 2019. Payment must be made in accordance with the payment methods set forth in 50 CFR 679.66(a)(4)(iv).

AIP Program Standard Price and Fee Percentage

The AIP Program allocates the Aleutian Islands directed pollock fishery TAC to the Aleut Corporation, consistent with the Consolidated Appropriations Act of 2004 (Pub. L. 108–109), and its implementing regulations. Annually, prior to the start of the pollock season, the Aleut Corporation provides NMFS with the identity of its designated representative for harvesting the Aleutian Islands directed pollock fishery TAC. The same individual is responsible for the submission of all cost recovery fees for pollock landed under the AIP Program. Cost recovery requirements for the AIP Program are at 50 CFR 679.67.

NMFS calculates the standard price for pollock using the most recent annual value information reported to the Alaska Department of Fish & Game for the Commercial Operator's Annual Report and compiled in the Alaska Commercial Fisheries Entry Commission Gross Earnings data for Aleutian Islands pollock. Due to the time required to compile the data, there is a one-year delay between the gross earnings data year and the fishing year to which it is applied. For example, NMFS used 2018 gross earnings data to calculate the standard price for 2019 pollock landings.

For the 2019 fishing year, the Aleut Corporation selected participants to harvest or process the Aleutian Islands directed pollock fishery TAC. Some harvest occurred; however, the majority of that TAC was eventually reallocated to the Bering Sea directed pollock fishery TAC. Due to the small harvest, the estimated percentage of direct program costs to fishery value for the 2019 calendar year were disproportionately high and well above 3.0 percent. Pursuant to section 304(d)(2)(B) of the Magnuson-Stevens Act, the fee percentage amount must not exceed 3.0 percent. Therefore, the 2019 fee percentage is set at 3.0 percent. To calculate the 2019 fee liability, NMFS applied the respective fee percentage to the pollock landings attributed to the AIP Program that occurred between January 1 and December 31. The 2019 fee payments must be submitted to NMFS on or before December 31, 2019. Payment must be made in accordance

with the payment methods set forth in 50 CFR 679.67(a)(3)(iv).

CDQ Standard Price and Fee Percentage

The CDQ Program was implemented in 1992 to provide access to BSAI fishery resources to villages located in Western Alaska. Section 305(i) of the Magnuson-Stevens Act identifies sixty-five villages eligible to participate in the CDQ Program and the six CDQ groups to represent these villages. CDQ groups receive exclusive harvesting privileges of the TACs for a broad range of crab species, groundfish species, and halibut. NMFS implemented a CDQ cost recovery program for the BSAI crab fisheries in 2005 (70 FR 10174, March 2, 2005) and published the cost recovery fee percentage for the 2019/2020 crab fishing year on August 22, 2019 (84 FR 43792). This notice provides the cost recovery fee percentage for the CDQ groundfish and halibut programs. Each CDQ group is subject to cost recovery fee requirements for landed groundfish and halibut, and the designated representative of each CDQ group is responsible for submitting payment for their CDQ group. Cost recovery requirements for the CDQ Program are at 50 CFR 679.33.

For most CDQ groundfish species, NMFS annually summarizes volume and value information for landings of all fishery species subject to cost recovery in order to estimate a standard price for each fishery species. The volume and value information is obtained from the First Wholesale Volume and Value Report and the Pacific Cod Ex-Vessel Volume and Value Report. For CDQ halibut and fixed-gear sablefish, NMFS calculates the standard prices using information from the Individual Fishing Quota (IFQ) Ex-Vessel Volume and Value Report, which collects information on both IFQ and CDQ volume and value.

Using the fee percentage formula described above, the estimated percentage of direct program costs to fishery value for the 2019 calendar year is 0.70 percent for the CDQ groundfish and halibut programs. For 2019, NMFS applied the calculated CDQ fee percentage to all CDQ groundfish and halibut landings made between January 1 and December 31 to calculate the CDQ fee liability for each CDQ group. The 2019 fee payments must be submitted to NMFS on or before December 31, 2019. Payment must be made in accordance with the payment methods set forth in 50 CFR 679.33(a)(3)(iv).

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 22, 2019.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2019–25769 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Science Advisory Board

AGENCY: National Oceanic and Atmospheric Administration (NOAA), Department of Commerce (DOC).

ACTION: Notice of public meetings.

SUMMARY: This notice sets forth the schedule and proposed agenda for the meeting of the Science Advisory Board (SAB). The members will discuss issues outlined in the section on Matters to be considered.

DATES: The meeting is scheduled for December 16–17, 2019 from 9:30 a.m. to 5:15 p.m. (EST) and December 17, 2019 from 8:30 a.m. to 12:15 p.m. (EST). This time and the agenda topics described below are subject to change. For the latest agenda please refer to the SAB website: *http://sab.noaa.gov/SABMeetings.aspx.*

ADDRESSES: The December 16–17, 2019 venue is to be determined; please check the website for the physical venue. The link for the webinar registration for the December 16–17, 2019 meeting may be found here: *https://attendee.gotowebinar.com/register/7581679532832078604.*

FOR FURTHER INFORMATION CONTACT: Dr. Cynthia Decker, Executive Director, SSMC3, Room 11230, 1315 East-West Hwy., Silver Spring, MD 20910; Phone Number: 301–734–1156; email: *Cynthia.Decker@noaa.gov;* or visit the SAB website at *http://sab.noaa.gov/SABMeetings.aspx.*

SUPPLEMENTARY INFORMATION: The NOAA Science Advisory Board (SAB) was established by a Decision Memorandum dated September 25, 1997, and is the only Federal Advisory Committee with responsibility to advise the Under Secretary of Commerce for Oceans and Atmosphere on strategies for research, education, and application of science to operations and information services. SAB activities and advice provide necessary input to ensure that National Oceanic and Atmospheric Administration (NOAA) science programs are of the highest quality and provide optimal support to resource management.

Status: The December 16–17, 2019 meeting will be open to public participation with a 15-minute public comment period at 5:00 p.m. EST. The SAB expects that public statements presented at its meetings will not be repetitive of previously submitted verbal or written statements. In general, each individual or group making a verbal presentation will be limited to a total time of three minutes. Written comments for the December 16–17, 2019 should be received in the SAB Executive Director's Office by December 9, 2019 to provide sufficient time for SAB review. Written comments received by the SAB Executive Director after this dates will be distributed to the SAB, but may not be reviewed prior to the meeting date.

Special Accommodations: This meeting is physically accessible to people with disabilities. Requests for special accommodations may be directed to the Executive Director no later than 12 p.m. on December 9, 2019.

Matters to be Considered: The meeting on December 16–17, 2019 will include the (1) NOAA Update, (2) Plans for the FY 2020–2021 SAB Work Plan, (3) Data Access, Data Science and AI-Based Analysis of Environmental Data, (4) Data Archiving and Access Requirements Working Group (DAARWG) Update, (5) Topic 3 Update: Enhance Strategic Investment and Use of Unmanned and Autonomous Systems, (6) Climate Working Group S2SD2 White Paper, (7) CWG report on the Review of the NOAA Ocean Acidification Strategic Plan, (8) IPCC Special Report on Oceans and Cryosphere, (9) Topic 9: New Technologies for Fisheries Stock Assessments Final Report and (10) NOAA Response to the SAB Citizen Science Report. Meeting materials, including work products, will be made available on the SAB website: *http://sab.noaa.gov/SABMeetings.aspx.*

Dated: November 21, 2019.

David Holst,

Chief Financial Officer/Administrative Officer, Office of Oceanic and Atmospheric Research, National Oceanic and Atmospheric Administration.

[FR Doc. 2019–25797 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–KD–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XW012]

Magnuson-Stevens Act Provisions; General Provisions for Domestic Fisheries; Pacific Coast Groundfish Fishery; Applications for Exempted Fishing Permits (EFP)

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; request for comments.

SUMMARY: NMFS announces renewal request applications for three exempted fishing permits. The applications, submitted by the San Francisco Community Fishing Association, Scott Cook, and Real Good Fish, request exemptions from prohibitions to fish for rockfish species inside the non-trawl Rockfish Conservation Areas during the 2020 fishing year. All three applicants request to test hook-and-line gear that selectively harvests underutilized, midwater rockfish species while avoiding bottom-dwelling, overfished rockfish species. NMFS previously evaluated these projects and issued exempted fishing permits for these applicants for the 2019 fishing year. NMFS requests public comment on these applications for the 2020 fishing year.

DATES: Comments must be received by December 12, 2019.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2019–0133, by any of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2019-0133,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments. The EFP applications will be available under Supporting Documents through the same link.
- *Mail:* Submit written comments to Lynn Massey, West Coast Region, NMFS, 501 W Ocean Blvd., Ste. 4200, Long Beach, CA 90802–4250.

Instructions: Comments must be submitted by one of the above methods to ensure that the comments are received, documented, and considered by NMFS. Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.) submitted voluntarily by the sender will be publicly accessible. Do not submit confidential business information, or otherwise sensitive or protected information. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

FOR FURTHER INFORMATION CONTACT: Lynn Massey, West Coast Region, NMFS, (562) 436–2462, *lynn.massey@noaa.gov.*

SUPPLEMENTARY INFORMATION: This action is authorized by the Pacific Coast Groundfish Fishery Management Plan and the regulations implementing the Magnuson-Stevens Fishery Conservation and Management Act at 50 CFR 600.745, which state that NMFS may issue exempted fishing permits (EFP) to authorize fishing activities that would otherwise be prohibited.

At the June 2018 Pacific Fishery Management Council (Council) meeting, the Council voted to recommend the following three 2019 EFP projects to NMFS, and made the preliminary decision to recommend continuing the EFP projects in 2020:

- Yellowtail Rockfish Jig Fishing for the 2019–2020 Fishing Seasons (San Francisco Community Fishing Association);
- Commercial Midwater Hook-and-Line Rockfish Fishing in the RCA off the Oregon Coast (Scott Cook); and,
- Monterey Bay Regional Exempted Fishing Permit—Chilipepper Rockfish (Real Good Fish).

NMFS published a description of the EFP projects in the **Federal Register** on September 6, 2018 (83 FR 45224), and solicited public comments through October 9, 2018. NMFS received one public comment in support of issuing the EFPs.

At the November 2019 Council meeting, the Council confirmed its recommendation to renew all three EFP projects for the 2020 fishing year. All three EFP applicants request to continue testing hook-and-line gear that selectively targets underutilized, midwater rockfish species (*e.g.* yellowtail rockfish) while avoiding overfished, bottom-dwelling rockfish species (*e.g.* yelloweye rockfish). An EFP is necessary for these activities because they will all occur inside the non-trawl rockfish conservation area (RCA), which is closed to fishing with non-trawl fixed gear to protect overfished groundfish stocks.

The only requested change for 2020 was an additional exemption for the Real Good Fish EFP project, which would permit vessel participants to take an EFP trip without a vessel monitoring system (VMS). The primary purpose of VMS is to monitor vessel movement to ensure that vessels do not fish in restricted areas. The current EFP exempts vessels from a prohibition on fishing in a restricted area (*i.e.,* the non-trawl RCA). In addition, there are no other closed areas near the area where vessels would conduct EFP fishing activity, and vessels are only permitted to conduct EFP fishing activities on EFP trips. For these reasons, it is not necessary to use VMS to monitor EFP vessel fishing activity inside the non-trawl RCA, or near the area where vessels would conduct EFP fishing activities. Therefore, NMFS does not expect any unintended biological impacts or enforcement issues if it issues this exemption. All EFP trips are still subject to specific catch limits and must carry an observer.

All applicants will adhere to EFP set-asides for targeted and incidental groundfish and other species, which the Council considered and approved for both the 2019 and 2020 fishing years at its June 2018 meeting. These EFP set-asides are off the top deductions from the 2020 applicable annual catch limits (ACLs), meaning any landings and discards that occur under these EFPs would be accounted for within the applicable ACLs.

Authority: 16 U.S.C. 1801 *et seq.,* 16 U.S.C. 773 *et seq.,* and 16 U.S.C. 7001 *et seq.*

Dated: November 21, 2019.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2019–25696 Filed 11–26–19; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XR029

Takes of Marine Mammals Incidental to Specified Activities; Taking Marine Mammals Incidental to Erickson Residence Marine Access Project in Juneau, Alaska

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; issuance of an incidental harassment authorization (IHA).

SUMMARY: In accordance with the regulations implementing the Marine Mammal Protection Act (MMPA) as amended, notification is hereby given that NMFS has issued an IHA to Jim Erickson to incidentally harass, by Level A and Level B harassment, marine mammals during pile driving activities associated with the Erickson Residence Marine Access Project in Juneau, Alaska.

DATES: This Authorization is effective from January 1, 2020 through December 31, 2020.

FOR FURTHER INFORMATION CONTACT: Amy Fowler, Office of Protected Resources, NMFS, (301) 427–8401. Electronic copies of the application and supporting documents, as well as a list of the references cited in this document, may be obtained online at: *https://www.fisheries.noaa.gov/permit/incidental-take-authorizations-under-marine-mammal-protection-act*. In case of problems accessing these documents, please call the contact listed above.

SUPPLEMENTARY INFORMATION:

Background

The MMPA prohibits the ''take'' of marine mammals, with certain exceptions. Sections 101(a)(5)(A) and (D) of the MMPA (16 U.S.C. 1361 *et seq.*) direct the Secretary of Commerce (as delegated to NMFS) to allow, upon request, the incidental, but not intentional, taking of small numbers of marine mammals by U.S. citizens who engage in a specified activity (other than commercial fishing) within a specified geographical region if certain findings are made and either regulations are issued or, if the taking is limited to harassment, a notice of a proposed incidental take authorization may be provided to the public for review.

Authorization for incidental takings shall be granted if NMFS finds that the taking will have a negligible impact on the species or stock(s) and will not have an unmitigable adverse impact on the availability of the species or stock(s) for taking for subsistence uses (where relevant). Further, NMFS must prescribe the permissible methods of taking and other ''means of effecting the least practicable adverse impact'' on the affected species or stocks and their habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance, and on the availability of such species or stocks for taking for certain subsistence uses (referred to in shorthand as ''mitigation''); and requirements pertaining to the mitigation, monitoring and reporting of such takings are set forth.

Summary of Request

On May 8, 2019, NMFS received a request from Jim Erickson for an IHA to take marine mammals incidental to pile driving activities associated with a dock replacement project in Auke Bay, north of Juneau, Alaska. The application was deemed adequate and complete on August 13, 2019. Mr. Erickson's request was for take of a small number of eight species of marine mammal by Level A and Level B harassment. Neither Mr. Erickson nor NMFS expects serious injury or mortality to result from this activity and, therefore, an IHA is appropriate.

Description of Activity

Mr. Erickson plans to replace his private moorage facility in Auke Bay in Juneau, Alaska to provide a safer, more accessible and secure dock. Six 12- to 16-inch (in) timber piles will be removed using a vibratory hammer, and six steel pipe piles (four 12.75-in steel pipe piles and two 20-in steel pipe piles) will be installed using vibratory and impact hammers over the course of up to eight days. Of those eight days, impact pile driving may occur on up to four days and vibratory pile removal and installation may occur on up to six days. Drilling may be required to install the larger diameter steel piles. If required, drilling may occur on up to two days. Vibratory pile removal and installation, impact pile installation, and drilling would introduce underwater sounds at levels that may result in take, by Level A and Level B harassment, of marine mammals in Auke Bay.

A detailed description of the planned project is provided in the **Federal Register** notice for the proposed IHA (84 FR 50387; September 25, 2019). Since that time, no changes have been made to the planned pile driving activities. Therefore, a detailed description is not provided here. Please refer to that **Federal Register** notice for the description of the specific activity.

Comments and Responses

A notice of NMFS's proposal to issue an IHA to Mr. Erickson was published in the **Federal Register** on September 25, 2019 (84 FR 50387). That notice described, in detail, Mr. Erickson's activity, the marine mammal species that may be affected by the activity, and the anticipated effects on marine mammals. During the 30-day public comment period, NMFS received a comment letter from the Marine Mammal Commission (Commission). The Commission recommended that NMFS issue the IHA, subject to the inclusion of the proposed mitigation, monitoring, and reporting measures.

Comment 1: The Commission recommended that NMFS require Mr. Erickson to keep a running tally of the total (extrapolated) takes for each species to ensure takes remain within the authorized limits.

Response: We agree that the applicant must ensure they do not exceed authorized takes. We have included in the authorization that the applicant must include extrapolation of the estimated takes by Level B harassment based on the number of observed exposures within the Level B harassment zone and the percentage of the Level B harassment zone that was not visible in the draft and final reports.

Comment 2: The Commission noted that the Level A harassment takes were subtracted from the Level B harassment takes but that harbor seals and harbor porpoises may be taken by both types of harassment during the proposed activities. The Commission recommended that NMFS clarify that the number of Level A takes authorized could apply to either Level A or Level B harassment.

Response: NMFS has noted in the Estimated Take section below that harbor seals and harbor porpoises taken by Level A harassment may also be taken by Level B harassment.

Comment 3: The Commission noted that the source level used for impact installation of 12.75-in piles is from water depths less than 5 m (in Caltrans 2015) but water depths near Mr. Erickson's dock range from approximately 2 to 13 m in depth. The Commission noted that source levels in deeper water may be 2 to 6 decibels (dB) greater than those in shallow water. As Caltrans (2015) does not include data for impact pile driving of 12-in steel pipe piles, the Commission recommended NMFS finish any outstanding internal reviews of source level data and make the source level data available to all NMFS analysts and relevant action proponents as soon as possible.

Response: NMFS agrees that source levels in deeper water are greater than those of the same size piles in shallow water. However, absent specific data on source levels for 12-in steel pipe piles in deeper water, NMFS is using the best available data and is proceeding with the available Caltrans source levels for 12-in steel piles as proxy for Mr. Erickson's 12.75-in piles. NMFS will make our comprehensive pile driving source level compendium available once the document is finalized.

Comment 4: The Commission recommended that NMFS refrain from using the proposed renewal process for Mr. Erickson's authorization. The renewal process should be used sparingly and selectively, by limiting its use only to those proposed incidental harassment authorizations that are expected to have the lowest levels of impacts on marine mammals and that require the least complex analyses. If NMFS elects to use the renewal process frequently or for authorizations that require a more complex review or for which much new information has been generated the Commission recommended that NMFS provide the Commission and other reviewers the full 30-day comment period as set forth in section 101(a)(5)(D)(iii) of the MMPA.

Response: We appreciate the Commission's input and direct the reader to our recent response to a similar comment, which can be found at 84 FR 52464 (October 2, 2019), pg. 52466.

Changes From the Proposed IHA to Final IHA

NMFS has updated the pulse duration for impact driving of 12.75-in piles from 50 milliseconds (msec) to 100 msec, consistent with the NMFS 2018 Technical Guidance. As a result, the calculated Level A harassment zones from impact driving of 12.75-in piles have increased. Additionally, NMFS has revised the shutdown and monitoring zones for vibratory driving of 12.75-in piles and the monitoring zone for impact installation of 12.75-in piles to round up to the nearest 5 m. NMFS has also added requirements for Mr. Erickson to conduct pile installation and removal only during daylight hours and to delay pile installation and removal in times of poor visibility until the entire shutdown zone is visible. Finally, NMFS has added a requirement to report total takes extrapolated from observed takes and to provide field observation data sheets with the monitoring report.

Description of Marine Mammals in the Area of Specified Activities

Sections 3 and 4 of the application summarize available information regarding status and trends, distribution and habitat preferences, and behavior and life history, of the potentially affected species. Additional information regarding population trends and threats may be found in NMFS's Stock Assessment Reports (SARs; *https://www.fisheries.noaa.gov/national/marine-mammal-protection/marine-mammal-stock-assessments*) and more general information about these species (*e.g.,* physical and behavioral descriptions) may be found on NMFS's website (*https://www.fisheries.noaa.gov/find-species*).

Table 1 lists all species with expected potential for occurrence in Auke Bay and summarizes information related to the population or stock, including regulatory status under the MMPA and ESA and potential biological removal (PBR), where known. For taxonomy, we follow Committee on Taxonomy (2018). PBR is defined by the MMPA as the maximum number of animals, not including natural mortalities, that may be removed from a marine mammal stock while allowing that stock to reach or maintain its optimum sustainable population (as described in NMFS's SARs). While no mortality is anticipated or authorized here, PBR and annual serious injury and mortality from anthropogenic sources are included here as gross indicators of the status of the species and other threats.

Marine mammal abundance estimates presented in this document represent the total number of individuals that make up a given stock or the total number estimated within a particular study or survey area. NMFS's stock abundance estimates for most species represent the total estimate of individuals within the geographic area, if known, that comprises that stock. For some species, this geographic area may extend beyond U.S. waters. All managed stocks in this region are assessed in NMFS's U.S. Alaska and U.S. Pacific SARs. All values presented in Table 1 are the most recent available at the time of publication and are available in the 2018 SARs (Muto *et al.,* 2019; Caretta *et al.,* 2019).

TABLE 1—MARINE MAMMALS THAT COULD OCCUR IN THE PROJECT AREA

Common name	Scientific name	Stock	ESA/MMPA status; Strategic (Y/N) [1]	Stock abundance (CV, N^{min}, most recent abundance survey) [2]	PBR	Annual M/SI [3]
Order Cetartiodactyla—Cetacea—Superfamily Mysticeti (baleen whales)						
Family Eschrichtiidae:						
Gray whale	Eschrichtius robustus	Eastern North Pacific	-/-; N	26,960 (0.05, 25,849, 2016).	801	138
Family Balaenopteridae (rorquals):						
Humpback whale	Megaptera novaeangliae	Central North Pacific	T/D; Y	10,103 (0.3, 7,890, 2006)	83	26
Minke whale	Balaenoptera acutorostrada	Alaska	-/-; N	N/A (see SAR, N/A, see SAR).	UND	0
Fin whale	Balaenoptera physalus	Northeast Pacific	E/D; Y	see SAR (see SAR, see SAR, 2013).	5.1	0.6
Superfamily Odontoceti (toothed whales, dolphins, and porpoises)						
Family Delphinidae:						
Killer whale	Orcinus orca	Alaska Resident	-/-; N	2,347 (N/A, 2347, 2012)	24	1
Killer whale	Orcinus orca	Northern Resident	-/-; N	261 (N/A, 261, 2011)	1.96	0
Killer whale	Orcinus orca	West Coast Transient	-/-; N	243 (N/A, 243, 2009)	2.4	0
Family Phocoenidae (porpoises):						
Harbor porpoise	Phocoena phocoena	Southeast Alaska	-/-; Y	975 (0.10; 896; 2012)	8.9	34
Dall's porpoise	Phocoenoides dalli	Alaska	-/-; N	83,400 (0.097, N/A, 1991).	UND	38
Order Carnivora—Superfamily Pinnipedia						
Family Otariidae (eared seals and sea lions):						

TABLE 1—MARINE MAMMALS THAT COULD OCCUR IN THE PROJECT AREA—Continued

Common name	Scientific name	Stock	ESA/ MMPA status; Strategic (Y/N) [1]	Stock abundance (CV, N^{min}, most recent abundance survey) [2]	PBR	Annual M/SI [3]
Steller sea lion	Eumetopias jubatus	Eastern DPS	E/D; Y	54,267 (see SAR, 54,267, 2017).	326	252
Steller sea lion	Eumetopias jubatus	Western DPS	-/-; N	41,638 (see SAR, 41,638, 2015).	2,498	108
California sea lion	Zalophus californianus	U.S.	-/-; N	257,606 (N/A, 233,515, 2014).	14,011	> 321
Family Phocidae (earless seals):						
Harbor seal	Phoca vitulina	Lynn Canal/Stephens Passage	-/-; N	9,478 (see SAR, 8,605, 2011).	155	50

1—Endangered Species Act (ESA) status: Endangered (E), Threatened (T)/MMPA status: Depleted (D). A dash (-) indicates that the species is not listed under the ESA or designated as depleted under the MMPA. Under the MMPA, a strategic stock is one for which the level of direct human-caused mortality exceeds PBR or which is determined to be declining and likely to be listed under the ESA within the foreseeable future. Any species or stock listed under the ESA is automatically designated under the MMPA as depleted and as a strategic stock.

2—NMFS marine mammal stock assessment reports online at: *www.nmfs.noaa.gov/pr/sars/.* CV is coefficient of variation; Nmin is the minimum estimate of stock abundance. In some cases, CV is not applicable.

3—These values, found in NMFS's SARs, represent annual levels of human-caused mortality plus serious injury from all sources combined (*e.g.,* commercial fisheries, ship strike). Annual M/SI often cannot be determined precisely and is in some cases presented as a minimum value or range. A CV associated with estimated mortality due to commercial fisheries is presented in some cases.

Note—Italicized species are not expected to be taken or proposed for authorization.

All species that could potentially occur in the area of the Erickson Residence are included in Table 1. However, the spatial and temporal occurrence of gray whales and fin whales in the area is such that take is not expected to occur, and they are not discussed further beyond the explanation provided here. Sightings of gray whales and fin whales are uncommon in the inland waters of southeast Alaska. These species are typically seen closer to the open waters of the Gulf of Alaska. Take of gray whales and fin whales was not requested and has not been authorized, and these species are not considered further in this document.

A detailed description of the of the species likely to be affected by Mr. Erickson's planned project, including brief introductions to the species and relevant stocks as well as available information regarding population trends and threats, and information regarding local occurrence, were provided in the **Federal Register** notice for the proposed IHA (84 FR 50387; September 25, 2019); since that time, we are not aware of any changes in the status of these species and stocks; therefore, detailed descriptions are not provided here. Please refer to that **Federal Register** notice for these descriptions. Please also refer to NMFS' website (*https://www.fisheries.noaa.gov/find-species*) for generalized species accounts.

Potential Effects of Specified Activities on Marine Mammals and Their Habitat

The effects of underwater noise from pile installation and removal activities for the Erickson Residence Marine Access Project have the potential to result in behavioral harassment of marine mammals in the vicinity of the action area. The **Federal Register** notice for the proposed IHA (84 FR 50387; September 25, 2019) included a discussion of the effects of anthropogenic noise on marine mammals, therefore that information is not repeated here; please refer to the **Federal Register** notice (84 FR 50387; September 25, 2019) for that information.

Marine Mammal Habitat Effects

The main impact associated with the Erickson Residence Marine Access Project would be temporarily elevated sound levels and the associated direct effects on marine mammals. The project would not result in permanent impacts to habitats used directly by marine mammals, such as haulout sites, but may have potential short-term impacts to food sources such as forage fish, and minor impacts to the immediate substrate during installation and removal of piles during the planned project. These potential effects are discussed in detail in the **Federal Register** notice for the proposed IHA (84 FR 50387; September 25, 2019), therefore that information is not repeated here; please refer to that **Federal Register** notice for that information.

Estimated Take

This section provides an estimate of the number of incidental takes authorized through this IHA, which will inform both NMFS' consideration of ''small numbers'' and the negligible impact determination.

Harassment is the only type of take expected to result from these activities. Except with respect to certain activities not pertinent here, section 3(18) of the MMPA defines ''harassment'' as any act of pursuit, torment, or annoyance, which (i) has the potential to injure a marine mammal or marine mammal stock in the wild (Level A harassment); or (ii) has the potential to disturb a marine mammal or marine mammal stock in the wild by causing disruption of behavioral patterns, including, but not limited to, migration, breathing, nursing, breeding, feeding, or sheltering (Level B harassment).

Authorized takes would primarily be by Level B harassment, as use of the vibratory and impact pile hammers and drill has the potential to result in disruption of behavioral patterns for individual marine mammals. There is also some potential for auditory injury (Level A harassment) to result, primarily for high frequency cetacean species and phocids because predicted auditory injury zones are larger than for other hearing groups. Auditory injury is unlikely to occur for other groups. The required mitigation and monitoring measures are expected to minimize the severity of such taking to the extent practicable.

As described previously, no mortality is anticipated or authorized for this activity. Below we describe how the take is estimated.

Generally speaking, we estimate take by considering: (1) Acoustic thresholds above which NMFS believes the best available science indicates marine mammals will be behaviorally harassed or incur some degree of permanent hearing impairment; (2) the area or volume of water that will be ensonified above these levels in a day; (3) the density or occurrence of marine mammals within these ensonified areas; and, (4) and the number of days of activities. We note that while these basic factors can contribute to a basic

calculation to provide an initial prediction of takes, additional information that can qualitatively inform take estimates is also sometimes available (*e.g.,* previous monitoring results or average group size). Below, we describe the factors considered here in more detail and present the authorized take.

Acoustic Thresholds

Using the best available science, NMFS has developed acoustic thresholds that identify the received level of underwater sound above which exposed marine mammals would be reasonably expected to be behaviorally harassed (equated to Level B harassment) or to incur permanent threshold shift (PTS) of some degree (equated to Level A harassment).

Level B Harassment for non-explosive sources—Though significantly driven by received level, the onset of behavioral disturbance from anthropogenic noise exposure is also informed to varying degrees by other factors related to the source (*e.g.,* frequency, predictability, duty cycle), the environment (*e.g.,* bathymetry), and the receiving animals (hearing, motivation, experience, demography, behavioral context) and can be difficult to predict (Southall *et al.,* 2007, Ellison *et al.,* 2012). Based on what the available science indicates and the practical need to use a threshold based on a factor that is both predictable and measurable for most activities, NMFS uses a generalized acoustic threshold based on received level to estimate the onset of behavioral harassment. NMFS predicts that marine mammals are likely to be behaviorally harassed in a manner we consider Level B harassment when exposed to underwater anthropogenic noise above received levels of 120 dB re 1 μPa (rms) for continuous (*e.g.,* vibratory pile-driving, drilling) and above 160 dB re 1 μPa (rms) for non-explosive impulsive (*e.g.,* seismic airguns) or intermittent (*e.g.,* scientific sonar) sources.

Mr. Erickson's planned activity includes the use of continuous (vibratory pile driving and removal, drilling) and impulsive (impact pile driving) sources, and therefore the 120 and 160 dB re 1 μPa (rms) thresholds are applicable.

Level A harassment for non-explosive sources—NMFS' Technical Guidance for Assessing the Effects of Anthropogenic Sound on Marine Mammal Hearing (Version 2.0) (Technical Guidance, 2018) identifies dual criteria to assess auditory injury (Level A harassment) to five different marine mammal groups (based on hearing sensitivity) as a result of exposure to noise from two different types of sources (impulsive or non-impulsive). Mr. Erickson's planned activity includes the use of impulsive (impact pile driving) and non-impulsive (vibratory pile driving and removal, drilling) source.

These thresholds are provided in Table 2. The references, analysis, and methodology used in the development of the thresholds are described in NMFS 2018 Technical Guidance, which may be accessed at *https://www.fisheries.noaa.gov/national/marine-mammal-protection/marine-mammal-acoustic-technical-guidance*.

TABLE 2—THRESHOLDS IDENTIFYING THE ONSET OF PERMANENT THRESHOLD SHIFT

Hearing group	PTS onset acoustic thresholds * (received level)	
	Impulsive	Non-impulsive
Low-Frequency (LF) Cetaceans	*Cell 1:* $L_{pk,flat}$: 219 dB; $L_{E,LF,24h}$: 183 dB	*Cell 2:* $L_{E,LF,24h}$: 199 dB.
Mid-Frequency (MF) Cetaceans	*Cell 3:* $L_{pk,flat}$: 230 dB; $L_{E,MF,24h}$: 185 dB	*Cell 4:* $L_{E,MF,24h}$: 198 dB.
High-Frequency (HF) Cetaceans	*Cell 5:* $L_{pk,flat}$: 202 dB; $L_{E,HF,24h}$: 155 dB	*Cell 6:* $L_{E,HF,24h}$: 173 dB.
Phocid Pinnipeds (PW) (Underwater)	*Cell 7:* $L_{pk,flat}$: 218 dB; $L_{E,PW,24h}$: 185 dB	*Cell 8:* $L_{E,PW,24h}$: 201 dB.
Otariid Pinnipeds (OW) (Underwater)	*Cell 9:* $L_{pk,flat}$: 232 dB; $L_{E,OW,24h}$: 203 dB	*Cell 10:* $L_{E,OW,24h}$: 219 dB.

* Dual metric acoustic thresholds for impulsive sounds: Use whichever results in the largest isopleth for calculating PTS onset. If a non-impulsive sound has the potential of exceeding the peak sound pressure level thresholds associated with impulsive sounds, these thresholds should also be considered.

Note: Peak sound pressure (L_{pk}) has a reference value of 1 μPa, and cumulative sound exposure level (L_E) has a reference value of 1μPa²s. In this Table, thresholds are abbreviated to reflect American National Standards Institute standards (ANSI 2013). However, peak sound pressure is defined by ANSI as incorporating frequency weighting, which is not the intent for this Technical Guidance. Hence, the subscript "flat" is being included to indicate peak sound pressure should be flat weighted or unweighted within the generalized hearing range. The subscript associated with cumulative sound exposure level thresholds indicates the designated marine mammal auditory weighting function (LF, MF, and HF cetaceans, and PW and OW pinnipeds) and that the recommended accumulation period is 24 hours. The cumulative sound exposure level thresholds could be exceeded in a multitude of ways (*i.e.,* varying exposure levels and durations, duty cycle). When possible, it is valuable for action proponents to indicate the conditions under which these acoustic thresholds will be exceeded.

Ensonified Area

Here, we describe operational and environmental parameters of the activity that will feed into identifying the area ensonified above the acoustic thresholds, which include source levels and transmission loss coefficient.

The sound field in the project area is the existing background noise plus additional construction noise from the planned project. Marine mammals are expected to be affected via sound generated by the primary components of the project (*i.e.,* impact pile driving, vibratory pile driving and removal). The area ensonified above the thresholds for harassment is governed by the topography of Auke Bay and the various islands located within and around the bay. The eastern part of Auke Bay is acoustically shadowed by Auke Cape, while Portland Island, Coghlan Island, Suedla Island, and Spuhn Island would inhibit sound transmission from reaching the more open waters toward Mansfield Peninsula (see Figure 2 in the IHA application). Additionally, vessel traffic and other commercial and industrial activities in the project area may contribute to elevated background noise levels which may mask sounds produced by the project.

The project includes vibratory removal of timber piles, vibratory and impact installation of steel pipe piles, and drilling. Source levels for these activities are based on reviews of measurements of the same or similar types and dimensions of piles available in the literature. Source levels for each activity are presented in Table 3 The source level for vibratory removal of timber piles is from in-water measurements generated by the Greenbusch Group (2018) from the Seattle Pier 62 project (83 FR 39709; April 10, 2018). Hydroacoustic monitoring results from Pier 62 determined unweighted rms ranging from 140 dB to 169 dB. NMFS analyzed source measurements at different distances for all 63 individual timber piles that were removed at Pier 62 and

normalized the values to 10 m. The results showed that the median is 152 dB SPLrms. There are no literature source levels for vibratory installation of 12.75-in steel piles so source levels from vibratory installation of 12-in steel piles from the Caltrans Compendium of Pile Driving Sound Data were used as a proxy (Caltrans 2015). Similarly, as no literature source levels exist for vibratory installation of 20-in steel piles, hydroacoustic measurements of vibratory installation of 24-in steel piles from the U.S. Navy's Test Pile Project were used as a proxy (Navy, 2015). Source levels for impact installation of 12.75-in piles were determined by using Caltrans measurements of impact installation of 12-in steel piles as a proxy (Caltrans 2015). Source levels for impact installation of 20-in piles are from installation of 20-in piles in the Columbia River, in similar water depths (Yurk *et al.,* 2016). Source levels for drilling are proxy from median measured source level from drilling of 24-in diameter piles at the Kodiak Ferry Terminal (Denes *et al.,* 2016, Table 72).

TABLE 3—SOUND SOURCE LEVELS FOR PILE SIZES AND DRIVING METHODS

Pile size	Method	Source level (at 10 m)			Literature source
		dB RMS	dB Peak	dB SEL	
12.75-in steel	Vibratory	155	171	155	Caltrans 2015 (proxy from 12-in).
20-in steel	Vibratory	161	—	—	Navy 2015 (proxy from 24-in).
12- to 16-in timber	Vibratory	152	—	—	Greenbusch Group 2018.
20-in steel	Drilling	166.2	—	—	Denes *et al.,* 2016 (proxy from 24-in).
12.75-in steel	Impact	177	192	—	Caltrans 2015 (proxy from 12-in).
20-in steel	Impact	190	205	175	Yurk *et al.,* 2016.

— indicates source level not reported.

Transmission loss (TL) is the decrease in acoustic intensity as an acoustic pressure wave propagates out from a source. TL parameters vary with frequency, temperature, sea conditions, current, source and receiver depth, water depth, water chemistry, and bottom composition and topography. The general formula for underwater TL is:

$$TL = B * Log_{10} (R_1/R_2),$$

Where:

TL = transmission loss in dB

B = transmission loss coefficient

R_1= the distance of the modeled SPL from the driven pile, and

R_2= the distance from the driven pile of the initial measurement

A practical spreading value of fifteen is often used under conditions, such as Auke Bay, where water increases with depth as the receiver moves away from the shoreline, resulting in an expected propagation environment that would lie between spherical and cylindrical spreading loss conditions. Practical spreading loss is assumed here.

TABLE 4—PILE DRIVING SOURCE LEVELS AND DISTANCES TO LEVEL B HARASSMENT THRESHOLDS

Pile size and type	Method	Source level at 10 m (dB re 1 μPa rms)	Level B threshold (dB re 1 μPa rms)	Distance to level B threshold (m)
12.75-in steel	Vibratory	155	120	2,154
20-in steel	Vibratory	161	120	5,412
12- to 16-in timber	Vibratory	152	120	1,359
20-in steel	Drilling	166.2	120	12,023
12.75-in steel	Impact	177	160	136
20-in steel	Impact	190	160	1,000

When the NMFS Technical Guidance (2016) was published, in recognition of the fact that ensonified area/volume could be more technically challenging to predict because of the duration component in the new thresholds, we developed a User Spreadsheet that includes tools to help predict a simple isopleth that can be used in conjunction with marine mammal density or occurrence to help predict takes. We note that because of some of the assumptions included in the methods used for these tools, we anticipate that isopleths produced are typically going to be overestimates of some degree, which may result in some degree of overestimate of Level A harassment take. However, these tools offer the best way to predict appropriate isopleths when more sophisticated 3D modeling methods are not available, and NMFS continues to develop ways to quantitatively refine these tools, and will qualitatively address the output where appropriate. For stationary sources (such as pile drivers), NMFS User Spreadsheet predicts the closest distance at which, if a marine mammal remained at that distance the whole duration of the activity, it would not incur PTS. Inputs used in the User Spreadsheet, and the resulting isopleths are reported below (Table 5). Mr. Erickson anticipates that the number of piles installed or removed per day may vary due to environmental conditions and equipment availability. To calculate the Level A harassment isopleths in the User Spreadsheet, Mr. Erickson conservatively entered the maximum number of piles that may be installed in

a day and the maximum potential duration per pile.

TABLE 5—USER SPREADSHEET INPUT PARAMETERS USED FOR CALCULATING LEVEL A HARASSMENT ISOPLETHS

Activity	Spreadsheet tab used	Weighting factor adjustment (kHz)	Source level at 10 m	Propagation (xLogR)	Strike duration (sec)	Strikes per pile	Driving duration for single pile (hours)	Max piles per day
Timber vibratory removal.	A.1	2.5	152 dB rms	15	N/A	N/A	0.25	6
12.75-in vibratory install.	A.1	2.5	155 dB rms	15	N/A	N/A	1	4
20-in vibratory install	A.1	2.5	161 dB rms	15	N/A	N/A	2	2
DTH Drilling	A.1	2.5	166.2 dB rms	15	N/A	N/A	5	2
12.75-in impact	E.1	2	177 dB rms	15	0.1	150	N/A	4
20-in impact	E.1	2	175 dB SEL	15	N/A	150	N/A	2

N/A indicates not applicable

TABLE 6—CALCULATED DISTANCES TO LEVEL A HARASSMENT ISOPLETHS

Activity	Level A harassment zone (m)				
	LF cetaceans	MF cetaceans	HF cetaceans	Phocids	Otariids
Timber vibratory removal	2.2	0.2	3.3	1.4	0.1
12.75-in vibratory install	6.9	0.6	10.1	4.2	0.3
20-in vibratory install	17.2	1.5	25.4	10.5	0.7
DTH Drilling	70.4	6.2	104.1	42.8	3.0
12.75-in impact	60.9	2.2	72.6	32.6	2.4
20-in impact	131.1	4.7	156.1	70.1	5.1

Marine Mammal Occurrence and Take Calculation and Estimation

In this section we provide the information about the presence, density, or group dynamics of marine mammals and describe how it is brought together with the information above to produce a quantitative take estimate. When available, peer-reviewed scientific publications were used to estimate marine mammal abundance in the project area. However, scientific surveys and resulting data such as population estimates, densities, and other quantitative information are lacking for most marine mammal populations and most areas of southeast Alaska, including Auke Bay. Therefore, Mr. Erickson gathered qualitative information from discussions with knowledgeable local people in the Auke Bay area, including biologists, the harbormaster, a tour operator, and other individuals familiar with marine mammals in the Auke Bay area.

Here we describe how the information provided above is brought together to produce a quantitative take estimate. Because reliable densities are not available, the applicant requests take based on the maximum number of animals that may occur in the harbor per day multiplied by the number of days of the activity.

Steller Sea Lion

Steller sea lions are common within Auke Bay but generally only occur in the area during winter. Most individuals that frequent Auke Bay haul out at Benjamin Island in Lynn Canal. The Auke Bay boating community observes Steller sea lions transiting between Auke Bay and Benjamin Island regularly during winter. Steller sea lions are not known to haul out on any beaches or structures within Auke Bay, but animals have been observed foraging within Auke Bay, and may rest in large raft groups in the water. Groups as large as 121 individuals have been observed in Auke Bay (Ridgway pers. observ.).

Mr. Erickson estimates that one large group (121 individuals) may be exposed to project-related underwater noise daily on 8 days of pile installation and removal activities, for a total of 968 exposures. As stated above, approximately 18.1 percent of Steller sea lions present in Auke Bay are expected to belong to the wDPS, for a total of 175 exposures of wDPS Steller sea lions and 793 exposures of eDPS Steller sea lions.

The largest Level A harassment zone for otariid pinnipeds extends 5.1 m from the source (Table 6). Mr. Erickson is planning to implement a minimum shutdown zone of 10 m during all pile driving activities, (see *Mitigation* section), which is expected to eliminate the potential for Level A take of Steller sea lions. Therefore, no takes of Steller sea lions by Level A harassment were requested and no takes by Level A harassment have been authorized.

California Sea Lion

California sea lions are rare in Southeast Alaska, but a single California sea lion was observed hauled out in Statter Harbor in September of 2017. While Statter Harbor is acoustically shadowed by the topography of Auke Bay and will not be ensonified above the Level B behavioral harassment threshold, a California sea lion could enter the Level B harassment zone within Auke Bay to forage. Therefore, Mr. Erickson estimates that a single California sea lion may enter the Level B harassment zone on each of the eight days of pile driving, for a total of eight exposures.

The largest Level A harassment zone for otariid pinnipeds extends 5.1 m from the source (Table 6). Mr. Erickson is planning to implement a minimum shutdown zone of 10 m during all pile driving activities, (see *Mitigation* section), which is expected to eliminate the potential for Level A take of California sea lions. Therefore, no takes of California sea lions by Level A harassment were requested or authorized.

Harbor Seal

Harbor seals are commonly sighted in the waters of the inside passages

throughout southeast Alaska. Seals occur year-round within the project area and are regularly sighted in Auke Bay, including Statter Harbor.

Up to 52 seals have been observed hauled out on a dock at Fisherman's Bend within Statter Harbor (Ridgway unpubl. data) which is acoustically sheltered from the planned pile driving activities, but it is assumed that these animals may leave the dock to forage within Auke Bay and may be exposed to noise levels in excess of the Level B harassment thresholds upon entering the water. Mr. Erickson estimates up to 52 harbor seals could be exposed to elevated sound levels on each day of pile driving, for a total of 416 exposures.

The largest Level A harassment zone for phocid pinnipeds results from impact installation of 20-in piles and extends 70.1 m from the pile (Table 6). There are no haulouts located within the Level A harassment zone and although it is unlikely that harbor seals will enter this area without detection while pile driving activities are underway, it is possible that harbor seals may approach and enter the Level A harassment zone undetected. Mr. Erickson has observed up to four harbor seals in the water near the existing dock. Therefore, Mr. Erickson estimates that up to four harbor seals may approach the site within 70 m of the source each day. Impact pile driving is expected to occur on up to four days. For this reason, NMFS authorized take of 16 harbor seals by Level A harassment. Harbor seals taken by Level A harassment may also be taken by Level B harassment.

Harbor Porpoise

Although there have been no systematic studies or observations of harbor porpoises specific to Auke Bay, there is the potential for them to occur within the project area. Abundance data for harbor porpoises in southeast Alaska were collected during 18 seasonal surveys spanning 22 years, from 1991 to 2012. During that study, a total of 398 harbor porpoises were observed in the northern inland waters of southeast Alaska, including Lynn Canal (Dahlheim *et al.,* 2015). Mean group size of harbor porpoises in southeast Alaska varies by season. In the fall, mean group size was determined to be 1.88 harbor porpoises (Dahlheim *et al.,* 2009). However, groups of five to six harbor porpoises have been observed in Auke Bay (B. Lambert, pers. comm.). Therefore, Mr. Erickson estimates that up to six harbor porpoises may enter the Level B harassment zone on each of the eight days of pile driving, for a total of 48 exposures.

The largest Level A harassment zone extends 156.1 m from the source (Table 6). Mr. Erickson is planning to implement shutdown zones that encompass the Level A harassment zones (see *Mitigation* section). However, harbor porpoises are known to be an inconspicuous species and are challenging for protected species observers (PSOs) to sight, making any approach to a specific area potentially difficult to detect. Because harbor porpoises move quickly and elusively, it is possible that they may enter the Level A harassment zone without detection. Mr. Erickson estimates that one pair of harbor porpoises may enter the Level A harassment zone on each of the four days of impact pile driving for a total of eight potential takes by Level A harassment. Harbor porpoises taken by Level A harassment may also be taken by Level B harassment.

Dall's Porpoise

Dall's porpoises are not expected to occur within Auke Bay because the shallow water habitat of the bay is atypical of areas where Dall's porpoises usually occur. However, Dall's porpoises may opportunistically inhabit nearshore habitat. The largest group of Dall's porpoises observed in Auke Bay was 10 individuals in 1994. Therefore, Mr. Erickson estimates that one group of ten Dall's porpoises may enter the Level B harassment zone once during construction, for a total of ten exposures.

Mr. Erickson is required to implement shutdown zones for porpoises that encompass the Level A harassment zones for each pile driving activities. The largest Level A harassment zone for Dall's porpoise extends 156.1 m from the source during impact installation of 20-in steel piles (Table 6). Given the larger group size and more conspicuous rooster-tail generated by swimming Dall's porpoises, which makes them more noticeable than harbor porpoises, PSOs are expected to detect Dall's porpoises prior to them entering the Level A harassment zone. Therefore, takes of Dall's porpoises by Level A harassment have not been requested and have not been authorized.

Killer Whale

Killer whales are known visitors of the Lynn Canal area, and occasionally enter Auke Bay. Oceanus Alaska compiled sightings records reported by Juneau residents and reported an average of 25 killer whales in the area per year between 2010 and 2017. Killer whales in the project area may be of the Northern Resident, Alaska Resident, or West Coast Transient stocks. The Alaska Resident group AG pod is known to frequent the Juneau Area in groups of up to 25 individuals (B. Lambert, pers. comm.). Mr. Erickson estimates that one group of up to 25 killer whales may enter the Level B harassment zone during the eight days of pile driving for a total of 25 exposures.

Mr. Erickson is required to implement shutdown zones that encompass the largest Level A harassment zones for killer whales during all pile driving activities. Killer whales are generally conspicuous and PSOs are expected to detect killer whales and implement a shutdown before the animals enter the Level A harassment zone. Therefore, takes by Level A harassment have not been requested and have not been authorized.

Humpback Whale

Use of Auke Bay by humpback whales is intermittent and irregular year-round. During winter, researchers have documented 1 to 19 individual humpback whales per month in waters close to the project area, including Lynn Canal (Moran *et al.,* 2018a; Straley *et al.,* 2018). Group sizes in southeast Alaska generally range from one to four individuals (Dahlheim *et al.,* 2009). Mr. Erickson estimates that one group of up to four individuals may be present in the Level B harassment zone per day during the eight days of pile driving, for a total of 32 takes by Level B harassment.

The largest Level A harassment zone for humpback whales extends 131.1 m from the source during impact installation of 20-in piles (Table 6). Given the irregular and small presence of humpback whales in Auke Bay, along with the fact that PSOs are expected to detect humpback whales before they enter the Level A harassment zone and implement shutdowns to prevent take by Level A harassment, no Level A takes have been requested or authorized.

Minke Whale

Dedicated surveys for cetaceans in southeast Alaska found that minke whales were scattered throughout inland waters from Glacier Bay and Icy Strait to Clarence Strait, with small concentrations near the entrance of Glacier Bay. All sightings were of single minke whales, except for a single sighting of multiple minke whales. Surveys took place in spring, summer, and fall, and minke whales were present in low numbers in all seasons and years (Dahlheim *et al.,* 2009). Anecdotal reports have not included minke whales near Auke Bay. However, minke whales are distributed throughout a wide variety of habitats and have been

observed in nearby Glacier Bay, indicating they may potentially occur within the Level B harassment zone. Therefore, Mr. Erickson estimates that one minke whale may enter the Level B harassment zone once during the eight days of pile driving activities, for a total of one take by Level B harassment.

The Level A harassment zones for minke whales are the same as for humpback whales, and the shutdown protocols will be the same as well. Therefore, given the low occurrence of minke whales combined with the mitigation, takes by Level A harassment have not been requested or authorized.

TABLE 7—AUTHORIZED TAKE BY LEVEL A AND LEVEL B HARASSMENT, BY SPECIES AND STOCK

Common name	Stock	Stock abundance [a]	Level A	Level B	Total authorized take	Authorized take as percentage of stock
Humpback whale	Central North Pacific	10,103	0	32	[b] 32	0.32
Minke Whale	Alaska	N/A	0	1	1	N/A
Killer whale	Alaska Resident	2,347	0	25	25	[d] 1.06
	Northern Resident	261				[d] 9.58
	West Coast Transient	243				[d] 10.3
Harbor porpoise	Southeast Alaska	975	8	40	48	4.92
Dall's porpoise	Alaska	83,400	0	10	10	< 0.1
Steller sea lion	Western U.S.	54,267	0	175	[c] 175	0.32
	Eastern U.S.	41,638	0	793	793	1.90
California sea lion	U.S.	257,606	0	8	8	< 0.01
Harbor seal	Lynn Canal/Stephens Passage.	9,478	16	400	416	4.39

[a] Stock or DPS size is N_{best} according to NMFS 2018 Draft Stock Assessment Reports.
[b] For ESA section 7 consultation purposes, 6.1 percent are designated to the Mexico DPS and the remaining are designated to the Hawaii DPS; therefore, we assigned 2 Level B takes to the Mexico DPS.
[c] Based on numbers reported in Hastings *et al.* (2019) and in consultation with the Alaska Regional Office, we used an 18.1 percent distinction factor to determine the number of animals potentially from the western DPS.
[d] These percentages assume all 25 takes may occur to each individual stock, thus the percentage of one or more stocks are likely inflated as the takes would be divided among multiple stocks.

Mitigation

In order to issue an IHA under Section 101(a)(5)(D) of the MMPA, NMFS must set forth the permissible methods of taking pursuant to such activity, and other means of effecting the least practicable impact on such species or stock and its habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance, and on the availability of such species or stock for taking for certain subsistence uses (latter not applicable for this action). NMFS regulations require applicants for incidental take authorizations to include information about the availability and feasibility (economic and technological) of equipment, methods, and manner of conducting such activity or other means of effecting the least practicable adverse impact upon the affected species or stocks and their habitat (50 CFR 216.104(a)(11)).

In evaluating how mitigation may or may not be appropriate to ensure the least practicable adverse impact on species or stocks and their habitat, as well as subsistence uses where applicable, we carefully consider two primary factors:

(1) The manner in which, and the degree to which, the successful implementation of the measure(s) is expected to reduce impacts to marine mammals, marine mammal species or stocks, and their habitat, as well as subsistence uses. This considers the nature of the potential adverse impact being mitigated (likelihood, scope, range). It further considers the likelihood that the measure will be effective if implemented (probability of accomplishing the mitigating result if implemented as planned), the likelihood of effective implementation (probability implemented as planned); and

(2) the practicability of the measures for applicant implementation, which may consider such things as cost, impact on operations, and, in the case of a military readiness activity, personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity.

Mitigation for Marine Mammals and Their Habitat

In addition to the measures described later in this section, Mr. Erickson is required to employ the following standard mitigation measures:

- Conduct briefings between construction supervisors and crews and the marine mammal monitoring team prior to the start of all pile driving activity, and when new personnel join the work, to explain responsibilities, communication procedures, marine mammal monitoring protocol, and operational procedures;
- For in-water heavy machinery work other than pile driving (*e.g.,* standard barges, etc.), if a marine mammal comes within 10 m, operations must cease and vessels must reduce speed to the minimum level required to maintain steerage and safe working conditions. This type of work could include the following activities: (1) Movement of the barge to the pile location; or (2) positioning of the pile on the substrate via a crane (*i.e.,* stabbing the pile);
- Work may only occur during daylight hours, when visual monitoring of marine mammals can be conducted;
- For those marine mammals for which Level B harassment take has not been requested, in-water pile installation/removal and drilling must shut down immediately if such species are observed within or on a path towards the monitoring zone (*i.e.,* Level B harassment zone); and
- If take reaches the authorized limit for an authorized species, pile installation and removal must be stopped as these species approach the Level B harassment zone to avoid additional take.

Establishment of Shutdown Zone for Level A Harassment—For all pile driving/removal and drilling activities, Mr. Erickson must establish a shutdown zone. The purpose of a shutdown zone is generally to define an area within which shutdown of activity would occur upon sighting of a marine

mammal (or in anticipation of an animal entering the defined area). These shutdown zones would be used to prevent incidental Level A exposures from impact pile driving for Steller sea lions, California sea lions, Dall's porpoises, killer whales, humpback whales, and minke whales, and to reduce the potential for such take for harbor seals and harbor porpoises. During all pile driving and removal activities, a minimum shutdown zone of 10 m must be enforced (Table 8). Shutdown zones for each specific activity are based on the Level A harassment zones and therefore vary by pile-size, type, driving method, and marine mammal hearing group (Table 8). If poor environmental conditions restrict full visibility of the shutdown zone(s), pile driving must be delayed until the entire shutdown zone is visible.

TABLE 8—SHUTDOWN ZONES FOR PILE DRIVING ACTIVITIES

Activity	Shutdown zone (m)				
	LF cetaceans	MF cetaceans	HF cetaceans	Phocid pinnipeds	Otariid pinnipeds
Vibratory Timber Pile Removal	10	10	10	10	10
Vibratory Pile Driving (12.75-in)	10	10	15	10	10
Vibratory Pile Driving (20-in)	20	10	30	15	10
Drilling	75	10	105	45	10
Impact Pile Driving 12.75-in	65	10	75	35	10
Impact Pile Driving 20-in	135	10	160	75	10

Establishment of Monitoring Zones for Level B Harassment—Mr. Erickson is required to establish monitoring zones to correlate with Level B disturbance zones or zones of influence which are areas where SPLs are equal to or exceed the 160 dB rms threshold for impact driving and the 120 dB rms threshold during vibratory driving and drilling. Monitoring zones provide utility for observing by establishing monitoring protocols for areas adjacent to the shutdown zones. Monitoring zones enable observers to be aware of and communicate the presence of marine mammals in the project area outside the shutdown zone and thus prepare for a potential cease of activity should the animal enter the shutdown zone. The required monitoring zones are described in Table 9. Should PSOs determine the monitoring zone cannot be effectively observed in its entirety, Level B harassment exposures must be recorded and extrapolated based upon the number of observed takes and the percentage of the Level B zone that was not visible.

TABLE 9—MARINE MAMMAL MONITORING ZONES

Activity	Monitoring zone (m)
Impact installation of 12.75-in piles	140
Impact installation of 20-in piles	1,000
Vibratory timber pile removal	1,360
Vibratory installation of 21.75-in piles	2,155
Vibratory installation of 20-in piles	5,415
Drilling	12,100

Soft Start—The use of soft-start procedures are believed to provide additional protection to marine mammals by providing warning and/or giving marine mammals a chance to leave the area prior to the hammer operating at full capacity. For impact pile driving, contractors are required to provide an initial set of strikes from the hammer at reduced energy, with each strike followed by a 30-second waiting period. This procedure must be conducted a total of three times before impact pile driving begins. Soft start must be implemented at the start of each day's impact pile driving and at any time following cessation of impact pile driving for a period of thirty minutes or longer. Soft start is not required during vibratory pile driving and removal activities.

Pre-Activity Monitoring—Prior to the start of daily in-water construction activity, or whenever a break in pile driving/removal or drilling of 30 minutes or longer occurs, PSOs must observe the shutdown and monitoring zones for a period of 30 minutes. The shutdown zone is considered cleared when a marine mammal has not been observed within the zone for a 30-minute period. If a marine mammal is observed within the shutdown zone, a soft-start cannot proceed until the animal has left the zone or has not been observed for 15 minutes. If the Level B harassment zone has been observed for 30 minutes and non-permitted species are not present within the zone, soft start procedures can commence and work can continue even if visibility becomes impaired within the Level B monitoring zone. If a marine mammal permitted for Level B take is present in the Level B harassment zone, activities may begin and Level B take must be recorded. As stated above, if the entire Level B zone is not visible at the start of construction, piling or drilling activities can begin. If work ceases for more than 30 minutes, the pre-activity monitoring of both the Level B and shutdown zone must commence.

Based on our evaluation of the applicant's planned measures, NMFS has determined that the required mitigation measures provide the means effecting the least practicable impact on the affected species or stocks and their habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance.

Monitoring and Reporting

In order to issue an IHA for an activity, Section 101(a)(5)(D) of the MMPA states that NMFS must set forth requirements pertaining to the monitoring and reporting of such taking. The MMPA implementing regulations at 50 CFR 216.104 (a)(13) indicate that requests for authorizations must include the suggested means of accomplishing the necessary monitoring and reporting that will result in increased knowledge of the species and of the level of taking or impacts on populations of marine mammals that are expected to be present in the planned action area. Effective reporting is critical both to compliance as well as ensuring that the most value is obtained from the required monitoring.

Monitoring and reporting requirements prescribed by NMFS should contribute to improved understanding of one or more of the following:

- Occurrence of marine mammal species or stocks in the area in which

take is anticipated (*e.g.,* presence, abundance, distribution, density);

• Nature, scope, or context of likely marine mammal exposure to potential stressors/impacts (individual or cumulative, acute or chronic), through better understanding of: (1) Action or environment (*e.g.,* source characterization, propagation, ambient noise); (2) affected species (*e.g.,* life history, dive patterns); (3) co-occurrence of marine mammal species with the action; or (4) biological or behavioral context of exposure (*e.g.,* age, calving or feeding areas);

• Individual marine mammal responses (behavioral or physiological) to acoustic stressors (acute, chronic, or cumulative), other stressors, or cumulative impacts from multiple stressors;

• How anticipated responses to stressors impact either: (1) Long-term fitness and survival of individual marine mammals; or (2) populations, species, or stocks;

• Effects on marine mammal habitat (*e.g.,* marine mammal prey species, acoustic habitat, or other important physical components of marine mammal habitat); and

• Mitigation and monitoring effectiveness.

Marine Mammal Visual Monitoring

Monitoring must be conducted by NMFS-approved observers. Trained observers must be placed from the best vantage point(s) practicable to monitor for marine mammals and implement shutdown or delay procedures when applicable through communication with the equipment operator. Observer training must be provided prior to project start, and shall include instruction on species identification (sufficient to distinguish the species in the project area), description and categorization of observed behaviors and interpretation of behaviors that may be construed as being reactions to the specified activity, proper completion of data forms, and other basic components of biological monitoring, including tracking of observed animals or groups of animals such that repeat sound exposures may be attributed to individuals (to the extent possible).

Monitoring must be conducted beginning 30 minutes before, during, and continuing through 30 minutes after pile driving/removal and drilling activities. In addition, observers must record all incidents of marine mammal occurrence, regardless of distance from activity, and must document any behavioral reactions in concert with distance from piles being driven or removed. Pile driving/removal and drilling activities include the time to install or remove a single pile or series of piles, as long as the time elapsed between uses of the pile driving equipment is no more than 30 minutes.

At least two PSOs must be on duty during all pile driving activities. One PSO must be stationed at the dock site to allow full monitoring of the waters within the shutdown zones and the closest waters of the Level B harassment monitoring zones. An additional PSO must be positioned in a vessel in Auke Bay to observe the larger monitoring zones. Most of the shoreline of Auke Bay is privately owned and unavailable for PSOs to access. Additionally, PSOs cannot be stationed on the shore of the various islands in Auke Bay due to safety concerns. Therefore, a vessel-based PSO is the most practicable position for this project. Potential PSO locations are shown in Figure 2 in Mr. Erickson's Marine Mammal Monitoring Plan.

PSOs must scan the waters using binoculars, and/or spotting scopes, and must use a handheld GPS or range-finder device to verify the distance to each sighting from the project site. All PSOs must be trained in marine mammal identification and behaviors and are required to have no other project-related tasks while conducting monitoring. In addition, monitoring must be conducted by qualified observers, placed at the best vantage point(s) practicable to monitor for marine mammals and implement shutdown/delay procedures when applicable by calling for the shutdown to the hammer operator. Mr. Erickson must adhere to the following observer qualifications:

(i) Independent observers (*i.e.,* not construction personnel) are required;

(ii) At least one observer must have prior experience working as an observer;

(iii) Other observers may substitute education (degree in biological science or related field) or training for experience; and

(iv) Mr. Erickson must submit observer CVs for approval by NMFS.

Additional standard observer qualifications include:

• Ability to conduct field observations and collect data according to assigned protocols;

• Experience or training in the field identification of marine mammals, including the identification of behaviors;

• Sufficient training, orientation, or experience with the construction operation to provide for personal safety during observations;

• Writing skills sufficient to prepare a report of observations including but not limited to the number and species of marine mammals observed; dates and times when in-water construction activities were conducted; dates and times when in-water construction activities were suspended to avoid potential incidental injury from construction sound of marine mammals observed within a defined shutdown zone; and marine mammal behavior; and

• Ability to communicate orally, by radio or in person, with project personnel to provide real-time information on marine mammals observed in the area as necessary.

A draft marine mammal monitoring report must be submitted to NMFS within 90 days after the completion of pile driving and removal and drilling activities. It must include an overall description of work completed, a narrative regarding marine mammal sightings, and associated PSO data sheets. Specifically, the report must include:

• Date and time that monitored activity begins or ends;

• Construction activities occurring during each observation period;

• Weather parameters (*e.g.,* percent cover, visibility);

• Water conditions (*e.g.,* sea state, tide state);

• Species, numbers, and, if possible, sex and age class of marine mammals observed;

• Description of any observable marine mammal behavior patterns, including bearing and direction of travel and distance from pile driving activity;

• Distance from pile driving activities to marine mammals and distance from the marine mammals to the observation point;

• Locations of all marine mammal observations;

• Other human activity in the area; and

• A summary of the total number of individuals of each species detected within the Level B Harassment Zone, and estimated as taken if correction factor appropriate, and the total number of individuals of each species detected within the Level A Harassment Zone and the average amount of time that they remained in that zone.

If no comments are received from NMFS within 30 days, the draft final report will constitute the final report. If comments are received, a final report addressing NMFS comments must be submitted within 30 days after receipt of comments.

In the unanticipated event that the specified activity clearly causes the take of a marine mammal in a manner prohibited by the IHA (if issued), such

as an injury, serious injury or mortality, Mr. Erickson must immediately cease the specified activities and report the incident to the Chief of the Permits and Conservation Division, Office of Protected Resources, NMFS, and the Alaska Regional Stranding Coordinator. The report must include the following information:

- Description of the incident;
- Environmental conditions (*e.g.,* Beaufort sea state, visibility);
- Description of all marine mammal observations in the 24 hours preceding the incident;
- Species identification or description of the animal(s) involved;
- Fate of the animal(s); and
- Photographs or video footage of the animal(s) (if equipment is available).

Activities must not resume until NMFS is able to review the circumstances of the prohibited take. NMFS would work with Mr. Erickson to determine what is necessary to minimize the likelihood of further prohibited take and ensure MMPA compliance. Mr. Erickson would not be able to resume pile driving activities until notified by NMFS via letter, email, or telephone.

In the event that Mr. Erickson discovers an injured or dead marine mammal, and the lead PSO determines that the cause of the injury or death is unknown and the death is relatively recent (*e.g.,* in less than a moderate state of decomposition as described in the next paragraph), Mr. Erickson must immediately report the incident to the Chief of the Permits and Conservation Division, Office of Protected Resources, NMFS, and the NMFS Alaska Stranding Hotline and/or by email to the Alaska Regional Stranding Coordinator. The report must include the same information identified in the paragraph above. Activities would be able to continue while NMFS reviews the circumstances of the incident. NMFS would work with Mr. Erickson to determine whether modifications in the activities are appropriate.

In the event that Mr. Erickson discovers an injured or dead marine mammal and the lead PSO determines that the injury or death is not associated with or related to the activities authorized in the IHA (*e.g.,* previously wounded animal, carcass with moderate to advanced decomposition, or scavenger damage), Mr. Erickson must report the incident to the Chief of the Permits and Conservation Division, Office of Protected Resources, NMFS, and the NMFS Alaska Stranding Hotline and/or by email to the Alaska Regional Stranding Coordinator, within 24 hours of the discovery. Mr. Erickson must provide photographs, video footage (if available), or other documentation of the stranded animal sighting to NMFS and the Marine Mammal Stranding Network.

Negligible Impact Analysis and Determination

NMFS has defined negligible impact as an impact resulting from the specified activity that cannot be reasonably expected to, and is not reasonably likely to, adversely affect the species or stock through effects on annual rates of recruitment or survival (50 CFR 216.103). A negligible impact finding is based on the lack of likely adverse effects on annual rates of recruitment or survival (*i.e.,* population-level effects). An estimate of the number of takes alone is not enough information on which to base an impact determination. In addition to considering estimates of the number of marine mammals that might be ''taken'' through harassment, NMFS considers other factors, such as the likely nature of any responses (*e.g.,* intensity, duration), the context of any responses (*e.g.,* critical reproductive time or location, migration), as well as effects on habitat, and the likely effectiveness of the mitigation. We also assess the number, intensity, and context of estimated takes by evaluating this information relative to population status. Consistent with the 1989 preamble for NMFS's implementing regulations (54 FR 40338; September 29, 1989), the impacts from other past and ongoing anthropogenic activities are incorporated into this analysis via their impacts on the environmental baseline (*e.g.,* as reflected in the regulatory status of the species, population size and growth rate where known, ongoing sources of human-caused mortality, or ambient noise levels).

Pile driving/removal and drilling activities associated with the project as outlined previously, have the potential to disturb or displace marine mammals. Specifically, the specified activities may result in take, in the form of Level A harassment and Level B harassment from underwater sounds generated from pile driving and removal. Potential takes could occur if individuals of these species are present in zones ensonified above the thresholds for Level A or Level B harassment identified above when these activities are underway.

The takes from Level A and Level B harassment would be due to potential behavioral disturbance, temporary threshold shift (TTS), and PTS. No mortality is anticipated given the nature of the activity and measures designed to minimize the possibility of injury to marine mammals. Level A harassment is only anticipated for harbor porpoise and harbor seal. The potential for harassment is minimized through the construction method and the implementation of the planned mitigation measures (see *Mitigation* section).

Effects on individuals that are taken by Level B harassment, on the basis of reports in the literature as well as monitoring from other similar activities, will likely be limited to reactions such as increased swimming speeds, increased surfacing time, or decreased foraging (if such activity were occurring) (*e.g.,* Thorson and Reyff 2006; HDR, Inc. 2012; Lerma 2014; ABR 2016). Most likely for pile driving, individuals will simply move away from the sound source and be temporarily displaced from the areas of pile driving and drilling, although even this reaction has been observed primarily only in association with impact pile driving. The pile driving activities analyzed here are similar to, or less impactful than, numerous other construction activities conducted in southeast Alaska, which have taken place with no known long-term adverse consequences from behavioral harassment. Level B harassment will be reduced to the level of least practicable adverse impact through use of mitigation measures described herein and, if sound produced by project activities is sufficiently disturbing, animals are likely to simply avoid the area while the activity is occurring. While vibratory driving and drilling associated with the planned project may produce sound at distances of many kilometers from the project site, thus intruding on some habitat, the project site itself is located in a busy harbor and the majority of sound fields produced by the specified activities are close to the harbor. Therefore, we expect that animals annoyed by project sound would simply avoid the area and use more-preferred habitats.

In addition to the expected effects resulting from authorized Level B harassment, we anticipate that harbor porpoises and harbor seals may sustain some limited Level A harassment in the form of auditory injury. However, given the relatively small size of the Level A harassment zones and the anticipated effectiveness of mitigation, animals in these locations that experience PTS would likely only receive slight PTS, *i.e.* minor degradation of hearing capabilities within regions of hearing that align most completely with the energy produced by pile driving, *i.e.* the low-frequency region below 2 kHz, not severe hearing impairment or impairment in the regions of greatest

hearing sensitivity. If hearing impairment occurs, it is most likely that the affected animal would lose a few decibels in its hearing sensitivity, which in most cases is not likely to meaningfully affect its ability to forage and communicate with conspecifics. As described above, we expect that marine mammals would be likely to move away from a sound source that represents an aversive stimulus, especially at levels that would be expected to result in PTS, given sufficient notice through use of soft start.

Nearly all inland waters of southeast Alaska, including Auke Bay, are included in the southeast Alaska humpback whale feeding BIA (Ferguson *et al.,* 2015), though humpback whale distribution in southeast Alaska varies by season and waterway (Dahlheim *et al.,* 2009). Humpback whales are present within Auke Bay intermittently and in low numbers. The area of the BIA that may be affected by the planned project is small relative to the overall area of the BIA, and the area of suitable humpback whale habitat that is not included in the BIA. The southeast Alaska humpback whale feeding BIA is active between March and November. While the exact timing of the planned project is unknown, Mr. Erickson's pile driving activities are expected to take only eight days. If the project were to occur between March and November, the days of activity represent a small fraction of the time the BIA is active and, thus, even if humpback whale feeding behaviors were interrupted by the activity, the disturbance would be short-term and alternative habitat and foraging opportunities are available nearby. Further, only a very small portion of the humpback stock is expected to enter the area and potentially be disturbed. Therefore, any adverse effects on humpback whales resulting from disturbances occurring in the southeast Alaska humpback whale feeding BIA are expected to be short-term and minor and not adversely impact reproduction or survival, much less the stock.

The project also is not expected to have significant adverse effects on affected marine mammals' habitat. The project activities would not modify existing marine mammal habitat for a significant amount of time. The activities may cause some fish to leave the area of disturbance, thus temporarily impacting marine mammals' foraging opportunities in a limited portion of the foraging range; but, because of the short duration of the activities and the relatively small area of the habitat that may be affected, the impacts to marine mammal habitat are not expected to cause significant or long-term negative consequences.

In summary and as described above, the following factors primarily support our determination that the impacts resulting from this activity are not expected to adversely affect the species or stock through effects on annual rates of recruitment or survival:

- No mortality is anticipated or authorized;
- The Level A harassment exposures are anticipated to result only in slight PTS, within the lower frequencies associated with pile driving;
- The anticipated incidents of Level B harassment would consist of, at worst, temporary modifications in behavior that would not result in fitness impacts to individuals;
- The area impacted by the specified activity is very small relative to the overall habitat ranges of all species, does not include ESA-designated critical habitat, and only temporally overlaps with the southeast Alaska humpback whale feeding BIA for two months of the planned six months of activity; and
- The required mitigation measures are expected to reduce the effects of the specified activity to the level of least practicable adverse impact.

In addition, although affected humpback whales and Steller sea lions may be from a DPS that is listed under the ESA, it is unlikely that minor noise effects in a small, localized area of habitat would have any effect on the stocks' ability to recover. In combination, we believe that these factors, as well as the available body of evidence from other similar activities, demonstrate that the potential effects of the specified activities will have only minor, short-term effects on individuals. The specified activities are not expected to impact rates of recruitment or survival and will therefore not result in population-level impacts.

Based on the analysis contained herein of the likely effects of the specified activity on marine mammals and their habitat, and taking into consideration the implementation of the required monitoring and mitigation measures, NMFS finds that the total marine mammal take from the planned activity will have a negligible impact on all affected marine mammal species or stocks.

Small Numbers

As noted above, only small numbers of incidental take may be authorized under Sections 101(a)(5)(A) and (D) of the MMPA for specified activities other than military readiness activities. The MMPA does not define small numbers and so, in practice, where estimated numbers are available, NMFS compares the number of individuals taken to the most appropriate estimation of abundance of the relevant species or stock in our determination of whether an authorization is limited to small numbers of marine mammals. Additionally, other qualitative factors may be considered in the analysis, such as the temporal or spatial scale of the activities.

Table 8 indicates the number of animals that could be exposed to received noise levels that could cause Level A and Level B harassment for the planned work in Auke Bay. Our analysis shows that less than 11 percent of each affected stock could be taken by harassment. The numbers of animals authorized to be taken for these stocks would be considered small relative to the relevant stock's abundances even if each estimated taking occurred to a new individual—an extremely unlikely scenario.

Based on the analysis contained herein of the planned activity (including the required mitigation and monitoring measures) and the anticipated take of marine mammals, NMFS finds that small numbers of marine mammals will be taken relative to the population size of the affected species or stocks.

Unmitigable Adverse Impact Analysis and Determination

In order to issue an IHA, NMFS must find that the specified activity will not have an ''unmitigable adverse impact'' on the subsistence uses of the affected marine mammal species or stocks by Alaskan Natives. NMFS has defined ''unmitigable adverse impact'' in 50 CFR 216.103 as an impact resulting from the specified activity: (1) That is likely to reduce the availability of the species to a level insufficient for a harvest to meet subsistence needs by: (i) Causing the marine mammals to abandon or avoid hunting areas; (ii) Directly displacing subsistence users; or (iii) Placing physical barriers between the marine mammals and the subsistence hunters; and (2) That cannot be sufficiently mitigated by other measures to increase the availability of marine mammals to allow subsistence needs to be met.

The planned project is not known to occur in an important subsistence hunting area. Auke Bay is a developed area with regular marine vessel traffic. Of the marine mammals considered in this IHA, only harbor seals are known to be used for subsistence in the project area. In a previous consultation with ADF&G, the Douglas Indian Association, Sealaska Heritage Institute, and the Central Council of the Tlingit and Haida

Indian Tribes of Alaska, representatives indicated that the primary concern with construction activities in Statter Harbor was impacts to herring fisheries, not marine mammals. As stated above, impacts to fish from the planned project are expected to be localized and temporary, so are not likely to impact herring fisheries. If any tribes express concerns regarding project impacts to subsistence hunting of marine mammals, further communication between will take place, including provision of any project information, and clarification of any mitigation and minimization measures that may reduce potential impacts to marine mammals.

Based on the description of the specified activity, the measures described to minimize adverse effects on the availability of marine mammals for subsistence purposes, and the required mitigation and monitoring measures, NMFS has determined that there will not be an unmitigable adverse impact on subsistence uses from Mr. Erickson's planned activities.

Endangered Species Act (ESA)

Section 7(a)(2) of the Endangered Species Act of 1973 (ESA: 16 U.S.C. 1531 *et seq.*) requires that each Federal agency insure that any action it authorizes, funds, or carries out is not likely to jeopardize the continued existence of any endangered or threatened species or result in the destruction or adverse modification of designated critical habitat. To ensure ESA compliance for the issuance of IHAs, NMFS consults internally, in this case with the Alaska Regional Office, whenever we propose to authorize take for endangered or threatened species.

NMFS Alaska Region issued a Biological Opinion to NMFS Office of Protected Resources on November 15, 2019, which concluded the issuance of an IHA to Mr. Erickson is not likely to jeopardize the continued existence of wDPS Steller sea lions or Mexico DPS humpback whales or adversely modify critical habitat.

National Environmental Policy Act

To comply with the National Environmental Policy Act of 1969 (NEPA; 42 U.S.C. 4321 *et seq.*) and NOAA Administrative Order (NAO) 216–6A, NMFS must review our action (*i.e.,* the issuance of an incidental harassment authorization) with respect to potential impacts on the human environment.

This action is consistent with categories of activities identified in Categorical Exclusion B4 (incidental harassment authorizations with no anticipated serious injury or mortality) of the Companion Manual for NOAA Administrative Order 216–6A, which do not individually or cumulatively have the potential for significant impacts on the quality of the human environment and for which we have not identified any extraordinary circumstances that would preclude this categorical exclusion. Accordingly, NMFS has determined that the issuance of the IHA qualifies to be categorically excluded from further NEPA review.

Authorization

NMFS has issued an IHA to Mr. Erickson for conducting pile installation and removal activities at the Erickson Residence between January 1, 2020 and December 31, 2020, provided the previously mentioned mitigation, monitoring, and reporting requirements are incorporated.

Dated: November 21, 2019.

Donna S. Wieting,

Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2019–25688 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

United States Patent and Trademark Office

Submission for OMB Review; Comment Request; Legal Processes

The United States Patent and Trademark Office (USTPO) will submit to the Office of Management and Budget (OMB) for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act of 1995.

Agency: United States Patent and Trademark Office, (USPTO).

Title: Legal Processes.

OMB Control Number: 0651–0046.

Form Number(s): None.

Type of Request: Extension of an existing information collection.

Number of Respondents: 309 responses per year. The USPTO estimates that approximately 10% of these responses will be from small entities.

Average Hours per Response: The USPTO estimates that it will take the public from 5 minutes (0.08 hours) to 6 hours to prepare a single item in this collection, including gathering the necessary information, preparing the appropriate documents, and submitting the information required for this collection.

Burden Hours: 132 hours.

Cost Burden (non-hourly): $7,621. This cost burden includes filing fees associated with the petition to waive or suspend the legal process rules under 37 CFR 104.3 and postage costs associated with the items in the collection.

Needs and Uses: The purpose of this collection is to cover information requirements related to civil actions and claims involving current and former employees of the United States Patent and Trademark Office (USPTO). The rules for these legal processes may be found under 37 CFR part 104, which outlines procedures for service of process, demands for employee testimony and production of documents in legal proceedings, reports of unauthorized testimony, employee indemnification, and filing claims against the USPTO under the Federal Tort Claims Act (28 U.S.C. 2672) and the corresponding Department of Justice regulations (28 CFR part 14). The public may also petition the USPTO Office of General Counsel under 37 CFR 104.3 to waive or suspend these rules in extraordinary cases.

There are no forms provided by the USPTO for this collection. For filing claims under the Federal Tort Claims Act, the public may use Standard Form 95 ''Claim for Damage, Injury, or Death,'' which is provided by the Department of Justice and approved by the Office of Management and Budget (OMB) under OMB Control Number 1105–0008.

Affected Public: Individuals or households; businesses or other for-profits; not-for-profit institutions; and the Federal Government.

Frequency: On occasion.

Respondent's Obligation: Required to Obtain or Retain Benefits.

OMB Desk Officer: Nicholas A. Fraser, email: *Nicholas_A._Fraser@omb.eop.gov*. Once submitted, the request will be publicly available in electronic format through *reginfo.gov*. Follow the instructions to view Department of Commerce collections currently under review by OMB.

Further information can be obtained by:

- *Email: InformationCollection@uspto.gov.* Include ''0651–0046 information request'' in the subject line of the message.
- *Mail:* Marcie Lovett, Records and Information Governance Branch, Office of the Chief Administration Officer, United States Patent and Trademark Office, P.O. Box 1450, Alexandria, VA 22313–1450.

Written comments and recommendations for the proposed information collection should be sent on or before December 27, 2019 to Nicholas A. Fraser, OMB Desk Officer, via email to *Nicholas_A._Fraser@omb.eop.gov,* or

by fax to 202–395–5167, marked to the attention of Nicholas A. Fraser.

Marcie Lovett,

Director, Records and Information Governance Branch, OAS, Office of the Chief Administrative Officer, United States Patent and Trademark Office.

[FR Doc. 2019–25747 Filed 11–26–19; 8:45 am]

BILLING CODE 3510–16–P

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Day of Service Application Instructions; Proposed Information Collection; Comment Request

AGENCY: Corporation for National and Community Service.

ACTION: Notice.

SUMMARY: The Corporation for National and Community Service (CNCS) has submitted a public information collection request (ICR) entitled Day of Service Application Instructions for review and approval in accordance with the Paperwork Reduction Act.

DATES: Written comments must be submitted to the individual and office listed in the **ADDRESSES** section by December 27, 2019.

ADDRESSES: Direct written comments and/or suggestions regarding the items contained in this Notice to the Attention: CNCS Desk Officer, Office of Information and Regulatory Affairs, 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.

FOR FURTHER INFORMATION CONTACT: Copies of this ICR, with applicable supporting documentation, may be obtained by calling the Corporation for National and Community Service, Sara Fry, at 202–815–4982 or by email to *sfry@cns.gov.*

SUPPLEMENTARY INFORMATION: The OMB is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of CNCS, 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;
- Propose ways to enhance the quality, utility, and clarity of the information to be collected; and
- Propose ways to 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.

Comments

A 60-day Notice requesting public comment was published in the **Federal Register** on August 29, 2019 at Vol. 84 page 45471. This comment period ended October 28, 2019. One public comment, which was not applicable to the Notice's content, was received.

Title of Collection: Day of Service Application Instructions.

OMB Control Number: 3045–0180.

Type of Review: Renewal.

Respondents/Affected Public: Nonprofit Organizations.

Total Estimated Number of Annual Responses: 70.

Total Estimated Number of Annual Burden Hours: 1,260.

Abstract: This information collection seeks feedback on CNCS's Day of Service Application Instructions for future Day of Service grant competitions after the expiration of the current Application Instructions. CNCS also seeks to continue using the currently approved information collection until the revised information collection is approved by OMB. The currently approved information collection is due to expire on December 31, 2019.

Dated: November 20, 2019.

Sara Fry,

Days of Service Program Officer.

[FR Doc. 2019–25751 Filed 11–26–19; 8:45 am]

BILLING CODE 6050–28–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2019–ICCD–0124]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Accrediting Agencies Reporting Activities for Institutions and Programs—Database of Accredited Postsecondary Institution and Programs (DAPIP)

AGENCY: Office of Postsecondary Education (OPE), 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 December 27, 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–0124. 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 Strategic Collections and Clearance Governance and Strategy Division, U.S. Department of Education, 400 Maryland Ave. SW, LBJ, Room 6W–208D, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Herman Bounds, 202–453–6128.

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: Accrediting Agencies Reporting Activities for Institutions and Programs—Database of Accredited Postsecondary Institution and Programs (DAPIP).

OMB Control Number: 1840–0838.

Type of Review: A revision of an existing information collection.

Respondents/Affected Public: Private Sector.

Total Estimated Number of Annual Responses: 6,654.

Total Estimated Number of Annual Burden Hours: 555.

Abstract: Sections 496(a)(7), (a)(8), (c)(7), and (c)(8) of the Higher Education Act (HEA), and federal regulations at 34 CFR 602.26 and 602.27(a)(6) and (a)(7) contain certain requirements for reporting by recognized accrediting agencies to the Department on the institutions and programs the agencies accredit. The proposed information collection outlines categories of terminology used by accrediting agencies to describe actions and statuses, and provides guidance to federally recognized accrediting agencies on the information to be reported to the Department under 34 CFR 602.26 and 602.27(a)(6) and (a)(7). Some of the reporting discussed is required; some is requested. This collection specifies which is which. It also discusses the channel for reporting this information, whether requested or required, and for reporting information the accrediting agency may wish to submit voluntarily to ensure that the Department's Database of Accredited Postsecondary Institutions and Programs is accurate and comprehensive.

Dated: November 22, 2019.

Kate Mullan,

PRA Coordinator, Strategic Collections and Clearance, Governance and Strategy Division, Office of Chief Data Officer.

[FR Doc. 2019–25783 Filed 11–26–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2019–ICCD–0121]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Form for Maintenance of Effort Waiver Requests

AGENCY: Office of Elementary and Secondary Education (OESE), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing an extension of an existing information collection.

DATES: Interested persons are invited to submit comments on or before December 27, 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–0121. 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 Strategic Collections and Clearance Governance and Strategy Division, U.S. Department of Education, 400 Maryland Ave. SW, LBJ, Room 6W–208D, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Todd Stephenson, 202–205–1645.

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: Form for Maintenance of Effort Waiver Requests.

OMB Control Number: 1810–0693.

Type of Review: An extension of an existing information collection.

Respondents/Affected Public: State, Local, and Tribal Governments.

Total Estimated Number of Annual Responses: 20.

Total Estimated Number of Annual Burden Hours: 1,600.

Abstract: Section 8521(a) of the Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act (ESEA) provides that a local educational agency (LEA) may receive funds under Title I, Part A and other ESEA ''covered programs'' for any fiscal year only if the State educational agency (SEA) finds that either the combined fiscal effort per student or the aggregate expenditures of the LEA and the State with respect to the provision of free public education by the LEA for the preceding fiscal year was not less than 90 percent of the combined fiscal effort or aggregate expenditures for the second preceding fiscal year. This provision is the maintenance of effort (MOE) requirements for LEAs under the ESEA.

If an LEA fails to meet the MOE requirement, under section 8521(b) of the ESEA, the SEA must reduce the amount of funds allocated under the programs covered by the MOE requirement in any fiscal year in the exact proportion by which the LEA fails to maintain effort by falling below 90 percent of either the combined fiscal effort per student or aggregate expenditures, if the LEA has also failed to maintain effort for 1 or more of the 5 immediately preceding fiscal years. In

reducing an LEA's allocation because it failed to meet the MOE requirement, the SEA uses the measure most favorable to the LEA.

Section 8521(c) gives the U.S. Department of Education (ED) the authority to waive the ESEA's MOE requirement for an LEA if it would be equitable to grant the waiver due to an exceptional or uncontrollable circumstance such as a natural disaster or a change in the organizational structure of the LEA or a precipitous decline in the LEA's financial resources. If an MOE waiver is granted, the reduction required by section 8521(b) does not occur for that year.

A request for a waiver of the MOE requirement is discretionary. Only an LEA that has failed to maintain effort and that believes its failure justifies a waiver would request one. To review an MOE waiver request, ED relies primarily on expenditure, revenue, and other data relevant to an LEA's request provided by the SEA. To assist an SEA with submitting this information, ED developed an MOE waiver form as part of the 2009 Title I, Part A Waiver Guidance, which covered a range of waivers that ED invited at that time.

The purpose of this collection is to renew approval for the MOE waiver form. This MOE waiver form has been updated to reflect the statutory changes in the ESEA, as amended by the Every Student Succeeds Act. ED believes that the proposed form, which is slightly modified from the currently approved version, will enable an SEA to provide the information needed in an efficient manner. This collection includes burden at the SEA level.

Dated: November 22, 2019.

Kate Mullan,

PRA Coordinator, Strategic Collections and Clearance, Governance and Strategy Division, Office of Chief Data Officer.

[FR Doc. 2019–25738 Filed 11–26–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2019–ICCD–0146]

Agency Information Collection Activities; Comment Request; Student Assistance General Provision—Subpart E—Verification Student Aid Application Information

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 January 27, 2020.

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–0146. 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 Strategic Collections and Clearance Governance and Strategy Division, U.S. Department of Education, 400 Maryland Ave. SW, LBJ, Room 6W–208D, Washington, DC 20202–4537.

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: Student Assistance General Provision—Subpart E—Verification Student Aid Application Information.

OMB Control Number: 1845–0041.

Type of Review: A revision of an existing information collection.

Respondents/Affected Public: State, Local, and Tribal Governments; Individuals or Households; Private Sector.

Total Estimated Number of Annual Responses: 25,180,342.

Total Estimated Number of Annual Burden Hours: 4,048,184.

Abstract: This request is for a revision of the information collection supporting the policies and reporting requirements contained in Subpart E of Part 668—Verification and Updating of Student Aid Application Information. Sections 668.53, 668.54, 668.55, 668.56, 668.57, 668.59 and 668.61 contain information collection requirements (OMB control number 1845–0041). This subpart governs the verification and updating of the Free Application for Federal Student Aid used to calculate an applicant's Expected Family Contribution for purposes of determining an applicant's need for student financial assistance under Title IV of Higher Education Act of 1965, as amended. The collection of this documentation helps ensure that students (and parents in the case of PLUS loans) receive the correct amount of Title IV program assistance by providing accurate information to calculate an applicant's expected family contribution. There has been no change to the regulatory language.

Dated: November 21, 2019.

Kate Mullan,

PRA Coordinator, Strategic Collections and Clearance, Governance and Strategy Division, Office of Chief Data Officer.

[FR Doc. 2019–25690 Filed 11–26–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2019–ICCD–0065]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Significant Disproportionality State Survey

AGENCY: Office of Special Education and Rehabilitative Services (OSERS), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing a new information collection.

DATES: Interested persons are invited to submit comments on or before December 27, 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–0065. 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 Strategic Collections and Clearance Governance and Strategy Division, U.S. Department of Education, 400 Maryland Ave. SW, LBJ, Room 6W208, D, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Mary Louise Dirrigl, 202–245–7324.

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: Significant Disproportionality State Survey.

OMB Control Number: 1820–NEW.

Type of Review: A new information collection.

Respondents/Affected Public: State, Local, and Tribal Governments.

Total Estimated Number of Annual Responses: 50.

Total Estimated Number of Annual Burden Hours: 100.

Abstract: This new collection will collect detailed information on the State's use of the standard methodology, or another methodology based upon risk ratios and risk ratio thresholds, to identify significant disproportionality in the LEAs of the State. The Department will use this information to support States and LEAs in their efforts to comply with the statutory requirement at section 618(d) of the IDEA. Specifically, the collection will include information about the extent to which each State has implemented the standard methodology, and steps necessary for States to be in compliance with the December 2016 regulation, including anticipated obstacles States will face and the extent to which States have considered safeguards to ensure compliance with federal law and the U.S. Constitution. This information will allow the Department to determine the appropriate time and manner for the States to report their standards required under 34 CFR 300.647(b)(7), and to fulfill its role of monitoring and enforcement for reasonableness under 34 CFR 300.647(b)(1)(iii).

Dated: November 22, 2019.

Kate Mullan,

PRA Coordinator, Strategic Collections and Clearance, Governance and Strategy Division, Office of Chief Data Officer.

[FR Doc. 2019–25804 Filed 11–26–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Advanced Scientific Computing Advisory Committee

AGENCY: Office of Science, Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: This notice announces a meeting of the Advanced Scientific Computing Advisory Committee (ASCAC). The Federal Advisory Committee Act requires that public notice of these meetings be announced in the **Federal Register**.

DATES: Monday, January 13, 2020; 8:30 a.m. to 5:00 p.m.; Tuesday, January 14, 2020; 9:00 a.m. to 12:00 p.m.

ADDRESSES: Holiday Inn Washington-Capitol, 550 C Street SW, Washington, DC 20024.

FOR FURTHER INFORMATION CONTACT: Christine Chalk, Office of Advanced Scientific Computing Research; SC–21/Germantown Building; U.S. Department of Energy; 1000 Independence Avenue SW, Washington, DC 20585; Telephone (301) 903–7486; email: *Christine.chalk@science.doe.gov.*

SUPPLEMENTARY INFORMATION:

Purpose of the Committee: The purpose of the committee is to provide advice and guidance on a continuing basis to the Office of Science and to the Department of Energy on scientific priorities within the field of advanced scientific computing research.

Purpose of the Meeting: This meeting is the semi-annual meeting of the Committee.

Tentative Agenda Topics:

- View from Washington
- View from Germantown
- Update on Exascale project activities
- Report from Subcommittee on 40 years of investments by the Department of Energy in advanced computing and networking
- Report from Exascale Transition Subcommittee
- Report from AI Town Halls
- New Charge on AI coordination across SC programs
- Technical presentations
- Public Comment (10-minute rule)

The meeting agenda includes an update on the budget, accomplishments and planned activities of the Advanced Scientific Computing Research program and the exascale computing project; an update from the Office of Science; technical presentations from funded researchers; updates from subcommittees and there will be an opportunity for comments from the public. The meeting will conclude at 12:00 p.m. on January 14, 2020. Agenda updates and presentations will be posted on the ASCAC website prior to the meeting: *https://science.osti.gov/ascr/ascac.*

Public Participation: The meeting is open to the public. Individuals and representatives of organizations who would like to offer comments and

suggestions may do so during the meeting. Approximately 30 minutes will be reserved for public comments. Time allotted per speaker will depend on the number who wish to speak but will not exceed 10 minutes. The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Those wishing to speak should submit your request at least five days before the meeting. Those not able to attend the meeting or who have insufficient time to address the committee are invited to send a written statement to Christine Chalk, U.S. Department of Energy, 1000 Independence Avenue SW, Washington DC 20585; email to: *Christine.Chalk@science.doe.gov*.

Minutes: The minutes of this meeting will be available within 90 days on the Advanced Scientific Computing website at: *https://science.osti.gov/ascr/ascac*.

Signed in Washington, DC on November 21, 2019.

LaTanya R. Butler,

Deputy Committee Management Officer.

[FR Doc. 2019–25743 Filed 11–26–19; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Exports of U.S-Origin Highly Enriched Uranium for Medical Isotope Production: Sufficient or Insufficient Supplies of Non-HEU-based Molybdenum-99 for United States Domestic Demand; Request for Public Comment

AGENCY: National Nuclear Security Administration, Department of Energy.

ACTION: Notice; request for public comment.

SUMMARY: The U.S. Department of Energy (DOE), in accordance with the American Medical Isotope Production Act of 2012 (AMIPA), is preparing for a Secretarial certification regarding the sufficiency of supply of non-HEU based molybdenum-99 (Mo-99). DOE will collect input from the public as part of its certification development process and consider this information as part of its analysis to determine the state of Mo-99 supply to meet U.S. patient needs.

DATES: DOE will accept comments, data, and information in response to this notice on or before December 27, 2019.

ADDRESSES: Interested persons may submit comments by any of the following methods.

1. *Email: joan.dix@nnsa.doe.gov;*
2. *Postal Mail:* Joan Dix, Deputy Director, Office of Conversion, Department of Energy, National Nuclear Security Administration, 1000 Independence Avenue SW, Washington, DC 20585.

Instructions: All submissions received must include the agency name for this request for public comment. No facsimiles (faxes) will be accepted. Due to potential delays in DOE's receipt and processing of mail sent through the U.S. Postal Service, DOE encourages responders to submit comments electronically to ensure timely receipt.

FOR FURTHER INFORMATION CONTACT: Requests for additional information may be sent to: Joan Dix, Deputy Director, Office of Conversion, *joan.dix@nnsa.doe.gov,* 202–586–2695.

SUPPLEMENTARY INFORMATION:

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I. Authority and Background
II. Issues on Which DOE Seeks Comment and Information
III. Submission of Comments
IV. Confidential Business Information

I. Authority and Background

The American Medical Isotopes Production Act of 2012 (AMIPA) (Subtitle F, Title XXXI of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112–139)), enacted on January 2, 2013, amended Section 134 of the Atomic Energy Act of 1954 (42 U.S.C. 2160d) by striking subsection c. and inserting language that prohibits the Nuclear Regulatory Commission (NRC) from issuing a license for the export of highly enriched uranium (HEU) from the United States for the purposes of medical isotope production, effective seven years after enactment of AMIPA subject to a certification regarding the sufficiency of Mo-99 supply in the United States.

The law requires the Secretary of Energy to either jointly certify, with the Secretary of Health and Human Services, that there is a sufficient supply of Mo-99 produced without the use of HEU available to meet U.S. patient needs, and that it is not necessary to export U.S.-origin HEU for the purposes of medical isotope production regarding the sufficiency of Mo-99 supply, or, to unilaterally certify that there is insufficient supply of Mo-99 produced without the use of HEU available to satisfy the domestic market and that the export of U.S.-origin HEU for the purposes of medical isotope production is the most effective temporary means to increase the supply of Mo-99 to the domestic U.S. market, thereby delaying the enactment of the export license ban for up to six years.

In accordance with AMIPA and to ensure public review and comments the development of the certification is being announced in the **Federal Register**.

The U.S. medical community depends on a reliable supply of the radioisotope Mo-99 for nuclear medical diagnostic and therapeutic procedures. Approximately 80 percent of all of these procedures depend on the use of technetium-99m (Tc-99m), a decay product of Mo-99. Tc-99m is used in approximately 40,000 diagnostic and therapeutic nuclear medicine procedures every day in the United States. Its primary uses include diagnosing heart disease, treating cancer, and studying organ structure and function. Historically, the United States has not had the capability to produce Mo-99 domestically and, until 2018, imported 100 percent of its supply from international producers, some of which was produced using targets fabricated with proliferation sensitive HEU.

II. Issues on Which DOE Seeks Comment and Information

This request for public comment seeks information from interested parties on the status of Mo-99 supplies for U.S. patients. For all comments, DOE requests that interested parties fully explain any assumptions that underlie their reasoning. DOE also requests that commenters provide underlying data or other information sufficient to allow DOE to review and verify any of the assumptions, calculations or views expressed by the commenters. DOE specifically invites public comment on the following questions:

(1) Do current supplies of Mo-99 meet U.S. patient demand?

(2) Do current supplies of non-HEU based Mo-99 meet U.S. patient demand?

(3) Have there been shortages of Mo-99 in the United States? If so, how severe, how often, and how did shortages impact patient care?

(4) What has caused shortages of Mo-99 in the United States?

(5) How would extending the period that the NRC may issue HEU export licenses for medical isotope production impact the supply of Mo-99 to the United States?

(6) How would enacting a ban on the export of HEU for medical isotope production impact the supply of Mo-99 to the United States?

Although comments are particularly welcome on the issues discussed above, DOE also requests comments on other topics that commenters consider significant in preparing for the Secretarial certification.

III. Submission of Comments

DOE will accept comments, data, and information in response to this notice on or before December 27, 2019. Any information that may be confidential and exempt by law from public disclosure should be submitted as described in section IV of this document, Confidential Business Information.

IV. Confidential Business Information

Pursuant to 10 CFR 1004.11, any person submitting information he or she believes to be confidential and exempt by law from public disclosure should submit via email or postal mail two well-marked copies: One copy of the document marked ''confidential'' including all the information believed to be confidential, and one copy of the document marked ''non-confidential'' with the information believed to be confidential deleted. DOE will make its own determination about the confidential status of the information and treat it according to its determination.

Dated: November 20, 2019.
For the Department of Energy.

Brent K. Park,

Deputy Administrator, Defense Nuclear Nonproliferation.

[FR Doc. 2019–25784 Filed 11–26–19; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Docket Number: PR20–11–000.
Applicants: Acadian Gas Pipeline System.
Description: Tariff filing per 284.123(b),(e)+(g): SOC Update to be effective 10/1/2019.
Filed Date: 11/20/19.
Accession Number: 201911205078.
Comments Due: 5 p.m. ET 12/11/19.
284.123(g) Protests Due: 5 p.m. ET 1/21/20.

Docket Numbers: RP19–1090–003.
Applicants: American Midstream (AlaTenn), LLC.
Description: Compliance filing Compliance to 724 to be effective 8/1/2019.
Filed Date: 11/19/19.
Accession Number: 20191119–5129.
Comments Due: 5 p.m. ET 12/2/19.

Docket Numbers: RP20–235–000.
Applicants: Southern Star Central Gas Pipeline, Inc.
Description: Compliance filing Annual Cash-out Refund Report 2019.
Filed Date: 11/20/19.
Accession Number: 20191120–5058.
Comments Due: 5 p.m. ET 12/2/19.

Docket Numbers: RP20–236–000.
Applicants: Northern Natural Gas Company.
Description: § 4(d) Rate Filing: 20191120 Negotiated Rates to be effective 11/21/2019.
Filed Date: 11/20/19.
Accession Number: 20191120–5103.
Comments Due: 5 p.m. ET 12/2/19.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: November 21, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2019–25722 Filed 11–26–19; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following exempt wholesale generator filings:

Docket Numbers: EG20–35–000.
Applicants: AES Kekaha Solar, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of AES Kekaha Solar, LLC.
Filed Date: 11/20/19.
Accession Number: 20191120–5120.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: EG20–36–000.
Applicants: Coachella Wind Holdings, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Coachella Wind Holdings, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5093.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–37–000.
Applicants: Desert Hot Springs, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Desert Hot Springs, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5095.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–38–000.
Applicants: Mojave 16/17/18 LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Mojave 16/17/18 LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5098.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–39–000.
Applicants: Oasis Alta, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Oasis Alta, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5102.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–40–000.
Applicants: Mojave 3/4/5 LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Mojave 3/4/5 LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5104.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–41–000.
Applicants: Painted Hills Wind Holdings, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Painted Hills Wind Holdings, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5107.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–42–000.
Applicants: Refresh Wind 2, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Refresh Wind 2, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5110.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–43–000.
Applicants: Refresh Wind, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Refresh Wind, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5113.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–44–000.

Applicants: San Jacinto Wind II, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of San Jacinto Wind II, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5117.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: EG20–45–000.
Applicants: Terra-Gen 251 Wind, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Terra-Gen 251 Wind, LLC.
Filed Date: 11/21/19.
Accession Number: 20191121–5122.
Comments Due: 5 p.m. ET 12/12/19.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER10–1852–031; ER10–1951–016; ER11–4462–037; ER16–1277–007; ER16–1293–006; ER16–1354–006; ER17–838–012; ER18–1952–006.
Applicants: Florida Power & Light Company, Gulf Power Company, Live Oak Solar, LLC, NEPM II, LLC, NextEra Energy Services Massachusetts, LLC, NextEra Energy Marketing, LLC, White Oak Solar, LLC, White Pine Solar, LLC.
Description: Notification of Non-material Change in Status of the NextEra Resource Entities.
Filed Date: 11/19/19.
Accession Number: 20191119–5169.
Comments Due: 5 p.m. ET 12/10/19.

Docket Numbers: ER12–672–013.
Applicants: Brea Power II, LLC.
Description: Notice of Non-Material Change in Status of Brea Power II, LLC.
Filed Date: 11/19/19.
Accession Number: 20191119–5174.
Comments Due: 5 p.m. ET 12/10/19.

Docket Numbers: ER19–2582–000.
Applicants: Pacific Gas and Electric Company.
Description: Response of Pacific Gas and Electric Company to October 4, 2019 letter requesting additional information; and also an Errata to Response of Pacific Gas and Electric Company to October 4, 2019 letter requesting additional information.
Filed Date: 11/19/19.
Accession Number: 20191119–5020, 20191119–5142.
Comments Due: 5 p.m. ET 12/10/19.

Docket Numbers: ER19–2893–001.
Applicants: El Paso Electric Company.
Description: Tariff Amendment: Rate Schedule No. 18 EPE Power Sales Agreement with RGEC to be effective 8/1/2017.
Filed Date: 11/20/19.
Accession Number: 20191120–5137.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–195–000.
Applicants: Diamond Leaf Energy, LLC.
Description: Supplement to October 25 2019 Diamond Leaf Energy, LLC tariff filing.
Filed Date: 11/8/19.
Accession Number: 20191108–5105.
Comments Due: 5 p.m. ET 12/2/19.

Docket Numbers: ER20–419–001.
Applicants: ITC Midwest LLC.
Description: Tariff Amendment: Amendment to Filing of a CIAC Agreement with Northern States to be effective 1/19/2020.
Filed Date: 11/20/19.
Accession Number: 20191120–5111.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–427–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: Revisions to Clarify Transmission Invoicing to be effective 1/19/2020.
Filed Date: 11/20/19.
Accession Number: 20191120–5112.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–428–000.
Applicants: Pacific Gas and Electric Company.
Description: § 205(d) Rate Filing: November 2019 Western IA Biannual Filing (SA 59) to be effective 2/1/2020.
Filed Date: 11/20/19.
Accession Number: 20191120–5126.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–429–000.
Applicants: Pacific Gas and Electric Company.
Description: § 205(d) Rate Filing: November 2019 Western WDT Service Agreement Biannual Filing (SA 17) to be effective 2/1/2020.
Filed Date: 11/20/19.
Accession Number: 20191120–5128.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–430–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2829R4 Midwest Energy/Evergy Kansas Central Meter Agent Agr to be effective 11/1/2019.
Filed Date: 11/20/19.
Accession Number: 20191120–5136.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–431–000.
Applicants: Ohio Power Company, AEP Ohio Transmission Company, Inc., PJM Interconnection, L.L.C.
Description: § 205(d) Rate Filing: AEP submits ILDSA, SA No. 1336 and 3 Facilities Agreements to be effective 1/21/2020.
Filed Date: 11/21/19.
Accession Number: 20191121–5004.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–432–000.
Applicants: The Empire District Electric Company.
Description: Application for Waiver of Affiliate Rules of The Empire District Electric Company.
Filed Date: 11/20/19.
Accession Number: 20191120–5143.
Comments Due: 5 p.m. ET 12/11/19.

Docket Numbers: ER20–433–000.
Applicants: Tampa Electric Company.
Description: Tariff Cancellation: Cancellation of Rate Schedule FERC No. 100—Plant City IA to be effective 12/18/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5021.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–434–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 3101R4 Heartland Consumers Power District NITSA and NOA to be effective 11/1/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5026.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–435–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 3114R4 Resale Power Group of Iowa to be effective 11/1/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5034.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–436–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 3473R1 Upstream Wind/Evergy Kansas Central Meter Agent Agr to be effective 11/1/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5038.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–437–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 3280R1 Marshall Wind/Evergy Kansas Central Meter Agent Agr to be effective 11/1/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5061.
Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–438–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2825R6 KMEA and Evergy Kansas Central Meter Agent Agreement to be effective 11/1/2019.
Filed Date: 11/21/19.
Accession Number: 20191121–5126.

Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–439–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: 2817R1 Flat Ridge 2 Wind Energy/ Evergy Kansas Meter Agent Ag to be effective 11/1/2019.

Filed Date: 11/21/19.

Accession Number: 20191121–5135.

Comments Due: 5 p.m. ET 12/12/19.

Docket Numbers: ER20–440–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: § 205(d) Rate Filing: 2019–11–21_SA 3373 Entergy Arkansas-Newport Solar GIA (J919) to be effective 11/6/2019.

Filed Date: 11/21/19.

Accession Number: 20191121–5148.

Comments Due: 5 p.m. ET 12/12/19.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: November 21, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2019–25723 Filed 11–26–19; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. NJ20–4–000]

South Central Generating LLC; Notice of Filing

Take notice that on November 19, 2019 South Central Generating LLC submitted a refund report during the period January 18, 2019, through May 31, 2019.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant and all the parties in this proceeding.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the eLibrary link and is available for electronic review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the website that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on December 10, 2019.

Dated: November 21, 2019.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2019–25725 Filed 11–26–19; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2013–0339; FRL—10002–40–OMS]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; NESHAP for Boat Manufacturing (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) has submitted an information collection request (ICR), NESHAP for Boat Manufacturing (EPA ICR Number 1966.07, OMB Control Number 2060–0546) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2020. Public comments were previously requested, via the **Federal Register**, on May 6, 2019 during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An agency may neither conduct nor sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before December 27, 2019.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2013–0339, to: (1) EPA online using *www.regulations.gov* (our preferred method), or by email to *docket.oeca@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460; and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change, including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI), or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Patrick Yellin, Monitoring, Assistance, and Media Programs Division, Office of Compliance, Mail Code 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: (202) 564–2970; fax number: (202) 564–0050; email address: *yellin.patrick@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov,* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit: *http://www.epa.gov/dockets.*

Abstract: The National Emission Standards for Hazardous Air Pollutants (NESHAP) for Boat Manufacturing (40

CFR part 63, subpart VVVV) apply to both existing and new boat manufacturing facilities that are a major source of hazardous air pollutant (HAP) emissions. This regulation covers resin and gel coat operations at fiberglass boat manufacturers, paint and coating operations at aluminum boat manufacturers, and carpet and fabric adhesive operations at all boat manufacturers. Air toxics are released during application and curing from the resins, gel coats, adhesives, coating, and solvents used in boat manufacturing. New facilities include those that commenced construction or reconstruction after the date of proposal. The EPA proposed revised standards to the NESHAP for Boat Manufacturing on May 17, 2019 (84 FR 22642); however, the proposed amendments have not been finalized; and therefore, the 'Burden' reflected in this ICR does not consider 'burden' from the proposed amendments, but is based on the existing standards.

This information is being collected to assure compliance with 40 CFR part 63, subpart VVVV. In general, all NESHAP standards require initial notifications, performance tests, and periodic reports by the owners/operators of the affected facilities. They are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notifications, reports, and records are essential in determining compliance, and are required of all affected facilities subject to NESHAP.

Form Numbers: None.

Respondents/Affected Entities: Boat manufacturing facilities.

Respondent's Obligation To Respond: Mandatory (40 CFR part 63, subpart VVVV).

Estimated Number of Respondents: 93 (total).

Frequency of Response: Initially, occasionally and semiannually.

Total Estimated Burden: 21,100 hours (per year). Burden is defined at 5 CFR 1320.3(b).

Total Estimated Cost: $2,450,000 (per year), which includes $0 for annualized capital and/or operation & maintenance costs.

Changes in the Estimates: The decrease in burden from the most-recently approved ICR is due to a decrease in the number of respondents subject to these standards. This decrease is not due to any program changes. This ICR, by in large, reflects the on-going burden and costs for existing facilities. Additionally, this ICR removes operation and maintenance costs which were included in the most-recently approved ICR for one source using add-on controls. Based on a recent inventory, at this time all facilities are estimated to comply with the rule using compliant materials and no facilities operate add-on controls.

Courtney Kerwin,

Director, Regulatory Support Division.

[FR Doc. 2019–25760 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2003–0041; FRL–10002–20–OMS]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; RadNet (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) has submitted an information collection request (ICR), RadNet (EPA ICR Number 0877.14, OMB Control Number 2060–0015) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2020. Public comments were previously requested via the **Federal Register** on May 13, 2019 during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. 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.

DATES: Additional comments may be submitted on or before December 27, 2019.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OAR–2003–0041, to (1) EPA online using *www.regulations.gov* (our preferred method), *a-and-r-Docket@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460, and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: John Griggs, OAR/ORIA/NAREL, 540 South Morris Ave., Montgomery, AL 36115; telephone number: (334) 270–3400; fax number: (334) 270–3454; email address: *Griggs.john@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Abstract: RadNet is a national network of stations collecting sampling media that include air, precipitation, and drinking water. Samples are sent to EPA's National Analytical Radiation Environmental Lab (NAREL) in Montgomery, Alabama, where they are analyzed for radioactivity. RadNet provides emergency response/homeland security and ambient monitoring information on levels of environmental radiation across the nation. All stations, usually operated by state and local personnel, participate in RadNet voluntarily. Station operators complete information forms that accompany the samples. The forms request information pertaining to sample type, sample location, start and stop date and times for sampling, length of sampling period, and volume represented. Data from RadNet are made available regularly on the Agency website—*https://www.epa.gov/radnet.*

Form Numbers: 5900–23, 5900–24, 5900–27, 5900–29.

Respondents/affected entities: Primarily State and Local Officials.

Respondent's obligation to respond: Voluntary.

Estimated number of respondents: 237 (total).

Frequency of response: Biweekly, monthly, quarterly.

Total estimated burden: 3,722 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $2,510,235 (per year), includes $2,363,476 annualized capital or operation & maintenance costs.

Changes in the Estimates: There is a decrease of 5 hours in the total

estimated respondent burden compared with the ICR currently approved by OMB. This decrease shows the program is in maturity and is expected to operate with minimal change.

Courtney Kerwin,

Director, Collection Strategies Division.

[FR Doc. 2019–25763 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2019–0634; FRL–10002–58–OAR]

Proposed Baseline Approval of the Remote-Handled Transuranic Waste Characterization Program Implemented at the Department of Energy's Sandia National Laboratories

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of availability; opening of a 45-day public comment period.

SUMMARY: The EPA is proposing to approve SNL's remote-handled transuranic waste characterization program based on the inspections conducted on June 24–25, 2014, and the offsite document review conducted April–July 2019. Until the Agency finalizes its baseline approval decision, the Carlsbad Field Office may not recertify SNL's waste characterization program and the site may not ship transuranic waste to the WIPP for disposal.

DATES: Comments must be received on or before January 13, 2020.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2019–0634, 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 electronically submit 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: Edward Feltcorn (202–343–9422) or Jerry Ellis (202–564–2766), Radiation Protection Division, Center for Waste Management and Regulations, Mail Code 6608T, U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue, Washington, DC 20460; fax number: 202–343–2305; email addresses: *feltcorn.ed@epa.gov* or *ellis.jerry@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

What should I consider as I prepare my comments for EPA?

Submitting CBI. Do not submit this information to the EPA through *www.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 the 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.

Tips for Preparing Your Comments. When submitting comments, remember to:

- Identify the rulemaking by docket number and other identifying information (subject heading, **Federal Register** date and page number).
- Follow directions: The Agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.
- Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.
- Describe any assumptions and provide any technical information and/or data that you used.
- If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.
- Provide specific examples to illustrate your concerns, and suggest alternatives.
- Explain your views as clearly as possible, avoiding the use of profanity or personal threats.
- Make sure to submit your comments by the comment period deadline identified.

II. Background

The Environmental Protection Agency (EPA or the Agency) is announcing the availability of, and soliciting public comment on, this proposed action. Initially, the EPA approved the Sandia National Laboratories' (SNL) remote-handled transuranic waste characterization program in November 2011 for a limited duration, allowing the site to ship waste to the Waste Isolation Pilot Plant (WIPP) for disposal (EPA Docket No. A–98–49; II–A4–155). In May 2014, the Department of Energy's Carlsbad Field Office informed the EPA that SNL had identified additional remote-handled transuranic debris waste requiring a new baseline inspection in accordance with 40 CFR 194.8. The EPA conducted this second baseline inspection in two phases. During the first phase, the EPA observed waste characterization activities while onsite at SNL in Albuquerque, New Mexico, and concurrently interviewed cognizant personnel offsite in Denver, Colorado, on June 24–25, 2014. In the second phase of the baseline inspection, the Agency reviewed waste characterization records offsite from April–July 2019 in Washington, DC. The EPA's report documenting the inspection results and proposed baseline approval is available for review in the public dockets listed in the **ADDRESSES** section of this document.

The DOE operates the WIPP facility near Carlsbad in southeastern New Mexico as a deep geologic repository for disposal of defense-related transuranic (TRU) radioactive waste. TRU waste contains more than 100 nanocuries of alpha-emitting TRU isotopes, with half-lives greater than twenty years, per gram of waste. Much of the existing TRU waste, which may also be contaminated with hazardous chemicals, consists of items contaminated during the production of nuclear weapons, such as debris waste (rags, equipment, tools) and solid waste (sludges, soil).

Section 8(d)(2) of the WIPP Land Withdrawal Act (LWA) of 1992 provided that the EPA would certify whether the WIPP facility will comply with the Agency's final disposal regulations, later codified at 40 CFR part 191, subparts B and C. On May 13, 1998, the Agency announced its final compliance certification to the Secretary of Energy (published May 18, 1998; 63 FR 27354), certifying that the WIPP will comply with the disposal regulations. The EPA's certification of the WIPP was subject to various conditions, including conditions concerning quality assurance and waste characterization relating to EPA inspections, evaluations and approvals of the site-specific TRU waste characterization programs to ensure compliance with various EPA regulatory requirements, including those at 40 CFR 194.8, 194.22(a)(2)(i), 194.22(c)(4), 194.24(c)(3) and 194.24(c)(5). In addition, under the LWA, the initial WIPP certification was subject to quinquennial (every five years) recertification by the Agency.

The EPA's inspection and approval processes for waste generator sites, including quality assurance and waste characterization programs, are described at 40 CFR 194.8. Between November 2005 and April 2012, the EPA inspected waste characterization programs of previously approved sites. The Agency has discretion in establishing technical priorities; the ability to accommodate variation in the site's waste characterization capabilities; and flexibility in scheduling site waste characterization inspections.

In accordance with the conditions in the WIPP compliance certification and relevant regulatory provisions, including 40 CFR 194.8, the EPA conducts ''baseline'' inspections at waste generator sites, as well as subsequent inspections to confirm continued compliance. As part of a baseline inspection, the EPA evaluates each waste characterization process component (equipment, procedures and personnel training and experience) for adequacy and appropriateness in characterizing TRU waste intended for disposal at the WIPP. During the inspection, the site demonstrates its capabilities to characterize TRU waste(s) and its ability to comply with the regulatory limits and tracking requirements under § 194.24. The baseline inspection can result in approval with limitations and conditions or may require follow-up inspection(s) before approval. Within the approval documentation, the EPA specifies what subsequent program changes should be reported to the Agency, referred to as Tier 1 or Tier 2 changes, depending largely on the anticipated effect of the changes on data quality.

A Tier 1 designation requires that the CBFO provide to the EPA documentation on proposed changes to the approved components of an individual site-specific waste characterization process (such as radioassay equipment) which the Agency must approve before the change can be implemented. Tier 2 designated changes are minor changes to the approved components of individual waste characterization processes (such as visual examination procedures) which must also be reported to the EPA, but the site may implement such changes without awaiting Agency approval. After receiving notification of Tier 1 changes, the EPA may choose to inspect the site to evaluate technical adequacy. The inspections conducted to evaluate Tier 1 or Tier 2 changes are under the authority of the EPA's WIPP compliance certification conditions and regulations, including 40 CFR 194.8 and 194.24(h). In addition to follow-up inspections, the EPA may opt to conduct continued compliance inspections at TRU waste sites with a baseline approval under the authority of the WIPP compliance certification regulations, including § 194.24(h).

In accordance with 40 CFR 194.8, the EPA issues a **Federal Register** notice proposing a baseline compliance decision, dockets the inspection report for public review, and seeks public comment on the proposed decision for a minimum period of 45 days. The report describes the waste characterization processes the EPA inspected at the site, as well as their compliance with 40 CFR 194.8 and 194.24 requirements.

Proposed Baseline Decision

This notice announces the EPA's proposed baseline approval of the remote-handled (RH) TRU debris waste characterization program implemented by the Central Characterization Program (CCP) at the DOE's SNL, in Albuquerque, New Mexico. In accordance with Title 40, Part 194, of the Code of Federal Regulations [40 CFR 94.8(b)], the EPA conducted Baseline Inspection No. EPA–SNL–CCP–RH–06.14–8 of the CCP's waste characterization program for RH TRU debris waste at SNL. Upon the EPA's final approval, DOE can emplace SNL–CCP RH TRU debris waste in the WIPP. The EPA previously approved SNL–CCP's RH TRU waste characterization program in November 2011 (EPA Docket No. A–98–49; II–A4–155). At the time, DOE expected that SNL–CCP would not have an active RH TRU waste characterization program beyond fiscal year 2012. In March 2012, the EPA approved one Tier 1 (T1) change (EPA Docket No. A–98–49; II–A4–160, EPA Air e-Docket No: EPA–HQ–OAR–2001–0012–0306). In May 2014, the Carlsbad Field Office (CBFO) informed the EPA that SNL had identified additional RH TRU debris waste requiring a new baseline inspection in accordance with 40 CFR 194.8. The EPA is proposing to approve the SNL–CCP waste characterization program implemented to characterize RH TRU debris waste as documented in the report (''Proposed Approval: EPA Baseline Inspection of the Central Characterization Program Remote-Handled Transuranic Waste Characterization Program for the Sandia National Laboratories''; hereafter, ''the report''). The baseline inspection addressed in this notice occurred over an extended period of time. The EPA conducted the second baseline inspection in two segments: (1) Observing waste characterization activities Dose-to-Curie (DTC) and Visual Examination (VE) onsite at SNL in Albuquerque, New Mexico, and interviewing Acceptable Knowledge (AK) personnel offsite in Denver, Colorado, on June 24–25, 2014; and (2) a desktop review of waste characterization records in Washington, DC, from April–July 2019. The results of the baseline inspection documented in the report are a combination of the results of the 2014 DTC and VE observations at SNL, AK personnel interviews in Denver and the 2019 desktop review of all waste characterization records.

This baseline inspection evaluated SNL–CCP's RH waste characterization program for technical adequacy and, when approved, SNL–CCP would be allowed to ship waste already characterized under that program and to use the program's components to characterize future RH waste in accordance with the conditions and limitations discussed in the report. SNL–CCP representatives stated that all SNL RH TRU waste has been characterized with completion of the activities described in the report. However, based on the EPA's experience with RH TRU waste characterization programs, this proposed approval provides for the characterization of additional RH TRU wastes, subject to the conditions described below. Specifically, the proposed approval includes:

(1) The AK process for RH TRU debris waste generated in the SNL Hot Cell Facility during the removal and packaging of experimental material and

decontamination operations in Building 6580 and added to Waste Stream SNL–HCF–S5400–RH. The proposed approval also includes process generated waste from cleanup of the Auxiliary Hot Cell Facility after repackaging containers from Waste Stream SNL–HCF–S5400–RH.

(2) The radiological characterization process using DTC and scaling factors for assigning radionuclide values for Waste Stream SNL–HCF–S5400–RH that is documented in Appendix C of CCP–AK–SNL–501, Revision 6, and supported by the calculation packages referenced in the report.

(3) The VE process to identify waste material parameters and the physical form of RH TRU debris waste.

CBFO currently presents the population of subject waste as 25 drums of RH TRU waste whose characterization activities were completed in 2015, using the processes observed and reviewed by the EPA in 2014. However, the Agency understands that there are two waste drums from Waste Stream SNL–HCF–S5400–RH that lack a clear path forward for disposal as RH TRU waste. One drum has an external dose rate that prevents shipment in its current configuration and, it appears, would require repacking into several drums to be eligible for shipment. The second drum contains HEPA filters associated with Waste Stream SNL–HCF–S5400–RH and SNL–CCP is not sure at the time of this notice if it will assay as contact-handled or RH TRU.

If the wastes within one or both of the drums are part of this waste stream, they would be covered by this proposed baseline approval, provided they were characterized by the EPA-approved processes described in the report. The Agency is aware that processing these drums would require SNL–CCP to perform DTC and VE activities, at a minimum, which would be a T1 change, as stated in Table 1. To be clear, commencement of any RH TRU waste characterization activities by SNL–CCP from the date of the final baseline approval must be reported to and approved by the EPA, according to Table 1. All T1 changes must be submitted for approval before their implementation and will be evaluated by the EPA. Upon approval, the Agency will post the results of the evaluations through the EPA's general WIPP eDocket. SNL–CCP must submit Tier 2 (T2) changes that have been implemented four times a year at the end of each fiscal quarter.

The EPA's final approval decision regarding the SNL–CCP RH TRU waste characterization program will be conveyed to DOE separately by letter following the EPA's review of public comments responding to this notice. This information will be provided through the EPA's WIPP docket provided for this action at *regulations.gov* (Docket No: EPA–HQ–OAR–2019–0634), in accordance with 40 CFR 194.8(b)(3). A summary of all WIPP-related EPA inspection statuses can also be found on the EPA website at *https://www.epa.gov/radiation/waste-isolation-pilot-plant-wipp-inspections,* and any interested party can get these and other WIPP updates via the Agency's WIPP–NEWS website (*https://www.epa.gov/radiation/wipp-news*). Individuals may also subscribe to the WIPP–NEWS email listserv using the instructions on the website.

TABLE 1—TIERING OF RH–TRU WASTE CHARACTERIZATION PROCESSES IMPLEMENTED BY SNL–CCP

[Based on June 24–25, 2014, and April–July 2019 Baseline Inspection]

Process elements	SNL–CCP RH waste characterization process—Tier 1 (T1) changes requiring EPA approval	SNL–CCP RH waste characterization process—reporting of Tier 2 (T2) changes *
Acceptable Knowledge	Implementation of payload management for any waste stream	Submission of a list of SNL–CCP RH AK Experts and Site Project Managers that performed work during the previous quarter. Notification to the EPA upon availability of or modification to AKSRs and certification test plans (*e.g.,* CCP–AK–SNL–500, CCP–AK–SNL–502). Notification to the EPA upon availability of or substantive modification *** to: • CCP–TP–005, Attachments 8 and 9, including associated memoranda (*e.g.,* add-container memoranda). • Waste stream profile form. • AK accuracy reports (annually, at a minimum). • Enhanced AK documents such as AK assessment, CCE and BOK memoranda (including addition of new figures or attachments). • Characterization procedures requiring CBFO approval.
Radiological Characterization, including Dose-To-Curie.	Any radiological characterization processes performed after approval of the 2019 Baseline Inspection. Substantive modification ** to EPA-approved radiological characterization reports (*e.g.,* CCP–AK–SNL–501).	Submission of a list of SNL–CCP DTC operators, expert analysts and independent technical reviewers that performed work during the previous quarter. Notification to the EPA upon availability of or non-substantive modification ** to radiological characterization reports (*e.g.,* CCP–AK–SNL–501). Notification to the EPA upon availability of or modification to characterization procedures requiring CBFO approval.
Visual Examination	Any VE performed after approval of the 2019 Baseline Inspection.	Submission of a list of SNL–CCP VE Operators, VE Experts and independent technical reviewers that performed work during the previous quarter. Notification to the EPA upon availability of or modification to characterization procedures requiring CBFO approval.
Real-Time Radiography	Any use of RTR	None.

* SNL–CCP will report all T2 changes to the EPA every three months.

** ''Substantive modification'' refers to a change with the potential to affect SNL–CCP's RH waste characterization processes or documentation of them, excluding changes that are solely related to the environment, safety and health; nuclear safety; or the Resource Conservation and Recovery Act; or that are editorial in nature or are required to address administrative concerns. The EPA may request copies of new references that DOE adds during a document revision.

III. Availability of the Baseline Inspection Report and Proposed Approval for Public Comment

The EPA has placed the report discussing the results of the inspection of the RH TRU waste characterization program at the Sandia National Laboratory in the public docket as described in the **ADDRESSES** section of this document. In accordance with 40 CFR 194.8, the Agency is providing the public 45 days to comment on this and other documents and the EPA's proposed decision to approve the SNL RH TRU waste characterization program. The Agency requests comments particularly concerning the Enhanced Acceptable Knowledge process, a major significant change made by the Sandia National Laboratory to its RH TRU waste characterization program as previously approved by the EPA in 2012. The Agency will accept public comment on this notice and supplemental information as described in Section I above. At the end of the public comment period, the EPA will evaluate all relevant public comments and, as the Agency may deem appropriate and necessary, revise the report and proposed decision or take other appropriate action. If the EPA concludes that there are no unresolved issues after the public comment period, the Agency will issue an approval letter and the final report. The letter of approval will authorize the DOE to use the approved waste characterization processes to characterize RH TRU waste at SNL.

Information on the approval decision will be filed in the official public docket opened for this action on *www.regulations.gov,* Docket ID No. EPA–HQ–OAR–2019–0634 (as listed in the **ADDRESSES** section of this document).

Dated: November 14, 2019.

Jonathan D. Edwards,

Director, Office of Radiation and Indoor Air.

[FR Doc. 2019–25671 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPA–2007–0042; FRL–10002–57–OLEM]

Proposed Information Collection Request; Comment Request; The National Oil and Hazardous Substance Pollution Contingency Plan Regulation, Subpart J (40 CFR 300.900) (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), ''The National Oil and Hazardous Substance Pollution Contingency Plan Regulation, Subpart J (40 CFR 300.900)'' (EPA ICR No. 1664.12, OMB Control No. 2050–0141) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. Before doing so, EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through October 31, 2020. 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.

DATES: Comments must be submitted on or before January 27, 2020.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OPA–2007–0042, online using *www.regulations.gov* (our preferred method) or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Wendy Hoffman, Office of Emergency Management, Regulations Implementation Division (5104A), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: 202–564–8794; fax number: 202–564–2620; email address: *hoffman.wendy@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Pursuant to section 3506(c)(2)(A) of the PRA (44 U.S.C. 3501 *et seq.*), EPA is soliciting comments and information to enable it to: (i) 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; (ii) 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; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) 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. EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: This Information Collection Request (ICR) renewal supports activities to implement the National Oil and Hazardous Substances Pollution Contingency Plan (NCP), Subpart J (40 CFR 300.900), ''Use of Dispersants and Other Chemicals.''

The use of bioremediation agents, dispersants, surface washing agents, surface collecting agents and miscellaneous oil spill control agents in response to oil spills in U.S. waters or adjoining shorelines is governed by Subpart J of the NCP regulation (40 CFR 300.900). Subpart J requirements include criteria for listing oil spill mitigating agents on the NCP Product Schedule, hereafter referred to as the Schedule. EPA's regulation, which is codified at 40 CFR 300.00, requires that EPA prepare a schedule of ''dispersants, other chemicals, and other spill mitigating devices and substances, if any, that may be used in carrying out the NCP.'' The Schedule is required by section 311(d)(2)(G) of the Clean Water Act (CWA), as amended by the Oil Pollution Act of 1990. The Schedule is used by Federal On-Scene Coordinators (FOSCs), Regional Response Teams (RRTs), and Area Planners to identify spill mitigating agents in preparation for and response to oil spills.

Under Subpart J, manufacturers who want to add a product to the Schedule must submit technical product data to the U.S. Environmental Protection Agency (EPA or Agency) as stipulated in 40 CFR 300.915. Subpart J requires the

manufacturer to conduct specific toxicity and effectiveness tests and submit the corresponding technical product data along with other detailed information to the EPA Office of Emergency Management, Office of Land and Emergency Management. For example, a dispersant must exceed the 50 percent (±5 percent) efficacy threshold in order to be listed on the Schedule. EPA places oil spill mitigating agents on the Schedule if all the required data are submitted and the product satisfies all requirements and meets or exceeds testing thresholds. The Schedule is available to FOSCs, RRTs, and Area Committees for selecting the most appropriate products to use in various spill scenarios.

As of June 2016, 117 products were listed on the Schedule. In the previous ICR renewal, EPA estimated that 11 products per year would be submitted to EPA for listing on the Schedule during the renewal period. Over the three-year period covered by the current ICR (2016 through 2019), EPA estimated that a total of 11 products would be listed annually. Additionally, EPA estimated that approximately 10 manufacturers would submit information to obtain sorbent certifications. The annual public reporting burden was estimated to be 315 hours. The total annual cost (including labor and non-labor) to manufacturers under Subpart J was estimated to be $89,590.

At 40 CFR 300.920(c), respondents may claim certain information in the technical product data submissions as confidential business information. EPA will handle such claims pursuant to the provisions in 40 CFR part 2, subpart B. Such information must be submitted separately from non-confidential information, clearly identified, and clearly marked ''Confidential Business Information.'' If the applicant fails to make such a claim at the time of submittal, EPA may make the information available to the public without further notice.

Forms: None.

Respondents/affected entities: Respondents include, but are not limited to, manufacturers of bioremediation agents, dispersants, surface collecting agents, surface washing agents, miscellaneous oil spill control agents, and other chemical agents and biological additives used as countermeasures against oil spills. Affected private industries can be expected to fall within the following industrial classifications:

- Manufacturers of industrial inorganic chemicals (SIC 281/NAICS 325188),
- Manufacturers of industrial organic chemicals (SIC 286/NAICS 325199), and
- Manufacturers of miscellaneous chemical products (SIC 289/NAICS 325988).

Respondent's obligation to respond: A manufacturer who wants their product to be listed on the Schedule for use as oil spill mitigating agent in an emergency response to an oil spill must submit certain mandatory product testing and information to EPA for review for the product to be listed on the Schedule. (The Schedule is required by section 311(d)(2)(G) of the Clean Water Act (CWA), as amended by the Oil Pollution Act of 1990).

Estimated number of respondents: The previous ICR renewal estimated 21 respondents per year, including 10 sorbent product manufacturers. There were 99 manufacturers and 117 products (27 bioremediation agents, 18 dispersants, 16 miscellaneous oil spill control agents, 54 surface washing agents, and 2 surface collecting agents) listed on the Schedule as of June 2016. EPA estimates that manufacturers will apply to list 11 products on the Schedule each year, including 2 bioremediation agents, 3 dispersants, 2 miscellaneous oil spill control agents, 1 surface collecting agent, and 3 surface washing agents during this ICR renewal period. In addition, EPA estimates that 10 manufacturers will apply to list sorbent products (one per manufacturer). Over the three-year period, EPA anticipates that manufacturers will apply to list a total of 6 bioremediation agents, 9 dispersants, 6 miscellaneous oil spill control agents, 3 surface collecting agent, 9 surface washing agents and 10 sorbents on the Schedule. These figures will be updated as needed during the 60-day OMB review period.

Frequency of response: Each manufacturer responds once per product submittal.

Total estimated burden: 315 hours (per year). This figure will be updated as needed during the 60-day OMB review period. Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $89,590 (per year), including $72,450 annualized capital or operation & maintenance costs. These figures will be updated with the most recent available wage rates from BLS and to account for any changes in O&M costs, burden and number of respondents.

Changes in Estimates: The above burden estimates are based on the current approved ICR. In the final notice for the renewal ICR, EPA will publish revised burden estimates based on updates to respondent data and unit costs. The revised burden estimates may increase or decrease from the current ICR based on the number of products added to the Schedule during the past ICR renewal period, and EPA's adjusted estimates for the number of products the Agency anticipates may be added to the Schedule during the upcoming ICR renewal period. Any change in burden will be described and explained in this section when the updated ICR Supporting Statement is completed during the 60-day OMB review period.

Dated: November 18, 2019.

Reggie Cheatham,

Director, Office of Emergency Management.

[FR Doc. 2019–25814 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2013–0336; FRL–10000–89–OMS]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; NESHAP for Off-Site Waste and Recovery Operations (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) has submitted an information collection request (ICR), NESHAP for Off-Site Waste and Recovery Operations (EPA ICR Number 1717.12, OMB Control Number 2060–0313), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2020. Public comments were previously requested, via the **Federal Register**, on Monday, May 6, 2019 during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An agency may neither conduct nor sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before December 27, 2019.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2013–0336, to: (1) EPA online using *www.regulations.gov* (our preferred method), or by email to

docket.oeca@epa.gov, or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460; and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change, including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI), or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Patrick Yellin, Monitoring, Assistance, and Media Programs Division, Office of Compliance, Mail Code 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: (202) 564–2970; fax number: (202) 564–0050; email address: *yellin.patrick@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov,* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit: *http://www.epa.gov/dockets.*

Abstract: The National Emission Standards for Hazardous Air Pollutants (NESHAP) for Off-Site Waste and Recovery Operations (OSWRO apply to existing facilities and new facilities with organic hazardous air pollutant (HAP) emissions that are involved in waste management and recovery operations, and that are not subject to Federal air standards under other subparts in Part 63. In addition, Subpart DD cross-references control requirements to be applied to specific types of affected sources: Tanks level-1; containers; surface impoundments; individual drain systems; oil-water separators; organic water separators; and loading, transfer, and storage systems. New facilities include those that commenced either construction or reconstruction after the date of proposal.

This information is being collected to assure compliance with 40 CFR part 63, subpart DD. In general, all NESHAP standards require initial notification reports, performance tests, and periodic reports by the owners/operators of the affected facilities. They are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notifications, reports, and records are essential in determining compliance, and are required of all affected facilities subject to NESHAP.

Form Numbers: None.

Respondents/affected entities: Facilities that are involved in waste management and recovery operations.

Respondent's obligation to respond: Mandatory (40 CFR part 63).

Estimated number of respondents: 50 (total).

Frequency of response: Semiannually.

Total estimated burden: 47,800 hours (per year). Burden is defined at 5 CFR 1320.3(b).

Total estimated cost: $6,420,000 (per year), which includes $892,000 in annualized capital/startup and/or operation & maintenance costs.

Changes in the Estimates: There is an adjustment increase in the burden in this ICR compared to the previous ICR. The increase is based on an increase in the number of sources subject to the NESHAP. This also results in an increase in the operation and maintenance costs. This ICR also adjusts the capital and operation and maintenance costs for installing electronic indicators on PRDs on stationary sources per the rule amendments and final action on reconsideration (83 FR 3986, January 29, 2019).

Courtney Kerwin,

Director, Regulatory Support Division.

[FR Doc. 2019–25762 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2013–0341; FRL–10002–62–OMS]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; NESHAP for Plywood and Composite Products (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) has submitted an information collection request (ICR), NESHAP for Plywood and Composite Products (EPA ICR Number 1984.08, OMB Control Number 2060–0552), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2020. Public comments were previously requested, via the **Federal Register**, on May 6, 2019 during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An agency may neither conduct nor sponsor, and a person is not required to respond to a collection of information, unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before December 27, 2019.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2013–0341, to: (1) EPA online using *www.regulations.gov* (our preferred method), or by email to *docket.oeca@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460; and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change, including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI), or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Patrick Yellin, Monitoring, Assistance, and Media Programs Division, Office of Compliance, Mail Code 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: (202) 564–2970; fax number: (202) 564–0050; email address: *yellin.patrick@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov,* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit: *http://www.epa.gov/dockets.*

Abstract: The National Emission Standards for Hazardous Air Pollutants

(NESHAP) for Plywood and Composite Products (40 CFR part 63, subpart DDDD) apply to both new and existing plywood and composite wood products (PCWP) facilities that are a major source of hazardous air pollutants (HAP). A PCWP manufacturing facility is a major source of HAP emissions either in and of itself, or because it is located with other major sources of HAP. A PCWP manufacturing facility is a facility that manufactures plywood and/or composite wood products by bonding wood material (fibers, particles, strands, veneers, etc.) or agricultural fiber, generally with resin under heat and pressure, to form a structural panel or engineered wood product. Plywood and composite wood products manufacturing facilities also include facilities that manufacture dry veneer and lumber kilns located at any facility. Plywood and composite wood products include, but are not limited to, plywood, veneer, particleboard, oriented strandboard, hardboard, fiberboard, medium density fiberboard, laminated strand lumber, laminated veneer lumber, wood I-joists, kiln-dried lumber, and glue-laminated beams. New facilities include those that commenced construction, or reconstruction after January 9, 2003. This information is being collected to assure compliance with 40 CFR part 63, subpart DDDD.

In general, all NESHAP standards require initial notifications, performance tests, and periodic reports by the owners/operators of the affected facilities. They are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notifications, reports, and records are essential in determining compliance, and are required of all affected facilities subject to NESHAP.

Form Numbers: None.

Respondents/affected entities: Plywood and composite wood products (PCWP) facilities.

Respondent's obligation to respond: Mandatory (40 CFR part 63, subpart DDDD).

Estimated number of respondents: 244 (total).

Frequency of response: Initially, semiannually.

Total estimated burden: 29,900 hours (per year). Burden is defined at 5 CFR 1320.3(b).

Total estimated cost: $3,550,000 (per year), which includes $105,000 in annualized capital/startup and/or operation & maintenance costs.

Changes in the Estimates: There is an adjustment increase in the total estimated burden as currently identified in the OMB Inventory of Approved Burdens. This increase is not due to any program changes. The adjustment increase in burden is due to several factors. The Agency developed a more accurate estimate of existing and anticipated new sources during the development of the proposed Risk and Technology Review for this subpart. The increase in the number of existing sources led to an increase in burden hours and costs for labor and operation and maintenance. The increase in the number of new sources led to an increase in burden hours and costs for labor, capital, performance testing, and operation and maintenance. New sources are required to purchase and install CMS, conduct performance testing, and send several notifications and reports to EPA. O&M costs for existing sources were updated to reflect more accurate costs for these O&M activities. Also, in the previous ICR, it was assumed that only 10% of sources kept daily records of continuous compliance and annual records of calibration of their CMS; we have corrected this assumption to reflect that 100% of PCWP facilities keep these records. The overall result is an increase in burden hours and costs.

Courtney Kerwin,

Director, Regulatory Support Division.

[FR Doc. 2019–25761 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–OAR–2019–0631; FRL–10002–74–OAR]

Proposed Information Collection Request; Comment Request; Regional Haze Regulations (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), ''Renewal of the ICR for the Regional Haze Regulations'' (EPA ICR No. 2540.03, OMB Control No. 2060–0704) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (PRA). Before doing so, the EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through August 31, 2020. 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.

DATES: Comments must be submitted on or before January 27, 2020.

ADDRESSES: *Comments.* Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2019–0631, at *http://www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *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 (*e.g.,* 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.* Certain other material, such as copyrighted material, will not be placed on the internet but may be viewed, with prior arrangement, at the EPA Docket Center. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Air and Radiation Docket and Information Center, EPA/DC, EPA William Jefferson Clinton West Building, Room 3334, 1301 Constitution Avenue NW, Washington, DC. 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 Air and Radiation Docket and Information Center is (202) 566–1742. For additional information about the EPA's public docket, visit the EPA Docket Center homepage at: *http://www.epa.gov/epahome/dockets.htm.*

FOR FURTHER INFORMATION CONTACT: Joseph Stein, Air Quality Policy Division, Office of Air Quality Planning and Standards, mail code C539–04, U.S. Environmental Protection Agency, Research Triangle Park, NC 27709;

telephone number: (919) 541–0195; fax number: (919) 541–4028; email address: *stein.joseph@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Pursuant to section 3506(c)(2)(A) of the PRA, the EPA is soliciting comments and information to enable it to: (i) 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; (ii) 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; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) 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. The EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, the EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: This ICR is for activities related to the implementation of the EPA's regional haze rule, for the time period between August 31, 2020, and August 31, 2023, and renews the previous ICR. The regional haze rule codified at 40 CFR parts 308 and 309, as authorized by sections 169A and 169B of the Clean Air Act, requires states to develop implementation plans to protect visibility in 156 federally protected Class I areas. Tribes may choose to develop implementation plans. For this time period, states will primarily be developing and submitting periodic comprehensive implementation plan revisions to comply with the regulations.

Form Numbers: None.

Respondents/affected entities: Entities potentially affected by this action are state, local and tribal air quality agencies, regional planning organizations and facilities potentially regulated under the Regional Haze Rule.

Respondent's obligation to respond: Mandatory [*see* 40 CFR 51.308(b), (f) and (g) and 40 CFR 51.309(d)(10)].

Estimated number of respondents: 52 (total); 52 state agencies.

Frequency of response: Approximately every 5 years.

Total estimated burden: 38,255 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $2,050,007 (per year). There are no annualized capital or operation & maintenance costs.

Changes in Estimates: There is increase of 24,945 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. This increase in burden reflects changes in labor rates and changes in the activities conducted due to the normal progression of the program, especially the fact that states will be working on and submitting periodic comprehensive State Implementation Plan (SIP) revisions. There are 52 SIP revisions due by July 31, 2021.

Dated: November 22, 2019.

Juan Santiago,

Acting Director, Air Quality Policy Division.

[FR Doc. 2019–25810 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OW–2019–0566; FRL–10002–29–OW]

Proposed Information Collection Request; Comment Request; Water Quality Certification Regulations

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), Water Quality Certification Regulations (EPA ICR No. 2603.03, OMB Control No. 2040–0295), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (PRA). Before doing so, EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed revision of an ICR (OMB Control No. 2040–0295), which is currently approved through February 29, 2020. 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.

DATES: Comments must be submitted on or before January 27, 2020.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OW–2019–0566, online using *www.regulations.gov* (our preferred method) or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

The EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI), or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Lauren Kasparek, Oceans, Wetlands, and Communities Division, Office of Wetlands, Oceans, and Watersheds, (MC 4504T), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: (202) 564–3351; email address: *cwa401@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Pursuant to section 3506(c)(2)(A) of the PRA, the EPA is soliciting comments and information to enable it to: (i) 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; (ii) 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; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) 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.,* electronic submission of responses.

The EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, the EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: This ICR describes the cost and burden associated with 40 CFR 121, the regulations that implement Clean Water Act (CWA) section 401. Under section 401, a federal agency may not issue a permit or license that may result in any discharge into waters of the United States unless the certifying authority where the discharge would originate issues a section 401 water quality certification verifying that the discharge will comply with certain water quality requirements or waives the certification requirement. CWA section 401 requires project proponents to submit project specific information to certifying authorities. Certifying authorities may act on project specific information by either granting, granting with conditions, denying, or waiving section 401 certification. CWA section 401 requires certifying authorities to submit information to the relevant federal licensing or permitting agency to indicate the action taken on a request for certification. The EPA is also responsible for coordinating input from certain neighboring or downstream states and tribes affected by a discharge from a federally licensed or permitted project under section 401(a)(2). Information collected directly collected by the EPA under section 401 in support of the section 402 permit program is already captured under an existing ICR (OMB Control Number 2040–0004, EPA ICR Number 0229.22) and therefore is not included in this analysis.

Form Numbers: None.

Respondents/affected entities: Applicants for certain federal licenses and permits; certifying authorities including states, territories, and authorized tribes.

Respondent's obligation to respond: Project Proponents: required to obtain or retain a benefit (33 U.S.C. 1341).

Certifying Authorities: Not mandatory.

Estimated number of respondents: 41,119 (total).

Frequency of response: Per Federal Application.

Total estimated burden: 328,000 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $18,000,000 (per year), includes $0 annualized capital or operation & maintenance costs.

Changes in Estimates: There is a change in the total estimated respondent burden, number of respondents, and number of responses compared with the ICR currently approved by OMB (OMB Control No. 2040–0295) due to refinements in how the estimates are calculated. See the Supporting Statement in the docket for more information on the changes in estimates.

Dated: November 21, 2019.

John Goodin,

Director, Office of Wetlands, Oceans, and Watersheds, Office of Water, Environmental Protection Agency.

[FR Doc. 2019–25693 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2003–0120; FRL–10002–67–OMS]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; National Volatile Organic Compound Emission Standards for Automobile Refinish Coatings (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The U.S. Environmental Protection Agency (EPA) has submitted an Information Collection Request (ICR), National Volatile Organic Compound Emission Standards for Automobile Refinish Coatings (EPA ICR Number 1765.09, OMB Control Number 2060–0353) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2020. Public comments were previously requested via the **Federal Register** on March 18, 2019, during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. 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.

DATES: Additional comments must be submitted on or before December 27, 2019.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OAR–2003–0120, to (1) the EPA online using *https://www.regulations.gov/* (our preferred method), by email to *a-and-r-docket@epa.gov,* or by mail to: EPA Docket Center, U.S. Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460, and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for the EPA.

The EPA's policy is that all comments received will be included in the public docket without change, including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Ms. Kim Teal, Sector Policies and Programs Division (D243–04), Office of Air Quality Planning and Standards, U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711; telephone number: (919) 541–5580; fax number: (919) 541–4991; email address: *teal.kim@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *https://www.regulations.gov/* or in person at the EPA Docket Center, EPA WJC West Building, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is (202) 566–1744. For additional information about the EPA's public docket, visit *https://www.epa.gov/dockets.*

Abstract: The EPA is required under section 183(e) of the Clean Air Act (CAA) to regulate volatile organic compound emissions from the use of consumer and commercial products. Pursuant to CAA section 183(e)(3), the EPA published a list of consumer and commercial products and a schedule for their regulation (60 FR 15264). Automobile refinish coatings were included on the list, and the standards for such coatings are codified at 40 CFR part 59, subpart B. The reports required under the standards enable the EPA to identify all coating and coating component manufacturers and importers in the United States and to determine which coatings and coating components are subject to the standards, based on dates of manufacture.

Form numbers: None.

Respondents/affected entities: Manufacturers and importers of automobile refinish coatings and coating components.

Respondent's obligation to respond: Mandatory, 40 CFR part 59, subpart B.

Estimated number of respondents: 30 (total).

Frequency of response: On occasion.

Total estimated burden: 14 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $980 (per year), includes $0 annualized capital or operation and maintenance costs.

Changes in estimates: There is no change in hours in the total estimated respondent burden compared with the ICR currently approved by OMB.

Courtney Kerwin,

Director, Regulatory Support Division.

[FR Doc. 2019–25764 Filed 11–26–19; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

[OMB 3060–0298; FRS 16278]

Information Collection Being Reviewed by the Federal Communications Commission

AGENCY: Federal Communications Commission.

ACTION: Notice and request for comments.

SUMMARY: As part of its continuing effort to reduce paperwork burdens, and as required by the Paperwork Reduction Act of 1995 (PRA), the Federal Communications Commission (FCC or Commission) invites the general public and other Federal agencies to take this opportunity to comment on the following information collections. Comments are requested concerning: 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; the accuracy of the Commission's burden estimate; ways to enhance the quality, utility, and clarity of the information collected; ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and ways to further reduce the information collection burden on small business concerns with fewer than 25 employees.

The FCC may not conduct or sponsor a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid OMB control number.

DATES: Written PRA comments should be submitted on or before January 27, 2020. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicole Ongele, FCC, via email *PRA@fcc.gov* and to *Nicole.ongele@fcc.gov.*

FOR FURTHER INFORMATION CONTACT: For additional information about the information collection, contact Nicole Ongele, (202) 418–2991.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0298.

Title: Part 61, Tariffs (Other than the Tariff Review Plan).

Form Number: N/A.

Type of Review: Revision of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents and Responses: 2,840 respondents; 5,605 responses.

Estimated Time per Response: 1–50 hours.

Frequency of Response: On occasion, annual, biennial, and one-time reporting requirements.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this information collection is contained in 47 U.S.C. Sections 151–155, 201–205, 208, 251–271, 403, 502 and 503 of the Communications Act of 1934, as amended.

Total Annual Burden: 196,677 hours.

Total Annual Cost: $1,444,800.

Privacy Act Impact Assessment: No impact(s).

Nature and Extent of Confidentiality: Respondents are not being asked to submit confidential information to the Commission. If the Commission requests respondents to submit information which respondents believe are confidential, respondents may request confidential treatment of such information under 47 CFR 0.459 of the Commission's rules.

Needs and Uses: On September 27, 2019, the Commission released the *Access Arbitrage Order,* WC Docket No. 18–155, FCC 19–94, making access-stimulating local exchange carriers (LECs) financially responsible for the terminating tandem switching and transport service access charges associated with the delivery of traffic from an interexchange carrier (IXC) to the access-stimulating LEC end office or its functional equivalent. The *Access Arbitrage Order* required that, within 45 days of its effective date, access-stimulating LECs remove any existing tariff provisions for terminating tandem switching or terminating tandem switched transport access charges. Affected intermediate access providers have the same time period to prepare any tariff revisions which they may wish to file. The *Access Arbitrage Order* also required that access-stimulating LECs provide notice of their assumption of that financial responsibility to the Commission by filing a record of its access-stimulating status and acceptance of financial responsibility to the Commission by filing a record of its access-stimulating status and acceptance of financial responsibility in the Commission's *Access Arbitrage Order* docket, and to provide notice to any affected IXCs and intermediate access providers of the same, within 45 days of approval by the Office of Management and Budget (OMB). If, after approval of this requirement by OMB, access-stimulating LECs no longer engage in access stimulation they must also file notice of that change in status with the Commission and with any affected IXCs and intermediate access providers.

The information collected through carriers' tariffs is used by the Commission and state commissions to determine whether services offered are just and reasonable, as the Act requires. The tariffs and any supporting documentation are examined in order to determine if the services are offered in a just and reasonable manner.

Federal Communications Commission.

Marlene Dortch,

Secretary, Office of the Secretary.

[FR Doc. 2019–25772 Filed 11–26–19; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL MARITIME COMMISSION

Notice of Agreements Filed

The Commission hereby gives notice of the filing of the following agreement under the Shipping Act of 1984. Interested parties may submit comments on the agreements to the Secretary by email at *Secretary@fmc.gov,* or by mail, Federal Maritime Commission, Washington, DC 20573, within twelve days of the date this notice appears in the **Federal Register**. Copies of agreements are available through the Commission's website (*www.fmc.gov*) or by contacting the Office of Agreements at (202) 523–5793 or *tradeanalysis@fmc.gov.*

Agreement No.: 011707–017.

Agreement Name: Gulf/South America Discussion Agreement.

Parties: BBC Chartering Carriers GmbH & Co. KG; Seaboard Marine Ltd.; and Zeamarine Carrier GmbH.

Filing Party: Wayne Rohde; Cozen O'Connor.

Synopsis: The amendment deletes Industrial Maritime Carriers, L.L.C. as a party to the Agreement.

Proposed Effective Date: 11/15/2019.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/684.

Agreement No.: 010099–067.

Agreement Name: International Council of Containership Operators.

Parties: CMA CGM S.A.; COSCO Shipping Co., Ltd.; Crowley Liner Services, Inc.; Evergreen Line Joint Service Agreement; Hapag-Lloyd AG; Hyundai Merchant Marine Co., Ltd.; Maersk A/S; Mediterranean Shipping Company S.A.; Orient Overseas Container Line Limited; Pacific International Lines (PTE) Ltd.; Wan Hai Lines Ltd.; Yang Ming Marine Transport Corporation; and ZIM Integrated Shipping Services Ltd.

Filing Party: John Longstreth; K&L Gates.

Synopsis: The amendment changes the name of Maersk Line A/S to Maersk A/S.

Proposed Effective Date: 11/15/2019.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/1032.

Agreement No.: 012460–004.

Agreement Name: COSCO Shipping/PIL/WHL Vessel Sharing and Slot Charter Agreement.

Parties: COSCO Shipping Lines Co., Ltd.; Pacific International Lines (PTE) Ltd.; Wan Hai Lines Ltd.; and Wan Hail Lines (Singapore) PTE Ltd.

Filing Party: Eric Jeffrey; Nixon Peabody.

Synopsis: The amendment expands the geographic scope and updates the shared strings and the slot exchanges among the Parties.

Proposed Effective Date: 11/20/2019.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/1948.

Agreement No.: 012460–005.

Agreement Name: COSCO Shipping/PIL/WHL Vessel Sharing and Slot Charter Agreement.

Parties: COSCO Shipping Lines Co., Ltd.; Pacific International Lines (PTE) Ltd.; Wan Hai Lines Ltd.; and Wan Hail Lines (Singapore) PTE Ltd.

Filing Party: Eric Jeffrey; Nixon Peabody.

Synopsis: The amendment expands the geographic scope to include export cargo to Singapore and Sri Lanka.

Proposed Effective Date: 1/4/2020.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/1948.

Agreement No.: 012439–004.

Agreement Name: THE Alliance Agreement.

Parties: Hapag-Lloyd AG and Hapag-Lloyd USA, LLC (acting as a single party); Hyundai Merchant Marine Co., Ltd.; Ocean Network Express Pte. Ltd.; and Yang Ming Marine Transport Corp., Yang Ming (Singapore) Pte. Ltd. and Yang Ming (UK) Ltd. (acting as a single party).

Filing Party: Josh Stein, Cozen O'Connor.

Synopsis: The Amendment adds Hyundai Merchant Marine Co., Ltd. as a party to the Agreement, makes conforming changes to other provisions of the Agreement, and extends the term of the Agreement through April 1, 2030. It also adds Yang Ming (Singapore) Pte. Ltd. as a party (acting together with Yang Ming Marine Transport Corp. and Yang Ming (UK) Ltd. as one party under the Agreement).

Proposed Effective Date: 1/5/2020.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/1912.

Dated: November 22, 2019.

Rachel E. Dickon,

Secretary.

[FR Doc. 2019–25806 Filed 11–26–19; 8:45 am]

BILLING CODE 6731–AA–P

FEDERAL RESERVE SYSTEM

Notice of Proposals To Engage in or To Acquire Companies Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y, (12 CFR part 225) to engage de novo, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than December 16, 2019.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. *Burling Bancorp, Inc., Chicago, Illinois;* to retain ownership of Burling Wealth Management Inc. and Burling Ventures Inc., both of Chicago, Illinois, and thereby engage in the nonbanking activities related to activities extending credit and investment advisory services, respectively, pursuant to sections 225.28(b)(2) and (b)(6) of Regulation Y.

Board of Governors of the Federal Reserve System, November 21, 2019.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2019–25704 Filed 11–26–19; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-20–1015]

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 the National Electronic Health Records Survey (NEHRS) 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 8, 2019, to obtain comments from the public and affected agencies. CDC received one comment 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

National Electronic Health Records Survey (NEHRS) (OMB Control No. 0920–1015, Exp. 07/31/2020)—Revision—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Electronic Health Records Survey (NEHRS) is a national survey of office-based physicians conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). NEHRS is sponsored by the Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (DHHS). The survey is conducted under the authority of Section 306 of the Public Health Service Act (41 U.S.C. 242k).

The purpose of this study is to collect information on office-based physicians' adoption and use of electronic health record (EHR) systems, practice information, patient engagement, controlled substances prescribing practices, use of health information exchange, and documentation and burden associated with medical record systems. The respondents are a sample of office-based physicians. Data collection is done directly through a self-administered web questionnaire, self-administered paper questionnaire or computer-assisted telephone interview. NEHRS collects information on characteristics of U.S. office-based physicians practicing ambulatory medical care, including specific focus on EHR adoption and use.

Having data that can identify a physician office's ability to perform specific computerized tasks helps track the adoption and use of new health information technologies across various physician and practice characteristics (*e.g.,* specialty, office type, and ownership) over time. These annual data, together with trend data, may be used to monitor the effects of change in the health care system, provide new insights into ambulatory medical care, and stimulate further research on the use, organization, and delivery of ambulatory care.

Data from the National Electronic Health Records Survey (NEHRS) have been used by researchers in reports and programs such as *Health, United States* and *Healthy People 2020,* in addition to various other reports and research across federal, public, and international communities. The results of the data will help provide more information about the use and adoption of EHRs by office-based physicians both nationally and by state.

A total of 5,151 annualized burden hours are requested for this three-year submission.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Office-based Physicians or office staff	NEHRS	10,302	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. 2019–25749 Filed 11–26–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–20–1178]

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 Comprehensive HIV Prevention and Care for Men Who Have Sex with Men of Color 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 13, 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

Comprehensive HIV Prevention and Care for Men Who Have Sex with Men of Color (OMB Contrtol No. 0920–1178, Exp. 4/30/2020)—Extension—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Approximately 40,000 people in the United States are newly infected with HIV each year. Gay, bisexual, and other men who have sex with men (MSM) remain the population most affected by HIV infection in the United States (US). Among MSM, those who are black and Hispanic comprise 64% of all new infections. Goals of the National HIV Prevention Strategy and the new initiative ''Ending the HIV Epidemic: A Plan for America'' include increasing the number of MSM of color living with HIV infection who achieve HIV viral suppression with antiretroviral treatment (ART), and decreasing the number of new HIV infections among MSM of color at risk of acquiring an HIV infection.

Antiretroviral (ARV) medications for pre-exposure prophylaxis (PrEP) can be used for HIV prevention by MSM at substantial risk for HIV acquisition or by those with a possible HIV exposure in the past 72 hours post-exposure prophylaxis (nPEP). The daily use of co-formulated tenofovir disoproxil fumarate and emtricitabine (marketed as Truvada) for PrEP has been proven to significantly reduce the risk of HIV acquisition among sexually active MSM. In July 2012, the US Food and Drug Administration (FDA) approved an HIV prevention indication for Truvada, and in May 2014 CDC published clinical practice guidelines for provision of PrEP. Given the high incidence of HIV among MSM of color, those who are sexually active are considered at risk for HIV acquisition and thus could benefit from prevention services such as routine and frequent HIV screening with lab-based fourth generation HIV tests, routine screening for STDs, assessment of PrEP eligibility, provision of PrEP (if at substantial risk for HIV acquisition), provision of nPEP (if a possible HIV exposure occurred in the past 72 hours), and/or other risk reduction interventions.

Among people living with HIV (PLWH), ARV treatment can suppress HIV viral load, which both improves health outcomes of individuals and reduces the risk of HIV transmission. Two studies, one that demonstrated the effectiveness of ARV treatment in preventing HIV transmission, and one that demonstrated improved health outcomes for individuals whose ARV treatment was initiated immediately, have led to increased public health focus on interventions and strategies designed to initiate ARV treatment, link, retain, and re-engage PLWH in HIV care, and to provide support for adherence to ARV medications.

The purpose of this project is to support state and local health departments to develop and implement demonstration projects for provision of comprehensive HIV prevention and care services for MSM of color by creating a collaborative with CBOs, clinics and other health care providers, and behavioral health and social services providers in their jurisdiction. Behavioral health services include mental health and substance abuse treatment to enable MSM of color to utilize HIV prevention and care services; social services include services that promote access to housing, job counseling, and employment services to enable MSM of color to utilize HIV prevention and care services.

Comprehensive models of HIV prevention and care for MSM of color will be developed and implemented by a collaborative that is led by the jurisdiction's health department and includes the following: Health care providers (*e.g.,* federally qualified health centers (FQHCs), FQHC Look-Alikes, other clinics, or health care providers); HIV care providers (*e.g.,* clinics funded through the Ryan White HIV/AIDS Program (RWHAP clinics), other HIV care clinics, or HIV care providers); behavioral health and social services providers (*i.e.,* mental health and substance abuse services, housing programs, and job training or employment services); and community based organizations (CBOs). Principles of high impact prevention should guide the selection and implementation of activities and strategies to focus on MSM of color at substantial risk for HIV infection (*i.e.,* eligible for prevention with PrEP), and those living with HIV. MSM of color who are at risk for HIV acquisition but not eligible for or decline PrEP will be provided risk reduction interventions, partner services if diagnosed with an STD, re-testing for HIV and STDs in 3–6 months, and behavioral health and social services. The risk of HIV acquisition should be assessed at every encounter with an individual, and MSM of color at substantial risk of HIV acquisition should be offered PrEP when indicated by the risk assessment.

There are a total of 24 required HIV prevention and care services that must be provided by the health department collaborative for this project, including 13 HIV prevention services for MSM of color at substantial risk for HIV infection and 11 HIV care services for MSM of color living with HIV infection.

HIV prevention services include: (1) HIV testing that uses lab-based 4th generation HIV tests; (2) Assessment of indications for pre-exposure prophylaxis (PrEP) and non-occupational post- exposure prophylaxis (nPEP); (3) Provision of PrEP and nPEP; (4) Adherence interventions for PrEP and nPEP; (5) Immediate linkage to care, ARV treatment, and partner services for those diagnosed with acute HIV infection; (6) Expedient linkage to care, ARV treatment, and partner services for those diagnosed with established HIV infection; (7) STD screening and treatment; (8) Partner services for patients with STDs; (9) Behavioral risk reduction interventions; (10) Screening for behavioral health and social services needs; (11) Linkage to behavioral health and social services; (12) Navigators to assist utilizing HIV prevention and behavioral health and social services; and (13) Navigators to assist enrollment in a health plan.

HIV care services include: (1) HIV primary care, including antiretroviral (ARV) treatment; (2) Retention interventions; (3) Re-engagement interventions; (4) Adherence interventions; (5) STD screening and treatment; (6) Partner services; (7) Behavioral risk reduction interventions; (8) Screening patients for behavioral health and social services needs; (9) Linkage to behavioral health and social services; (10) Navigators to assist linking to care and accessing behavioral health and social services; and (11) Navigators to assist enrollment in a health plan.

CDC HIV program grantees will collect, enter or upload, and report agency-identifying information, budget data, information on HIV prevention and care services, and client demographic characteristics. The total annual burden hours are 1,534 hours. There are no other costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
THRIVE Partners	Monitoring and Evaluation Data Elements on HIV Prevention and Care Services.	80	2	9
	Qualitative Interview: Collaborative Process Evaluation.	80	1	40/60
	Collaborative Assessment Tool	80	1	20/60
THRIVE Awardees	Monitoring and Evaluation Data Elements on HIV Prevention and Care Services.	7	2	1
	Qualitative Interview: Collaborative Process Evaluation.	7	1	40/60
	Collaborative Assessment Tool	7	1	20/60
	Funding Allocation Report	7	1	20/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2019–25746 Filed 11–26–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–10630 and CMS–855S]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by December 27, 2019.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, 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 Number: (202) 395–5806 *OR,* Email: *OIRA_submission@omb.eop.gov.*

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' website address at website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

1. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

2. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

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. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision with change of a currently approved collection; *Title of Information Collection:* Programs of All-Inclusive Care for the Elderly (PACE) 2020 Audit Protocol; *Use:* Sections 1894(e)(4) and 1934(e)(4) of the Act and the implementing regulations at 42 CFR 460.190 and 460.192 mandate that CMS, in conjunction with the SAA, audit PACE organizations (POs) annually for the first 3 years (during the trial period), and then at least every 2 years following the trial period. The information gathered during this audit will be used by the Medicare Parts C and D Oversight and Enforcement Group (MOEG) within the Center for Medicare (CM) and CMS Regional Offices, as well as the SAA, to assess PO's compliance with PACE program requirements. If outliers or other data anomalies are detected, CMS' Regional Offices will work in collaboration with MOEG and other divisions within CMS for follow-up and resolution. Additionally, POs will receive the audit results, and will be required to implement corrective action to correct any identified deficiencies.

CMS currently uses 18 data collection instruments for conducting PACE audits. These instruments are categorized as a PACE audit process and data request, a questionnaire, a pre-audit issue summary, a Root Cause Analysis template and 16 impact analyses templates. Beginning in audit

year 2020, the number of data collection tools will increase from 18 to the following 22 documents. The data collected with the data request tools included in this package allow CMS to conduct a comprehensive review of PACE organizations' compliance in accordance with specific federal regulatory requirements.

CMS developed and implemented a revised PACE audit protocol. The audit protocol was designed to account for the continued growth of the PACE program and CMS' commitment to a more targeted, data-driven and outcomes-based audit approach, focused on high-risk areas that have the greatest potential for participant harm. *Form Number:* CMS–10630 (OMB control number: 0938–1327); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 35; *Total Annual Responses:* 735; *Total Annual Hours:* 42,000. (For policy questions regarding this collection contact Caroline Zeman at 410 786–0116.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers; *Use:* The CMS–855S is submitted by an applicant to the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) to initially apply for a Medicare billing number, and thereafter to add a new business location, revalidate Medicare enrollment, reactivate Medicare enrollment, to report a change to current Medicare enrollment information, changing the tax identification number, and to voluntary terminate the supplier's Medicare enrollment, as applicable. It is used by new applicants as well as suppliers already enrolled in Medicare but need to submit the form for a reason other than initial enrollment into the Medicare program. *Form Number:* CMS–855S (OMB control number: 0938–1056); *Frequency:* Yearly; *Affected Public:* Private Sector, Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 135,351; *Total Annual Responses:* 44,757; *Total Annual Hours:* 265,471. (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374.)

Dated: November 21, 2019.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2019–25717 Filed 11–26–19; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Advisory General Medical Sciences Council.

The meeting will be open to the public as indicated below, with a short public comment period at the end. Attendance is limited by the space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting. The open session will also be videocast and can be accessed from the NIH Videocasting and Podcasting website (*http://videocast.nih.gov*).

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 Advisory General Medical Sciences Council.

Date: January 16, 2020.

Open: 8:30 a.m. to 12:00 p.m.

Agenda: To review and evaluate for the discussion of program policies and issues; opening remarks; report of the Director, NIGMS; and other business of the Council.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 45 Center Drive, Bethesda, MD 20892.

Closed: 12:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 45 Center Drive, Bethesda, MD 20892.

Contact Person: Erica L. Brown, Ph.D., Acting Associate Director for Extramural Activities, National Institute of General Medical Sciences, National Institutes of Health, Natcher Building, Room 2AN24F, Bethesda, MD 20892, 301–594–4499, *erica.brown@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.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *http://www.nigms.nih.gov/About/Council,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives; 93.859, Biomedical Research and Research Training, National Institutes of Health, HHS)

Dated: November 21, 2019.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–25701 Filed 11–26–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; 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: National Institute of Neurological Disorders and Stroke Special Emphasis Panel; Clinical Trials in Stroke.

Date: December 2, 2019.
Time: 9:00 a.m. to 2:00 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, Neuroscience Center Building (NSC), 6001 Executive Boulevard, Rockville, MD 20852 (Virtual Meeting).
Contact Person: Shanta Rajaram, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, NINDS/NIH, NSC, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892, (301) 435–6033, *rajarams@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel; Research Education Opportunities R25.
Date: December 11, 2019.
Time: 12:30 p.m. to 5:30 p.m.
Agenda: To review and evaluate grant applications.
Place: National Institutes of Health, Neuroscience Center Building (NSC), 6001 Executive Boulevard, Rockville, MD 20852.
Contact Person: Delany Torres, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, NINDS, Neuroscience Center Building (NSC), 6001 Executive Blvd., Suite 3208, Bethesda, MD 20892, *delany.torressalazar@nih.gov.*

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel; Diversity K Grant Mechanism Review.
Date: December 16, 2019.
Time: 8:00 a.m. to 5:00 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: William C. Benzing, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, NINDS, NIH, NSC, 6001 Executive Blvd., Suite 3204, MSC 9529, Bethesda, MD 20892–9529, (301) 496–0660, *benzingw@mail.nih.gov.*

Name of Committee: Neurological Sciences Training Initial Review Group; NST–1 Subcommittee.
Date: January 27–28, 2020.
Time: 8:00 a.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Washington Marriott Georgetown, 1221 22nd Street NW, Washington, DC 20037.
Contact Person: William C. Benzing, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, NINDS, NIH, NSC, 6001 Executive Blvd., Suite 3204, MSC 9529, Bethesda, MD 20892–9529, (301) 496–0660, *benzingw@mail.nih.gov.*

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel; DSPAN Review Meeting.
Date: February 3, 2020.
Time: 7:00 a.m. to 6:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Bourbon Orleans Hotel, 717 Orleans Street, New Orleans, LA 70116.
Contact Person: William C. Benzing, Ph.D., Scientific Review Officer, Scientific Review Branch, Division of Extramural Activities, NINDS, NIH, NSC, 6001 Executive Blvd., Suite 3204, MSC 9529, Bethesda, MD 20892–9529, (301) 496–0660, *benzingw@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: November 21, 2019.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2019–25700 Filed 11–26–19; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2019–0862]

Port Access Route Study: Approaches to the Chesapeake Bay, Virginia

AGENCY: Coast Guard, DHS.

ACTION: Notice of study; request for comments.

SUMMARY: The Coast Guard is conducting a Port Access Route Study (PARS) to determine whether existing or additional vessel routing measures are necessary in the approaches to the Chesapeake Bay, VA. This PARS will consider whether existing or additional routing measures are necessary to improve navigation safety due to factors such as planned or potential offshore development, current port capabilities and planned improvements, increased vessel traffic, changing vessel traffic patterns, weather conditions, or navigational difficulty. Vessel routing measures are measures aimed at reducing the risk of casualties and include among others, traffic separation schemes, two-way routes, recommended tracks, deep-water routes, precautionary areas, and areas to be avoided. The recommendations of the study may lead to future rulemakings or appropriate international agreements.

DATES: Comments and related material must be received on or before January 27, 2020. Requests for a public meeting must be submitted on or before December 27, 2019.

ADDRESSES: You may submit comments identified by docket number USCG–2019–0862 using the Federal eRulemaking Portal *http://www.regulations.gov*. See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** section for further instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: If you have questions about this notice or study, call or email Mr. Jerry Barnes, Fifth Coast Guard District (dpw), U.S. Coast Guard; telephone (757) 398–6230, email *Jerry.R.Barnes@uscg.mil*; or Mr. Matt Creelman, Fifth Coast Guard District (dpw), U.S. Coast Guard; telephone (757) 398–6225, email *Matthew.K.Creelman2@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Public Participation and Request for Comments

We encourage you to participate in this study by submitting comments and related materials. All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you have provided.

A. Submitting Comments: If you submit comments to the online public docket, please include the docket number for this rulemaking (USCG–2019–0862), indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. We accept anonymous comments.

To submit your comment online, go to *http://www.regulations.gov,* and insert ''USCG–2019–0862'' in the ''search box.'' Click ''Search'' and then click ''Comment Now.'' We will consider all comments and material received during the comment period.

B. Public Meetings: The Coast Guard may hold public meeting(s) if there is sufficient public interest. You must submit a request for one on or before December 27, 2019. You may submit your request for a public meeting online via *http://www.regulations.gov.* Please explain why you believe a public meeting would be beneficial. If we determine that a public meeting would aid in the study, we will hold a meeting at a time and place announced by a later notice in the **Federal Register**.

C. Viewing Comments and Documents: To view the comments and documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* click on the ''read comments'' box, which will then become highlighted in blue. In the ''Keyword'' box insert ''USCG–2019–0862'' and click ''Search.'' Click the

''Open Docket Folder'' in the ''Actions'' column.

D. Privacy Act: We accept anonymous comments. All comments received will be posted without change to *https://www.regulations.gov* and will include any personal information you have provided. For more about privacy and submissions in response to this document, see DHS's Correspondence System of Records notice (84 FR 48645, September 26, 2018). Documents mentioned in this notice as being available in the docket, and all public comments, will be in our online docket at *https://www.regulations.gov* and can be viewed by following that website's instructions. Additionally, if you go to the online docket and sign up for email alerts, you will be notified when comments are posted or a final rule is published.

II. Background and Purpose

A. Requirements for Port Access Route Studies: Under Section 70003 of title 46 of the United States Code, the Commandant of the Coast Guard may designate necessary fairways and traffic separation schemes (TSSs) to provide safe access routes for vessels proceeding to and from U.S. ports. The designation of fairways and TSSs recognizes the paramount right of navigation over all other uses in the designated areas.

Before establishing or adjusting fairways or TSSs, the Coast Guard must conduct a PARS, *i.e.,* a study of potential traffic density and the need for safe access routes for vessels. Through the study process, the Coast Guard must coordinate with Federal, State, and foreign state agencies (as appropriate) and consider the views of maritime community representatives, environmental groups, and other interested stakeholders. The primary purpose of this coordination is, to the extent practicable, to reconcile the need for safe access routes with other reasonable waterway uses such as construction and operation of renewable energy facilities and other uses of the Atlantic Ocean in the study area.

In addition to aiding the Coast Guard in establishing new or adjusting fairways or TSSs, the PARS may recommend establishing or amending other vessel routing measures. Examples of other routing measures, among others, include two-way routes, recommended tracks, deep-water routes (for the benefit primarily of ships whose ability to maneuver is constrained by their draft), precautionary areas (where ships must navigate with particular caution), and areas to be avoided (for reasons of exceptional danger or especially sensitive ecological and environmental factors).

B. Previous Port Access Route Studies: The Coast Guard last studied the approaches to the Chesapeake Bay, VA in 2002, and published the final results in 2004 (69 FR 3869, January 27, 2004). The study was conducted in response to the slow, continuous southward movement of the Nautilus Shoal and primarily examined the location of the Eastern Approach to determine a location that would better accommodate vessels. Study available at *https://www.navcen.uscg.gov/pdf/PARS/CHESAPEAKE_BAY_PARS.pdf.*

C. Need for a New Port Access Route Study: In 2016, the Coast Guard published a notice of its Atlantic Coast Port Access Route Study (ACPARS) (81 FR 13307, March 14, 2016) that analyzed the Atlantic Coast waters seaward of existing port approaches within the U.S. Exclusive Economic Zone and announced the report as final in 2017 (82 FR 16510, April 5, 2017). This multiyear study, began in 2011, included public participation, and identified the navigation routes customarily followed by ships engaged in commerce between international and domestic U.S. ports. Study available at *https://navcen.uscg.gov/?pageName=PARSReports.*

In 2019, the Coast Guard announced a new study of routes used by ships to access ports on the Atlantic Coast of the United States (84 FR 9541, March 15, 2019). This new study of routes supplements and builds on the ACPARS. As part of the study, the Coast Guard will conduct several PARS to examine ports along the Atlantic coast that are economically significant, support military operations or critical national defense and related international entry and departure transit areas that are integral to the safe and efficient and unimpeded flow of commerce to/from major international shipping lanes.

The purpose of this notice is to announce commencement of the PARS to examine the approaches to the Chesapeake Bay, VA, in conjunction with the implementation of recommendations of the ACPARS, and to solicit public comments. We encourage you to participate in the study process by submitting comments in response to this notice. Comments should address impacts to navigation in the approaches to the Chesapeake Bay resulting from factors such as planned or potential offshore development, current port capabilities and planned improvements, increased vessel traffic, changing vessel traffic patterns, weather conditions, or navigational difficulty. Similar to the ACPARS, the PARS will use AIS data and information from stakeholders to identify and verify customary navigation routes as well as potential conflicts involving alternative activities, such as wind energy generation and offshore mineral exploitation and exploration.

III. Chesapeake Bay PARS: Timeline, Study Area, and Process

The Fifth Coast Guard District and Coast Guard Sector Hampton Roads will conduct this PARS. The study will commence upon publication of this notice and may take 12 months or more to complete.

The study area is described as an area bounded by a line connecting the following geographic positions:

- 38°16′ N, 71°16′ W;
- 35°19′ N, 71°16′ W;
- 35°19′ N, 75°21′ W;
- 36°56′ N, 76°03′ N;
- 38°16′ N, 75°16′ W.

This area extends approximately 220 nautical miles seaward of the Chesapeake Bay, between Ocean City, MD, and Cape Hatteras, NC. An illustration showing the study area is available in the docket where indicated under **ADDRESSES**. Additionally, the study area is available for viewing on the Mid-Atlantic Ocean Data Portal at *http://portal.midatlanticocean.org/visualize/.* See the ''Maritime'' portion of the Data Layers section.

The PARS will analyze navigation routes to/from the Chesapeake Bay, VA, to the proposed fairways outlined in the ACPRS as well as international routes to/from the United States. Current capabilities and planned improvements to handle maritime conveyances will be considered. Analyses will be conducted in accordance with COMDTINST 16003.2B, Marine Planning to Operate and Maintain the Marine Transportation System (MTS) and Implement National Policy. Instruction available at *https://media.defense.gov/2019/Jul/10/2002155400/-1/-1/0/CI_16003_2B.PDF.*

We will publish the results of the PARS in the **Federal Register**. It is possible that the study may validate the status quo (no additional fairways or routing measures) and conclude that no changes are necessary. It is also possible that the study may recommend one or more changes to address navigational safety and the efficiency of vessel traffic management. The recommendations may lead to future rulemakings or appropriate international agreements.

This notice is published under the authority of 5 U.S.C. 552(a).

Dated: November 21, 2019.

Keith M. Smith,

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

[FR Doc. 2019–25757 Filed 11–26–19; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Approval of AmSpec LLC (La Porte, TX), as a Commercial Gauger

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice of approval of AmSpec LLC (La Porte, TX), as a commercial gauger.

SUMMARY: Notice is hereby given, pursuant to CBP regulations, that AmSpec LLC (La Porte, TX), has been approved to gauge petroleum and certain petroleum products for customs purposes for the next three years as of June 12, 2019.

DATES: AmSpec LLC (La Porte, TX) was approved, as a commercial gauger as of June 12, 2019. The next triennial inspection date will be scheduled for June 2022.

FOR FURTHER INFORMATION CONTACT: Dr. Eugene Bondoc, Laboratories and Scientific Services Directorate, U.S. Customs and Border Protection, 1300 Pennsylvania Avenue NW, Suite 1500N, Washington, DC 20229, tel. 202–344–1060.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to 19 CFR 151.13, that AmSpec LLC, 631 N 16th Street, La Porte, TX 77571 has been approved to gauge petroleum and certain petroleum products for customs purposes, in accordance with the provisions of 19 CFR 151.13. AmSpec LLC (La Porte, TX) is approved for the following gauging procedures for petroleum and certain petroleum products from the American Petroleum Institute (API):

API chapters	Title
3	Tank Gauging.
7	Temperature Determination.
8	Sampling.
11	Physical Properties Data.
12	Calculations.
17	Marine Measurement.

Anyone wishing to employ this entity to conduct gauger services should request and receive written assurances from the entity that it is approved by the U.S. Customs and Border Protection to conduct the specific gauger service requested. Alternatively, inquiries regarding the specific gauger service this entity is accredited or approved to perform may be directed to the U.S. Customs and Border Protection by calling (202) 344–1060. The inquiry may also be sent to *CBPGaugersLabs@cbp.dhs.gov.* Please reference the website listed below for a complete listing of CBP approved gaugers and accredited laboratories. *http://www.cbp.gov/about/labs-scientific/commercial-gaugers-and-laboratories.*

Dated: October 23, 2019.

Dave Fluty,

Executive Director, Laboratories and Scientific Services Directorate.

[FR Doc. 2019–25754 Filed 11–26–19; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Customs Broker User Fee Payment for 2020

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: General notice.

SUMMARY: This document provides notice to customs brokers that the annual user fee that is assessed for each permit held by a broker, whether it may be an individual, partnership, association, or corporation, is due by January 31, 2020. Pursuant to fee adjustments required by the Fixing America's Surface Transportation Act (FAST ACT) and U.S. Customs and Border Protection (CBP) regulations, the annual user fee payable for calendar year 2020 will be $147.89.

DATES: Payment of the 2020 Customs Broker User Fee is due by January 31, 2020.

FOR FURTHER INFORMATION CONTACT: Melba Hubbard, Broker Management Branch, Office of Trade, (202) 325–6986, or *melba.hubbard@cbp.dhs.gov.*

SUPPLEMENTARY INFORMATION:

Background

Pursuant to section 111.96 of title 19 of the Code of Federal Regulations (19 CFR 111.96(c)), U.S. Customs and Border Protection (CBP) assesses an annual user fee for each customs broker district and national permit held by an individual, partnership, association, or corporation. CBP regulations provide that this fee is payable for each calendar year in each broker district where the broker was issued a permit to do business by the due date. *See* 19 CFR 24.22(h) and (i)(9). Broker districts are defined in the General Notice entitled, ''Geographic Boundaries of Customs Brokerage, Cartage and Lighterage Districts,'' published in the **Federal Register** on March 15, 2000 (65 FR 14011), and corrected, with minor changes, on March 23, 2000 (65 FR 15686) and on April 6, 2000 (65 FR 18151).

Sections 24.22 and 24.23 of title 19 of the Code of Federal Regulations (19 CFR 24.22 and 24.23) provide for and describe the procedures that implement the requirements of the Fixing America's Surface Transportation Act (FAST Act) (Pub. L. 114–94, December 4, 2015). Specifically, paragraph (k) in section 24.22 (19 CFR 24.22(k)) sets forth the methodology to determine the change in inflation as well as the factor by which the fees and limitations will be adjusted, if necessary. The customs broker user fee is set forth in Appendix A of part 24. (19 CFR 24.22 Appendix A). On August 2, 2019, CBP published a **Federal Register** notice, CBP Dec. 19–08, which among other things, announced that the annual broker permit user fee would increase to $147.89 for calendar year 2020. *See* 84 FR 37902.

As required by 19 CFR 111.96, CBP must provide notice in the **Federal Register** no later than 60 days before the date that the payment is due for each broker permit. This document notifies customs brokers that for calendar year 2020, the due date for payment of the user fee is January 31, 2020.

Dated: November 22, 2019.

Brenda B. Smith,

Executive Assistant Commissioner, Office of Trade.

[FR Doc. 2019–25753 Filed 11–26–19; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

[1651–0093]

Agency Information Collection Activities: Declaration of Owner and Declaration of Consignee When Entry Is Made by an Agent

AGENCY: U.S. Customs and Border Protection (CBP), Department of Homeland Security.

ACTION: 30-Day notice and request for comments; extension of an existing collection of information.

SUMMARY: The Department of Homeland Security, U.S. Customs and Border

Protection will be submitting 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 (PRA). The information collection is published in the **Federal Register** to obtain comments from the public and affected agencies.

DATES: Comments are encouraged and must be submitted (no later than December 27, 2019) to be assured of consideration.

ADDRESSES: Interested persons are invited to submit written comments on this proposed information collection to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments should be addressed to the OMB Desk Officer for Customs and Border Protection, Department of Homeland Security, and sent via email to *dhsdeskofficer@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: Requests for additional PRA information should be directed to Seth Renkema, Chief, Economic Impact Analysis Branch, U.S. Customs and Border Protection, Office of Trade, Regulations and Rulings, 90 K Street NE, 10th Floor, Washington, DC 20229–1177, Telephone number 202–325–0056 or via email *CBP_PRA@cbp.dhs.gov.* Please note that the contact information provided here is solely for questions regarding this notice. Individuals seeking information about other CBP programs should contact the CBP National Customer Service Center at 877–227–5511, (TTY) 1–800–877–8339, or CBP website at *https://www.cbp.gov/.*

SUPPLEMENTARY INFORMATION: CBP invites the general public and other Federal agencies to comment on the proposed and/or continuing information collections pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). This proposed information collection was previously published in the **Federal Register** (84 FR 45786) on August 30, 2019, allowing for a 60-day comment period. This notice allows for an additional 30 days for public comments. This process is conducted in accordance with 5 CFR 1320.8. Written comments and suggestions from the public and affected agencies should address one or more of the following four points: (1) 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) 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) suggestions to enhance the quality, utility, and clarity of the information to be collected; and (4) suggestions to 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. The comments that are submitted will be summarized and included in the request for approval. All comments will become a matter of public record.

Overview of This Information Collection

Title: Declaration of Owner and Declaration of Consignee When Entry is made by an Agent.

OMB Number: 1651–0093.

Form Number: CBP Forms 3347 and 3347A.

Abstract: CBP Form 3347, *Declaration of Owner,* is a declaration from the owner of imported merchandise stating that he/she agrees to pay additional or increased duties, therefore releasing the importer of record from paying such duties. This form must be filed within 90 days from the date of entry. CBP Form 3347 is provided for by 19 CFR 24.11 and 141.20.

When entry is made in a consignee's name by an agent who does not meet the qualifications in 19 CFR 141.19(b)(2), meaning that the agent does not have knowledge of the facts and/or is not authorized under a proper power of attorney by that consignee, a declaration from the consignee on CBP Form 3347A, *Declaration of Consignee When Entry is Made by an Agent,* may be filed with the entry documentation or the entry summary. If the declaration is filed on CBP Form 3347A, then no bond to produce a declaration of the consignee is required. If the declaration is not filed at entry or entry summary, bond must be given to produce such declaration, and the declaration must be presented within six months after the date that the bond was given. CBP Form 3347A is provided for by 19 CFR 141.19(b)(2).

CBP Forms 3347 and 3347A are authorized by 19 U.S.C. 1485 and are accessible at *https://www.cbp.gov/newsroom/publications/forms?title=3347&=Apply.*

Action: CBP proposes to extend the expiration date of this information collection with no change to the estimated burden hours or to the information collected.

Type of Review: Extension (without change).

Affected Public: Businesses.

CBP Form 3347

Estimated Number of Respondents: 900.

Estimated Number of Responses per Respondent: 6.

Estimated Total Annual Responses: 5,400.

Estimated Time per Response: 6 minutes.

Estimated Total Annual Burden Hours: 540.

CBP Form 3347A

Estimated Number of Respondents: 50.

Estimated Number of Responses per Respondent: 6.

Estimated Total Annual Responses: 300.

Estimated Time per Response: 6 minutes.

Estimated Total Annual Burden Hours: 30.

Dated: November 22, 2019.

Seth D. Renkema,

Branch Chief, Economic Impact Analysis Branch, U.S. Customs and Border Protection.

[FR Doc. 2019–25793 Filed 11–26–19; 8:45 am]

BILLING CODE P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2019–0026; OMB No. 1660–0069]

Agency Information Collection Activities: Proposed Collection; Comment Request; National Fire Incident Reporting System (NFIRS) v5.0

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice and request for comments.

SUMMARY: The Federal Emergency Management Agency (FEMA), as part of its continuing effort to reduce paperwork and respondent burden, invites the general public to take this opportunity to comment on a reinstatement, with change, of a previously approved information collection for which approval has expired. In accordance with the Paperwork Reduction Act of 1995, this notice seeks comments concerning National Fire Incident Reporting System (NFIRS) v5.0. The program provides a well-established mechanism, using standardized reporting methods, to collect and analyze fire incident data at the Federal, State, and local levels with

a myriad of life and property saving uses and benefits.

DATES: Comments must be submitted on or before January 27, 2020.

ADDRESSES: To avoid duplicate submissions to the docket, please use only one of the following means to submit comments:

(1) *Online.* Submit comments at *www.regulations.gov* under Docket ID FEMA–2019–0026. Follow the instructions for submitting comments.

(2) *Mail.* Submit written comments to Docket Manager, Office of Chief Counsel, DHS/FEMA, 500 C Street SW, 8NE, Washington, DC 20472–3100.

All submissions received must include the agency name and Docket ID. Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the Federal eRulemaking Portal at *http://www.regulations.gov,* and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy Act notice that is available via the link in the footer of *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: William Troup, Chief, United States Fire Administration-National Fire Data Center, (301) 447–1231. You may contact the Information Management Division for copies of the proposed collection of information at email address: *FEMA-Information-Collections-Management@fema.dhs.gov.*

SUPPLEMENTARY INFORMATION: The National Commission on Fire Prevention and Control conducted a comprehensive study of the Nation's fire problem and recommended to Congress actions to mitigate the fire problem, reduce loss of life and property, and educate the public on fire protection and prevention. As a result of the study, Congress enacted Public Law 93–498, Federal Fire Prevention and Control Act of 1974, which establishes the U.S. Fire Administration to administer fire prevention and control programs, supplement existing programs of research, training, and education, and encourage new and improved programs and activities by State and local governments. Section 9(a) of the Act authorizes the Administrator, U.S. Fire Administration (USFA), to operate directly or through contracts or grants, an integrated, comprehensive method to select, analyze, publish, and disseminate information related to prevention, occurrence, control, and results of fires of all types.

NFIRS was established in the mid-1970s and is mandated by the Federal Fire Prevention and Control Act of 1974 (Pub. L. (PL) 93–498, as amended) which authorizes the National Fire Data Center to gather and analyze information such as (1) the frequency, causes, spread, and extinguishment of fires; (2) injuries and deaths resulting from fires; (3) information on injuries sustained by a firefighter; and (4) information on firefighting activities. The act further authorizes USFA to develop uniform data reporting methods, and to encourage and assist Federal, State, local and other agencies in developing and reporting information. NFIRS is a reporting standard that fire departments use to uniformly report on the full range of their activities, from fire to emergency medical services to severe weather and natural disasters. This reporting allows fire departments, as well as many other government and non-government agencies, to quantify their actions and identify incident and response trends.

This information collection expired on 04/30/2019. FEMA is requesting a reinstatement, without change, of a previously approved information collection for which approval has expired.

Collection of Information

Title: National Fire Incident Reporting System (NFIRS) v5.0.

Type of Information Collection: Reinstatement, with change, of a previously approved information collection for which approval has expired.

OMB Number: OMB No. 1660–0069.

Form Titles and Numbers: The National Fire Incident Reporting System (NFIRS) v5.0 Modules 1–11.

Abstract: NFIRS provides a mechanism using standardized reporting methods to collect and analyze fire incident data at the Federal, State, and local levels. Data analysis helps local fire departments and States to focus on current problems, predict future problems in their communities, and measure whether their programs are working.

Affected Public: State, Local or Tribal, and Federal Government.

Estimated Number of Respondents: 23,500.

Estimated Number of Responses: 28,059,000.

Estimated Total Annual Burden Hours: 12,626,550.

Estimated Total Annual Respondent Cost: $471,980,439.

Estimated Respondents' Operation and Maintenance Costs: $1,974,000.

Estimated Respondents' Capital and Start-Up Costs: $1,128,000.

Estimated Total Annual Cost to the Federal Government: $3,356,189.

Comments

Comments may be submitted as indicated in the **ADDRESSES** caption above. Comments are solicited to (a) evaluate whether the proposed data collection is necessary for the proper performance of the agency, including whether the information shall have practical utility; (b) 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; (c) enhance the quality, utility, and clarity of the information to be collected; and (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.

Maile Arthur,

Acting Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2019–25735 Filed 11–26–19; 8:45 am]

BILLING CODE 9111–76–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2019–0020 OMB No. 1660–0125]

Agency Information Collection Activities: Proposed Collection; Comment Request; FEMA Preparedness Grants: Homeland Security Grant Program (HSGP)

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice and request for comments.

SUMMARY: The Federal Emergency Management Agency, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public to take this opportunity to comment on a revision of a currently approved information collection. In accordance with the Paperwork Reduction Act of 1995, this notice seeks comments concerning the HSGP.

DATES: Comments must be submitted on or before January 27, 2020.

ADDRESSES: To avoid duplicate submissions to the docket, please use only one of the following means to submit comments:

(1) *Online.* Submit comments at *www.regulations.gov* under Docket ID FEMA–2019–0020. Follow the instructions for submitting comments.

(2) *Mail.* Submit written comments to Docket Manager, Office of Chief Counsel, DHS/FEMA, 500 C Street SW, 8NE, Washington, DC 20472–3100.

All submissions received must include the agency name and Docket ID. Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the Federal eRulemaking Portal at *http://www.regulations.gov,* and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy Act notice that is available via the link in the footer of *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Laila Ouhamou, Acting Branch Chief, Program Development and Support Brach, Grant Programs Directorate, FEMA, 202–786–9461. You may contact the Information Management Division for copies of the proposed collection of information at email address: *FEMA-Information-Collections-Management@fema.dhs.gov.*

SUPPLEMENTARY INFORMATION: FEMA's Homeland Security Grant Program (HSGP) supports State and local efforts to prevent terrorism and other catastrophic events and to prepare the Nation for the threats and hazards that pose the greatest risk to the security of the United States. The HSGP provides funding to implement investments that build, sustain, and deliver the 32 core capabilities essential to achieving the National Preparedness Goal (the Goal) of a secure and resilient Nation. The building, sustainment, and delivery of these core capabilities are not exclusive to any single level of government, organization, or community, but rather, require the combined effort of the whole community. The HSGP supports core capabilities across the five mission areas of Prevention, Protection, Mitigation, Response, and Recovery based on allowable costs. HSGP is comprised of three grant programs: State Homeland Security Program (SHSP), Urban Area Security Initiative (UASI), and Operation Stonegarden (OPSG). Together, these grant programs fund a range of activities, including planning, organization, equipment purchase, training, exercises, and management and administration across all core capabilities and mission areas. The authorizing authority of the HSGP is Section 2002 of the *Homeland Security Act of 2002,* as amended (Pub. L. 107–296, as amended) (6 U.S.C. 603).

Collection of Information

Title: FEMA Preparedness Grants: Homeland Security Grant Program (HSGP).

Type of Information Collection: Revision of a currently approved information collection.

OMB Number: 1660–0125.

FEMA Forms: FEMA Form 089–1, HSGP Investment Justification (SHSP and UASI); FEMA Form 089–16, OPSG Operations Order Report; FEMA Form 089–20, OPSG Inventory of Operation Orders.

Abstract: The HSGP is an important tool among a comprehensive set of measures to help strengthen the Nation against risks associated with potential terrorist attacks. DHS/FEMA uses the information to evaluate applicants' familiarity with the national preparedness architecture and identify how elements of this architecture have been incorporated into regional/State/local planning, operations, and investments.

The HSGP is a primary funding mechanism for building and sustaining national preparedness capabilities. The HSGP is comprised of three separate grant programs: The SHSP, the UASI, and OPSG. Together, these grants fund a range of preparedness activities, including planning, organization, equipment purchase, training, exercises, and management and administration costs.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 2,209.

Estimated Number of Responses: 548,327.

Estimated Total Annual Burden Hours: 866,988.

Estimated Total Annual Respondent Cost: $65,795,719.

Estimated Respondents' Operation and Maintenance Costs: $0.

Estimated Respondents' Capital and Start-Up Costs: $0.

Estimated Total Annual Cost to the Federal Government: $1,503,065.

Comments

Comments may be submitted as indicated in the **ADDRESSES** caption above. Comments are solicited to (a) evaluate whether the proposed data collection is necessary for the proper performance of the agency, including whether the information shall have practical utility; (b) 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; (c) enhance the quality, utility, and clarity of the information to be collected; and (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.

Maile Arthur,

Acting Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2019–25736 Filed 11–26–19; 8:45 am]

BILLING CODE 9111–19–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7014–N–30]

60-Day Notice of Proposed Information Collection: FHA TOTAL Mortgage Scorecard

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* January 27, 2020.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Colette Pollard, Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 7th Street SW, Room 4176, Washington, DC 20410–5000; telephone 202–402–3400 (this is not a toll-free number) or email at *Colette.Pollard@hud.gov* for a copy of the proposed forms or other available information. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

FOR FURTHER INFORMATION CONTACT: Colette Pollard, Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 7th Street SW, Room 4176, Washington, DC 20410–5000; telephone 202–402–3400 (this is not a toll-free number) or email at *Colette.Pollard@hud.gov* for a copy of the proposed forms or other available information. Copies of available documents submitted to OMB may be obtained from Ms. Pollard.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in Section A.

A. Overview of Information Collection

Title of Information Collection: FHA TOTAL Mortgage Scorecard.

OMB Approval Number: 2502–0556.

Type of Request: Extension of currently approved collection.

Form Number: None.

Description of the need for the information and proposed use: FHA-approved mortgagees must certify compliance with HUD regulations, Handbooks, Guidebooks, and Mortgagee Letters. Within this scope, mortgagees must certify compliance with FHA TOTAL Mortgage Scorecard requirements at 24 CFR 203.255(b)(5). This certification is performed electronically for initial access and annual ongoing access to FHA TOTAL Mortgage Scorecard.

Respondents: Business or other for-profit (lenders).

Estimated Number of Respondents: 2,440.

Estimated Number of Responses: 2,440.

Frequency of Response: One per FHA-approved mortgagee.

Average Hours per Response: 0.05 hour.

Total Estimated Burdens: 122.

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) 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) The accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Ways to enhance the quality, utility, and clarity of the information to be collected; and (4) Ways to minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35.

Dated: November 19, 2019.

John L. Garvin,

General Deputy Assistant Secretary for Housing.

[FR Doc. 2019–25694 Filed 11–26–19; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029093]

Notice of Inventory Completion: Tennessee Valley Authority, Knoxville, TN

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Tennessee Valley Authority (TVA) has completed an inventory of human remains, in consultation with the appropriate federally recognized Indian Tribes, and has determined that there is a cultural affiliation between the human remains and present-day Indian Tribes or Native Hawaiian organizations. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request to the TVA. If no additional requestors come forward, transfer of control of the human remains to lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to the TVA at the address in this notice by December 27, 2019.

ADDRESSES: Dr. Thomas O. Maher, TVA, 400 West Summit Hill Drive, WT11C, Knoxville,' TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov*.

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains under the control of the Tennessee Valley Authority, Knoxville, TN. The human remains were removed from an archeological site in Marshall County, AL.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by TVA professional staff in consultation with representatives of the Absentee-Shawnee Tribe of Indians of Oklahoma; Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Cherokee Nation; Coushatta Tribe of Louisiana; Eastern Band of Cherokee Indians; Mississippi Band of Choctaw Indians; Poarch Band of Creeks (previously listed as the Poarch Band of Creek Indians of Alabama); The Chickasaw Nation; The Choctaw Nation of Oklahoma; The Muscogee (Creek) Nation; The Seminole Nation of Oklahoma; and the United Keetoowah Band of Cherokee Indians in Oklahoma (hereafter referred to as ''The Consulted Tribes'').

History and Description of the Remains

The site listed in this notice was excavated as part of TVA's Guntersville Reservoir project by the Alabama Museum of Natural History (AMNH) at the University of Alabama, using labor and funds provided by the Works Progress Administration. Details regarding these excavations and sites may be found in a report, ''*An Archaeological Survey of Guntersville Basin on the Tennessee River in Northern Alabama,*'' by William S. Webb and Charles G. Wilder. Human remains and other associated funerary objects from this site were previously listed in a Notice of Inventory Completion published in the **Federal Register** on September 5, 2017 (82 FR 41986–41987, September 5, 2017), and were transferred to the Alabama-Coushatta Tribe of Texas, Alabama-Quassarte Tribal Town, Coushatta Tribe of Louisiana, and The Muscogee (Creek) Nation. Additional human remains were found during a recent improvement in the curation of the TVA archeological collections at AMNH.

Between September 1938 and January 1939, human remains representing, at minimum, one individual were removed

from the Laws site, 1MS100, on Pine Island in Marshall County, AL, after TVA purchased the site on April 21, 1937. Excavations began at the levee adjacent to the river and proceeded by both vertical slicing and horizontal excavations. There appear to have been at least four occupations at this site, including a pre-ceramic period with steatite vessels; a village using limestone-tempered pottery during the Flint River phase (A.D. 500–1000); a late Mississippian occupation using shell-tempered ceramics and rectilinear wall trench structures (Crow Creek phase, A.D. 1500–1700); and the Euro-American trade period (circa A.D. 1670–1715). The human remains are from the Mississippian or historic Native American occupation. No known individuals were identified. No associated funerary objects are present.

Although there is no absolute certainty that Native Americans of the Mississippian period are directly related to modern federally recognized Tribes, a relationship of shared group identity can reasonably be traced between these modern Tribes and the human remains of the earlier culture identified as Mississippian. The preponderance of the evidence indicates that the cultural items from Mississippian and early historic occupations at site 1MS100 are culturally affiliated with Native Americans descendants of the Koasati/Kaskinampo. These descendants include the Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Alabama-Quassarte Tribal Town; Coushatta Tribe of Louisiana; and The Muscogee (Creek) Nation.

Chronicles from Spanish explorers of the 16th century and French explorers of the 17th and 18th centuries indicate the presence of chiefdom-level tribal entities in the southeastern United States which resemble the Mississippian chiefdoms. Linguistic analysis of place names noted by multiple Spanish explorers indicates that Koasati speaking groups inhabited northeastern Alabama. Early maps and research into the historic Native American occupation of northeastern Alabama indicates that the Koasati (as called by the English) or the Kaskinampo (as called by the French) were found at multiple sites in Jackson and Marshall Counties in the 17th and 18th centuries. Oral history, traditions, and expert opinions of the descendants of Koasati/Kaskinampo indicate that this portion of the Tennessee River valley was a homeland of their Tribe. The subsequent involuntary diaspora of these peoples resulted in descendants of the Koasati/Kaskinampo living among multiple federally recognized Tribes.

Determinations Made by the Tennessee Valley Authority

Officials of the Tennessee Valley Authority have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of one individual of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Alabama-Quassarte Tribal Town; Coushatta Tribe of Louisiana; and The Muscogee (Creek) Nation.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to Dr. Thomas O. Maher, TVA, 400 West Summit Hill Drive, WT11C, Knoxville, TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains to the Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Alabama-Quassarte Tribal Town; Coushatta Tribe of Louisiana; and The Muscogee (Creek) Nation may proceed.

The Tennessee Valley Authority is responsible for notifying The Consulted Tribes that this notice has been published.

Dated: October 8, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25731 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029194; PPWOCRADN0–PCU00RP14.R50000]

Notice of Intent To Repatriate Cultural Items: Thomas Burke Memorial Washington State Museum, University of Washington, Seattle, WA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Thomas Burke Memorial Washington State Museum (Burke Museum), in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, has determined that the cultural items listed in this notice meet the definition of unassociated funerary objects. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to claim these cultural items should submit a written request to the Burke Museum. If no additional claimants come forward, transfer of control of the cultural items to the lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to claim these cultural items should submit a written request with information in support of the claim to the Burke Museum at the address in this notice by December 27, 2019.

ADDRESSES: Peter Lape, Burke Museum, University of Washington, Box 353010, Seattle, WA 98195, telephone (206) 685–3849 x2, email *plape@uw.edu.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate cultural items under the control of the Thomas Burke Memorial Washington State Museum, University of Washington, Seattle, WA, that meet the definition of unassociated funerary objects under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American cultural items. The National Park Service is not responsible for the determinations in this notice.

History and Description of the Cultural Items

Between 1953 and 1954, two cultural items were removed from site 45–KL–27 in Klickitat County, WA, as part of a University of Washington Field Project led by Warren Caldwell. The cultural items were formally accessioned by the Burke Museum in 1966 (Burke Accn. #1966–86). The two unassociated funerary objects are two lots of unmodified wood.

Site 45–KL–27 borders the Columbia River in Washington. Museum

documentation indicates that the cultural items were found in context with burials. Early and late published ethnographic documentation indicates that this was the aboriginal territory of the Western Columbia River Sahaptins, Wasco, Wishram, Yakima, Walla Walla, Umatilla, Tenino and Skin (Daughtery 1973, Hale 1841, Hunn and French 1998, French and French 1998, Mooney 1896, Murdock 1938, Ray 1936 and 1974, Spier 1936, Stern 1998). The descendants of these peoples are members of the present-day Confederated Tribes and Bands of the Yakama Nation; Confederated Tribes of the Umatilla Indian Reservation (previously listed as the Confederated Tribes of the Umatilla Reservation, Oregon); and the Confederated Tribes of the Warm Springs Reservation of Oregon (hereafter referred to as ''The Tribes'').

Determinations Made by the Thomas Burke Memorial Washington State Museum

Officials of the Thomas Burke Memorial Washington State Museum have determined that:

- Pursuant to 25 U.S.C. 3001(3)(B), the two cultural items described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony and are believed, by a preponderance of the evidence, to have been removed from a specific burial site of a Native American individual.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the unassociated funerary objects and The Tribes.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to claim these cultural items should submit a written request with information in support of the claim to Peter Lape, Burke Museum, University of Washington, Box 353010, Seattle, WA 98195, telephone (206) 685–3849 x2, email *plape@uw.edu,* by December 27, 2019. After that date, if no additional claimants have come forward, transfer of control of the unassociated funerary objects to The Tribes may proceed.

The Thomas Burke Memorial Washington State Museum is responsible for notifying The Tribes that this notice has been published.

Dated: October 24, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25728 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029091; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: Los Angeles Pierce College, Woodland Hills, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: Los Angeles Pierce College has completed an inventory of human remains and associated funerary objects, in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, and has determined that there is a cultural affiliation between the human remains and associated funerary objects and present-day Indian Tribes or Native Hawaiian organizations. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to Los Angeles Pierce College. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Los Angeles Pierce College at the address in this notice by December 27, 2019.

ADDRESSES: Ronald K. Faulseit, Los Angeles Pierce College, 6201 Winnetka Avenue, Woodland Hills, CA 91371, telephone (818) 610–6560, email *faulserk@piercecollege.edu.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of Los Angeles Pierce College, Woodland Hills, CA. The human remains and associated funerary objects were removed from the Chatsworth and Chatsworth Cairn archeological sites (CA LAN 357 and CA LAN 21), Los Angeles, CA.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by Los Angeles Pierce College's professional staff in consultation with representatives of the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California and the Fernandeño Tataviam Band of Mission Indians, a non-federally recognized Indian group.

History and Description of the Remains

Members of the Anthropology Department of Los Angeles Pierce College have found the human remains of, at minimum, 18 individuals and 72 associated funerary objects in the Anthropology storeroom at Pierce College. Analysis of archived field notebooks and site excavation forms in our possession demonstrates that these human remains and funerary objects were collected between 1970 and 1976 during excavations directed by Robert Pence (Pierce College) and Mike McIntyre (Californian State University Northridge [CSUN]) at the Chatsworth and Chatsworth Cairn archeological sites (CA LAN 357 and CA LAN 21). The non-funerary materials collected from CA LAN 357, such as chipped stone tools, worked animal bone, and ground stone items, indicate clear prehistoric Native American affiliation, while the project notebooks and forms contain no indication that any of the items collected were of non-native origin.

CA LAN 357 is a well-documented archeological site that today is found mostly on the grounds of the Chatsworth Hills Academy in Chatsworth, CA (McIntyre 1975). It is associated with two other nearby sites, CA LAN 209 (now mostly covered by California state highway 118) and the Chatsworth Cairn site, CA LAN 21. The latter site was excavated originally by Edwin Walker in 1939, and later by McIntyre of CSUN. Today, the location consists of multiple housing developments (Raab 1986). According to Hull (2012), some of the features

excavated by Walker date as early as the intermediate period (1000 B.C. to A.D. 1000), but the site is mostly a late prehistoric to historic settlement that contained both residential and ceremonial elements. The Fernandeño consider these three archeological sites as a single multi-component settlement known as Momonga, while the Chumash use the term Calucscoho. A number of rock art panels have been documented at the Chatsworth site, and the excavations by Pence, Walker, and McIntyre uncovered objects consistent with Native American occupation. An article by Sanburg et al. (1978) states:

> The Chatsworth Site was occupied into historic times (Walker 1952:85; Leonard 1974), but there is some conflict as to which group, the Fernandeno or the Chumash, was associated with it. Kroeber (1925: 621) and Johnston (1966: 9, 11) consider the site to be within the Fernandeno area whose boundary with the Chumash they set a short distance to the west at the Santa Susana Pass. This has been questioned by Forbes (1966: 138) who states that the Chumash extended as far east as El Escorpion, located in the southwestern section of the San Fernando Valley and probably were found to the north all along the valley's western edge. [Sanburg et al. 1978, page 28].

Sanburg et al. (1978) conclude that the ''petrographic art present at the Chatsworth Site relates well to the previously presented material from the Chumash Area.'' Based on the documentary evidence, the site most likely had dual-ethnic components with either simultaneous or subsequent use or occupation. Therefore, the site holds significant ritual and ceremonial importance to both the Fernandeño and Chumash people.

During consultation, Pierce College received correspondence from the Tribal President of the Fernandeño Tataviam Band, Rudy J. Ortega Jr., citing various archeological and historic publications linking the Fernandeño Tribe to the site. Mr. Ortega's letter also included information about the Tribe's ethnic makeup, territorial boundaries, and connection to the Momonga site (CA LAN 357/CA LAN 21).

One individual was recovered from a burial at CA LAN 357 during Pence's excavations in 1970 and 1971. The human remains were found in very poor condition, with 65–70% of the skull and torso missing. Several photographs taken during the burial excavation show the bones of the lower portion (legs) of an individual in the flexed (fetal) position. According to the excavators, the individual was a middle-aged adult of undetermined sex.

One individual was recovered from the excavation of a burial during the 1972 field season. The human remains recovered are too fragmentary to allow specification of the sex, age, or stature of the individual. According to the excavators, the individual was a young adult of undetermined sex, but the excavators considered the individual to be male because of the associated objects recovered with the burial. These items, consisting mostly of hammerstone fragments and chipped stone tools, could not be located.

Four individuals are represented by solitary teeth that were recovered from excavation units during Pence's 1970s field seasons. The teeth were found in individually labeled small bags and consist of one fragment of a molar from excavation unit L28, one premolar (reg. no. 72–1202), one incisor (reg. no. 70–0787), and one maxillary canine (reg. no. 72–1199). One individual is represented by a solitary tibia fragment that is likely to have come from McIntyre's excavations of the CA LAN 21 site in 1976.

Human remains representing, at minimum, least 11 individuals were stored separately in boxes marked Series A, B, D, E–1, E–2, and T. Each box was treated as a separate burial context. Series A, B, D, and E–1 boxes contained fragmented human remains representing at least one individual each. Series E–2 box contain the fragmented human remains of at least three individuals. Series' T and K boxes contained fragmented human remains representing at least two individuals each. No known individuals were identified. The 72 associated funerary objects are 17 chipped stone scrapers, two shaped sandstone tools, six chipped stone projectile points, four chipped-stone core fragments, one rim fragment from a ground stone bowl, one small bag of ochre fragments, four sandwich bags of small animal bone fragments, three sandwich bags of chipped stone flakes and debitage, and 34 fragments of animal bones.

Determinations Made by Los Angeles Pierce College

Officials of Los Angeles Pierce College have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of 18 individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the 72 objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California, and, if joined, the Fernandeño Tataviam Band of Mission Indians, a non-federally recognized Indian group.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Ronald K Faulseit, Los Angeles Pierce College, 6201 Winnetka Avenue, Woodland Hills, CA 91371, telephone (818) 610–6560, email *faulserk@piercecollege.edu,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California, and the Fernandeño Tataviam Band of Mission Indians (if joined with the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California) may proceed.

The Los Angeles Pierce College is responsible for notifying the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California and the Fernandeño Tataviam Band of Mission Indians that this notice has been published.

Dated: October 8, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25729 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029192; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: Pima County Office of the Medical Examiner, Tucson, AZ

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Pima County Office of the Medical Examiner (PCOME) has completed an inventory of human remains and associated funerary objects, in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, and has determined that

there is a cultural affiliation between the human remains and associated funerary objects and present-day Indian Tribes or Native Hawaiian organizations. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to the PCOME. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to the PCOME at the address in this notice by December 27, 2019.

ADDRESSES: Dr. Bruce Anderson, Forensic Anthropologist, Pima County Office of the Medical Examiner, 2825 E District Street, Tucson, AZ 85714, telephone (520) 724–8600, email *bruce.anderson@pima.gov.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of the Pima County Office of the Medical Examiner, Tucson, AZ. The human remains and associated funerary objects were removed from San Manuel, Pinal County, AZ.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by the PCOME professional staff in consultation with representatives of the Ak-Chin Indian Community (previously listed as the Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona); Fort McDowell Yavapai Nation, Arizona; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Hopi Tribe of Arizona; Navajo Nation, Arizona, New Mexico & Utah; Pascua Yaqui Tribe of Arizona; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; San Carlos Apache Tribe of the San Carlos Reservation, Arizona; White Mountain Apache Tribe of the Fort Apache Reservation, Arizona; and the Zuni Tribe of the Zuni Reservation, New Mexico (hereafter referred to as ''The Consulted Tribes'').

History and Description of the Remains

On July 7, 2009, human remains representing, at minimum, one individual were removed from a wash near the San Pedro River in San Manuel, Pinal County, AZ. The human remains were discovered in the base of a dried wash by a young man on a run that morning. Personnel from the Pinal County Sheriff's Office arrived on the scene, where they recovered and transported the recovered human remains to the Pinal County Medical Examiner's Office. On July 8, 2009, the Pinal County Medical Examiner, Dr. Rebecca Hsu, transferred the human remains to the Pima County Office of the Medical Examiner, to be examined by the Pima County Forensic Anthropologist, Dr. Bruce Anderson. According to Dr. Anderson, the human remains are of an adult individual of Native American ancestry, and are likely prehistoric. The human remains were designated case ML09–01398, and they have since resided in the PCOME as an unidentified, prehistoric case. No known individuals were identified. No associated funerary objects are present.

Although the human remains were not discovered at a known archeological site, the area where the human remains were recovered, near the San Pedro River and south of the Gila River, constitutes part of the core area of the Hohokam tradition. The Grewe-Casa Grande settlement complex on the middle Gila River is one of the largest Hohokam settlements in the prehistoric American Southwest. The classic period of Hohokam Culture (A.D. 1150–1450) is characterized by the aggregation of Hohokam villages into larger villages located primarily along the middle Gila and lower San Pedro Rivers where the human remains were discovered.

On December 15, 2010, human remains representing, at minimum, one individual were discovered near the San Pedro River in San Manuel, Pinal County, AZ. The human remains were discovered on the south bank of a wash by an unknown individual whom had been removing a tree on the wash bank. The human remains were recovered by personnel of the Pinal County Sherriff's Office and brought to the Pinal County Medical Examiner, Dr. Rebecca Hsu. On December 16, 2010, the human remains were transferred to the Pima County Office of the Medical Examiner to be examined by the Pima County Forensic Anthropologist, Dr. Bruce Anderson. According to Dr. Anderson, the human remains were prehistoric due to the condition of the remains, the dental wear, and the associated funerary objects. In addition, Dr. Anderson estimated the human remains to be a probable female 20 years old (+/− 3 years). The human remains were designated case ML10–02448, and have resided in the PCOME as an unidentified prehistoric case. No known individuals were identified. The 387 associated funerary objects are 387 conus shell beads.

The human remains were discovered near a site discovered along the San Pedro River, on part of the Johnny Rhodes' Sacaton Ranch, where a burial containing a possible necklace composed of conus shell beads had been found. Prehistoric ruins, as well as sherds of Gila Polychrome pottery and Tanque Verde Red-on Brown pottery were also discovered at the site. Sites along the lower San Pedro River are associated with the Classic Period (A.D. 1150–1450) of Hohokam Culture.

Determinations Made by the Pima County Office of the Medical Examiner

Officials of the Pima County Office of the Medical Examiner have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of two individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the 387 objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Tohono O'odham Nation of Arizona.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Dr. Bruce Anderson,

Forensic Anthropologist, Pima County Office of the Medical Examiner, 2825 E District Street, Tucson, AZ 85714, telephone (520) 724–8600, email *bruce.anderson@pima.gov,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Tohono O'odham Nation of Arizona may proceed.

The Pima County Office of the Medical Examiner is responsible for notifying the Tohono O'odham Nation of Arizona and The Consulted Tribes that this notice has been published.

Dated: October 24, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25732 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–AKR–ANIA–CAKR–DENA–GAAR–KOVA–LACL–WRST–28636;PPAKAKROR4, PPMPRLE1Y.LS0000]

Request for Nominations for the National Park Service Alaska Region Subsistence Resource Commission Program

AGENCY: National Park Service, Interior.

ACTION: Request for nominations.

SUMMARY: The National Park Service (NPS) is seeking nominations for new members to represent subsistence users on the following Subsistence Resource Commissions (SRC): The Aniakchak National Monument SRC, the Cape Krusenstern National Monument SRC, the Denali National Park SRC, the Gates of the Arctic National Park SRC, the Lake Clark National Park SRC, the Kobuk Valley National Park SRC, and the Wrangell-St. Elias National Park SRC.

DATES: Nominations must be postmarked by December 27, 2019.

ADDRESSES: Nominations should be sent to: Joshua T. Ream, Ph.D., (Xíxch'i Toowóo), Subsistence Program Manager, National Park Service, Alaska Regional Office, 240 W 5th Avenue, Anchorage, AK 99501, or email at *joshua_ream@nps.gov.*

FOR FURTHER INFORMATION CONTACT: Joshua T. Ream, Ph.D., (Xíxch'i Toowóo), Subsistence Program Manager, National Park Service, Alaska Regional Office, 240 W 5th Avenue, Anchorage, AK 99501, or email at *joshua_ream@nps.gov,* or via telephone at (907) 644–3596.

SUPPLEMENTARY INFORMATION: The NPS SRC program is authorized under section 808 of the Alaska National Interest Lands Conservation Act (16 U.S.C. 3118). The SRCs hold meetings to develop NPS subsistence program recommendations and advise on related regulatory proposals and resource management issues.

Each SRC is composed of nine members: (a) Three members appointed by the Secretary of the Interior; (b) three members appointed by the Governor of the State of Alaska; and (c) three members appointed by a Regional Advisory Council (RAC), established pursuant to 16 U.S.C. 3115, which has jurisdiction within the area in which the park is located. Each of the three members appointed by the RAC must be a member of either the RAC or a local advisory committee within the region who also engages in subsistence uses within the Park or Park Monument.

We are now seeking nominations for those three members of each of the SRCs listed above. These members are to be appointed by the Secretary of the Interior.

Members will be appointed for a term of three years. Members of the SRC serve without compensation. However, while away from their homes or regular places of business in the performance of services for the SRC, and as approved by the Designated Federal Officer (DFO), members may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in Government service are allowed such expenses under Section 5703 of Title 5 of the United States Code.

SRC meetings will take place at such times as designated by the DFO. Members are expected to make every effort to attend all meetings. Members may not appoint deputies or alternates.

We are seeking nominations for members to represent subsistence users on each of the seven SRCs listed above. All those interested in serving as members, including current members whose terms are expiring, must follow the same nomination process.

Nominations should be typed and should include a resume providing an adequate description of the nominee's qualifications, including information that would enable the Department of the Interior to make an informed decision regarding meeting the membership requirements of the SRC, and to permit the Department to contact a potential member.

Public Disclosure of Information: Before including your address, phone number, email address, or other personal identifying information in your nomination, you should be aware that your entire nomination—including your personal identifying information—may be made publicly available at any time. While you can ask us in your nomination to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Authority: 5 U.S.C. Appendix 2.

Alma Ripps,

Chief, Office of Policy.

[FR Doc. 2019–25726 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029205; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: The University of Oregon Museum of Natural and Cultural History, Eugene, OR

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The University of Oregon Museum of Natural and Cultural History has completed an inventory of human remains and associated funerary objects, in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, and has determined that there is a cultural affiliation between the human remains and associated funerary objects and present-day Indian Tribes or Native Hawaiian organizations. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to the University of Oregon Museum of Natural and Cultural History. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to the University of Oregon Museum of Natural and Cultural History, at the address in this notice by December 27, 2019.

ADDRESSES: Dr. Pamela Endzweig, Director of Collections, University of Oregon Museum of Natural and Cultural History, 1224 University of Oregon, Eugene, OR 97403–1224, telephone (541) 346–5120, email *endzweig@uoregon.edu.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of the University of Oregon Museum of Natural and Cultural History, Eugene, OR. The human remains and associated funerary objects were removed from Klamath County, OR.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains and associated funerary objects was made by University of Oregon Museum of Natural and Cultural History professional staff in consultation with representatives of the Alturas Indian Rancheria, California; Klamath Tribes; Pit River Tribe, California (includes XL Ranch, Big Ben, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias); Round Valley Indian Tribes, Round Valley Reservation, California (previously listed as the Round Valley Indian Tribes of the Round Valley Reservation, California); Susanville Indian Rancheria, California; and The Modoc Tribe of Oklahoma (hereafter referred to as ''The Tribes'').

History and Description of the Remains

In 1962, human remains representing, at minimum, three individuals were removed from Big Boulder Village, site 35KL18, Klamath County, OR, during legally authorized excavations conducted by University of Oregon archeologists. The human remains were subsequently transferred to the museum (Acc. #230) and consist of three adults of indeterminate sex (Cat. #11–525). No known individuals were identified. The nine associated funerary objects are three worked flakes, three obsidian fragments, one lot of fiber pieces, one scraper, and one projectile point.

According to written materials on excavations at Big Boulder Village, the historic range places the site in Klamath-Modoc territory, while artifact and feature comparisons suggest either Modoc or Achumawi affiliation. All burials precede house construction and may date to early prehistoric times (5800 B.C. to 2800 B.C.). Historical documents, ethnographic sources, and oral history indicate that the Klamath, Modoc, and Achumawi peoples have occupied this area of south-central Oregon and north-central California. The human remains are determined to be Native American based on archeological context and are reasonably believed to be Modoc or Achumawi. The Modoc, and Achumawi are represented today by the Alturas Indian Rancheria, California; Klamath Tribes; Pit River Tribe, California (includes XL Ranch, Big Ben, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias); Round Valley Indian Tribes, Round Valley Reservation, California (previously listed as the Round Valley Indian Tribes of the Round Valley Reservation, California); Susanville Indian Rancheria, California; and The Modoc Tribe of Oklahoma.

Determinations Made by the University of Oregon Museum of Natural and Cultural History

Officials of the University of Oregon Museum of Natural and Cultural History have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of three individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the nine objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and The Tribes.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Dr. Pamela Endzweig, Director of Collections, University of Oregon Museum of Natural and Cultural History, 1224 University of Oregon, Eugene, OR 97403–1224, telephone (541) 346–5120, email *endzweig@uoregon.edu,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects The Tribes may proceed.

The University of Oregon Museum of Natural and Cultural History is responsible for notifying The Tribes that this notice has been published.

Dated: October 25, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25727 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029196; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: University of California, Santa Cruz, Santa Cruz, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The University of California, Santa Cruz (U.C. Santa Cruz) has completed an inventory of human remains and associated funerary objects in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, and has determined that there is no cultural affiliation between the human remains and associated funerary objects and any present-day Indian Tribes or Native Hawaiian organizations. Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to U.C. Santa Cruz. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the non-federally recognized Indian group stated in this notice may proceed.

DATES: Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to U.C. Santa Cruz at the address in this notice by December 27, 2019.

ADDRESSES: Diane Gifford-Gonzalez, Curator, Monterey Bay Archaeology Archives, University of California, Santa Cruz, 1156 High Street, Santa Cruz, CA 95064–1077, telephone (831) 459–2633, email *dianegg@ucsc.edu.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of the University of California, Santa Cruz, Santa Cruz, CA. The human remains and associated funerary objects were removed from sites CA–SCR–3, CA–SCR–12, CA–SCR–18, CA–SCR–19, CA–SCR–35, CA–SCR–44 in Santa Cruz County, CA, as well as from unknown locations within Santa Cruz city limits, and CA–MNT–414, Elkhorn Slough, Monterey County, CA.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by U.C. Santa Cruz professional staff in consultation with the Amah Mutsun Tribal Band; Costanoan Rumsen Carmel Tribe; Muwekma Ohlone Tribe; and the Ohlone Costanoan Esselen Nation, which are all non-federally recognized Indian groups. Three Indian Tribes who are geographically closest to the non-federally recognized Indian groups were invited to participate, but were not involved in consultations. These are the Federated Indians of Graton Rancheria, California; Picayune Rancheria of Chukchansi Indians of California; and the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California. There are no other federally recognized Tribes with aboriginal territory in the south-San Francisco and Monterey Bay areas.

History and Description of the Remains

Between 1964 and 1973, human remains representing, at minimum, 29 individuals were removed from the locations in Santa Cruz and northern Monterey County, as listed below.

In 1974, human remains representing, at minimum, one individual were removed from site CA–MNT–414 on the northwest side of upper Elkhorn Slough, Monterey County, CA, by Professor Rob Edwards of Cabrillo College and the Santa Cruz Archaeological Society. In 1975, the excavated materials, including artifacts, shell, and vertebrate fauna, were transferred to the Monterey Bay Archaeology Archives at the University of California, Santa Cruz (MBAA). The human remains consist of isolated fragments representing individuals of unknown age and sex. No known individuals were identified. No associated funerary objects are present.

In 1969, human remains representing, at minimum, six individuals were removed from site CA–SCR–3 (a.k.a. SCR–42) during an archeological field school conducted by the University of California, Berkeley, in Marshall Field on the campus of U.C. Santa Cruz. The site consisted of two low mounds containing two burials. Burial 1 contained the commingled remains of two individuals, represented by a partial skeleton of an adult female 18–25 years in age, and tibial fragments, a possible scapula fragment, and part of a right ulna belonging to an adult male 20–40 years in age. Burial 2 contained the commingled remains of three individuals, represented by a cranium and partial skeleton of an adult male, tibial fragments of an adult of indeterminate sex, and a left tibia of an adult of indeterminate sex. The excavated materials were transferred to the MBAA sometime in the 1970s. During later analysis of the vertebrate faunal materials recovered from the site, isolated fragments of human remains were discovered. No known individuals were identified. The 29 associated funerary objects are six lots of *Olivella* shell beads, two bone awls, one small mortar, one soil sample from inside mortar, one pestle, one projectile point, two scrapers, two net-sinkers, six handstones, one hammerstone, two milling slabs, one soil sample, one unmodified stone placed in mouth, and two limonite ''red ochre'' deposits.

In 1974, human remains representing, at minimum, two individuals were removed from site CA–SCR–12 on Beach Hill, within the city of Santa Cruz, CA. Professor John Fritz and Dr. Margaret Conkey led an excavation conducted by U.C. Santa Cruz students and members of the Santa Cruz Archaeological Society. During later analysis of the vertebrate faunal materials recovered from the site, isolated fragments of human remains were discovered, representing individuals of unknown age and sex. No known individuals were identified. No associated funerary objects are present.

In 1977, human remains representing, at minimum, five individuals were removed from site CA–SCR–18 in Davenport, Santa Cruz County, CA. A salvage screening was conducted by Cabrillo College students under Professor Rob Edwards in response to an excavation of a private house basement that impacted a known archeological site. The materials were transferred to U.C. Santa Cruz in 1978. During later analysis of the vertebrate faunal materials recovered from the site, isolated fragments of human remains were discovered, representing individuals of unknown age and sex. No known individuals were identified. No associated funerary objects are present.

Between 1969 and 1976, human remains representing, at minimum, one individual were removed from site CA–SCR–19 in Santa Cruz County, CA. The archeological materials were donated to the MBAA prior to 1976. During later analysis of the vertebrate faunal materials, isolated fragments of human remains were discovered, representing individuals of unknown age and sex. No known individuals were identified. No associated funerary objects are present.

In 1971, human remains representing, at minimum, eight individuals were removed from site CA–SCR–35 in Santa Cruz County, CA. Professor John Fritz of U.C. Santa Cruz and Dr. Karen Bruhns of San Jose State University led excavations on land owned by Mr. Ralph Edwards, located just north of the Santa Cruz city limits. The excavated materials included artifacts, shell, animal bones, and two disturbed partial human burials. Most of the materials were deposited at U.C. Santa Cruz, but some went to San Jose State University. In 1975 additional excavations at the site uncovered additional shell and stone artifacts, which were also transferred to U.C. Santa Cruz. In 1979 all of the materials that were housed at San Jose State University, as well as materials loaned to West Valley College (Saratoga, CA), were returned to U.C. Santa Cruz. During later analysis of the vertebrate fauna materials, isolated fragments of human remains were discovered, representing individuals of unknown age and sex. No known individuals were identified. No associated funerary objects are present.

At an unknown date prior to July, 1974, human remains representing, at minimum, one individual were removed from site CA–SCR–44 outside Watsonville in Santa Cruz County, CA. A salvage screening was conducted by Cabrillo College students under Professor Rob Edwards in response to an excavation of a known late pre-contact cemetery site. In July, 1974 the excavated materials, including artifacts and vertebrate fauna, were transferred to the MBAA. During later analysis of the vertebrate faunal materials recovered from the site, isolated fragments of human remains were discovered, representing individuals of unknown age and sex. No known individuals were

identified. No associated funerary objects are present.

At an unknown dates after 1969 and prior to the fall of 1976, human remains representing, at minimum, five individuals were removed from unknown locations in Santa Cruz City, CA, and deposited at the U.C. Santa Cruz Anthropology Department. No further information is known about the provenience of these human remains. No known individuals were identified. No associated funerary objects are present.

Determinations Made by the University of California, Santa Cruz

Officials of the University of California, Santa Cruz have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice are Native American based on physical/biological characteristics.
- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of 29 individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the 29 objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and associated funerary objects and any present-day federally recognized Indian Tribe.
- Pursuant to 43 CFR 10.11(c)(1), a ''tribal land'' or ''aboriginal land'' provenience cannot be ascertained.
- Pursuant to 43 CFR 10.10(g)(2)(ii) and 43 CFR 10.16, the disposition of the human remains and associated funerary objects will be to the Amah Mutsun Tribal Band, a non-federally recognized Indian group.

Pursuant to 43 CFR 10.16, the Secretary of the Interior may make a recommendation for a transfer of control of culturally unidentifiable human remains and associated funerary objects. In November of 2018, U.C. Santa Cruz requested that the Secretary, through the Native American Graves Protection and Repatriation Review Committee, recommend the proposed transfer of control of the culturally unidentifiable Native American human remains and associated funerary objects in this notice to the Amah Mutsun Tribal Band, a non-federally recognized Indian group. The Review Committee, acting pursuant to its responsibility under 25 U.S.C. 3006(c)(5), considered the request and U.C. Santa Cruz's determinations at its August of 2019 meeting, and recommended to the Secretary that the proposed transfer of control proceed. An October 2019 letter on behalf of the Secretary of Interior from the National Park Service Associate Director for Cultural Resources, Partnerships, and Science transmitted the Secretary's independent review and concurrence with the Review Committee that:

- No Indian Tribes or Indian groups objected to the proposed transfer of control, and
- the University of California, Santa Cruz may proceed with the agreed upon transfer of control of the culturally unidentifiable human remains and associated funerary objects to the Amah Mutsun Tribal Band, a non-federally recognized Indian group.

Transfer of control is contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement.

Additional Requestors and Disposition

Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Diane Gifford-Gonzalez, Curator, Monterey Bay Archaeology Archives, University of California, Santa Cruz, 1156 High Street, Santa Cruz, CA 95064–1077, telephone (831) 459–2633, email *dianegg@ucsc.edu,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Amah Mutsun Tribal Band, a non-federally recognized Indian group, may proceed.

The University of California, Santa Cruz is responsible for notifying the Amah Mutsun Tribal Band, a non-federally recognized Indian group, that this notice has been published.

Dated: October 24, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25734 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–BSD–CONC–NPS0028083; PPWOBSADC0, PPMVSCS1Y.Y00000 (200), OMB Control Number 1024–0268]

Agency Information Collection Activities; Commercial Use Authorizations

AGENCY: National Park Service, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, we, the National Park Service (NPS) are proposing to renew an information collection with revisions.

DATES: Interested persons are invited to submit comments on or before December 27, 2019.

ADDRESSES: Send written comments on this information collection request (ICR) to the Office of Management and Budget's (OMB) Desk Officer for the Department of the Interior by email at *OIRA_Submission@omb.eop.gov;* or by facsimile at 202–395–5806. Please provide a copy of your comments to Phadrea Ponds, Information Collection Clearance Officer, National Park Service, 1201 Oakridge Drive, Fort Collins, CO 80525; or by email at *phadrea_ponds@nps.gov.* Please reference OMB Control Number 1024–0268 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Samantha Towery, National Park Service, 12795 West Alameda Parkway, Lakewood, CO 80228; or by email at *Samantha_Towery@nps.gov.* Please reference OMB Control Number 1024–0268 in the subject line of your comments. You may also view the ICR at *http://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

On May 28, 2019, we published a **Federal Register** notice soliciting comments on this collection of information for 60 days, ending on July

29, 2019 (84 FR 24539). The NPS received 17 comments from the 60-day **Federal Register** notice. We have summarized the comments received into the following seven categories:

1. Comments Unrelated to the ICR

Comments received regarding the proposed changes to NPS commercial tour fees that did not specifically address the information collection or matters specifically related to the forms.

*NPS Response: The **Federal Register** Notice you've referenced is only about the continued use of the commercial use authorization (CUA) application and reporting forms. The approval of these forms is separate from the issues related to commercial tour fees and requirements. Only comments related to the application and reporting forms will be recorded as a part of the record for this collection. All other comments will be forwarded to the CUA program for its records.*

All federal agencies with forms designed to collect information from the public are required to obtain approval of those forms from the Office of Management and Budget every three years in order for the agency to continue to use the forms. So, again, this is ONLY about the form and not commercial tour fees and requirements.

2. Administrative Burden Due to Increased Paperwork or Fees

Comments were received from road-based commercial tour industry related to the administrative burden and fees charged to road-based commercial tour operators during the CUA application and reporting process.

NPS Response: The NPS requires all types of commercial operators to complete the same OMB approved CUA applications and reporting forms and Public Law 105–391, Section 418 requires the collection of a reasonable fee for associated administrative and management costs. The CUA application and reporting forms gather the minimum key information necessary for NPS to determine the capability, resources, and fitness of the applicant to provide the service. It also gathers the minimum amount of information needed to ensure the activity does not have more than a minimal impact on park resources and values. In response to this feedback, NPS completed a burden assessment to determine standard administrative and management fees for road-based commercial tour CUAs and will set the standard road-based commercial tour CUA application fee to allow for legislatively required cost recovery. Again, this process is only about the forms, not commercial tour fees.

3. Financial Burden Due to CUA Permit Fee or Entry Fee

Comments from destination marketing organizations suggested that the new CUA requirements would impose increased financial burdens on local businesses.

NPS Response: Public Law 105–391, Section 418 requires the collection of a reasonable fee for administrative and management costs associated with issuing and managing commercial use authorizations (CUAs).

Entrance fees are managed by another NPS program and are separate from the issues related to commercial tour CUA fees and requirements. Only comments related to the CUA application and reporting forms will be recorded as a part of the record for this collection.

4. Concern Regarding Sharing Financial Earning Information With NPS

Comments received from commercial tour operators suggested that reporting on annual financial earnings posed an undue burden on CUA applicants.

NPS Response: The CUA annual report collects service activity (visitors served), gross annual revenues, and injury information. The required financial information is very simple and there are no requirements for audited financial statements, advanced recordkeeping, or retention of records beyond what the IRS requires. The required financial information allows the NPS to determine that a CUA holder is not exceeding the legislatively mandated financial limits for in-park operations (gross receipts not to exceed $25,000). The NPS maintains this operational information and, with the exception of the visitor use statistics, will release other information only as request by law. NPS will not routinely disseminate financial information about individual CUA holders. NPS does report information collectively at the park, regional, or national level (e.g., number of CUA's, reported revenue, fees retained by NPS, etc.).

5. Negative Impact on Group Visits Due to Proposed Fees Associated With the Collection

Comments received from commercial tour operators suggested that an increased fee associated with the CUA would substantially reduce the number of visitors accessing parks through third party tour services.

NPS Response: Public Law 105–391, Section 418 requires the collection of a reasonable fee for administrative and management costs associated with issuing and managing commercial use authorizations. The information required by the forms does not affect the ability of anyone to come to a park. These forms implement the administrative process of allowing and managing commercial uses in units of the National Park System.

6. Ambiguous or Opaque Rules, Procedures, or Deadlines

Comments received from commercial service providers the suggested reporting burden of the CUA was prohibitive in the level of detail requested to process applications.

NPS Response: The legislative mandate of the National Park Service (NPS), found in 54 U.S.C. 100101(a), is to preserve America's natural wonders unimpaired for future generations, while also making them available for the enjoyment of visitors. Meeting this mandate requires the NPS to balance preservation with use. Maintaining a good balance requires CUA management at the unit-level. Unit managers must evaluate commercial uses to determine the impact on the resources and the appropriateness of the activity to ensure the impact does not exceed the legislatively allowed minimum impact. Units vary in staffing levels and seasonality so CUA application seasons vary. Some units have firm deadlines and some do not, though CUA applicants may always contact a unit directly to determine if it will accept late applications. Units post application acceptance dates on websites well in advance.

During the past four and a half years, NPS has provided online trainings, frequently updates Q&As, and has participated in numerous meetings with the road-based commercial tour industry. The NPS believes it has been transparent and continues to engage so the industry is prepared for CUA requirements and fees.

7. Impractical Information Requested on Form, Specifically Mentioned Insurance Documentation Requirements

Comments received from road-based commercial tour industry expressed difficulty in furnishing Commercial Vehicle Insurance maintained by chartered motor coaches external to the tour operator.

NPS Response: Public Law 105–391, Section 418 requires the NPS to limit the liability of the United States arising from activities under CUA's. NPS implements this requirement, in part, by requiring all commercial operators conducting business in a unit of the

National Park System to carry and maintain the appropriate categories of insurance and minimum amounts of coverage. CUA holders must have commercial general liability as well as other coverages specific to the commercial operation, including commercial automobile insurance. NPS has determined the minimum general commercial liability policy limit is $500,000 per occurrence. Higher risk operations have increased minimums ultimately determined by the unit manager. Minimum commercial automobile liability policy limits are determined by state requirements for intrastate operations and the Federal Motor Carrier Safety Act.

We are again soliciting comments on the proposed ICR described below. We are especially interested in public comment addressing the following issues: (1) Is the collection necessary to the proper functions of the NPS; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the NPS enhance the quality, utility, and clarity of the information to be collected; and (5) how might the NPS minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. We will include or summarize each comment in our request to OMB to approve this ICR. 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 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.

Abstract: The purpose of the forms in this information collection is to assist the NPS in managing the Commercial Use Authorization Program. Section 418, Public Law 105–391 (54 U.S.C. 101925) specifies that the Secretary of the Interior has the authority to approve a private person, corporation, or other entity to provide services to visitors in units of the National Park System through a commercial use authorization (CUA). The information collected will allow the NPS to evaluate requests for a CUA and determine the suitability of the applicants to provide safe, effective, and appropriate services to the visiting public.

This renewal includes a request to collect information using a new form, 10–550s, ''Commercial Use Authorization—Short Term.'' This form proposes to streamline the application process for companies who wish to operate for seven days or less within a park. The form will be used for one-time events, such as vendors during farmer's markets. The proposed form will collect the minimum amount of information necessary to grant short-term authorizations and is significantly shorter than the 10–550 application form.

We made adjustments in hour and cost burden estimates because the number of received CUA applications fluctuates on a yearly basis. Over the last three years the NPS has seen annual decrease of approximately 100 CUA applicants.

Based on public comments received, the NPS is requesting to add Form 10–550s, ''Commercial Use Application—Short-Term' to this collection. This form proposes to streamline the application process for short-term CUAs applicants requesting one-time events or for operations lasting seven days or less. The proposed 10–550s, will collect the information necessary to meet legislative requirements allowing NPS to manage services provided by CUAs, while reducing the application burden on CUA applicants.

Based on our experiences with annual and monthly reports, we have revised the number of responses that resulted in a change in the burden hours

- Form 10–550—In 2016, NPS estimated the number of CUA applicants at 5,900. Based on the number of applications received between 2016 and 2019, NPS now assumes it will receive approximately 5,880 CUA applications (Form 10–550) annually. The net decrease of 100 responses results in the net decrease of 250 burden hours.
- Form 10–550s—This is a new form that will cause a net increase of 120 responses and 180 burden hours.
- Form 10–660—Annual Report—Based upon the revised estimated number of Form 10–550, we expect to receive 5,900 reports which will cause a net decrease of 100 respondents submitting annual reports causing a net increase decrease of 125 hours.
- Form 10–660A—Monthly Report—In 2016, NPS estimated it would receive Form 10–660A from 5,900 CUA holders 9 months out of the year, equating to 53,1000 total responses and 39,825 burden hours. This overestimated because NPS assumed all CUA holders would submit Form 10–660A. Currently, approximately 10% of CUA holders are required by NPS units to submit Form 10–660. The reduction of 920 responses resulted in a net decrease of 625 hours.

We are requesting approval to use the following NPS forms: 10–550, ''Commercial Use Authorization Application,'' 10–660, ''Commercial Use Authorization Annual Report,'' and 10–660A, ''Commercial Use Authorization Monthly Report.'' to:

- Manage the program and operations.
- Determine the qualifications and abilities of the commercial operators to provide a high quality, safe, and enjoyable experience for park visitors.
- Determine the impact on the park's natural and cultural resources.
- Manage the use and impact of multiple operators.

Regulations resulting in information collection required for a CUA include:

- 36 CFR 1.6—Permits;
- 36 CFR 2—Resource Protection, Public Use and Recreation;
- 36 CFR 5—Commercial and Private Operations;
- 36 CFR 7—Special Regulations;
- 36 CFR 13—National Park System Units in Alaska.

Title of Collection: Commercial Use Authorizations.

OMB Control Number: 1024–0268.

Form Number: 10–550, ''Commercial Use Authorization;'' 10–550s ''Commercial Use Authorization—Short Term;'' 10–660, ''Commercial Use Authorization Annual Report;'' and 10–660A, ''Commercial Use Authorization Monthly Report.''

Type of Review: Revision of a currently approved collection.

Respondents/Affected Public: Individuals or small businesses that wish to provide commercial services to visitors in areas of the National Park System.

Respondent's Obligation: Required to Obtain or Retain a Benefit.

Frequency of Collection: On occasion.

Total Estimated Annual Nonhour Burden Cost: $1,480,000 ($250 × 6,000 Forms 10–550, ''Commercial Use Authorization Application'' per year).

Activity	Number of annual responses	Completion time per response	Total annual hours
Form 10–550—Application	5,880	2.5 hours	14,700
Form 10–550s—Application Short-Term	120	1.5 hours	180
Form 10–660—Annual Report (incl. recordkeeping)	5,800	1.25 hours	7,250
Form 10–660A—Monthly Report (incl. recordkeeping)	52,200	45 minutes	39,150
Totals	63,920		61,080

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. The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Phadrea Ponds,

Acting NPS Information Collection Clearance Officer, National Park Service.

[FR Doc. 2019–25782 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–VRP–USPP–NPS0028079; PPWOUSPPS1, PPMPRPP02.Y00000 (199); OMB Control Number 1024–0245]

Agency Information Collection Activities; United States Park Police Pre-Employment Suitability Determination Process

AGENCY: National Park Service, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, we, the National Park Service (NPS) are proposing to renew an information collection.

DATES: Interested persons are invited to submit comments on or before December 27, 2019.

ADDRESSES: Send written comments on this information collection request (ICR) to the Office of Management and Budget's (OMB) Desk Officer for the Department of the Interior by email at *OIRA_Submission@omb.eop.gov;* or by facsimile at 202–395–5806. Please provide a copy of your comments to Phadrea Ponds, Information Collection Clearance Officer, National Park Service, 1201 Oakridge Drive, Fort Collins, CO 80525; or by email at *phadrea_ponds@nps.gov.* Please reference OMB Control Number 1024–0245 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Captain Jerry Marshall, 1100 Ohio Dr. SW, Washington, DC 20242; or by email at *jerry_marshall@nps.gov.* Please reference OMB Control Number 1024–0245 in the subject line of your comments. You may also view the ICR at *http://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

On June 13th, 2019, we published a **Federal Register** notice soliciting comments on this collection of information for 60 days, ending on August 12th, 2019 (84 FR 27653). We received one (1) public comment from the American Association of Nurse Practitioners requesting Nurse Practitioners be granted the ability to sign for the 10–2201E, ''Physician Consent Form.'' The USPP will consider amending Form 10–2201E based on guidance from the Federal Occupational Health, Program Support Center, U.S. Department of Health and Human Services in the future to include the signature authority of Nurse Practitioners and Physician's Assistants authority of Nurse Practitioners and Physician's Assistants.

We are again soliciting comments on the proposed ICR described below. We are especially interested in public comment addressing the following issues: (1) Is the collection necessary to the proper functions of the NPS; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the NPS enhance the quality, utility, and clarity of the information to be collected; and (5) how might the NPS minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. We will include or summarize each comment in our request to OMB to approve this ICR. 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 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.

Abstract: The United States Park Police (USPP) collects information from applicants during the Pre-employment Suitability Determination Phase as part of the application process for consideration as a candidate for park police positions. The USPP is authorized by Title 5, CFR, Section 5.2, ''Investigation and evaluations,'' to collect information as required in the USPP Pre-employment Suitability Process. The USPP uses the forms described below as a part of the application process required to conduct an OPM background investigation.

Form 10–2201, ''Personal Qualifications Statement''—provides information on the personal history of the candidate.

Form 10–2201A, ''Information Release Form''—authorizes the release of all personal and confidential records, to include medical records concerning physical and mental health.

Form 10–2201B, ''Release to Obtain a Credit Report''—authorizes the release of information from consumer reporting agencies.

Form 10–2201C, ''Lautenberg Certification''—requires information and certification by the applicant regarding a conviction of a misdemeanor crime of domestic violence.

Form 10–2201D, ''Physical Efficiency Battery Waiver''—requires the candidate to provide information regarding medical conditions which may impede their ability to meet the minimum

efficiency score on the Physical Efficiency Battery (PEB).

Form 10–2201E, ''Physician Consent Form''—requires physician certification for the candidate to participate in the PEB.

Form 10–2201F, ''Applicant Documentation Form''—required to be completed by the applicant when declining or deferring employment with the USPP.

Title of Collection: United States Park Police Pre-Employment Suitability Determination Process, 5 CFR 5.2.

OMB Control Number: 1024–0245.

Form Number: NPS Forms 10–2201, 10–2201A through 10–2201F.

Type of Review: Extension of a currently approved collection.

Respondents/Affected Public: Candidates for employment as a United States Park Police Officer.

Respondent's Obligation: Required to obtain or retain a benefit.

Frequency of Collection: On occasion.

Total Estimated Annual Nonhour Burden Cost: $181,900 (printing, notarizing and to providing supporting documentation).

Activity	Estimated number of annual responses	Estimated completion time per response	Estimated total annual burden hours
Form 10–2201, ''Personal Qualification Statement''	1,700	7 hours	11,900
Form 10–2201A, ''Information Release Form''	1,700	15 minutes	425
Form 10–2201B, ''Release to Obtain a Credit Report''	1,700	10 minutes	283
Form 10–2201C, ''Lautenberg Certification''	1,700	5 minutes	142
Form 10–2201D, ''Physical Efficiency Battery ''Waiver'' ''	1,700	10 minutes	283
Form 10–2201E, ''Physician Consent Form''	1,700	10 minutes	283
Form 10–2201F, ''Applicant Documentation Form''	12	5 minutes	1
Totals	10,212		13,317

* Rounded.

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.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Phadrea Ponds,

Acting, NPS Information Collection Clearance Officer, National Park Service.

[FR Doc. 2019–25781 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029193; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: The Wistar Institute, Philadelphia, PA, and the University of Pennsylvania Museum of Archaeology and Anthropology, Philadelphia, PA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Wistar Institute and the University of Pennsylvania Museum of Archaeology and Anthropology have completed an inventory of human remains in consultation with the appropriate Indian Tribes or Native Hawaiian organizations, and has determined that there is a cultural affiliation between the human remains and present-day Indian Tribes or Native Hawaiian organizations. Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request to the University of Pennsylvania Museum of Archaeology and Anthropology. If no additional requestors come forward, transfer of control of the human remains to the lineal descendants, Indian Tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to the University of Pennsylvania Museum of Archaeology and Anthropology at the address in this notice by December 27, 2019.

ADDRESSES: Dr. Julian Siggers, University of Pennsylvania Museum of Archaeology and Anthropology, 3260 South Street, Philadelphia, PA 19104–6324, telephone (215) 898–4050.

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains under the control of the Wistar Institute, Philadelphia, PA, and in the physical custody of the University of Pennsylvania Museum of Archaeology and Anthropology, Philadelphia, PA. The human remains were removed from the Fort Peck Reservation, Valley County, MT.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by the University of Pennsylvania Museum of Archaeology and Anthropology professional staff on behalf of the Wistar Institute in consultation with representatives of the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana.

History and Description of the Remains

Sometime between July 6 and July 15, 1900, human remains representing, at minimum, two individuals (37946 and 37947) were removed from box graves on the prairie outside of the Fort Peck Indian Reservation in Valley County, MT, by Robert Stewart Culin, Curator of the American and General Ethnology Section of the University of Pennsylvania Museum of Archaeology and Anthropology (1899–1903). Culin was leading a collecting expedition to the American West for the University of Pennsylvania Museum of Archaeology and Anthropology funded by John Wanamaker, a Philadelphia businessman and philanthropist. From 1900 to 1915, the human remains were housed at the University of Pennsylvania Museum of Archaeology

and Anthropology. On January 11, 1915, the human remains were donated to the Wistar Institute of Philadelphia (15525 and 15526). The human remains were transferred to the University of Pennsylvania Museum of Archaeology and Anthropology on a long-term loan in 1956 (L–1011–54 and L–1011–211), where they are currently housed. No known individuals were identified. No associated funerary objects are present.

The physical condition of the human remains and the collector's description about the circumstance surrounding their removal indicate that the remains were of relatively recent historical origin at the time of removal. The human remains have been identified as Native American based on the specific cultural and geographic attribution identified in Museum records. Museum documentation and collector records identify the two sets of human remains as ''Dakota, Sioux.'' The Dakota, Sioux descendants in Montana are represented by the present-day Assiniboine and Sioux Tribes of the Fort Peck Reservation, Montana.

Determinations Made by the Wistar Institute and the University of Pennsylvania Museum of Archaeology and Anthropology

Officials of the Wistar Institute, through its agent the University of Pennsylvania Museum of Archaeology and Anthropology, have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of two individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to Dr. Julian Siggers, Williams Director, University of Pennsylvania Museum of Archaeology and Anthropology, 3260 South Street, Philadelphia, PA 19104–6324, telephone (215) 898–4050, by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains to the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana may proceed.

The Wistar Institute, through its agent the University of Pennsylvania Museum of Archaeology and Anthropology, is responsible for notifying the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana that this notice has been published.

Dated: October 24, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25733 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–NPS0029092; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: Tennessee Valley Authority, Knoxville, TN

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Tennessee Valley Authority (TVA) has completed an inventory of human remains in consultation with the appropriate Indian Tribes and Native Hawaiian organizations, and has determined that there is no cultural affiliation between the human remains and any present-day Indian Tribes or Native Hawaiian organizations. Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request to the TVA. If no additional requestors come forward, transfer of control of the human remains to the Indian Tribes or Native Hawaiian organizations stated in this notice may proceed.

DATES: Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to the TVA at the address in this notice by December 27, 2019.

ADDRESSES: Dr. Thomas O. Maher, TVA, 400 West Summit Hill Drive, WT11C, Knoxville, TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains under the control of the Tennessee Valley Authority, Knoxville, TN. The human remains were removed from archeological sites in Lauderdale and Madison Counties, AL.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3) and 43 CFR 10.11(d). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by TVA professional staff in consultation with representatives of the Absentee-Shawnee Tribe of Indians of Oklahoma; Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Cherokee Nation; Coushatta Tribe of Louisiana; Eastern Band of Cherokee Indians; Poarch Band of Creeks (previously listed as the Poarch Band of Creek Indians of Alabama); The Chickasaw Nation; The Choctaw Nation of Oklahoma; The Muscogee (Creek) Nation; The Seminole Nation of Oklahoma; and the United Keetoowah Band of Cherokee Indians in Oklahoma (hereafter referred to as ''The Consulted Tribes'').

History and Description of the Remains

The sites listed in this notice were excavated as part of TVA's Wheeler Reservoir project by the Alabama Museum of Natural History (AMNH) at the University of Alabama, using labor and funds provided by the Works Progress Administration. Details regarding these excavations and sites may be found in a report, ''*An Archaeological Survey of Wheeler Basin on the Tennessee River in Northern Alabama,*'' by William S. Webb. Human remains and other associated funerary objects from the two sites covered by this notice were previously listed in a Notice of Inventory Completion published in the **Federal Register** on December 21, 2018 (83 FR 65730–65731, December 21, 2018), and were transferred to the Cherokee Nation, Eastern Band of Cherokee Indians, The Chickasaw Nation, and the United Keetoowah Band of Cherokee Indians in Oklahoma. Additional human remains were found during a recent improvement in the curation of the TVA archaeological collections at AMNH.

In March 1934, human remains representing, at minimum, five individuals were removed from site 1LU86 in Lauderdale County, AL. TVA

acquired this site on October 9, 1934, for the Wheeler Reservoir project. The excavation in March 1934, undertaken prior to the acquisition of the site, was conducted using Federal funds in anticipation of the inundation of the site. This site was 350 feet long and 200 feet wide. Although described as a mound, it appears to have been an accumulation of shell, midden debris, and natural floodplain soils, rather than intentionally constructed earthen works. No structures were identified, but there were multiple hearths, midden-filled pits, and human burials. There are no radiocarbon dates for this site. Recovered artifacts suggest multiple occupations including Late Archaic (4000–1000 B.C.), Early Woodland (1000–500 B.C.), Middle Woodland Copena Phase (A.D. 100–500), Late Woodland (A.D. 500–1000) and Mississippian (A.D. 1200–1500) periods. The human remains include four adults and one infant of indeterminate sex. No known individuals were identified. There are no associated funerary objects.

From February through March 1934, human remains representing, at minimum, three individuals were removed from site 1MA4, in Madison County, AL. TVA acquired a strip of land around the periphery of Hobbs Island encompassing this site on May 23, 1939, as part of the Wheeler Reservoir project. The excavation in March 1934 was conducted with Federal funds in anticipation of the inundation of this site. The site was a shell midden 300 x 125 feet and adjacent to the island's shoreline. There are no radiocarbon dates available for this site, but artifacts from a non-mortuary context suggest Langston (A.D. 900–1200) and Hobbs Island (A.D. 1200–1450) phase occupations. The human remains include two adults and one child of indeterminate sex. No known individuals were identified. There are no associated funerary objects.

Determinations Made by the Tennessee Valley Authority

Officials of the Tennessee Valley Authority have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice are Native American based on their presence in prehistoric archeological sites and an osteological analysis.
- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of eight individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and any present-day Indian Tribe.
- According to final judgments of the Indian Claims Commission or the Court of Federal Claims, the land from which the Native American human remains were removed is the aboriginal land of the Cherokee Nation; Eastern Band of Cherokee Indians; and the United Keetoowah Band of Cherokee Indians in Oklahoma.
- The Treaty of September 20, 1816, indicates that the land from which the Native American human remains were removed is the aboriginal land of The Chickasaw Nation.
- Pursuant to 43 CFR 10.11(c)(1), the disposition of the human remains may be to the Cherokee Nation; Eastern Band of Cherokee Indians; The Chickasaw Nation; and the United Keetoowah Band of Cherokee Indians in Oklahoma.

Additional Requestors and Disposition

Representatives of any Indian Tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains should submit a written request with information in support of the request to Dr. Thomas O. Maher, TVA, 400 West Summit Hill Drive, WT11C, Knoxville, TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov,* by December 27, 2019. After that date, if no additional requestors have come forward, transfer of control of the human remains to the Cherokee Nation; Eastern Band of Cherokee Indians; The Chickasaw Nation; and the United Keetoowah Band of Cherokee Indians in Oklahoma may proceed.

The Tennessee Valley Authority is responsible for notifying The Consulted Tribes that this notice has been published.

Dated: October 8, 2019.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2019–25730 Filed 11–26–19; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

Bureau of Safety and Environmental Enforcement

[Docket ID BSEE–2019–0002; 201E1700D2 ET1SF0000.EAQ000 EEEE500000; OMB Control Number 1014–0028]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Well Operations and Equipment

AGENCY: Bureau of Safety and Environmental Enforcement, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of Safety and Environmental Enforcement (BSEE) proposes to renew an information collection.

DATES: Interested persons are invited to submit comments on or before December 27, 2019.

ADDRESSES: Send written comments on this information collection request (ICR) to the Office of Management and Budget's Desk Officer for the Department of the Interior by email at *OIRA_Submission@omb.eop.gov;* or via facsimile to (202) 395–5806. Please provide a copy of your comments to the Bureau of Safety and Environmental Enforcement; Regulations and Standards Branch; ATTN: Nicole Mason; 45600 Woodland Road, Sterling, VA 20166; or by email to *kye.mason@bsee.gov.* Please reference OMB Control Number 1014–0028 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Nicole Mason by email at *kye.mason@bsee.gov,* or by telephone at (703) 787–1607. You may also view the ICR at *http://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

A **Federal Register** notice with a 60-day public comment period soliciting comments on this collection of information was published on July 23,

2019 (84 FR 35418). No comments were received.

We are again soliciting comments on the proposed ICR that is described below. We are especially interested in public comments addressing the following issues: (1) Is the collection necessary to the proper functions of BSEE; (2) Will this information be processed and used in a timely manner; (3) Is the estimate of burden accurate; (4) How might BSEE enhance the quality, utility, and clarity of the information to be collected; and (5) How might BSEE minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. 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 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.

Abstract: The regulations at 30 CFR part 250, subpart G, concern well operations and equipment regulatory requirements of oil, gas, and sulphur operations in the Outer Continental Shelf (OCS) (including the associated forms), and are the subject of this collection. This request also covers any related Notices to Lessees and Operators (NTLs) that BSEE issues to clarify, supplement, or provide additional guidance on some aspects of our regulations.

BSEE uses the information to ensure safe drilling, workover, completion, and decommissioning operations and to protect the human, marine, and coastal environment. BSEE analyzes and evaluates these information/requirements to reduce the likelihood of an event similar to Deepwater Horizon and to reduce the risk of fatalities, injuries, and spills. BSEE also utilizes these requirements in the approval, disapproval, or modification process for well operations.

Specifically, BSEE uses the information in Subpart G to ensure:

- Certain well designs and operations have been reviewed by appropriate third parties/engineers/classification societies and that, after one year, have been approved by BSEE;
- rig tracking data is available to locate rigs during major storms;
- casing or equipment repairs are acceptable and tested;
- up-to-date engineering documents are available;
- the BOP and associated components are fit for service for its intended use;
- that the BOP will function as intended;
- that BOP components are properly maintained and inspected;
- the proper engineering reviews and approvals for all BOP designs, repairs, and modifications are met.

BSEE uses the information obtained from Rig Movement Notification Report, Form BSEE–0144, to schedule inspections and verify that the equipment being used complies with approved permits. The information on this form is used by all 3 regions, but primarily in the GOM, to ascertain the precise arrival and departure of all rigs in OCS waters in the GOM. The accurate location of these rigs is necessary to facilitate the scheduling of inspections by BSEE personnel.

Title of Collection: 30 CFR part 250, subpart G, Well Operations and Equipment.

OMB Control Number: 1014–0028.

Form Number: Form BSEE–0144.

Type of Review: Extension of a currently approved collection.

Respondents/Affected Public: Potential respondents are comprised of Federal OCS oil, gas, and sulphur lessees/operators and holders of pipeline rights-of-way.

Total Estimated Number of Annual Respondents: Not all of the potential respondents will submit information in any given year and some may submit multiple times.

Total Estimated Number of Annual Responses: 43,408.

Estimated Completion Time per Response: 6 minutes to 2,160 hours, depending on activity.

Total Estimated Number of Annual Burden Hours: 160,842.

Respondent's Obligation: Most responses are mandatory, while others are required to obtain or retain benefits, or are voluntary.

Frequency of Collection: Submissions are generally on occasion, daily, weekly, monthly, quarterly, biennially, and as a result of situations encountered depending upon the requirement.

Total Estimated Annual Nonhour Burden Cost: $867,500.

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.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Dated: November 4, 2019.

Amy White,

Acting Chief, Regulations and Standards Branch.

[FR Doc. 2019–25796 Filed 11–26–19; 8:45 am]

BILLING CODE 4310–VH–P

DEPARTMENT OF THE INTERIOR

Bureau of Safety and Environmental Enforcement

[Docket ID BSEE–2019–0007; 201E1700D2 ET1SF0000.EAQ000 EEEE500000; OMB Control Number 1014–0004]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Oil and Gas Well-Completion Operations

AGENCY: Bureau of Safety and Environmental Enforcement, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of Safety and Environmental Enforcement (BSEE) proposes to renew an information collection.

DATES: Interested persons are invited to submit comments on or before December 27, 2019.

ADDRESSES: Send written comments on this information collection request (ICR) to the Office of Management and Budget's Desk Officer for the Department of the Interior by email at *OIRA_Submission@omb.eop.gov;* or via facsimile to (202) 395–5806. Please provide a copy of your comments to the Bureau of Safety and Environmental Enforcement; Regulations and Standards Branch; ATTN: Nicole Mason; 45600 Woodland Road, Sterling, VA 20166; or by email to *kye.mason@bsee.gov.* Please reference OMB Control Number 1014–0004 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Nicole Mason by email at *kye.mason@bsee.gov,* or by telephone at (703) 787–1607. You may also view the ICR at *http://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's

reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

A **Federal Register** notice with a 60-day public comment period soliciting comments on this collection of information was published on July 23, 2019 (84 FR 35420). No comments were received.

We are again soliciting comments on the proposed ICR that is described below. We are especially interested in public comments addressing the following issues: (1) Is the collection necessary to the proper functions of BSEE; (2) Will this information be processed and used in a timely manner; (3) Is the estimate of burden accurate; (4) How might BSEE enhance the quality, utility, and clarity of the information to be collected; and (5) How might BSEE minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. 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 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.

Abstract: The regulations at 30 CFR part 250, subpart E, concern Oil and Gas Well-Completion Operations regulatory requirements of oil, gas, and sulphur operations in the Outer Continental Shelf (OCS) and are the subject of this collection. This request also covers any related Notices to Lessees and Operators (NTLs) that BSEE issues to clarify, supplement, or provide additional guidance on some aspects of our regulations.

The BSEE uses the information collected under the Subpart E regulations to ensure that operations on the OCS are carried out in a safe and pollution-free manner, do not interfere with the rights of other users on the OCS, and balance the protection and development of OCS resources. Specifically, we use the information collected to ensure:

- Compliance with personnel safety training requirements;
- crown block safety device is operating and can be expected to function to avoid accidents;
- proposed operation of the annular preventer is technically correct and provides adequate protection for personnel, property, and natural resources;
- well-completion operations are conducted on well casings that are structurally competent;
- BOP equipment complies with the most recent WCR and API Standard 53; and
- sustained casing pressures are within acceptable limits.

Title of Collection: 30 CFR part 250, subpart E, *Oil and Gas and Sulfur Operations in the OCS—Oil and Gas Well-Completion Operations.*

OMB Control Number: 1014–0004.

Form Number: None.

Type of Review: Extension of a currently approved collection.

Respondents/Affected Public: Potential respondents comprise Federal OCS oil, gas, and sulfur lessees/operators and holders of pipeline rights-of-way.

Total Estimated Number of Annual Respondents: Not all potential respondents will submit information in any given year and some may submit multiple times.

Total Estimated Number of Annual Responses: 5,898.

Estimated Completion Time per Response: Varies from 1.5 hours to 13 hours, depending on activity.

Total Estimated Number of Annual Burden Hours: 17,985.

Respondent's Obligation: Responses are mandatory.

Frequency of Collection: Generally weekly, biennially, and on occasion depending on the requirement.

Total Estimated Annual Nonhour Burden Cost: None.

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.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Amy White,

Acting Chief, Regulations and Standards Branch.

[FR Doc. 2019–25795 Filed 11–26–19; 8:45 am]

BILLING CODE 4310–VH–P

DEPARTMENT OF THE INTERIOR

Bureau of Safety and Environmental Enforcement

[Docket ID BSEE–2019–0003; 201E1700D2 ET1SF0000.EAQ000 EEEE500000; OMB Control Number 1014–0010]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Decommissioning Activities

AGENCY: Bureau of Safety and Environmental Enforcement, Interior.

ACTION: Notice of information collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of Safety and Environmental Enforcement (BSEE) proposes to renew an information collection with revisions.

DATES: Interested persons are invited to submit comments on or before December 27, 2019.

ADDRESSES: Send written comments on this information collection request (ICR) to the Office of Management and Budget's Desk Officer for the Department of the Interior by email at *OIRA_Submission@omb.eop.gov;* or via facsimile to (202) 395–5806. Please provide a copy of your comments to the Bureau of Safety and Environmental Enforcement; Regulations and Standards Branch; ATTN: Nicole Mason; 45600 Woodland Road, Sterling, VA 20166; or by email to *kye.mason@bsee.gov.* Please reference OMB Control Number 1014–0010 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Nicole Mason by email at *kye.mason@bsee.gov,* or by telephone at (703) 787–1607. You may also view the ICR at *http://www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

A **Federal Register** notice with a 60-day public comment period soliciting comments on this collection of

information published on July 23, 2019 (84 FR 35421). No comments were received.

We are again soliciting comments on the proposed ICR that is described below. We are especially interested in public comments addressing the following issues: (1) Is the collection necessary to the proper functions of BSEE; (2) Will this information be processed and used in a timely manner; (3) Is the estimate of burden accurate; (4) How might BSEE enhance the quality, utility, and clarity of the information to be collected; and (5) How might BSEE minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. 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 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.

Abstract: The regulations at 30 CFR part 250, subpart Q, concern the decommissioning regulatory requirements of oil, gas, and sulphur operations in the Outer Continental Shelf (OCS) and are the subject of this collection. This request also covers any related Notices to Lessees and Operators (NTLs) that BSEE issues to clarify, supplement, or provide additional guidance on some aspects of our regulations.

The BSEE uses the information collected under the Subpart Q regulations to ensure that operations on the OCS are carried out in a safe and pollution-free manner, do not interfere with the rights of other users on the OCS, and balance the protection and development of OCS resources. Specifically, we use the information collected:

- To determine the necessity for allowing a well to be temporarily abandoned, the lessee/operator must demonstrate that there is a reason for not permanently plugging the well, and the temporary abandonment will not interfere with fishing, navigation, or other uses of the OCS. We use the information and documentation to verify that the lessee/operator is diligently pursuing the final disposition of the well and has performed the temporary plugging of the wellbore.
- To ensure the information submitted in initial decommissioning plans in the Alaska and Pacific OCS Regions will permit BSEE to become involved on the ground floor planning of platform removals anticipated to occur in these OCS regions.
- To ensure that all objects (wellheads, platforms, etc.) installed on the OCS are properly removed using procedures that will protect marine life and the environment during removal operations, and the site cleared so as not to conflict with or harm other uses of the OCS in coordination with other Federal, State, and local government agencies.
- To ensure that information regarding decommissioning a pipeline in place will not constitute a hazard to navigation and commercial fishing operations, unduly interfere with other uses of the OCS, such as sand resource areas for coastal restoration projects, or have adverse environmental effects.
- To verify that decommissioning activities comply with approved applications and procedures and are satisfactorily completed.
- To evaluate and approve the adequacy of the equipment, materials, and/or procedures that the lessee or operator plans to use during well modifications and changes in equipment, etc.
- To help BSEE better estimate future decommissioning costs for OCS leases, rights-of-way, and rights of use and easements. BSEE's future decommissioning cost estimates may then be used by BOEM to set necessary financial assurance levels to minimize or eliminate the possibility that the government will incur abandonment liability. The information will assist BSEE and BOEM in meeting their stewardship responsibilities and in their roles as regulators.

Title of Collection: 30 CFR part 250, subpart Q, *Oil and Gas and Sulfur Operations in the OCS—Decommissioning Activities.*

OMB Control Number: 1014–0010.

Form Number: None.

Type of Review: Revision of a currently approved collection.

Respondents/Affected Public: Potential respondents comprise Federal OCS oil, gas, and sulfur lessees/operators and holders of pipeline rights-of-way.

Total Estimated Number of Annual Respondents: Not all of the potential respondents will submit information in any given year and some may submit multiple times.

Total Estimated Number of Annual Responses: 3,245.

Estimated Completion Time per Response: Varies from 15 minutes to 28 hours, depending on activity.

Total Estimated Number of Annual Burden Hours: 11,677.

Respondent's Obligation: Mandatory.

Frequency of Collection: Submissions are generally on occasion, varies by section, and annual.

Total Estimated Annual Nonhour Burden Cost: $1,143,556.

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.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Amy White,

Acting Chief, Regulations and Standards Branch.

[FR Doc. 2019–25794 Filed 11–26–19; 8:45 am]

BILLING CODE 4310–VH–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–1185]

Certain Smart Thermostats, Smart HVAC Systems, and Components Thereof Institution of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that a complaint was filed with the U.S. International Trade Commission on October 23, 2019, under section 337 of the Tariff Act of 1930, as amended, on behalf of EcoFactor, Inc. of Palo Alto, California. The complaint 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 smart thermostats, smart HVAC systems, and components thereof by reason of infringement of certain claims of U.S. Patent No. 8,131,497 (''the '497 patent''); U.S. Patent No. 8,423,322 (''the '322 patent''); U.S. Patent No. 8,498,753 (''the '753 patent''); and U.S. Patent No. 10,018,371 (''the '371 patent''). The complaint further alleges that an industry in the United States exists as required by the applicable Federal Statute.

The complainant requests that the Commission institute an investigation and, after the investigation, issue a limited exclusion order and cease and desist orders.

ADDRESSES: The complaint, except for any confidential information contained

therein, is 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, Room 112, Washington, DC 20436, telephone (202) 205–2000. Hearing impaired individuals are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at (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.*

FOR FURTHER INFORMATION CONTACT: Pathenia M. Proctor, The Office of Unfair Import Investigations, U.S. International Trade Commission, telephone (202) 205–2560.

SUPPLEMENTARY INFORMATION:

Authority: The authority for institution of this investigation is contained in section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337, and in section 210.10 of the Commission's Rules of Practice and Procedure, 19 CFR 210.10 (2019).

Scope of Investigation: Having considered the complaint, the U.S. International Trade Commission, on November 21, 2019, *ordered that*—

(1) Pursuant to subsection (b) of section 337 of the Tariff Act of 1930, as amended, an investigation be instituted to determine whether there is a violation of subsection (a)(1)(B) of section 337 in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain products identified in paragraph (2) by reason of infringement of one or more of claims 1–12 of the '497 patent; claims 1–7 of the '322 patent; claims 1–20 of the '753 patent; and claims 1–24 of the '371 patent; and whether an industry in the United States exists as required by subsection (a)(2) of section 337;

(2) Pursuant to section 210.10(b)(1) of the Commission's Rules of Practice and Procedure, 19 CFR 210.10(b)(1), the plain language description of the accused products or category of accused products, which defines the scope of the investigation, is ''smart thermostats, smart HVAC (heating, ventilation, and air conditioning) systems, and components thereof'';

(3) For the purpose of the investigation so instituted, the following are hereby named as parties upon which this notice of investigation shall be served:

(a) The complainant is: EcoFactor, Inc., 441 California Avenue, Number 2, Palo Alto, CA 94301.

(b) The respondents are the following entities alleged to be in violation of section 337, and is/are the parties upon which the complaint is to be served:

Ecobee Ltd., 207 Queens Quay West, Suite 600, Toronto, ON M5J 1A7.
Ecobee, Inc., 207 Queens Quay West, Suite 600, Toronto, ON M5J 1A7.
Google LLC, 1600 Amphitheatre Parkway, Mountain View, CA 94043.
Alarm.com Incorporated, 8281 Greensboro Drive, Suite 100, Tysons, VA 22102.
Alarm.com Holdings, Inc., 8281 Greensboro Drive, Suite 100, Tysons, VA 22102.
Daikin Industries, Ltd., Umeda Center Bldg., 2–4–12, Nakazaki-Nishi, Kita-ku, Osaka 530–8323, Japan.
Daikin America, Inc., 20 Olympic Drive, Orangeburg, NY 10962.
Daikin North America LLC, 5151 San Felipe, Suite 500, Houston, TX 77056.
Schneider Electric USA, Inc., 800 Federal Street, Andover, MA 01810.
Schneider Electric SE, 35, rue Joseph Monier—CS 30323, F–92506 Rueil-Malmaison Cedex, France.
Vivint, Inc., 4931 North 300 West, Provo, UT 84604.

(c) The Office of Unfair Import Investigations, U.S. International Trade Commission, 500 E Street SW, Suite 401, Washington, DC 20436; and

(4) For the investigation so instituted, the Chief Administrative Law Judge, U.S. International Trade Commission, shall designate the presiding Administrative Law Judge.

Responses to the complaint and the notice of investigation must be submitted by the named respondents in accordance with section 210.13 of the Commission's Rules of Practice and Procedure, 19 CFR 210.13. Pursuant to 19 CFR 201.16(e) and 210.13(a), such responses will be considered by the Commission if received not later than 20 days after the date of service by the Commission of the complaint and the notice of investigation. Extensions of time for submitting responses to the complaint and the notice of investigation will not be granted unless good cause therefor is shown.

Failure of a respondent to file a timely response to each allegation in the complaint and in this notice may be deemed to constitute a waiver of the right to appear and contest the allegations of the complaint and this notice, and to authorize the administrative law judge and the Commission, without further notice to the respondent, to find the facts to be as alleged in the complaint and this notice and to enter an initial determination and a final determination containing such findings, and may result in the issuance of an exclusion order or a cease and desist order or both directed against the respondent.

By order of the Commission.

Issued: November 22, 2019.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2019–25789 Filed 11–26–19; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

Notice of Receipt of Complaint; Solicitation of Comments Relating to the Public Interest

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission has received a complaint entitled *Dissolving Microneedle Patch Technology for Cosmetic and Pharmaceutical Use, DN 3420;* the Commission is soliciting comments on any public interest issues raised by the complaint or complainant's filing pursuant to the Commission's Rules of Practice and Procedure.

FOR FURTHER INFORMATION CONTACT: Lisa R. Barton, Secretary to the Commission, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436, telephone (202) 205–2000. The public version of the complaint can be accessed on the Commission's Electronic Document Information System (EDIS) at *https://edis.usitc.gov,* and 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 United States International Trade Commission (USITC) at *https://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's Electronic Document Information System (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 has received a complaint and a submission pursuant to § 210.8(b) of the Commission's Rules of Practice and Procedure filed on behalf of TheraJect, Inc. on November 21, 2019. The complaint alleges violations of section 337 of the Tariff Act of 1930 (19 U.S.C. 1337) in the importation into the United States, the sale for importation, and the sale within the United States after importation of dissolving microneedle patch for cosmetic and pharmaceutical use. The complaint names as respondents: Raphas Co., Ltd. of South Korea. The complainant requests that the Commission issue a limited exclusion, cease and desist orders, and impose a bond upon respondents' alleged infringing articles during the 60-day Presidential review period pursuant to 19 U.S.C. 1337(j).

Proposed respondents, other interested parties, and members of the public are invited to file comments on any public interest issues raised by the complaint or § 210.8(b) filing. Comments should address whether issuance of the relief specifically requested by the complainant in this investigation would affect the public health and welfare in the United States, competitive conditions in the United States economy, the production of like or directly competitive articles in the United States, or United States consumers.

In particular, the Commission is interested in comments that:

(i) Explain how the articles potentially subject to the requested remedial orders are used in the United States;

(ii) identify any public health, safety, or welfare concerns in the United States relating to the requested remedial orders;

(iii) identify like or directly competitive articles that complainant, its licensees, or third parties make in the United States which could replace the subject articles if they were to be excluded;

(iv) indicate whether complainant, complainant's licensees, and/or third party suppliers have the capacity to replace the volume of articles potentially subject to the requested exclusion order and/or a cease and desist order within a commercially reasonable time; and

(v) explain how the requested remedial orders would impact United States consumers.

Written submissions on the public interest must be filed no later than by close of business, eight calendar days after the date of publication of this notice in the **Federal Register**. There will be further opportunities for comment on the public interest after the issuance of any final initial determination in this investigation. Any written submissions on other issues must also be filed by no later than the close of business, eight calendar days after publication of this notice in the **Federal Register**. Complainant may file replies to any written submissions no later than three calendar days after the date on which any initial submissions were due. Any submissions and replies filed in response to this Notice are limited to five (5) pages in length, inclusive of attachments.

Persons filing written submissions must file the original document electronically on or before the deadlines stated above and submit 8 true paper copies to the Office of the Secretary by noon the next day pursuant to § 210.4(f) of the Commission's Rules of Practice and Procedure (19 CFR 210.4(f)). Submissions should refer to the docket number (''Docket No. 3420'') in a prominent place on the cover page and/or the first page. (*See* Handbook for Electronic Filing Procedures, Electronic Filing Procedures [1]). Persons with questions regarding filing should contact the Secretary (202–205–2000).

Any person desiring to submit a document to the Commission in confidence must request confidential treatment. All such requests should be directed to the Secretary to the Commission and must include a full statement of the reasons why the Commission should grant such treatment. *See* 19 CFR 201.6. Documents for which confidential treatment by the Commission is properly sought will be treated accordingly. All information, including confidential business information and documents for which confidential treatment is properly sought, submitted to the Commission for purposes of this Investigation may be disclosed to and used: (i) By the Commission, its employees and Offices, and contract personnel (a) for developing or maintaining the records of this or a related proceeding, or (b) in internal investigations, audits, reviews, and evaluations relating to the programs, personnel, and operations of the Commission including under 5 U.S.C. Appendix 3; or (ii) by U.S. government employees and contract personnel,[2] solely for cybersecurity purposes. All nonconfidential written submissions will be available for public inspection at the Office of the Secretary and on EDIS.[3]

This action is taken under the authority of section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and of §§ 201.10 and 210.8(c) of the Commission's Rules of Practice and Procedure (19 CFR 201.10, 210.8(c)).

By order of the Commission.

Issued: November 22, 2019.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2019–25748 Filed 11–26–19; 8:45 am]

BILLING CODE 7020–02–P

[1] Handbook for Electronic Filing Procedures: *https://www.usitc.gov/documents/handbook_on_filing_procedures.pdf.*

[2] All contract personnel will sign appropriate nondisclosure agreements.

[3] Electronic Document Information System (EDIS): *https://edis.usitc.gov.*

DEPARTMENT OF LABOR

Employment and Training Administration

Notice of the Federal Unemployment Tax Act (FUTA) Credit Reduction Applicable in 2019

ACTION: Notice.

Sections 3302(c)(2)(A) and 3302(d)(3) of the FUTA provide that employers in a state that has outstanding advances under Title XII of the Social Security Act on January 1 of two or more consecutive years are subject to a reduction in credits otherwise available against the FUTA tax for the calendar year in which the most recent such January 1 occurs, if advances remain on November 10 of that year. Further, Section 3302(c)(2)(C) of FUTA provides for an additional credit reduction for a year if a state has outstanding advances on five or more consecutive January 1 and has a balance on November 10 for such years. Section 3302(c)(2)(C) also provides for waiver of this additional credit reduction and substitution of the credit reduction provided in Section 3302(c)(2)(B) if a state meets certain conditions.

Employers in the U.S. Virgin Islands (USVI) were potentially liable for the additional credit reduction under Section 3302(c)(2)(C) of FUTA. The jurisdiction applied for the waiver of this additional credit reduction. The Employment and Training Administration determined that USVI met all of the criteria of the section necessary to qualify for the waiver of the additional credit reduction. Therefore employers in USVI will have no

additional credit reduction applied for calendar year 2019. However, as a result of having outstanding advances on each January 1 of 2010 through 2019, which had outstanding balances on November 10, 2019, employers in USVI are subject to a FUTA credit reduction of 2.7 percent in 2019.

John Pallasch,

Assistant Secretary for Employment and Training.

[FR Doc. 2019–25742 Filed 11–26–19; 8:45 am]

BILLING CODE 4510–FW–P

OFFICE OF MANAGEMENT AND BUDGET

Request for Comments on Improving Vulnerability Identification, Management, and Remediation

AGENCY: Office of Management and Budget.

ACTION: Notice of public comment period.

SUMMARY: The Office of Management and Budget (OMB) is seeking public comment on a draft memorandum titled, ''Improving Vulnerability Identification, Management, and Remediation.''

DATES: The 30-day public comment period on the draft memorandum begins on the day it is published in the **Federal Register** and ends 30 days after date of publication in the **Federal Register**.

ADDRESSES: Interested parties should provide comments via electronic mail to *ofcio@omb.eop.gov.* The Office of Management and Budget is located at 725 17th Street NW, Washington, DC 20503. No physical copies will be accepted.

FOR FURTHER INFORMATION CONTACT: Matthew T. Cornelius, OMB, at 202.881.7386 or *matthew.t.cornelius@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: The Office of Management and Budget (OMB) is proposing guidance to Federal agencies on the publication and implementation of Vulnerability Disclosure Policies (VDPs). VDPs, which are processes for the intake and addressing of security vulnerabilities uncovered by security researchers and the public, are among the most effective methods for obtaining new insights regarding security vulnerability information. They also provide protection for those who uncover these vulnerabilities by differentiating between acceptable and unacceptable means of gathering security information (also known as ''authorizing good faith security research''). VDPs make it easier for the security research community to report vulnerabilities to appropriate agency contacts, who can then use the reports to address vulnerabilities of which they may not have been aware.

Authority for this notice is granted under the Federal Information Security Modernization Act of 2014 (44 U.S.C. 3553–3554).

Suzette Kent,

Federal Chief Information Officer, Office of the Federal Chief Information Officer.

[FR Doc. 2019–25715 Filed 11–26–19; 8:45 am]

BILLING CODE 3110–05–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

National Endowment for the Humanities

Humanities Panel Advisory Committee

AGENCY: National Endowment for the Humanities; National Foundation on the Arts and the Humanities.

ACTION: Notice of Charter Renewal for Humanities Panel advisory committee.

SUMMARY: The National Endowment for the Humanities (NEH) gives notice that the Charter for the Humanities Panel advisory committee was renewed for an additional two-year period on November 22, 2019.

FOR FURTHER INFORMATION CONTACT: Elizabeth Voyatzis, Committee Management Officer, 400 Seventh Street SW, Washington, DC 20506. Telephone: (202) 606–8322, facsimile (202) 606–8600, or email at *gencounsel@neh.gov.* Hearing-impaired individuals are advised that information on this matter may be obtained by contacting the National Endowment for the Humanities' TDD terminal at (202) 606–8282.

SUPPLEMENTARY INFORMATION: Pursuant to section 9(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) and its implementing regulations, 41 CFR 102–3.65, the National Endowment for the Humanities (NEH) gives notice that the Charter for the Humanities Panel advisory committee was renewed for an additional two-year period on November 22, 2019. The NEH Chairman determined that the renewal of the Humanities Panel is necessary and in the public interest in connection with the performance of duties imposed upon the Chairperson of NEH by the National Foundation on the Arts and the Humanities Act of 1965, 20 U.S.C. 951 *et seq.,* as amended.

Elizabeth Voyatzis,

Committee Management Officer, National Endowment for the Humanities.

[FR Doc. 2019–25770 Filed 11–26–19; 8:45 am]

BILLING CODE 7536–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–608; NRC–2019–0173]

SHINE Medical Technologies, LLC

AGENCY: Nuclear Regulatory Commission.

ACTION: Intent to prepare a supplement to the final environmental impact statement and conduct scoping.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) intends to gather information through the public scoping process to prepare a supplement the to the final environmental impact statement (FEIS) on the construction permit related to the operating license application for the SHINE Medical Isotope Production Facility. The NRC is seeking public input on the proposed action and has scheduled a public scoping meeting.

DATES: Submit comments by January 13, 2020. Comments received after this date will be considered if it is practical to do so, but the Commission is able to ensure consideration only for comments received before this date.

ADDRESSES: You may submit comments by any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2019–0173. Address questions about NRC docket 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.
- *Mail comments to:* Office of Administration, Mail Stop: TWFN–7–A60M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, ATTN: Program Management, Announcements and Editing Staff.
- For additional direction on obtaining information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Jennifer A. Davis, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission,

Washington, DC 20555–0001, telephone: 301–415–3835; email: *Jennifer.Davis@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2019–0173 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document by any of the following methods:

- *Federal Rulemaking Website:* Go to *https://www.regulations.gov* and search for Docket ID NRC–2019–0173.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the NRC Library at *https://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 in this document (if that document is available in ADAMS) is provided the first time that a document is referenced. SHINE Medical Technologies, LLC's (SHINE) operating license application for the SHINE Medical Isotope Production Facility can be found in ADAMS under Package Accession No. ML19211C143.
- *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.
- *Library:* A copy of the SHINE supplemental environmental report (ER) is available at the Hedberg Public Library, 316 South Main Street, Janesville, Wisconsin 53545.

B. Submitting Comments

Please include Docket ID NRC–2019–0173 in the subject line of your comment submission in order to ensure that the NRC is able to make your comment submission available to the public in this docket.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your comment submission. The NRC will post all comment submissions at *https://www.regulations.gov* as well as enter the comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment submissions into ADAMS.

II. Discussion

By letter dated July 17, 2019 (ADAMS Accession No. ML19211C044), SHINE filed with the NRC, pursuant to Section 103 of the Atomic Energy Act and part 50, ''Domestic Licensing of Production and Utilization Facilities,'' of title 10 of the *Code of Federal Regulations* (10 CFR), an application for a 30-year operating license for the SHINE Medical Isotope Production Facility to be located in Janesville, Wisconsin (ADAMS Package Accession No. ML19211C143). In addition to general and financial information, the application included a final safety analysis report and a supplemental ER. A notice of receipt and availability of this application was previously published in the **Federal Register** (*FR*) on September 10, 2019 (84 FR 47557). A notice of acceptance of the application for docketing was published in the *FR* on October 15, 2019 (84 FR 55187). In accordance with the provisions of 10 CFR 2.105, ''Notice of proposed action,'' a separate notice of opportunity to file a petition for leave to intervene in a hearing will be published at a later date.

SHINE has proposed to construct and operate a facility in Janesville, Wisconsin to produce molybdenum-99 through the irradiation and processing of a uranyl sulfate solution. As described in the operating license application, the proposed SHINE facility would comprise an irradiation facility and radioisotope production facility. The irradiation facility would consist of eight subcritical operating assemblies (or irradiation units) and the radioisotope production facility would consist of hot cell structures for the processing of irradiated material.

By letters dated March 26 and May 31, 2013 (ADAMS Accession Nos. ML13088A192 and ML13172A361, respectively), SHINE (at the time known as SHINE Medical Technologies, Inc.) submitted a construction permit application, as updated in 2015, for its eight utilization facilities and one production facility (ADAMS Package Accession No. ML15258A431). The NRC issued Construction Permit No. CPMIF–001 to SHINE on February 29, 2016 (ADAMS Package Accession No. ML16041A473), as supported by NUREG–2189, ''Safety Evaluation Report Related to SHINE Medical Technologies, Inc. Construction Permit Application for a Medical Radioisotope Production Facility,'' dated August 2016 (ADAMS Accession No. ML16229A140), and NUREG–2183, ''Environmental Impact Statement for the Construction Permit for the SHINE Medical Radioisotope Production Facility,'' dated October 2015 (ADAMS Accession No. ML15288A046). In accordance with 10 CFR 51.95(b), in connection with SHINE's operating license application, the NRC will prepare a supplement to NUREG–2183, which will update the prior environmental review. The supplement will only cover matters that differ from or reflect significant new information concerning matters discussed in NUREG–2183.

III. Request for Comments

This notice informs the public of the NRC's intention to conduct scoping and prepare a supplement to NUREG–2183 as part of the review of the SHINE operating license application, and to provide the public an opportunity to participate in the environmental scoping process, as defined in 10 CFR 51.29, ''Scoping-environmental impact statement and supplement to environmental impact statement.''

The regulations in 36 CFR 800.8, ''Coordination with the National Environmental Policy Act,'' allow agencies to use their National Environmental Policy Act of 1969 (NEPA) process to fulfill the requirements of Section 106 of the National Historic Preservation Act (NHPA). Therefore, pursuant to 36 CFR 800.8(c), the NRC intends to use its NEPA process and documentation to comply with Section 106 of the NHPA in lieu of the procedures set forth at 36 CFR 800.3 through 800.6.

In accordance with 10 CFR 51.53(b), SHINE submitted a supplement to its construction permit ER as part of the operating license application. The supplement updates the information presented in the previous ER submitted as part of the construction permit application. The supplemental ER was prepared pursuant to 10 CFR part 51 and is publicly available in ADAMS under Accession No. ML19211C139. The supplemental ER may also be viewed on the internet at *https://www.nrc.gov/docs/ML1921/ML19211C139.pdf.* In addition, a paper

copy of ER is available for public review at the Hedberg Public Library, 316 South Main Street, Janesville, Wisconsin 53545.

When a FEIS has been prepared in connection with the issuance of a construction permit for a production or utilization facility, the NRC is required to prepare a supplement to the FEIS on the construction permit in connection with the issuance of an operating license in accordance with 10 CFR 51.95(b). The supplement will only cover matters that differ from the final environmental impact statement or that reflect significant new information concerning matters discussed in the final environmental impact statement.

The NRC will first conduct scoping and will then prepare a draft supplement for public comment. Participation in the scoping process by members of the public and local, State, Tribal, and Federal government agencies is encouraged. The scoping process will be used to accomplish the following:

a. Define the proposed action;

b. Determine the scope and identify the significant issues to be analyzed in depth;

c. Identify and eliminate from detailed study those issues that are peripheral or are not significant; or were covered by a prior environmental review;

d. Identify any environmental assessments and other ElSs that are being or will be prepared that are related to, but are not part of, the scope of the supplement being considered;

e. Identify other environmental review and consultation requirements related to the proposed action;

f. Indicate the relationship between the timing of the preparation of the environmental analyses and the Commission's tentative planning and decision-making schedule;

g. Identify any cooperating agencies and, as appropriate, allocate assignments for preparation and schedules for completing the supplement; and

h. Describe how the supplement will be prepared, including any contractor assistance to be used.

The NRC invites the following entities to participate in scoping:

a. The applicant, SHINE;

b. Any Federal agency that has jurisdiction by law or special expertise with respect to any environmental impact involved or that is authorized to develop and enforce relevant environmental standards;

c. Affected State and local government agencies, including those authorized to develop and enforce relevant environmental standards;

d. Any affected Indian Tribe;

e. Any person who requests or has requested an opportunity to participate in the scoping process; and

f. Any person who has petitioned or intends to petition for leave to intervene under 10 CFR 2.309.

IV. Public Scoping Meeting

In accordance with 10 CFR 51.26, the scoping process may include a public scoping meeting to help identify significant issues related to a proposed activity and to determine the scope of issues to be addressed. The NRC will hold a public scoping meeting for the SHINE environmental review on December 12, 2019, from 6:00 p.m. to 8:00 p.m. at The Celtic House at Glen Erin Golf Club, 1417 W Airport Rd., Janesville, WI 53546. There will be an open house one hour before the meeting for members of the public to meet with the NRC staff and sign in to speak at the meeting.

The meeting will be transcribed and will include: (1) An overview by the NRC staff of the safety and NEPA environmental review processes, the proposed scope of the supplement to the FEIS; and (2) the opportunity for interested government agencies, organizations, and individuals to submit comments or suggestions on the environmental issues or the proposed scope. The main objectives of this meeting are to describe the environmental review process and receive public comments on the appropriate scope and content to be considered in the staff's review. To be considered, comments must be provided either at the transcribed public meeting or in writing, as discussed in the **ADDRESSES** section of this document.

Persons may register to attend or present oral comments at the meeting on the scope of the NEPA review by contacting the NRC Environmental Project Manager, Ms. Jennifer Davis, by telephone at 301–415–3835, or by email at *Jennifer.Davis@nrc.gov* no later than December 5, 2019. Members of the public may also register to speak during the registration period prior to the start of the meeting. Individual oral comments may be limited by the time available, depending on the number of persons who register. Members of the public who have not registered may also have an opportunity to speak if time permits. Public comments will be considered in the scoping process for the SHINE environmental review. Please contact Ms. Davis no later than December 5, 2019, if accommodations or special equipment is needed to attend or present information at the public meeting, so that the NRC staff can determine whether the request can be accommodated.

Participation in the scoping process does not entitle participants to become parties to the proceeding to which the supplement relates. Matters related to participation in any hearing are outside the scope of matters to be discussed at this public meeting.

Dated at Rockville, Maryland, this 22nd day of November 2019.

For the Nuclear Regulatory Commission.

Robert B. Elliott,

Chief, Environmental Review License Renewal Branch, Division of Rulemaking, Environmental, and Financial Support, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2019–25788 Filed 11–26–19; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. EA–18–130; NRC–2019–0232]

In the Matter of Southern Nuclear Operating Company

AGENCY: Nuclear Regulatory Commission.

ACTION: Confirmatory Order; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is issuing a Confirmatory Order to Southern Nuclear Operating Company (SNC). This action is based on two investigations conducted by the NRC Office of Investigations (OI), that apparent willful violations of NRC's regulations regarding ''Employee Protection,'' occurred. Specifically, two contract employees at Vogtle Units 3 and 4 were terminated from employment in 2016 and 2017, respectively. The NRC determined that these terminations were, in part, because the contract employees engaged in protected activity. An ADR mediation session was held on August 5, 2019, with SNC, and a preliminary settlement agreement was reached. Subsequently, SNC consented to the specific actions listed in section V of the Confirmatory Order and the NRC agrees to no pursue any further enforcement action in connection with this apparent violation. The Confirmatory Order becomes effective upon issuance.

DATES: The Confirmatory Order containing the agreements made between SNC and the NRC was issued on November 20, 2019.

ADDRESSES: Please refer to Docket ID NRC–2019–0232 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 *https://www.regulations.gov/* and search for Docket ID NRC–2019–0232. Address questions about NRC docket 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 *https://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 Confirmatory Order is available in ADAMS under Accession No. ML19269C005.

• *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: Catherine Thompson, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–287–9515, email: *Catherine.Thompson@nrc.gov.*

SUPPLEMENTARY INFORMATION: The text of the Confirmatory Order is attached.

Dated at Rockville, Maryland, this 21st day of November 2019.

For the Nuclear Regulatory Commission.

George A. Wilson,

Director, Office of Enforcement.

Attachment—Confirmatory Order Prohibiting Involvement in NRC-Licensed Activities

United States of America

Nuclear Regulatory Commission

In the Matter of Southern Nuclear Operating Company; Vogtle Electric Generating Plant, Units 3 and 4

Docket No.: 5200025, 5200026; License No.: NPF–91, NPF–92; EA–18–130 and EA–18–171

Confirmatory Order Modifying License

Effective Upon Issuance

I

Southern Nuclear Operating Company (SNC or Licensee) is the holder of License Nos. NPF–2, NPF–8, DPR–57, NPF–5, NPF–68, NPF–81, and Combined Licenses NPF–91 and NPF–92, issued by the U.S. Nuclear Regulatory Commission (NRC or Commission) pursuant to Part 50 and Part 52 of *Title 10 of the Code of Federal Regulations* (10 CFR). The licenses authorize the operation of the Joseph M. Farley, Nuclear Plant Units 1 and 2, the Edwin I. Hatch Nuclear Plant, Units 1 and 2, the Vogtle Electric Generating Plant, Units 1 and 2, and the combined construction and operation of Vogtle Electric Generating Plant, Units 3 and 4 (Vogtle), in accordance with conditions specified therein. These facilities are located in Columbia, Alabama; Baxley, Georgia; and Waynesboro, Georgia, respectively.

This Confirmatory Order (CO) is the result of an agreement reached during an Alternative Dispute Resolution (ADR) mediation session conducted on August 5, 2019 in Rockville, Maryland to address two apparent violations. The NRC and SNC agree to disagree as to whether the violations occurred.

II

On February 13, 2018, the NRC, Office of Investigations (OI), issued a report (2–2017–004) related to SNC Vogtle Units 3 and 4, currently under construction. Based on the evidence developed during its investigation, the NRC identified an apparent violation of 10 CFR 52.5, ''Employee Protection,'' and determined that the apparent violation of 10 CFR 52.5 was willful. The NRC determined that SNC directed a contract employee at the Vogtle Units 3 and 4 construction site be removed in December 2015, in part, for engaging in protected activity. The contract employee was subsequently terminated by his employer on February 3, 2016. By letter dated May 15, 2019, the NRC notified SNC of the results of the investigation with an opportunity to: (1) Attend a predecisional enforcement conference or (2) participate in an ADR mediation session in an effort to resolve this concern.

On November 20, 2018, the NRC, Office of Investigations (OI), issued a report (2–2017–032) related to SNC, Vogtle Units 3 and 4, currently under construction. Based on the evidence developed during its investigation, the NRC identified an apparent violation of 10 CFR 52.5, ''Employee Protection,'' and determined that the apparent violation of 10 CFR 52.5 was willful. The NRC determined that a contract employee was removed from the site by an SNC official on July 13, 2017, in part, for engaging in protected activity when he was employed by a different contractor on the site from 2014–2015. The contract employee was subsequently terminated by his employer on July 14, 2017. By letter dated June 12, 2019, the NRC notified SNC of the results of the investigation with an opportunity to: (1) Attend a predecisional enforcement conference or (2) participate in an ADR mediation session in an effort to resolve this concern.

In response to the NRC's offers, SNC requested the use of the NRC's ADR process. In recognition of the substantially similar broad corrective actions expected from the two cases, the NRC and SNC agreed to include both cases in this mediation. On August 5, 2019 the NRC and SNC met in an ADR session mediated by a professional mediator, arranged through Cornell University's Institute on Conflict Resolution. The ADR process is one in which a neutral mediator, with no decision-making authority, assists the parties in their attempt to reach an agreement on resolving any differences regarding the dispute. This Confirmatory Order is issued pursuant to the agreement reached during the August 5, 2019 mediation.

III

During the ADR mediation session, SNC and the NRC reached a preliminary settlement agreement. The elements of the agreement included: (1) Corrective actions that SNC has already completed to improve the nuclear safety culture (NSC) and safety conscious work environment (SCWE) at the site (provided to the NRC at the August 5, 2019 ADR mediation session); (2) agreed upon future actions; and (3) general provisions.

Previously Completed Corrective Actions

1. Implemented the One Project Employee Concerns Program (One Project ECP):

a. Consolidated all individuals on the construction site under the One Project ECP. SNC's One Project ECP manages the intake of all construction concerns, investigations, referrals when necessary and tracking of associated corrective actions.

b. Expanded the scope of the One Project ECP. One Project ECP reviews a range of concerns broader than those explicitly described as nuclear safety concerns. This builds trust with the construction site population, as well as helps identify issues that might not appear to be nuclear safety concerns but either become nuclear safety concerns or have some tie to a nuclear safety concern.

c. One Project ECP has expanded ECP staff to have representatives available

for at least 3 hours during the night shift.

2. Implemented a single project-wide Corrective Action Program which provides for SNC ownership of all Corrective Action Program activities on the project.

3. Implemented a Discipline Review Process for construction contractors to require review of certain terminations for potential SCWE issues. Additional oversight by SNC HR of Contractors' implementation of the Discipline Review Process was added in December 2018 as a result of CR# 50009752.

4. Enhanced the presence and visibility of ECP in the field. SNC ECP provides SCWE training to contractor employees during onboarding. ECP personnel spend time in the field, handing out cards, discussing the program and locations, assessing SCWE knowledge, and educating when necessary.

5. Project and Leadership Reset conducted on July 25, 2018, with the expectation that employees, contractors and leaders on the Vogtle 3 and 4 project site read and sign a ''Recommitment to Project Expectations'' and ''Recommitment to Leadership Expectations,'' respectively, which included ''My behaviors will demonstrate and support a strong nuclear safety culture and an environment for raising concerns.''

6. SNC SCWE policy was updated on October 22, 2018, to explicitly state that violations of the policy may result in termination; dismissal of contracted third-party representatives; cancellation of contracts or service-level agreements; loss of access or other privileges; barring individuals from access to facilities, property or any system or network owned or controlled by the Company or its affiliates.

Agreed Upon Future Actions

1. Employee Concerns Program (ECP)

a. SNC-Fleet Wide (FW) will maintain an ECP for plants authorized to operate (fleet-wide ECP) (see Attachment) in substantially the same form as SNC Policy 701, ''Employee Concerns Program,'' revised 02/2017.

b. SNC-Vogtle 3 and 4 (V) will maintain the existing Vogtle 3 and 4 One Project ECP through commercial operation of each unit, or until such time that SNC determines transition to fleet-wide ECP is warranted.

2. Adverse Action Review Processes

a. SNC–FW/V [1] will maintain a review process covering significant adverse actions (termination or suspension) taken by SNC with respect to SNC employees which requires consideration of protected activity, if any, prior to taking the significant adverse action.

b. SNC–V will maintain a Discipline Review Process (DRP), applicable to SNC contractors or subcontractors (collectively ''contractors'') at the Vogtle 3 and 4 Project site who are engaged in nuclear safety related work. Contractors must follow this process when termination is under consideration. This process also applies to SNC when (1) SNC requests removal of a contractor employee from the Vogtle 3 and 4 Project pursuant to contractual rights, and (2) when SNC releases from the Vogtle Project a supplemental worker assigned to support SNC. SNC may allow for exceptions to the DRP in the following instances: Terminations related to Part 26 FFD or Site Access failures; reduction in force (RIF)-related terminations; any action dictated by a collective bargaining (or similar) agreement applicable to contractor employees; violations of project work rules which do not depend on supervisory discretion; and end of assignment releases.

c. In the event the results of the review process in 2a. or 2b. reveal a SCWE policy violation that is substantiated by the SNC–FW/V Compliance and Concerns organization, corrective actions arising from that violation which may include discipline will be tracked and confirmed as completed by the SNC Compliance and Concerns organization.

3. Training

a. Within four (4) months of issuance of this confirmatory order, and until three (3) years thereafter, SNC-FW/V will require all SNC employees who are onboarding to complete SCWE training, including training on 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4, definition of adverse action as it appears in the RIS 2005–18, and acknowledge the SNC SCWE policy within two (2) months of reporting to work.

b. Within four (4) months of issuance of this confirmatory order, SNC–V will provide SCWE training to management in the Vogtle 3 and 4 Project site. Lessons learned from these issues will be included in the training materials. The management covered by this item includes superintendents, managers and above (both contractors and SNC) up to and including the project executive vice president, who are in those roles as of the date that is three (3) months after the issuance of this confirmatory order. Such training shall be developed by a third party with experience in the area of employee protection and shall include training on 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4, the definition of adverse action as it appears in the RIS 2005–18, and relevant case studies.

c. Beginning no later than two (2) months of issuance of this confirmatory order, and until three (3) years thereafter, SNC will require all new SNC-FW/V supervisors (a leader responsible for performance management and work direction for individual contributors) to receive SCWE training within six (6) months of their beginning work as a supervisor at SNC.

d. Within six (6) months of issuance of this confirmatory order, SNC-FW/V will review and make appropriate revisions to include SCWE with its construction and fleet General Employee Training (GET) program, or successor training, to ensure adequate coverage of 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4. Lessons learned from these or similar issues will be identified and addressed in these training materials.

4. Other Activities

a. Within twelve (12) months from the issuance of this confirmatory order, SNC will deliver a presentation to provide SCWE insights that were derived from these events to present at an appropriate industry-sharing forum (*e.g.,* the NRC's Regulatory Information Conference, the National Association of Employee Concerns Professionals). The presentation shall be made available for NRC review.

b. Within three (3) months of issuance of this confirmatory order, SNC-FW will revise the SCWE policy to address lessons learned from these issues.

c. Within three (3) months of issuance of this confirmatory order, a senior SNC executive will issue a written communication to all SNC-FW/V employees and to contractors at the Vogtle 3 and 4 project site reinforcing SNC's commitment to maintaining a SCWE and reaffirming SNC's insistence upon the protection of employees' rights and obligations to raise safety issues without fear of retaliation. SNC-FW/V will mandate that SNC first line leaders and construction management (superintendents and above) inform their reports of the contents of the communication.

d. Within six (6) months of issuance of this confirmatory order, SNC–V will obtain an independent SCWE survey of Vogtle 3 and 4 project site. SNC–V will obtain a second independent SCWE survey of Vogtle 3 and 4 no later than thirty (30) months after issuance of this

[1] SNC–FW/V refers to both SNC's entire operating fleet and Vogtle Units 3 and 4 (see Attachment).

confirmatory order. Results of each survey will be summarized into reports which will be made available for inspection by NRC. Recommendations (if any) from the survey reports will be entered into the Corrective Action Program or Employee Concerns Program, as appropriate, depending on the nature of the recommendation, for disposition.

General Provisions

1. The proposed settlement does not affect other potential escalated enforcement actions, including ongoing investigations by the NRC's Office of Investigations. However, as part of its deliberations and consistent with the philosophy of the Enforcement Policy, Section 3.3, ''Violations Identified Because of Previous Enforcement Action,'' the NRC will consider enforcement discretion for violations of the NRC Employee Protection Rules (10 CFR 50.7, 10 CFR 52.5) that occur prior to or during implementation of the corrective actions aimed at correcting that specific condition as specified in the Confirmatory Order.

2. The NRC and SNC agree to disagree as to whether the violations occurred.

3. The NRC will not cite a violation or issue a civil penalty.

4. This order will be placed on the Vogtle 3 & 4 dockets only.

5. This order will not count as escalated enforcement in the civil penalty assessment process for future cases unless they are violations of the NRC Employee Protection Rules.

6. In the event of the transfer of the operating license of Southern Nuclear Operating Company to another entity, the terms and conditions set forth hereunder shall continue to apply to Southern Nuclear Operating Company and accordingly survive any transfer of ownership or license.

On November 20, 2019, SNC consented to issuing this Confirmatory Order with the commitments, as described in Section V below. SNC further agreed that this Confirmatory Order is to be effective upon issuance, the agreement memorialized in this Confirmatory Order settles the matter between the parties, and that it has waived its right to a hearing.

IV

I find that SNC's completed corrective actions, as described in Section III above, combined with the commitments as set forth in Section V are acceptable and necessary, and conclude that with these commitments the public health and safety are reasonably assured. In view of the foregoing, I have determined that public health and safety require that SNC commitments be confirmed by this Order. Based on the above and SNC's consent, this Confirmatory Order is effective upon issuance.

V

Accordingly, pursuant to Sections 103, 161b, 161i, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR part 52, *it is hereby ordered, effective upon issuance, that License Nos. NPF–2, NPF–8, DPR–57, NPF–5, NPF–68, NPF–81, NPF–91, and NPF–92 are modified as follows:*

1. Employee Concerns Program (ECP)

a. SNC–FW will maintain a fleetwide ECP for plants authorized to operate in substantially the same form as SNC Policy 701, ''Employee Concerns Program,'' revised 02/2017.

b. SNC–V will maintain the existing Vogtle 3 and 4 One Project ECP through commercial operation of each unit, or until such time that SNC determines transition to fleet-wide ECP is warranted.

2. Adverse Action Review Processes

a. SNC–FW/V will maintain a review process covering significant adverse actions (termination or suspension) taken by SNC with respect to SNC employees which requires consideration of protected activity, if any, prior to taking the significant adverse action.

b. SNC–V will maintain a Discipline Review Process (DRP), applicable to SNC contractors or subcontractors (collectively ''contractors'') at the Vogtle 3 and 4 Project site who are engaged in nuclear safety related work. Contractors must follow this process when termination is under consideration. This process also applies to SNC when (1) SNC requests removal of a contractor employee from the Vogtle 3 and 4 Project pursuant to contractual rights, and (2) when SNC releases from the Vogtle Project a supplemental worker assigned to support SNC. SNC may allow for exceptions to the DRP in the following instances: Terminations related to Part 26 FFD or Site Access failures; reduction in force (RIF)-related terminations; any action dictated by a collective bargaining (or similar) agreement applicable to contractor employees; violations of project work rules which do not depend on supervisory discretion; and end of assignment releases.

c. In the event the results of the review process in 2a. or 2b. reveal a SCWE policy violation that is substantiated by the SNC–FW/V Compliance and Concerns organization, corrective actions arising from that violation, which may include discipline, will be tracked and confirmed as completed by the SNC Compliance and Concerns organization.

3. Training

a. Within four (4) months of issuance of this confirmatory order, and until three (3) years thereafter, SNC–FW/V will require all SNC employees who are onboarding to complete SCWE training, including training on 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4, definition of adverse action as it appears in RIS 2005–18, and acknowledge the SNC SCWE policy within two (2) months of reporting to work.

b. Within four (4) months of issuance of this confirmatory order, SNC–V will provide SCWE training to management in the Vogtle 3 and 4 Project site. Lessons learned from these issues will be included in the training materials. The management covered by this item includes both contractors' and SNC superintendents and managers, up to and including the project executive vice president, who are in those roles as of the date that is three (3) months after the issuance of this confirmatory order. Such training shall be developed by a third party with experience in the area of employee protection and shall include training on 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4, the definition of adverse action as it appears in RIS 2005–18, and relevant case studies.

c. Beginning no later than two (2) months after issuance of this confirmatory order, and until three (3) years thereafter, SNC will require all new SNC–FW/V supervisors (a leader responsible for performance management and work direction for individual contributors) to receive SCWE training within six (6) months of their beginning work as a supervisor at SNC.

d. Within six (6) months of issuance of this confirmatory order, SNC–FW/V will review and make appropriate revisions to include SCWE with General Employee Training (GET) program, or successor training, to ensure adequate coverage of 10 CFR 50.7, 10 CFR 52.5, 10 CFR 50.5, and 10 CFR 52.4. Lessons learned from these or similar issues will be identified and addressed in these training materials.

4. Other Activities

a. Within twelve (12) months of the issuance of this order, SNC will deliver a presentation to provide SCWE insights that were derived from these events to present at an appropriate industry-sharing forum (*e.g.,* the NRC's

Regulatory Information Conference, the National Association of Employee Concerns Professionals). The presentation shall be made available for NRC review.

b. Within three (3) months of issuance of this order, SNC–FW will revise the SNC SCWE policy to address lessons learned from these issues.

c. Within three (3) months of issuance of this order, a senior SNC executive will issue a written communication to all SNC–FW/V employees and to contractors at the Vogtle 3 and 4 project site reinforcing SNC's commitment to maintaining a SCWE and reaffirming SNC's insistence upon the protection of employees' rights and obligations to raise safety issues without fear of retaliation. SNC–FW/V will mandate that SNC first line leaders and construction management (superintendents and above) inform their reports of the contents of the communication.

d. Within six (6) months of issuance of this order, SNC–V will obtain a third-party, independent SCWE survey of Vogtle 3 and 4 project site. SNC–V will obtain a second third-party, independent SCWE survey of Vogtle 3 and 4 no later than thirty (30) months after issuance of this confirmatory order. Results of each survey will be summarized into reports which will be made available for inspection by NRC. Recommendations (if any) from the survey reports will be entered into the Corrective Action Program or Employee Concerns Program, as appropriate, depending on the nature of the recommendation, for disposition.

This agreement is binding upon successors and assigns of SNC.

The Director, Office of Enforcement may, in writing, relax or rescind any of the above conditions upon demonstration by SNC or its successors of good cause.

VI

In accordance with 10 CFR 2.202 and 10 CFR 2.309, any person adversely affected by this Confirmatory Order, other than SNC, may request a hearing within thirty (30) calendar days of the date of issuance of this Confirmatory Order. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and include a statement of good cause for the extension.

All documents filed in NRC adjudicatory proceedings, including a request for hearing, a petition for leave to intervene, any motion or other document filed in the proceeding prior to the submission of a request for hearing or petition to intervene (hereinafter ''petition''), and documents filed by interested governmental entities participating under 10 CFR 2.315(c), must be filed in accordance with the NRC's E-Filing rule (72 FR 49139; August 28, 2007, as amended at 77 FR 46562, August 3, 2012). The E-Filing process requires participants to submit and serve all adjudicatory documents over the internet, or in some cases to mail copies on electronic storage media. Participants may not submit paper copies of their filings unless they seek an exemption in accordance with the procedures described below.

To comply with the procedural requirements of E-Filing, at least 10 days prior to the filing deadline, the participant should contact the Office of the Secretary by email at *hearing.docket@nrc.gov,* or by telephone at 301–415–1677, to (1) request a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign submissions and access the E-Filing system for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a petition or other adjudicatory document (even in instances in which the participant, or its counsel or representative, already holds an NRC-issued digital ID certificate). Based upon this information, the Secretary will establish an electronic docket for the hearing in this proceeding if the Secretary has not already established an electronic docket.

Information about applying for a digital ID certificate is available on the NRC's public website at *https://www.nrc.gov/site-help/e-submittals/getting-started.html.* Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit adjudicatory documents. Submissions must be in Portable Document Format (PDF). Additional guidance on PDF submissions is available on the NRC's public website at *https://www.nrc.gov/site-help/electronic-sub-ref-mat.html.* A filing is considered complete at the time the document is submitted through the NRC's E-Filing system. To be timely, an electronic filing must be submitted to the E-Filing system no later than 11:59 p.m. Eastern Time on the due date. Upon receipt of a transmission, the E-Filing system time-stamps the document and sends the submitter an email notice confirming receipt of the document. The E-Filing system also distributes an email notice that provides access to the document to the NRC's Office of the General Counsel and any others who have advised the Office of the Secretary that they wish to participate in the proceeding, so that the filer need not serve the document on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before adjudicatory documents are filed so that they can obtain access to the documents via the E-Filing system.

A person filing electronically using the NRC's adjudicatory E-Filing system may seek assistance by contacting the NRC's Electronic Filing Help Desk through the ''Contact Us'' link located on the NRC's Public website at *https://www.nrc.gov/site-help/e-submittals.html,* by email to *MSHD.Resource@nrc.gov,* or by a toll-free call at 1–866–672–7640. The NRC Electronic Filing Help Desk is available between 9 a.m. and 6 p.m., Eastern Time, Monday through Friday, excluding government holidays.

Participants who believe that they have good cause for not submitting documents electronically must file an exemption request, in accordance with 10 CFR 2.302(g), with their initial paper filing stating why there is good cause for not filing electronically and requesting authorization to continue to submit documents in paper format. Such filings must be submitted by: (1) First class mail addressed to the Office of the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, 11555 Rockville Pike, Rockville, Maryland 20852, Attention: Rulemaking and Adjudications Staff. Participants filing adjudicatory documents in this manner are responsible for serving the document on all other participants. Filing is considered complete by first-class mail as of the time of deposit in the mail, or by courier, express mail, or expedited delivery service upon depositing the document with the provider of the service. A presiding officer, having granted an exemption request from using E-Filing, may require a participant or party to use E-Filing if the presiding officer subsequently determines that the reason for granting the exemption from use of E-Filing no longer exists.

Documents submitted in adjudicatory proceedings will appear in the NRC's electronic hearing docket which is available to the public at *https://adams.nrc.gov/ehd,* unless excluded

pursuant to an Order of the Commission or the presiding officer. If you do not have an NRC-issued digital ID certificate as described above, click ''Cancel'' when the link requests certificates and you will be automatically directed to the NRC's electronic hearing dockets where you will be able to access any publicly available documents in a particular hearing docket. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or personal phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. For example, in some instances, individuals provide home addresses in order to demonstrate proximity to a facility or site. With respect to copyrighted works, except for limited excerpts that serve the purpose of the adjudicatory filings and would constitute a Fair Use application, participants are requested not to include copyrighted materials in their submission.

The Commission will issue a notice or order granting or denying a hearing request or intervention petition, designating the issues for any hearing that will be held and designating the Presiding Officer. A notice granting a hearing will be published in the **Federal Register** and served on the parties to the hearing.

If a person (other than SNC) requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Confirmatory Order and shall address the criteria set forth in 10 CFR 2.309(d) and (f).

If a hearing is requested by a person whose interest is adversely affected, the Commission will issue an order designating the time and place of any hearings. If a hearing is held, the issue to be considered at such hearing shall be whether this Confirmatory Order should be sustained.

In the absence of any request for hearing, or written approval of an extension of time in which to request a hearing, the provisions specified in Section V above shall be final 30 days from the date of this Confirmatory Order without further order or proceedings. If an extension of time for requesting a hearing has been approved, the provisions specified in Section V shall be final when the extension expires if a hearing request has not been received.

For the Nuclear Regulatory Commission

George A. Wilson,
Director, Office of Enforcement

Dated this 20th day of November 2019

Attachment: As stated.

All Facilities Owned and Operated by Southern Nuclear Operating Company

All items in this order that apply to Vogtle Units 3 and 4, or are designated with a ''V'' apply to the following facilities:

Vogtle Electric Generating Plant, Units 3 and 4
Docket Nos. 05200025, 05200026
License Nos. NPF–91, NPF–92

All items in this order that apply to SNC's entire fleet, or are designated as ''fleet-wide'' or with an ''FW'' apply to the following facilities:

Vogtle Electric Generating Plant, Units 1 and 2
Docket Nos. 05000424, 05000425
License Nos. NPF–68, NPF–81

Joseph M. Farley Nuclear Plant, Units 1 and 2
Docket Nos. 05000348, 05000364
License Nos. NPF–2, NPF–8

Edwin I. Hatch Nuclear Plant, Units 1 and 2
Docket Nos. 05000321, 05000366
DPR–57, NPF–5

[FR Doc. 2019–25709 Filed 11–26–19; 8:45 am]

BILLING CODE 7590–01–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2020–35 and CP2020–33]

New Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing for the Commission's consideration concerning a negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* December 3, 2019.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Introduction
II. Docketed Proceeding(s)

I. Introduction

The Commission gives notice that the Postal Service filed request(s) for the Commission to consider matters related to negotiated service agreement(s). The request(s) may propose the addition or removal of a negotiated service agreement from the market dominant or the competitive product list, or the modification of an existing product currently appearing on the market dominant or the competitive product list.

Section II identifies the docket number(s) associated with each Postal Service request, the title of each Postal Service request, the request's acceptance date, and the authority cited by the Postal Service for each request. For each request, the Commission appoints an officer of the Commission to represent the interests of the general public in the proceeding, pursuant to 39 U.S.C. 505 (Public Representative). Section II also establishes comment deadline(s) pertaining to each request.

The public portions of the Postal Service's request(s) can be accessed via the Commission's website (*http://www.prc.gov*). Non-public portions of the Postal Service's request(s), if any, can be accessed through compliance with the requirements of 39 CFR 3007.301.[1]

The Commission invites comments on whether the Postal Service's request(s) in the captioned docket(s) are consistent with the policies of title 39. For request(s) that the Postal Service states concern market dominant product(s), applicable statutory and regulatory requirements include 39 U.S.C. 3622, 39 U.S.C. 3642, 39 CFR part 3010, and 39 CFR part 3020, subpart B. For request(s) that the Postal Service states concern competitive product(s), applicable statutory and regulatory requirements include 39 U.S.C. 3632, 39 U.S.C. 3633, 39 U.S.C. 3642, 39 CFR part 3015, and 39 CFR part 3020, subpart B. Comment deadline(s) for each request appear in section II.

II. Docketed Proceeding(s)

1. *Docket No(s).:* MC2020–35 and CP2020–33; *Filing Title:* USPS Request to Add Priority Mail Contract 565 to Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* November 21, 2019; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3020.30 *et seq.,* and 39 CFR 3015.5; *Public Representative:* Christopher C.

[1] *See* Docket No. RM2018–3, Order Adopting Final Rules Relating to Non-Public Information, June 27, 2018, Attachment A at 19–22 (Order No. 4679).

Mohr; *Comments Due:* December 3, 2019.

This Notice will be published in the **Federal Register**.

Darcie S. Tokioka,

Acting Secretary.

[FR Doc. 2019–25779 Filed 11–26–19; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket No. R2020–1; Order No. 5318]

Market Dominant Price Adjustment

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently filed Postal Service response to Order No. 5203 to set the price for 5-Digit Automation Presort Letters and address the inflation-based rate adjustments affecting market dominant domestic and international products and services, along with temporary mailing promotions and numerous proposed classification changes. The adjustments and other changes are scheduled to take effect January 26, 2020. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* November 27, 2019.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Introduction and Overview
II. Background
III. Response to Order No. 5302
IV. Initial Administrative Actions
V. Ordering Paragraphs

I. Introduction and Overview

In Order No. 5302, the Commission remanded the Postal Service's planned First-Class Mail price adjustments [1] for non-compliance with certain legal requirements. On November 20, 2019, the Postal Service filed a Response to Order No. 5302 proposing to set the price for 5-Digit Automation Presort Letters as $0.389, instead of $0.391 as previously proposed.[2] The Postal Service proposes to maintain all other prices and associated classification changes previously proposed for First-Class Mail and the intended effective date of January 26, 2020. Response to Order No. 5302 at 1, 20.

II. Background

On October 9, 2019, the Postal Service filed a notice of inflation-based price adjustments affecting market dominant domestic and international products and services, along with temporary mailing promotions and associated proposed classification changes to the Mail Classification Schedule (MCS).[3] On November 13, 2019, the Commission determined that the Postal Service's planned First-Class Mail price adjustments would exceed the price cap limitations specified by 39 U.S.C. 3622(d), as calculated in accordance with 39 CFR 3010.21. Order No. 5302 at 2. The Commission identified that the Postal Service made impermissible adjustments to the billing determinants related to Inbound Letter Post, resulting in the Postal Service miscalculating the percentage change in rates for First-Class Mail. *Id.* Accordingly, the Commission remanded all planned First-Class Mail price adjustments to allow the Postal Service to modify its proposal to comply with applicable law. *Id.* at 2, 25–26.

Additionally, the Commission corrected other technical issues with the Postal Service's supporting workpapers and described issues raised by commenters concerning the Postal Service's compliance with the requirements of 39 CFR 3010.12(b)(6), (7) and (12). *Id.* at 2–3, 20–21, 23–25. The Commission reserved final disposition of issues, including comments, relating to First-Class Mail pending review of the Postal Service's revised proposal. *Id.* at 2, 25–26. The Commission also reserved discussion of the planned price adjustments and mail classification changes for USPS Marketing Mail, Periodicals, Package Services, and Special Services for a separate order. *Id.* at 1.

III. Response to Order No. 5302

In its Response to Order No. 5302, the Postal Service proposes to set the price for 5-Digit Automation Presort Letters as $0.389, instead of $0.391 as previously proposed. Response to Order No. 5302 at 11–12. The Postal Service proposes to maintain all other prices and associated classification changes previously proposed for First-Class Mail and the intended effective date of January 26, 2020. *Id.* at 1, 20. The Postal Service asserts that its discussion of the section 3622 objectives and factors provided in its Notice continues to apply. *Id.* at 13. It also discusses how the new price for 5-Digit Automation Presort Letters complies with section 3622 objectives and factors. *Id.* at 13–16. In addition, the Postal Service responds to comments relating to other First-Class Mail products. *Id.* at 16–18.

However, because the Postal Service disagrees with the Commission's rejection of the billing determinants adjustment for Inbound Letter Post to reflect the expected July 1, 2020 transfer of Inbound Letter Post small packet and bulky letter mailpieces, it requests that the Commission reconsider. *Id.* at 1, 9. The Postal Service asserts that the fundamental premise upon which the Commission's rejection of the Inbound Letter Post adjustment rests, that 39 CFR 3010.23(d)(2) does not permit for billing determinant adjustments for classification changes that occur after a price change, is illogical and unsound. *Id.* at 3–10. The Postal Service claims that the Commission's treatment of the Inbound Letter Post adjustment in Order No. 5302 contradicts its treatment of promotions and the plain language of 39 CFR 3010.23(d)(2). *Id.* at 4–6, 8. The Postal Service filed workpapers that reflect the inclusion of the Inbound Letter Post adjustment. *Id.* at 1–2.

In the alternative, the Postal Service requests that the Commission accelerate the transfer of Inbound Letter Post small packet and bulky letter mailpieces from the stated expected July 1, 2020 implementation date to January 1, 2020. *Id.* at 2, 10. To reflect a January 1, 2020 transfer of these mailpieces, the Postal Service filed workpapers that remove Inbound Letter Post small packets and bulky letters from the First-Class Mail price cap calculation entirely. *Id.* at 10.

IV. Initial Administrative Actions

Pursuant to 39 CFR 3010.11(g), the Commission invites comments from interested persons on whether the Response to Order No. 5302 is consistent with the applicable statutory and regulatory requirements, including 39 U.S.C. 3622 and 39 CFR part 3010. Comments are due no later than November 27, 2019.[4]

[1] Order Remanding Price Adjustments for First-Class Mail, November 13, 2019, at 2, 25–26 (Order No. 5302).

[2] United States Postal Service Response to Order No. 5302, November 20, 2019, at 11–12 (Response to Order No. 5302).

[3] United States Postal Service Notice of Market-Dominant Price Change, October 9, 2019 (Notice).

[4] As stated previously, the Commission continues to use the 7-day comment period as set forth in 39 CFR 3010.11(g). Order No. 5302 at 3. The Commission acknowledges that the Postal Service

The public portions of the Postal Service's filing are available for review on the Commission's website (*http://www.prc.gov*). Comments and other material filed in this proceeding will be available for review on the Commission's website, unless the information contained therein is subject to an application for non-public treatment. The Commission's rules on non-public materials (including access to documents filed under seal) appear in 39 CFR part 3007.

Pursuant to 39 U.S.C. 505, Anne C. O'Connor continues to be designated as an officer of the Commission (Public Representative) to represent the interests of the general public in this proceeding.[5]

V. Ordering Paragraphs

It is ordered:

1. Comments on the planned price adjustments and related classification changes for First-Class Mail, as amended, are due no later than November 27, 2019.

2. Pursuant to 39 U.S.C. 505, Anne C. O'Connor will continue to serve as an officer of the Commission (Public Representative) to represent the interests of the general public in this proceeding.

3. The Commission directs the Secretary of the Commission to arrange for prompt publication of this notice in the **Federal Register**.

By the Commission.

Darcie S. Tokioka,

Acting Secretary.

[FR Doc. 2019–25705 Filed 11–26–19; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL SERVICE

Product Change—Priority Mail Negotiated Service Agreement

AGENCY: Postal Service™.

ACTION: Notice.

SUMMARY: The Postal Service gives notice of filing a request with the Postal Regulatory Commission to add a domestic shipping services contract to the list of Negotiated Service Agreements in the Mail Classification Schedule's Competitive Products List.

DATES: *Date of required notice:* November 27, 2019.

FOR FURTHER INFORMATION CONTACT: Sean Robinson, 202–268–8405.

SUPPLEMENTARY INFORMATION: The United States Postal Service® hereby gives notice that, pursuant to 39 U.S.C. 3642 and 3632(b)(3), on November 21, 2019, it filed with the Postal Regulatory Commission a *USPS Request to Add Priority Mail Contract 565 to Competitive Product List.* Documents are available at *www.prc.gov,* Docket Nos. MC2020–35, CP2020–33.

Sean Robinson,

Attorney, Corporate and Postal Business Law.

[FR Doc. 2019–25716 Filed 11–26–19; 8:45 am]

BILLING CODE 7710–12–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 33703; File No. 812–15021]

Blackstone Alternative Alpha Fund, et al.

November 22, 2019.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice.

Notice of an application for an order pursuant to: (a) Section 6(c) of the Investment Company Act of 1940 (''Act'') granting an exemption from sections 18(f) and 21(b) of the Act; (b) section 12(d)(1)(J) of the Act granting an exemption from section 12(d)(1) of the Act; (c) sections 6(c) and 17(b) of the Act granting an exemption from sections 17(a)(1), 17(a)(2) and 17(a)(3) of the Act; and (d) section 17(d) of the Act and rule 17d–1 under the Act to permit certain joint arrangements and transactions. Applicants request an order that would permit certain registered management investment companies to participate in a joint lending and borrowing facility.

Applicants: Blackstone Alternative Investment Funds, registered under the Act as an open-end management investment company on behalf of all existing series;[1] Blackstone Alternative Alpha Fund, Blackstone Alternative Alpha Fund II, and Blackstone Alternative Alpha Master Fund, each registered under the Act as a closed-end management investment company; and Blackstone Alternative Asset Management L.P. (''BAAM'') and Blackstone Alternative Investment Advisors LLC (''BAIA''), each registered as an investment adviser under the Investment Advisers Act of 1940.

Filing Dates: The application was filed on April 18, 2019 and amended on September 5, 2019.

Hearing or Notification of Hearing: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail.

Hearing requests should be received by the Commission by 5:30 p.m. on December 17, 2019 and should be accompanied by proof of service on the applicants, in the form of an affidavit, or, for lawyers, a certificate of service. Pursuant to Rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, any facts bearing upon the desirability of a hearing on the matter, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090; Applicants: c/o James Hannigan, Blackstone Alternative Investment Advisors LLC, 345 Park Avenue, 28th Floor, New York, NY 10154.

FOR FURTHER INFORMATION CONTACT: Erin Loomis Moore, Senior Counsel, at (202) 551–6721, or Parisa Haghshenas, Branch Chief, at (202) 551–6723 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's website by searching for the file number, or an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090.

Summary of the Application

1. Applicants request an order that would permit the applicants to participate in an interfund lending facility where each Fund could lend money directly to and borrow money directly from other Funds to cover unanticipated cash shortfalls, such as unanticipated redemptions or trade fails.[2] The Funds will not borrow under

seeks issuance of a final order by December 12, 2019. *See* Response to Order No. 5302 at 21. However, the Commission notes that in order to sufficiently address the issues identified in *Carlson* v. *Postal Reg. Comm'n,* 938 F.3d 337 (D.C Cir. 2019), the Commission's determination may exceed the 14-day deadline set forth in 39 CFR 3010.11(h). Order No. 5302 at 3.

[5] *See* Notice and Order on Price Adjustments and Classification Changes for Market Dominant Products, October 10, 2019, at 4, 5 (Order No. 5273).

[1] Certain of the Funds (defined below) may be money market funds that comply with Rule 2a–7 under the Act (each a ''Money Market Fund''). None of the existing Funds is a Money Market Fund, but if Money Market Funds rely on this relief in the future, they typically will not participate as borrowers because such Funds rarely need to borrow cash to meet redemptions.

[2] Applicants request that the order apply to the applicants and to any existing or future registered

Continued

the facility for leverage purposes and the loans' duration will be no more than 7 days.[3]

2. Applicants anticipate that the proposed facility would provide a borrowing Fund with a source of liquidity at a rate lower than the bank borrowing rate at times when the cash position of the Fund is insufficient to meet temporary cash requirements. In addition, Funds making short-term cash loans directly to other Funds would earn interest at a rate higher than they otherwise could obtain from investing their cash in repurchase agreements or certain other short-term money market instruments. Thus, applicants assert that the facility would benefit both borrowing and lending Funds.

3. Applicants agree that any order granting the requested relief will be subject to the terms and conditions stated in the application. Among others, the Advisers, through a designated committee, would administer the facility as a disinterested fiduciary as part of its duties under the investment management agreements with each Fund and would receive no additional fee as compensation for their services in connection with the administration of the facility. The facility would be subject to oversight and certain approvals by the Funds' Boards, including, among others, approval of the interest rate formula and of the method for allocating loans across Funds, as well as review of the process in place to evaluate the liquidity implications for the Funds. A Fund's aggregate outstanding interfund loans will not exceed 15% of its current net assets, and the Fund's loans to any one Fund will not exceed 5% of the lending Fund's net assets.[4]

4. Applicants assert that the facility does not raise the concerns underlying section 12(d)(1) of the Act given that the Funds are part of the same group of investment companies and there will be no duplicative costs or fees to the Funds.[5] Applicants also assert that the proposed transactions do not raise the concerns underlying sections 17(a)(1), 17(a)(3), 17(d) and 21(b) of the Act as the Funds would not engage in lending transactions that unfairly benefit insiders or are detrimental to the Funds. Applicants state that the facility will offer both reduced borrowing costs and enhanced returns on loaned funds to all participating Funds and each Fund would have an equal opportunity to borrow and lend on equal terms based on an interest rate formula that is objective and verifiable. With respect to the relief from section 17(a)(2) of the Act, applicants note that any collateral pledged to secure an interfund loan would be subject to the same conditions imposed by any other lender to a Fund that imposes conditions on the quality of or access to collateral for a borrowing (if the lender is another Fund) or the same or better conditions (in any other circumstance).[6]

5. Applicants also believe that the limited relief from section 18(f)(1) of the Act that is necessary to implement the facility (because the lending Funds are not banks) is appropriate in light of the conditions and safeguards described in the application and because the open-end Funds would remain subject to the requirement of section 18(f)(1) that all borrowings of the open-end Fund, including combined interfund loans and bank borrowings, have at least 300% asset coverage.

6. Section 6(c) of the Act permits the Commission to exempt any persons or transactions from any provision of the Act if such exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act. Section 12(d)(1)(J) of the Act provides that the Commission may exempt any person, security, or transaction, or any class or classes of persons, securities, or transactions, from any provision of section 12(d)(1) if the exemption is consistent with the public interest and the protection of investors. Section 17(b) of the Act authorizes the Commission to grant an order permitting a transaction otherwise prohibited by section 17(a) if it finds that (a) the terms of the proposed transaction are fair and reasonable and do not involve overreaching on the part of any person concerned; (b) the proposed transaction is consistent with the policies of each registered investment company involved; and (c) the proposed transaction is consistent with the general purposes of the Act. Rule 17d–1(b) under the Act provides that in passing upon an application filed under the rule, the Commission will consider whether the participation of the registered investment company in a joint enterprise, joint arrangement or profit sharing plan on the basis proposed is consistent with the provisions, policies and purposes of the Act and the extent to which such participation is on a basis different from or less advantageous than that of the other participants.

For the Commission, by the Division of Investment Management, under delegated authority.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25798 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

open-end or closed-end management investment company or series thereof for which BAAM or BAIA or any successor thereto or an investment adviser controlling, controlled by, or under common control (within the meaning of Section 2(a)(9) of the 1940 Act) with BAAM or BAIA or any successor thereto serves as investment adviser (each such investment adviser entity being included in the term ''Adviser,'' and each such investment company, or series thereof, a ''Fund'' and collectively the ''Funds''). For purposes of the requested order, ''successor'' is limited to any entity that results from a reorganization into another jurisdiction or a change in the type of a business organization. The Funds that are closed-end management investment companies will not participate as borrowers in the interfund lending facility.

[3] Any Fund, however, will be able to call a loan on one business day's notice.

[4] Under certain circumstances, a borrowing Fund will be required to pledge collateral to secure the loan.

[5] Applicants state that the obligation to repay an interfund loan could be deemed to constitute a security for the purposes of sections 17(a)(1) and 12(d)(1) of the Act.

[6] Applicants state that any pledge of securities to secure an interfund loan could constitute a purchase of securities for purposes of section 17(a)(2) of the Act.

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87581; File No. SR–CboeBZX–2019–076)]

Self-Regulatory Organizations; Cboe BZX Exchange, Inc.; Notice of Designation of a Longer Period for Commission Action on a Proposed Rule Change, as Modified by Amendment No. 1, To List and Trade Shares of the Clearbridge Small Cap Value ETF Under Currently Proposed Rule 14.11(k)

November 21, 2019.

On September 26, 2019, Cboe BZX Exchange, Inc. 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 of the Clearbridge Small Cap Value ETF under currently proposed Rule 14.11(k) (Managed Portfolio Shares). On October 9, 2019, the Exchange filed Amendment No. 1 to the proposed rule change, which amended and replaced the rule change in its entirety. The proposed rule change, as modified by Amendment No. 1, was published for comment in the **Federal Register** on October 17, 2019.[3]

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 87286 (October 10, 2019), 84 FR 55608.

The Commission has received no comment letters on the proposed rule change.

Section 19(b)(2) of the Act[4] provides that, within 45 days of the publication of notice of the filing of a proposed rule change, or within such longer period up to 90 days as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or as to which the self-regulatory organization consents, the Commission shall either approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether the proposed rule change should be disapproved. The 45th day after publication of the notice for this proposed rule change is December 1, 2019. The Commission is extending this 45-day time period.

The Commission finds that it is appropriate to designate a longer period within which to take action on the proposed rule change so that it has sufficient time to consider the proposed rule change, as modified by Amendment No. 1. Accordingly, the Commission, pursuant to Section 19(b)(2) of the Act,[5] designates January 15, 2020, as the date by which the Commission shall either approve or disapprove, or institute proceedings to determine whether to disapprove, the proposed rule change (File Number SR–CboeBZX–2019–076), as modified by Amendment No. 1.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[6]

Eduardo Aleman,

Deputy Secretary.

[FR Doc. 2019–25703 Filed 11–26–19; 8:45 am]

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[4] 15 U.S.C. 78s(b)(2).

[5] *Id.*

[6] 17 CFR 200.30–3(a)(31).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87596; File No. SR–CTA/CQ–2019–03]

Consolidated Tape Association; Notice of Filing and Immediate Effectiveness of the Thirty-Second Substantive Amendment to the Second Restatement of the CTA Plan and Twenty-Third Substantive Amendment to the Restated CQ Plan

November 22, 2019.

Pursuant to Section 11A of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 608 thereunder,[2] notice is hereby given that on October 24, 2019,[3] the Participants[4] in the Second Restatement of the Consolidated Tape Association (''CTA'') Plan and the Restated Consolidated Quotation (''CQ'') Plan (''CTA/CQ Plans'' or ''Plans'') filed with the Securities and Exchange Commission (''Commission'') a proposal to amend the Plans. The amendments represent the Thirty-Second Substantive Amendment to the CTA Plan and Twenty-Third Substantive Amendment to the CQ Plan (''Amendments''). Under the Amendments, the Participants propose to add Long-Term Stock Exchange, Inc. (''LTSE'') as a Participant to the Plans and effectuate changes that certain Participants have made to their names and addresses.

The proposed Amendments have been filed by the Participants pursuant to Rule 608(b)(3)(ii) under Regulation NMS[5] as concerned solely with the administration of the Plans and as ''Ministerial Amendments'' under both Section IV(b) of the CTA Plan and Section IV(c) of the CQ Plan. As a result, the Amendments become effective upon filing and can be submitted by the Chair of the Plan's Operating Committee. The Commission is publishing this notice to solicit comments on the Amendment from interested persons. Set forth in Sections I and II is the statement of the purpose and summary of the Amendments, along with the information required by Rules 608(a) and 601(a) under the Act, prepared and submitted by the Participants to the Commission.

I. Rule 608(a)

A. Purpose of the Amendment

The above-captioned Amendments add LTSE as a Participant to the Plans and effectuate changes that certain Participants have made to their names and addresses, as set forth in Sections I(q), III(a), and VIII(a) of the CTA Plan and Section III(a) of the CQ Plan.

B. Governing or Constituent Documents

Not applicable.

C. Implementation of Amendment

Because the Amendments constitute ''Ministerial Amendments'' under both Section IV(b) of the CTA Plan and Section IV(c) under the CQ Plan, the Chairman of the Plan's Operating Committee may submit the Amendments to the Commission on behalf of the Participants in the Plans. Because the Participants designate the Amendments as concerned solely with the administration of the Plans, the Amendments become effective upon filing with the Commission.

D. Development and Implementation Phases

Not applicable.

E. Analysis of Impact on Competition

The Amendments do not impose any burden on competition because they simply add LTSE as a Participant to the Plans and effectuate a change in the names and addresses of certain Participants. LTSE has completed the required steps to be added to the Plans, and the Amendments represent the final step to officially add LTSE as a Participant. For the same reasons, the Participants do not believe that the Amendments introduce terms that are unreasonably discriminatory for purposes of Section 1lA(c)(l)(D) of the Act.

F. Written Understanding or Agreement Relating to Interpretation of, or Participating in Plan

Not applicable.

G. Approval by Sponsors in Accordance With Plan

See Item I.C. above.

H. Description of Operation of Facility Contemplated by the Proposed Amendment

Not applicable.

I. Terms and Conditions of Access

Not applicable.

J. Method of Determination and Imposition and Amount of, Fees and Charges

Not applicable.

K. Method and Frequency of Processor Evaluation

Not applicable.

L. Dispute Resolution

Not applicable.

[1] 15 U.S.C 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] *See* Letter from Robert Books, Chairman, Operating Committee, CTA/CQ Plans, to Vanessa Countryman, Secretary, Commission, dated October 23, 2018 [sic].

[4] The Participants are: Cboe BYX Exchange, Inc., Cboe BZX Exchange, Inc., Cboe EDGA Exchange, Inc., Cboe EDGX Exchange, Inc., Cboe Exchange, Inc., Financial Industry Regulatory Authority, Inc., The Investors' Exchange LLC, Long-Term Stock Exchange, Inc., Nasdaq BX, Inc., Nasdaq ISE, LLC, Nasdaq PHLX, Inc., The Nasdaq Stock Market LLC, New York Stock Exchange LLC, NYSE American LLC, NYSE Arca, Inc., NYSE Chicago, Inc., and NYSE National, Inc. (collectively, the ''Participants'').

[5] 17 CFR 242.608(b)(2).

II. Regulation NMS Rule 601(a)

A. Equity Securities for Which Transaction Reports Shall Be Required by the Plan

Not applicable.

B. Reporting Requirements

Not applicable.

C. Manner of Collecting, Processing, Sequencing, Making Available and Disseminating Last Sale Information

Not applicable.

D. Manner of Consolidation

Not applicable.

E. Standards and Methods Ensuring Promptness, Accuracy and Completeness of Transaction Reports

Not applicable.

F. Rules and Procedures Addressed to Fraudulent or Manipulative Dissemination

Not applicable.

G. Terms of Access to Transaction Reports

Not applicable.

H. Identification of Marketplace of Execution

Not applicable.

III. Solicitation of Comments

The Commission seeks comments on the Amendments. Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed Amendments are 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–CTA/CQ–2019–03 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–CTA/CQ–2019–03. 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 website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all written statements with respect to the proposed Amendments that are filed with the Commission, and all written communications relating to the proposed Amendments 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 website viewing and printing at the principal office of the Plan. 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–CTA/CQ–2019–03 and should be submitted on or before December 12, 2019.

By the Commission.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25801 Filed 11–26–19; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87583; File No. SR–MSRB–2019–13]

Self-Regulatory Organizations; Municipal Securities Rulemaking Board; Notice of Filing of a Proposed Rule Change To Amend the Information Facility of the MSRB's Electronic Municipal Market Access (EMMA®) System

November 21, 2019.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'' or ''Exchange Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 19, 2019 the Municipal Securities Rulemaking Board (''MSRB'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the MSRB. 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 MSRB filed with the Commission a proposed rule change to amend the information facility of the MSRB's Electronic Municipal Market Access (EMMA®) system (the ''EMMA IF'') [3] to provide for (1) the automated calculation and static display of the number of days between (i) the annual fiscal period end date for an issuer [4] or obligated person [5] and (ii) the date an annual financial disclosure [6] is

[3] The EMMA IF serves to outline the basic functionality and the high-level parameters by which the MSRB operates the EMMA system. As further described in the EMMA IF, the EMMA system consists of the EMMA Primary Market Disclosure Service, the EMMA Continuing Disclosure Service, the EMMA Trade Price Transparency Service and the EMMA Short-Term Obligation Rate Transparency Service. *See* EMMA IF, available at: *http://www.msrb.org/Rules-and-Interpretations/MSRB-Rules/Facilities/EMMA-Facility.aspx.*

[4] Under 17 CFR 240.15c2–12 of the Exchange Act (''Rule 15c2–12'' or the ''Rule''), the Commission has generally defined the term ''issuer of municipal securities'' to mean any governmental issuer specified in section 3(a)(29) of the Act and the issuer of any separate security, including a separate security as defined in rule 3b–5(a) under the Act. *See* 17 CFR 240.15c2–12(f)(4). The proposed rule change uses the term issuer consistent with Rule 15c2–12(f)(4) to mean any such ''issuer of municipal securities'' submitting continuing disclosure documents and related information to the EMMA system, whether on a voluntary basis or pursuant to a contractual undertaking, such as a continuing disclosure agreement (as hereinafter defined in note 6 *infra*).

[5] Section 15B(e)(10) of the Act defines ''obligated person'' as ''any person, including an issuer of municipal securities, who is either generally or through an enterprise, fund, or account of such person, committed by contract or other arrangement to support the payment of all or part of the obligations on the municipal securities to be sold in an offering of municipal securities.'' 15 U.S.C. 78o–4(e)(10). As interpreted by the Commission in Rule 15c2–12(f)(10), the term ''obligated person'' means any person, including an issuer of municipal securities, who is either generally or through an enterprise, fund, or account of such person committed by contract or other arrangement to support payment of all, or part of the obligations on the municipal securities to be sold in the offering (other than providers of municipal bond insurance, letters of credit, or other liquidity facilities). *See* 17 CFR 240.15c2–12(f)(10). The proposed rule change uses the term obligated person consistent with Rule 15c2–12(f)(10) to mean any such ''obligated person'' submitting continuing disclosure documents and related information to the EMMA system, whether on a voluntary basis or pursuant to a contractual undertaking, such as a continuing disclosure agreement.

[6] Under Rule 15c2–12, a participating underwriter in an offering of certain municipal securities must determine that an issuer or obligated person has undertaken in a written agreement or contract for the benefit of holders of the municipal securities to provide certain information to the MSRB (a ''continuing disclosure agreement''), which includes a requirement, among others, to provide certain annual financial and operating information (*i.e.,* ''annual financial filings'') and audited financial statements (*i.e.,* ''audited financial filings''), if available (collectively, ''annual financial disclosures''). *See* 17 CFR 240.15c2–12(b)(5)(i).

submitted to the EMMA system for such annual fiscal period (the ''Submission Calculator'') and (2) the reconfiguration of certain information shown on the EMMA public website (*emma.msrb.org*) (the ''EMMA Portal'')[7] to more prominently display an issuer's or obligated person's annual financial disclosures and related information (the ''proposed rule change'').

The Board is proposing these amendments to the EMMA IF and corresponding enhancements to the EMMA system to promote greater transparency in the municipal securities market, including by making financial information more readily apparent to investors, market professionals, and the general public through the EMMA Portal. The Board believes the proposed rule change is consistent with the Act. By promoting greater transparency and awareness of the financial disclosures available in the municipal securities market, the Board believes the proposed rule change would promote (1) the protection of investors and the public interest and (2) the prevention of fraudulent and manipulative acts and practices. The Board has determined to file the proposed rule change under Section 19(b)(2) of the Act and requests that the proposed rule change become operative on a date to be determined by the MSRB through a notice published on its website not later than 180 days following the publication of the Commission's approval of the proposed rule change in the **Federal Register**, with such operative date being not more than one year from the date of such MSRB notice.

The text of the proposed rule change is available on the MSRB's website at *www.msrb.org/Rules-and-Interpretations/SEC-Filings/2019-Filings.aspx,* at the MSRB'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 MSRB 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 MSRB 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 proposed rule change consists of amendments to the EMMA IF that would provide for (1) the development and operation of the Submission Calculator and (2) the reconfiguration of certain information shown on the EMMA Portal, in order to more prominently display an issuer's or obligated person's annual financial disclosures and related information.

The Collection and Display of Financial Information on the EMMA Portal

The EMMA System and EMMA Portal. The EMMA system consists of several component functions that process and disseminate market information submitted to the MSRB. For example, the EMMA Trade Price Transparency Service publishes information on the EMMA Portal about trading activity in the municipal securities market when such information is reported by brokers, dealers, and municipal securities dealers (collectively, ''dealers'') in accordance with MSRB Rule G–14, on reports of sales or purchases. Similarly, the EMMA Primary Market Disclosure Service processes submissions of official statements, preliminary official statements, and related pre-sale documents for display on the EMMA Portal when such information is submitted voluntarily or in compliance with MSRB Rule G–32, on disclosures in connection with primary offerings. Consequently, issuers, obligated persons, dealers, investors, and the general public routinely interact with the EMMA system in order to submit or access information. The EMMA Portal averages more than 95,000 pageviews per day, which amounts to over 35 million pageviews in a full year. In this way, the EMMA Portal is relied upon as a free and credible source of market information and provides unprecedented transparency about the municipal securities market.[8]

Rule 15c2–12 and the EMMA Continuing Disclosure Service. A continuing disclosure agreement that is entered into consistent with the requirements of Rule 15c2–12 commits an issuer or obligated person to provide continuing disclosure documents in conformance with the process and other requirements prescribed by the MSRB, including the entry of certain identifying information.[9] The EMMA Continuing Disclosure Service is the component of the EMMA system authorized to receive, process, and disseminate continuing disclosure information submitted by issuers, obligated persons, and their agents (collectively, ''disclosure submitters'' or ''submitters'').[10] Upon receipt and processing, the EMMA Continuing Disclosure Service disseminates annual financial disclosures, event notices, and other disclosure documents on the EMMA Portal, making them publicly available at no cost. The EMMA system uses certain identifying information provided by submitters to electronically index and systematically display submissions, which allows external users to more readily find and access disclosure documents on the EMMA Portal.

Submission Process for Annual Financial Disclosures. In authorizing the EMMA Continuing Disclosure Service, the Commission granted authority to the MSRB to prescribe the identifying information collected by the EMMA system for purposes of sorting, categorizing, and retrieving continuing disclosure submissions.[11] When

[7] As further defined in the EMMA IF, the EMMA Portal is the functionality for displaying and otherwise making certain documents and data available to the public without charge.

[8] *See, e.g.,* Securities and Exchange Commission, Report on the Municipal Securities Market, at p. 35 (July 31, 2012) (''2012 Municipal Report'') (stating EMMA ''significantly improved the availability of both primary market and continuing disclosure documents to investors''), available at *https://www.sec.gov/news/studies/2012/munireport073112.pdf,* and Commissioner Michael S. Piwowar, Remarks at MSRB Dinner to Celebrate Milestones in Municipal Market Transparency (April 24, 2018) (stating EMMA has ''empowered investors with a level of transparency that was previously unknown in this market and has transformed the municipal securities industry''), available at *https://www.sec.gov/news/speech/speech-piwowar-20180424.*

[9] *See* 17 CFR 240.15c2–12(b)(5)(i); *see also* Release No. 34–59062 (December 5, 2008) 73 FR 76104 (December 15, 2008) (File No. S7–21–08) (the ''Sole Repository Release'') (''The final amendments require a Participating Underwriter to reasonably determine that the issuer or obligated person has agreed at the time of a primary offering: (1) To provide the continuing disclosure documents to the MSRB instead of to each NRMSIR and the appropriate SID, if any; and (2) to provide the continuing disclosure documents in an electronic format and accompanied by identifying information as prescribed by the MSRB.''). As further described herein, the EMMA system uses certain identifying information provided by a submitter to electronically index a disclosure document.

[10] *See* Release No. 34–59061 (December 5, 2008), 73 FR 75778 (December 12, 2008) (File No. SR–MSRB–2008–05) (December 8, 2008) (the ''Continuing Disclosure Service Release'') (establishing the EMMA Continuing Disclosure Service ''for the receipt of, and for making available to the public, continuing disclosure documents and related information to be submitted by issuers, obligated persons and their agents pursuant to continuing disclosure undertakings entered into consistent with Rule 15c2–12'').

[11] *See* 17 CFR 240.15c2–12(b)(5)(i). *See also* the Sole Repository Release, *supra* note 9, 73 FR at

Continued

receiving the submission of an annual financial disclosure, the MSRB generally requires [12] disclosure submitters to enter the following information:

• *Disclosure Category.* Submitters identify the appropriate indexing category for the annual financial disclosure (the ''disclosure category'') as being an annual financial filing and/or audited financial filing.[13]

• *Brief Content Description.* Submitters may provide a brief description of the content of the annual financial filing and/or audited financial filing.

• *Fiscal Period Covered.* Submitters enter the annual fiscal period covered by the annual financial disclosure in the date field, including a fiscal year end date (the ''Fiscal Period End Date'').[14]

Once published by a disclosure submitter, the EMMA Continuing Disclosure Service (1) timestamps the annual financial disclosure to register the time and date of the submission of the annual financial disclosure to the EMMA system (the ''Posted Date''), (2) processes the information entered by a submitter to classify and index the annual financial disclosure on the EMMA Portal, and (3) disseminates the annual financial disclosure document and related information, such as the fiscal period information, on the EMMA Portal, making the annual financial disclosure and related information publicly available at no cost.

Concerns Regarding the Timeliness of Annual Financial Disclosures

The timeliness of financial disclosures is often cited as an important factor in their usefulness to investors and other market participants, and the subject of how to improve the timeliness of financial disclosures in the municipal securities market has been, and continues to be, a significant concern of the Commission and various market participants.[15]

The Commission's 1994 Interpretive Release and Rule Amendments. The Commission has emphasized the importance of timely disclosure for decades. As early as its 1994 interpretive release regarding the disclosure obligations of municipal security issuers and others, the Commission stated that, ''[t]o avoid providing investors with a stale, and therefore potentially misleading, picture of financial condition and results of operations, issuers and obligors need to release their annual financial statements as soon as practical.'' [16] Later in the same year when it amended Rule 15c2–12 to require continuing disclosure agreements to thereafter incorporate provisions regarding annual financial disclosures and certain event notices, the Commission further highlighted the importance of financial information in the secondary market, declaring that ''purchasers in the secondary market need the same level of financial information and operating data in making investment decisions as purchasers in the underwritten offering.'' [17]

The Commission's 2012 Municipal Report. Building on its prior statements, the Commission's 2012 Municipal Report affirmed that, ''[t]imely financial reporting, including timely issuance of audited annual financial information, not only aids market participants in making informed investment decisions, but is critical to the function of an efficient trading market.'' [18] Citing comments from market participants, the 2012 Municipal Report concluded that, ''[t]he major challenge in the secondary market disclosure, according to market participants, is the timeliness and completeness of filings as well as compliance with continuing disclosure agreements.'' The report also noted certain concerns raised by municipal issuers about the burden of increased regulation,[19] including the concern that mandating a specific timeframe for the dissemination of financial information may not be feasible for the municipal market.[20] In acknowledgment of the limitations on the regulation of municipal issuers under the existing regulatory scheme, the 2012 Municipal Report made a series of recommendations involving ''a combination of approaches, including legislative, regulatory and industry-based initiatives.'' [21] One of those recommendations included the enhancement of the EMMA system, so that ''retail investors have better access to disclosure with respect to municipal securities as soon as practicable.'' [22]

76114 (''We [*i.e.,* the SEC] believe that providing identifying information with each submitted document will permit the repository to sort and categorize the document efficiently and accurately. We also anticipate that the inclusion with each submission of the basic information needed to accurately identify the document will facilitate the ability of investors, market participants, and others to reliably search for and locate relevant disclosure documents.'') and the Continuing Disclosure Service Release, *supra* note 10, 73 FR at 75781, fn. 48 (stating ''the commitment by an issuer to provide identifying information exists only if it were included in a continuing disclosure agreement. As a result, issuers submitting continuing disclosure documents pursuant to the terms of undertakings that were entered into prior to the effective date of [the amendments to the Rule effectuated by the Sole Repository Release] and that did not require identifying information will be able to submit documents without supplying identifying information.'')

[12] As noted in the Continuing Disclosure Service Release, a continuing disclosure agreement specifies whether an issuer or obligated persons must provide identifying information. As a result, issuers and obligated persons submitting continuing disclosure documents pursuant to the terms of certain continuing disclosure agreements—*i.e.,* agreements entered into prior to the effective date of the Commission's 2008 amendments to the Rule that did not require identifying information—are permitted to submit documents without supplying such identifying information. *See* Continuing Disclosure Release, *supra* note 10, at 73 FR 75781, fn. 48.

[13] Disclosure submitters select the ''Annual Financial Information and Operating Data (Rule 15c2–12)'' disclosure category field for an annual financial filing and/or the ''Audited Financial Statements or CAFR (Rule 15c2–12)'' disclosure category field for an audited financial filing.

[14] The EMMA Dataport Manual for Continuing Disclosure Submissions provides instructions and other information for issuers, obligated persons, dealers, municipal advisors, or staff of any other organization submitting to the EMMA Continuing Disclosure Service via the EMMA Dataport web user interface. The manual is published on the MSRB's website and is available at: *http://www.msrb.org/~/media/pdfs/msrb1/EMMA/pdfs/EMMACDManual.ashx?la=en.*

[15] *See, e.g.,* 2012 Municipal Report, *supra* note 8 at p. 74 (citing Release No. 34–33741, ''Statement of the Commission Regarding Disclosure Obligations of Municipal Securities Issuers and Others'' (March 9, 1994), 59 FR 12748 (March 9, 1994)).

[16] Release No. 34–33741, ''Statement of the Commission Regarding Disclosure Obligations of Municipal Securities Issuers and Others'' (March 9, 1994), 59 FR 12748, at 12753 (March 9, 1994) (File No. S7–4–94).

[17] Release No. 34–34961 (November 10, 1994), 59 FR 59950 (November 17, 1994) (File No. S7–5–94).

[18] 2012 Municipal Report, *supra* note 8, at p. 74.

[19] *Id.,* at p. iv (''the Report notes concerns raised by issuers about potential burdens that could result from increased regulation.'')

[20] *Id.,* at p. 80 (citing to the concerns of issuer representatives at certain hearings regarding ''the necessity, or even feasibility, of a mandated shorter timeframe for the dissemination of financial information'' and the possibility that ''shorter deadlines could diminish the value of financial information'' by causing governments to adopt a ''reduced set of basic financial statements'').

[21] *Id.,* at p. vii (''First, in light of the Commission's limited regulatory authority, we recommend a number of potential legislative changes which, if implemented by Congress, would provide the Commission with additional authority to initiate changes to improve municipal securities disclosures made by issuers. The legislative changes would not result, however, in the repeal or modification to the existing proscriptions on the SEC or the MSRB requiring any presale filing of disclosure documents, known as the 'Tower Amendment' (discussed in more detail in the Report). The legislative recommendations would nonetheless give the Commission the authority to take regulatory steps that it determines to be appropriate to meaningfully enhance disclosure practices by municipal issuers, which could be accomplished in a short period of time.'')

[22] *Id.,* at p. 141; *see also* Recommendation of Market Structure Subcommittee of IAC [*i.e.,* the Commission's Investor Advisory Committee], Select Enhancements to Protect Retail Investors in Municipal and Corporate Bonds, July 5, 2018, available at *https://www.sec.gov/spotlight/investor-advisory-committee-2012/iac061418-market-structure-subcommittee-recommendation.pdf* (recommending the MSRB enhance the EMMA Portal to highlight to ''investors, when they reach

Recent Commission Statements. Echoing the language of the 2012 Municipal Report, SEC Chairman Jay Clayton stated in December 2018 that, ''[t]imely and accurate information is essential for investors and analysts. Without that, it is challenging to accurately evaluate the current financial condition of a municipal issuer (or any issuer for that matter).'' [23] In the same speech, Chairman Clayton tasked the Commission's Office of Municipal Securities to work with the MSRB and other stakeholders to explore potential approaches to improve transparency around the age and type of financial information.[24] Reiterating his thoughts more recently, Chairman Clayton stated in July 2019 that ''the timeliness of municipal issuer financial reporting . . . can and should be improved.'' [25]

NFMA Letter to the Board. In May 2019, the Board received a letter from the National Federation of Municipal Analysts (NFMA) that expressed concerns regarding the timing of financial information in the municipal securities market. The letter asserted that ''[u]sers of EMMA do not have an easy way to determine the currency of financial reporting by an issuer'' and encouraged the Board to ''create a counter that would calculate and prominently display the greater of the number of days since the end of the last fiscal year to the audit filing date or the number of days since the last fiscal year for which there is not a submitted audit.'' [26]

The Board has developed the proposed rule change cognizant of the historical evolution of disclosure practices in the municipal securities market [27] and the present concerns of certain market participants regarding the timing of financial disclosures in the municipal securities market.[28] The Board believes the proposed rule change would further promote transparency and efficiency in the municipal securities market—primarily by making information about the timing of annual financial disclosures more prominent on the EMMA Portal, so that market participants can make more informed decisions—without imposing significant additional burdens on dealers, municipal issuers, or obligated persons.

The Submission Calculator and Illustrative Examples

The Board believes that the Submission Calculator would provide an important transparency tool for market participants that would make information reported to the EMMA system regarding the timing of annual financial disclosures more readily apparent. As discussed above, the Submission Calculator would automatically calculate and statically display the elapsed number of days between (1) the Fiscal Period End Date for an issuer or obligated person, as such date is entered by a submitter through the process of publishing an annual financial disclosure on the EMMA Portal, and (2) the Posted Date of an annual financial disclosure submitted to the EMMA system for such annual fiscal period.[29] The Submission Calculator would depend on the existing information required to be provided by a submitter, calculating the number of days elapsed based solely on the entry of the Fiscal Period End Date and the Posted Date for an annual financial disclosure.[30] The day of the Posted Date would be included in the calculation, as further demonstrated below.[31] This number of days elapsed would be displayed on the EMMA Portal at the individual security details level.[32] Importantly, the MSRB would not evaluate the substantive content of the documents and information submitted, and the Submission Calculator would not analyze the relevant content to evaluate an issuer's or obligated person's compliance with the terms of an applicable continuing disclosure agreement or any applicable law, regulation, or other legal obligation.[33]

The following are illustrative examples of the submission process and resulting calculations of the Submission Calculator.

an obligor's landing page, if the obligor is out of compliance with its continuing disclosure requirements as it relates to financial reporting'').

[23] *See* Chairman Jay Clayton, Opening Remarks at the Municipal Securities Conference, December 6, 2018, available at *https://www.sec.gov/news/public-statement/statement-clayton-120618.*

[24] *Id* (''To be clear: I believe that there are potential steps that the SEC and the MSRB can take—that would be wholly consistent with the words and spirit of the Tower Amendment—to improve transparency around the age and type of financial information.'').

[25] *See* Chairman Jay Clayton, Remarks to the SEC Fixed Income Market Structure Advisory Committee, July 29, 2019, available at *https://www.sec.gov//public-statement/clayton-remarks-fimsac-072919#_ftn1.*

[26] Letter from Scott Andreson, Chair, National Federation of Municipal Analysts (NFMA), dated May 3, 2019 (the ''NFMA Letter''), available at *https://www.nfma.org/assets/documents/position.stmt/nfmaLetterSECMSRBmay3.pdf* (last accessed on October 15, 2019).

[27] In February 2017, the MSRB published a report analyzing the timing of the submission of annual financial disclosures to the EMMA system between the years 2010 and 2016. *See* MSRB: Timing of Annual Financial Disclosures by Issuers of Municipal Securities (February 2017), available at *http://www.msrb.org/msrb1/pdfs/MSRB-CD-Timing-of-Annual-Financial-Disclosures-2016.pdf.* The Government Accounting Standards Board (GASB) assessed the timeliness of audited annual financial reports in a 2018 research memorandum measuring the number of days to the release of audited annual financial reports broken down by various factors such as size and type of government. *See* GASB, *Research Memorandum: Timeliness of Financial Reporting* (December 12, 2018), available at *https://www.gasb.org/cs/ContentServer?c=Document_C&cid=1176171975910&d=&pagename=GASB%2FDocument_C%2FDocumentPage* (last accessed on October 15, 2019).

[28] The Board is also aware that the Government Finance Officers Association (GFOA) has announced an industry working group to address timely and meaningful disclosures. *See* GFOA, Weekly Members News, GFOA Launches Industry Working Group on Municipal Bond Disclosure (July 25, 2019), available at *http://www.estoregfoa.org/StaticContent/staticpages/NL07252019.html* (last accessed on October 15, 2019); *see also* Sarah Wynn, *New GFOA working group to address timely disclosure,* The Bond Buyer (July 26, 2019), available at *https://www.bondbuyer.com/news/new-gfoa-working-group-to-address-timely-disclosure* (last accessed on October 15, 2019).

[29] Both dates are currently visible on the EMMA Portal.

[30] Consistent with its current functionality, the EMMA system would continue to intake, display, and disseminate annual financial disclosures and related information. The EMMA system would continue to conduct format checks, validate the submitter, and timestamp annual financial disclosures with a Posted Date; however, there would not be an evaluative analysis of the documents or information submitted, nor a validation of the disclosure categories selected by the submitter (*e.g.,* ''Other Financial/Operating Data'' is erroneously selected rather than ''Annual Financial Information and Operating Data (Rule 15c2–12)'' or ''Audited Financial Statements or CAFR (Rule 15c2–12)''). Nevertheless, the submission calculator would show as not applicable upon the entry of erroneous information that would result in negative calculations and, in the future, the EMMA system may provide soft data checks requesting submitters to confirm entries that are likely erroneous. *See* Release No. 34–84837 (December 17, 2018), 83 FR 65765, at 65767 (November 21, 2018) (File No. SR–MSRB–2018–09) (describing the ''ministerial'' functioning of the EMMA system). Accordingly, the submitter would remain responsible for the content of the documents and information submitted to the EMMA system related to an annual financial disclosure, including the proper disclosure category (or categories) of an annual financial disclosure. Moreover, as the resulting calculation performed by the Submission Calculator would depend on this information, it is imperative that disclosure submitters make accurate and complete submissions.

[31] Stated differently, the Posted Date would *not* count as an additional full day toward the Submission Calculator's count total. For illustrative purposes, if an issuer submitted an annual financial disclosure on the same day as the date of the end of its annual fiscal period, the Submission Calculator would display zero days as the timing of such annual financial disclosure. If an issuer submitted an annual financial disclosure on the day following the date of the end of its annual fiscal period, the Submission Calculator would display one day as the timing of such annual financial disclosure, and so on.

[32] The EMMA Portal's security details pages enable users to access documents and information associated with a particular municipal security, such as an official statement, continuing disclosure document, and/or trade report.

[33] Consistent with the EMMA system's current functionality, if a submitter enters an erroneous Fiscal Period End Date for an annual financial disclosure, then the Submission Calculator would perform its calculation based on the erroneous Fiscal Period End Date entered by the submitter. *See also* note 30.

• *Example One—Single Submission.* An issuer submits its audited financial statements to the EMMA system on December 23, 2020 and identifies [34] (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing [35] and (2) the Fiscal Period End Date for the annual financial disclosure as June 30, 2020. The Submission Calculator would display the number of days between the Posted Date for the issuer's annual financial disclosure and the Fiscal Period End Date of the issuer's 2020 annual fiscal period as 176 days.[36]

Example Two—Second Year Submission. An issuer submits its audited financial statements to the EMMA system on December 23, 2020 and identifies (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing and (2) the Fiscal Period End Date for the annual financial disclosure as June 30, 2020. The Submission Calculator would display the number of days between the Posted Date for the issuer's latest annual financial disclosure and the Fiscal Period End Date of the issuer's 2020 annual fiscal period as 176 days. Subsequently, the issuer's next annual fiscal period ends on June 30, 2021. On January 4, 2022, the issuer submits its audited financial statements to the EMMA system for its annual fiscal period ending on June 30, 2021. The issuer identifies (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing and (2) the Fiscal Period End Date for the annual financial disclosure as June 30, 2021. Upon processing of the subsequent submission, the Submission Calculator would refresh to display the number of days between the Posted Date for the issuer's latest annual financial disclosure and the Fiscal Period End Date of the issuer's 2021 annual fiscal period as 188 days.[37]

• *Example Three—Annual Financial Disclosures through Sequential Submissions for the Same Fiscal Period.* An issuer submits its annual financial information and operating data, which does not include the issuer's audited financial statements, to the EMMA system on December 23, 2020. The issuer identifies (1) the annual financial disclosure as meeting the disclosure category of an annual financial filing and (2) the Fiscal Period End Date for the annual financial disclosure as June 30, 2020. The Submission Calculator would display the number of days between the Posted Date for the issuer's annual financial disclosure and the Fiscal Period End Date of the issuer's 2020 fiscal period as 176 days. Subsequently, the issuer submits its audited financial statements on January 4, 2021 for the same annual fiscal period and identifies (1) the annual financial disclosure as meeting the disclosure category of an audited financial filing and (2) the Fiscal Period End Date as June 30, 2020. The Submission Calculator would continue to display the number of days between the Posted Date for the issuer's annual financial disclosure and the Fiscal Period End Date of the issuer's 2020 annual fiscal period as 176 days, because the Submission Calculator would generate its calculation from the earlier Posted Date for the submission of the unaudited financial information and operating data.[38]

• *Example Four—Annual Financial Disclosures with Sequential Submissions for Issues with Multiple Obligated Persons with Different Fiscal Periods.* An obligated person for an issue of municipal securities (''Obligated Person One'') submits its audited financial statements as an annual financial disclosure for an issue of municipal securities on December 23, 2020. Obligated Person One identifies (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing and (2) its Fiscal Period End Date as June 30, 2020. The Submission Calculator would display the number of days between the Posted Date of the issue's annual financial disclosure and the Fiscal Period End Date of Obligated Person One's 2020 annual fiscal period as 176 days.

Subsequently, another obligated person for the same issue of municipal securities (''Obligated Person Two'') submits its audited financial statements as an annual financial disclosure for the issue on January 4, 2021. Obligated Person Two identifies (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing and (2) its Fiscal Period End Date as June 30, 2020. The Submission Calculator would not refresh and continue to display the number of days between the Posted Date of the issue's prior annual financial disclosure submitted by Obligated Person One and the Fiscal Period End Date of Obligated Person One's 2020 annual fiscal period as 176 days, because the Submission Calculator would perform its calculation based on the earliest Posted Date for an annual financial disclosure with the most recent Fiscal Period End Date.

Subsequently, a third obligated person for the same issue of municipal securities (''Obligated Person Three'') submits its audited financial statements as an annual financial disclosure for the issue on January 5, 2021. Obligated Person Three identifies (1) the annual financial disclosure as meeting both disclosure categories of an audited financial filing and annual financial filing and (2) its Fiscal Period End Date as July 31, 2020. Upon processing, the Submission Calculator would refresh to display the number of days between the Posted Date of the issue's annual financial disclosure submitted by Obligated Person Three and the Fiscal Period End Date of Obligated Person Three's 2020 annual fiscal period as 158

[34] A submitter would need to select the appropriate disclosure category (or disclosure categories) applicable to the submission of an annual financial disclosure for the Submission Calculator to perform its calculation. For example, if the submitter in this fact pattern only identified the submission as falling within the disclosure category of ''Other,'' then the Submission Calculator would not have the necessary information to perform or display its calculation. In these circumstances, the Submission Calculator would display as not applicable on the EMMA Portal for the relevant securities until such time as the issuer submits a disclosure selected as meeting the disclosure category of an annual financial disclosure with a Fiscal Period End Date.

[35] Submitters may select multiple disclosure categories for a continuing disclosure filing, including an annual financial disclosure. The fields currently entitled ''Annual Financial Information and Operating Data (Rule 15c2–12)'' and ''Audited Financial Information Statements or CAFR (Rule 15c2–12)'' are respectively intended for the submission of annual financial filings and audited financial filings.

[36] The Submission Calculator would display the calculation available for the annual financial disclosure with the earliest Posted Date for the most recent Fiscal Period End Date. The results of a Submission Calculator would show as not applicable on the EMMA Portal for securities that do not yet have a published annual financial disclosure submission.

[37] The Submission Calculator would continue to reflect its calculation for the most recent annual fiscal period until such time as a submitter publishes a new annual financial disclosure for a subsequent fiscal period, as identified by the Fiscal Period End Date entered by a submitter. Upon the processing of a new annual financial disclosure for a subsequent fiscal period, the EMMA system would no longer display the prior calculation for the preceding annual fiscal period. Using the facts of this example to illustrate this point, the Submission Calculator would continue to display the number of days between the issuer's latest annual financial disclosure and the end of its 2020 annual fiscal period as 176 days until the second submission is submitted and processed on January 4, 2022, at which time the Submission Calculator would then display the number of days between the issuer's latest annual financial disclosure and the Fiscal Period End Date of its 2021 annual fiscal period as 188 days.

[38] The Submission Calculator would apply similar logic in other fact patterns where annual financial disclosures are published to the EMMA system in a piecemeal method, as through multiple submissions on different dates. *See* Example Four.

days, because the Submission Calculator would perform its calculation based on the Posted Date for Obligated Person Three's annual financial disclosure, which has the most recent Fiscal Period End Date.

Enhancement of the EMMA Display

In addition to providing for the development and operation of the Submission Calculator, the proposed rule change would also provide for the enhancement and reconfiguration of certain information shown on the EMMA Portal to more prominently display an issuer's or obligated person's annual financial disclosures and related information. More specifically, the revised EMMA Portal would more prominently display the information reported about an annual financial disclosure for a municipal security, including the Fiscal Period End Date, the Posted Date, and the results of the Submission Calculator. The MSRB would also increase the prominence of the links provided by any issuer through its customized homepage to other websites containing relevant information.[39] With these enhancements to the EMMA Portal and the implementation of the Submission Calculator, the security details page for a municipal security generally would provide the information shown in *Figure 1* below, which is shown as processed with the hypothetical facts and resulting calculation from ''*Example One—Single Submission*'' above.

FIGURE 1

Timing of Annual Financial Disclosure
Fiscal Period End Date: 06/30/2020.
Posted Date: 12/23/2020.
Timing of Disclosure: 176 Days.
Hyperlink to Disclosure Document PDF(s).
Hyperlink(s) to Other Website(s) if Provided.

While each of these data points, other than the Submission Calculator results shown as the Timing of Disclosure in *Figure 1,* are currently available on the EMMA Portal, the proposed rule change is intended to improve users' awareness of this information. Nothing about this display would be evaluative of an issuer's or obligated person's compliance with the applicable terms of a continuing disclosure agreement. The proposed rule change would not modify how submitters provide this information to the EMMA system, nor require submitters to input any new data, but it would augment the display of information reported to the EMMA system to make it more apparent to users.

Discussion of Proposed Amendments to the Text of the EMMA IF

The proposed rule change would amend the text of the EMMA IF to provide for the development and otherwise describe the operation of the Submission Calculator. More specifically, the proposed rule change would amend the EMMA IF to define the term ''EMMA metrics'' to mean the calculations, data, and metrics derived from municipal securities disclosure documents and related information submitted to the EMMA system. In this way, the calculations, data, and metrics generated by the Submission Calculator would be included in the term ''EMMA metrics.'' This definition is intended to provide greater clarity regarding the various types of information that may be disseminated by the EMMA system in light of the Submission Calculator's new functionality,[40] including more precisely delineating the distinctions between disclosure documents, related information, indexing information, and EMMA metrics.[41]

2. Statutory Basis

The proposed rule change is consistent with the provisions of Section 15B(b)(2)(C) of the Act,[42] which provides that the MSRB's rules shall:

> . . . be 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 regulating, clearing, settling, processing information with respect to, and facilitating transactions in municipal securities and municipal financial products, to remove impediments to and perfect the mechanism of a free and open market in municipal securities and municipal financial products, and, in general, to protect investors, municipal entities, obligated persons, and the public interest.

The Board believes the proposed rule change is consistent with the Act because the proposed rule change would promote (1) the protection of investors and the public interest and (2) the prevention of fraudulent and manipulative acts and practices, principally by promoting greater transparency and awareness of the financial disclosures available in the municipal securities market through the EMMA Portal. The proposed rule change would promote the protection of investors and the public interest by increasing investors' and the general public's awareness of the type and timing of financial information available in the municipal securities market and, consequently, enable investors and other market participants to make more informed decisions. More broadly, the proposed rule change would enable the general public to more readily access the financial information reported to the EMMA Portal. The proposed rule change would promote the prevention of fraudulent and manipulative acts and practices by fostering a better understanding among all market participants of the type and timing of financial information available in the municipal securities market, including by making the type and timing of financial information more readily apparent on the EMMA Portal, and, thereby, mitigating some information asymmetries that may exist in the market, such as between retail investors and institutional investors. In short, the Board believes that the proposed rule change is consistent with the Act because it would enhance market transparency regarding existing municipal issuer financial disclosure practices, including by improving the accessibility and availability of information displayed on the EMMA Portal and by making the Submission Calculator results readily apparent to EMMA users.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Board has conducted an analysis on the proposed rule change to gauge its overall economic impact and assess its burden on competition.[43] For the

[39] The EMMA system allows issuers to enhance the display of their municipal securities information on EMMA Portal by creating a free custom EMMA issuer homepage. One of the customizations supported is the ability for an issuer to designate links to independent websites. *See* the MSRB's Customizing an EMMA® Issuer Homepage, available at *http://www.msrb.org/msrb1/EMMA/pdfs/EMMA-Issuer-Homepage-Fact-Sheet-for-Issuers.pdf.*

[40] Assuming approval of the proposed rule change, on the operative date the EMMA system would only process the EMMA metrics generated by the Submission Calculator for dissemination and display on EMMA Portal.

[41] For example, the proposed rule change more precisely articulates that the term 'indexing information' is a subset of 'related information' that includes the disclosure category fields of ''Annual Financial Information and Operating Data (Rule 15c2–12)'' and the ''Audited Financial Statements or CAFR (Rule 15c2–12)'' for purposes of the Submission Calculator's functionality. This clarification is important to delineate the Submission Calculator's use of indexing information as entered by a submitter from the EMMA metrics generated by the Submission Calculator.

[42] 15 U.S.C. 78*o*–4(b)(2)(C).

[43] *See* ''Policy on the Use of Economic Analysis in MSRB Rulemaking,'' available at *http://msrb.org/Rules-and-Interpretations/Economic-Analysis-Policy.aspx.* In evaluating the potential burden on competition, the Board was guided by its principles that require the Board to consider costs and benefits of a rule change, its impact on capital formation,

Continued

reasons discussed below, the Board has determined that the proposed rule change would not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Exchange Act.

The Board's Determinations Regarding the Burden on Competition

Section 15B(b)(2)(C)[44] of the Exchange Act requires that MSRB rules shall ''not be designed . . . to impose any burden on competition not necessary or appropriate in furtherance of the purposes of this title.'' The Board believes the proposed rule change is consistent with Section 15B(b)(2)(C)[45] because the proposed rule change promotes transparency in the municipal securities market by (1) calculating and clearly displaying the timing between an issuer's or obligated person's reported Fiscal Period End Date and the Posted Date for the submission of certain of its annual financial disclosures and (2) making existing information about annual financial disclosures more readily apparent on the EMMA Portal. Consequently, the Board believes the proposed rule change would improve the awareness and understanding of market participants regarding the type and timing of financial information currently available on the EMMA Portal. Investors and other market participants would benefit from these enhancements by being able to more readily locate relevant financial information and, thereby, the proposed rule change would improve overall transparency in the market. Similarly, the calculations displayed by the Submission Calculator would assist investors in their analysis of a municipal security's financial information by clearly and prominently displaying a metric for the standardized measure of the timing of that information.[46]

Burdens on Disclosure Submitters. The Board believes that the proposed rule change does not create any new compliance or reporting burdens and, thereby, does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Exchange Act. While the information provided to the EMMA Portal by submitters might take on new prominence by virtue of the manner in which the information would be displayed on the EMMA Portal under the proposed rule change, the proposed enhancements would not alter the basic process for submitting annual financial disclosures or change the type of information collected related to such disclosures.[47] Accordingly, the proposed rule change would not alter the burdens on submitters in publishing annual financial disclosures to the EMMA system in this way, and so does not result in any new burdens on competition in this regard.

Improvement to Market Transparency. The Board believes that the proposed rule change would increase the accessibility and understanding of financial disclosures in the municipal securities market and, thereby, increase overall transparency in the market. The Submission Calculator would depend entirely on the information entered by a submitter, and the Board is cognizant of the potential for the Submission Calculator to result in the display of a calculation generated from erroneous information published by a submitter. To the degree that the Submission Calculator would provide new prominence to this information, the Board believes that submitters would have an additional incentive to properly categorize and describe annual financial disclosures, and so the incidences of submissions with erroneous information would be expected to marginally decline from current rates.[48] To promote accuracy, the Board would continue to provide educational resources and other tools to assist submitters in properly completing the publication process. Similarly, the Board believes that some of the misperceptions and other information asymmetry that may result from market participants accessing erroneous information published by submitters can be mitigated through appropriate investor education. Consequently, the Board believes at this time that the benefits of the additional awareness and understanding that would result from the adoption of the Submission Calculator would exceed any potential negative consequences of the display of a calculation generated from erroneous information published by a submitter.

The Board's Analysis of Alternatives to the Proposed Rule Change

The Board has assessed alternative approaches to the proposed rule change and has determined that the Submission Calculator and other enhancements to the EMMA Portal are superior to these alternatives.

Alternative Transparency Tools. The Board has considered various iterations of the Submission Calculator for the calculation and display of information regarding the timing of financial disclosures, including various active counters that would sequentially increase each day. One such alternative is a counter that would update each day to dynamically display the number of days elapsed between an issuer's or obligated person's annual fiscal period end and the current date. Similarly, the Board has considered a counter that would dynamically display the number of days elapsing between any financial disclosures submitted by an issuer or obligated person, including interim financial information, rather than just annual financial disclosures.

The Board has determined at this time that such alternatives would be inferior to the proposed rule change's Submission Calculator. In evaluating these alternative approaches, the Board determined that (1) limiting the Submission Calculator to evaluating the timing of annual financial disclosures was most appropriate at this time, particularly in light of the lack of uniformity in the disclosure of interim financial information, and (2) displaying a static calculation would be most easily understood by EMMA users and, thereby, the Submission Calculator would best promote market transparency at this time. Among other considerations, the Board evaluated whether dynamic tools might confuse some users who repeatedly return to the

and the main reasonable alternative regulatory approaches.

[44] 15 U.S.C. 78*o*–4(b)(2)(C).

[45] *Id.*

[46] Recent economic literature bolsters the statements of market participants that the timing of financial disclosures is a significant factor in their usefulness. Specifically, academic research finds that a delay in reporting is likely to convey a negative signal with respect to issuers and have negative effects on the capital markets, such as higher yield and lower liquidity. *See* Henke, Trent S. and John J. Maher, ''Government Reporting Timeliness and Municipal Credit Market Implications,'' Journal of Governmental & Nonprofit Accounting, Vol. 5, No. 1, 2016, and Sherrill, D. Eli and Rustin T. Yerkes, ''Municipal Disclosure Timeliness and the Cost of Debt,'' The Financial Review, 53, 2018. At the same time, the MSRB notes that timing may be one among many significant factors in the usefulness of a financial disclosure, as for example the timing of a disclosure generally does not speak to the quality or completeness of a disclosure's contents.

[47] While the proposed enhancements would not alter the basic process for submitting such information or change the type of information collected, the MSRB is continually evaluating how user's interface with the EMMA system and has ongoing projects to improve that interface. *See, e.g.,* ''MSRB Improves Search Functionality on EMMA'' (May 29, 2019), available at *http://www.msrb.org/News-and-Events/Press-Releases/2019/MSRB-Launches-Quick-Search.aspx.*

[48] To the degree that submitters exert greater diligence in completing the disclosure submission process in response to the Submission Calculator's functionality and the other enhancements to the display of information on the EMMA Portal, the MSRB believes that any additional burdens created by this change in market behavior is exceeded by the benefits of greater market transparency through the improved availability and understanding of market information currently displayed on the EMMA Portal.

EMMA Portal and misunderstand the increasing display count. Additionally, the Board considered concerns that, at this time, other approaches with more complex functionality may require significant alterations to the submission process and/or require disclosure submitters to provide additional information to the EMMA system. Accordingly, the Board has determined that, at this time, alternatives that would create new burdens on disclosure submitters would be inferior to the Submission Calculator.

Rulemaking Alternatives. The Board has also considered new rulemaking initiatives as an alternative to the proposed rule change. The Board ultimately determined that the MSRB should focus at this time on the proposed rule change's transparency efforts to more prominently display existing financial information on the EMMA Portal and should consider any related rulemaking initiatives in light of the MSRB's ongoing retrospective rule review.[49]

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Board did not solicit written comments on the proposed change. However, as previously noted above, the Board did receive one written comment directly relevant to the proposed rule change from NFMA in May 2019.[50] Among other recommendations on how to improve disclosure practices in the municipal securities market, the NFMA Letter encouraged the MSRB to modernize the EMMA system, including to provide greater transparency on the currency of audit filings.[51] More specifically, NFMA encouraged the MSRB to ''create a counter that would calculate and prominently display the greater of the number of days since the end of the last fiscal year to the audit filing date or the number of days since the last fiscal year for which there is not a submitted audit.'' [52] While the proposed rule change would not incorporate such a dynamic counter,[53] the MSRB believes that the Submission Calculator and other enhancements to the EMMA system are responsive to this particular recommendation.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 45 days of the date of publication of this notice in the **Federal Register** or within such longer period of up to 90 days (i) as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve or disapprove such proposed rule change, or

(B) institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, 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–MSRB–2019–13 on the subject line.

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–MSRB–2019–13. 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 MSRB. 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–MSRB–2019–13 and should be submitted on or before December 18, 2019.

For the Commission, pursuant to delegated authority.[54]

Eduardo Aleman,

Deputy Secretary.

[FR Doc. 2019–25707 Filed 11–26–19; 8:45 am]

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[49] The Board recently prioritized an ongoing effort to review the MSRB's rules and related interpretive guidance for dealers and municipal advisors. The purpose of the retrospective rule review is to help ensure MSRB rules and interpretive guidance are effective in their principal goal of protecting investors, issuers and the public interest; not overly burdensome; clear; harmonized with the rules of other regulators, as appropriate; and reflective of current market practices. Among other criteria, retrospective rulemaking priorities are evaluated based on whether the benefits of the rule are commensurate with its burdens. *See http://www.msrb.org/Rules-and-Interpretations/Retrospective-Rule-Review-Overview.aspx.*

[50] *See* NFMA Letter, *supra* note 26.

[51] *Id.,* at p. 4.

[52] *Id.*

[53] The Board did not incorporate this aspect of NFMA's recommendation into the proposed rule change because the Board determined at this time that such a dynamic counter would be inferior to the Submission Calculator, in that the non-static functionality of the dynamic counter might counterproductively confuse some users who repeatedly return to the EMMA Portal and misunderstand the dynamic nature of the increasing display count, among other reasons. *See* related discussion under *The Board's Analysis of Alternatives to the Proposed Rule Change.*

[54] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87598; File No. 4–518]

Joint Industry Plan; Notice of Filing and Immediate Effectiveness of Amendment to the Plan Establishing Procedures Under Rule 605 of Regulation NMS To Add the Long Term Stock Exchange, Inc. as a Participant

November 22, 2019.

Pursuant to Section 11A(a)(3) of the Securities Exchange Act of 1934 (''Exchange Act'') [1] and Rule 608 thereunder,[2] notice is hereby given that on October 18, 2019, Long Term Stock Exchange, Inc. (''LTSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') [3] an amendment to the national market system plan establishing procedures under Rule 605 of Regulation NMS

[1] 15 U.S.C 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] *See* Letter from Howard Steinberg, Chief Regulatory Officer, Long Term Stock Exchange, Inc., to Vanessa Countryman, Secretary, Commission, dated July 2, 2019.

(''Plan'').[4] The amendment adds LTSE as a Participant [5] to the Plan. The Commission is publishing this notice to solicit comments on the amendment from interested persons.

I. Description and Purpose of the Plan Amendment

As noted above, the sole proposed amendment to the Plan is to add the Exchange as a Participant. On May 10, 2019, the Commission issued an order granting LTSE's application for registration as a national securities exchange.[6] A condition of the Commission's approval was the requirement for LTSE to join the Plan.

Under Section II(c) of the Plan, any entity registered as a national securities exchange or national securities association under the Exchange Act may become a Participant by: (i) Executing a copy of the Plan, as then in effect; (ii) providing each then-current Participant with a copy of such executed Plan; and (iii) effecting an amendment to the Plan as specified in Section III(b) of the Plan. Section III(b) of the Plan sets forth the process for a prospective new Participant to effect an amendment of the Plan. Specifically, the Plan provides that such an amendment to the Plan may be effected by the new national securities exchange or national securities association by executing a copy of the Plan, as then in effect (with the only changes being the addition of the new Participant's name in Section II(a) of the Plan and the new Participant's single-digit code in Section VI(a)(1) of the Plan) and submitting such executed Plan to the Commission. The amendment will be effective when it is approved by the Commission in accordance with Rule 608 of Regulation NMS, or otherwise becomes effective pursuant to Rule 608 of Regulation NMS.

LTSE has executed a copy of the Plan currently in effect, with the only changes being the addition of its name in Section II(a) of the Plan and adding its single-digit code in Section VI(a)(1) of the Plan, and has provided a copy of the Plan executed by LTSE to each of the other Participants. LTSE has also submitted the executed Plan to the Commission. Accordingly, all of the Plan requirements for effecting an amendment to the Plan to add LTSE as a Participant have been satisfied.

II. Effectiveness of the Proposed Plan Amendment

The foregoing Plan amendment has become effective pursuant to Rule 608(b)(3)(iii) of the Exchange Act [7] because it involves solely technical or ministerial matters. At any time within sixty days of the filing of this amendment, the Commission may summarily abrogate the amendment and require that it be refiled pursuant to paragraph (a)(1) of Rule 608,[8] if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanisms of, a national market system or otherwise in furtherance of the purposes of the Exchange Act.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the amendment is consistent with the Exchange 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 4–518 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 4–518. 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 plan amendment that are filed with the Commission, and all written communications relating to the amendment 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 LTSE. 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 4–518 and should be submitted on or before December 12, 2019.

By the Commission.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25799 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

[4] 17 CFR 242.605. On April 12, 2001, the Commission approved a national market system plan for the purpose of establishing procedures for market centers to follow in making their monthly reports available to the public under Rule 11Ac1–5 under the Exchange Act (n/k/a Rule 605 of Regulation NMS). *See* Securities Exchange Act Release No. 44177 (April 12, 2001), 66 FR 19814 (April 17, 2001).

[5] The term ''Participant'' is defined as a party to the Plan.

[6] *See* Securities Exchange Act Release No. 85828 (May 10, 2019), 84 FR 21841 (May 15, 2019).

[7] 17 CFR 242.608(b)(3)(iii).

[8] 17 CFR 242.608(a)(1).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87580; File No. SR–NYSE–2019–64]

Self-Regulatory Organizations; New York Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend Exchange Rule 7.37 To Specify in Exchange Rules the Exchange's Source of Data Feeds From NYSE American LLC

November 21, 2019.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that on November 15, 2019, New York Stock Exchange LLC (''NYSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Rule 7.37 to update the Exchange's

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

source of data feeds from NYSE American LLC (''NYSE American'') for purposes of order handling, order execution, order routing, and regulatory compliance. The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those 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 parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to update and amend the use of data feeds table in Rule 7.37, which sets forth on a market-by-market basis the specific securities information processor and proprietary data feeds that the Exchange utilizes for the handling, execution, and routing of orders, and for performing the regulatory compliance checks related to each of those functions. Specifically, the table would be amended to reflect that the Exchange will receive a direct feed from NYSE American as its primary source of data for order handling, order execution, order routing, and regulatory compliance.

Rule 7.37 currently provides that the Exchange will utilize the securities information processor (''SIP'') data feed as its primary source for the handling, execution, and routing of orders, as well as for regulatory compliance. In connection with NYSE American's elimination of its delay mechanism,[4] the Exchange will begin using a direct feed from NYSE American as its primary data feed. To reflect this change, the Exchange proposes to amend the table in Rule 7.37(e) to specify that it will use a direct feed from NYSE American, rather than the SIP data feed, as the primary source for that market, and that the Exchange would use the SIP data feed as a secondary source for that market.

The Exchange will implement this change on the same date that NYSE American eliminates its delay mechanism, which, subject to effectiveness of proposed rule changes, will be implemented in November 2019. The Exchange will announce this date via Trader Update.

2. Statutory Basis

The proposed rule change is consistent with Section 6(b) of the Securities Exchange Act of 1934 (the ''Act''),[5] in general, and furthers the objectives of Section 6(b)(5),[6] in particular, because 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. The Exchange believes its proposal to amend the table in Rule 7.37(e) to update the data feed source for NYSE American will ensure that Rule 7.37 correctly identifies and publicly states on a market-by-market basis all of the specific securities information processor and proprietary data feeds that the Exchange utilizes for the handling, execution, and routing of orders, and for performing the regulatory compliance checks for each of those functions. The proposed rule change also removes impediments to and perfects the mechanism of a free and open market and protects investors and the public interest by providing additional specificity, clarity, and transparency in the Exchange's rules.

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 purposes of the Act. The proposed change is not designed to address any competitive issue, but rather would provide the public and investors with up-to-date information about which data feeds the Exchange uses for the handling, execution, and routing of orders, as well as for regulatory compliance.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act[7] and Rule 19b–4(f)(6) thereunder.[8] Because the 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 prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6)(iii) thereunder.[9]

A proposed rule change filed under Rule 19b–4(f)(6)[10] normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b4(f)(6)(iii),[11] the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. The Exchange has asked the Commission to waive the 30-day operative delay so that the proposal may become operative immediately upon filing. The Exchange represents that the proposal would correctly identify and publicly state on a market-by-market basis all of the specific network processor and proprietary data feeds that the Exchange utilizes for the handling, execution and routing of orders, and for performing the regulatory compliance checks to each of those functions. Further, the Exchange represents that the proposal would enhance the clarity and transparency in Exchange Rules. The Commission believes that waiver of the 30-day operative delay is consistent with the protection of investors and the public

[4] *See* SR–NYSEAmer–2019–48 (NYSE American proposal to eliminate its delay mechanism, which was filed on November 4, 2019).

[5] 15 U.S.C. 78f(b).

[6] 15 U.S.C. 78f(b)(5).

[7] 15 U.S.C. 78s(b)(3)(A).

[8] 17 CFR 240.19b–4(f)(6).

[9] In addition, Rule 19b–4(f)(6)(iii) requires the Exchange to give the Commission written notice of the Exchange's intent to file the proposed rule change, along with a brief description and text of 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.

[10] 17 CFR 240.19b–4(f)(6).

[11] 17 CFR 240.19b–4(f)(6)(iii).

interest, and hereby waives the operative delay and designates the proposed rule change as operative upon filing.[12]

At any time within 60 days of the filing of such 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 under Section 19(b)(2)(B)[13] of the Act to determine whether the proposed rule change 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–NYSE–2019–64 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–NYSE–2019–64. 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–NYSE–2019–64 and should be submitted on or before December 18, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[14]

Eduardo Aleman,

Deputy Secretary.

[FR Doc. 2019–25706 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

[12] For purposes only of waiving the operative delay for this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[13] 15 U.S.C. 78s(b)(2)(B).

[14] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87594; File No. S7–24–89]

Consolidated Tape Association; Notice of Filing and Immediate Effectiveness of the Forty-Sixth Amendment to the Joint Self-Regulatory Organization Plan Governing the Collection, Consolidation and Dissemination of Quotation and Transaction Information for Nasdaq-Listed Securities Traded on Exchanges on an Unlisted Trading Privileges Basis

November 22, 2019.

Pursuant to Section 11A of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 608 thereunder,[2] notice is hereby given that on October 24, 2019,[3] the Participants[4] in the Joint Self-Regulatory Organization Plan Governing the Collection, Consolidation and Dissemination of Quotation and Transaction Information for Nasdaq-Listed Securities Traded on Exchanges on an Unlisted Trading Privileges Basis (''UTP Plan'' or ''Plan'') filed with the Securities and Exchange Commission (''Commission'') a proposal to amend the UTP Plan. The amendment represents the Forty-Sixth Amendment to the Plan (''Amendment''). Under the Amendment, the Participants propose to add Long-Term Stock Exchange, Inc. (''LTSE'') as a Participant to the Plan and effectuate changes that certain Participants have made to their names and addresses.

The proposed Amendment has been filed by the Participants pursuant to Rule 608(b)(3)(ii) under Regulation NMS[5] as concerned solely with the administration of the Plan and as a ''Ministerial Amendment'' under Section XVI of the Plan. As a result, the Amendment becomes effective upon filing and was submitted by the Chair of the Plan's Operating Committee. The Commission is publishing this notice to solicit comments on the Amendment from interested persons. Set forth in Sections I and II is the statement of the purpose and summary of the Amendment, along with the information required by Rules 608(a) and 601(a) under the Act, prepared and submitted by the Participants to the Commission.

I. Rule 608(a)

A. Purpose of the Amendment

The above-captioned Amendment adds LTSE as a Participant to the UTP Plan and effectuates changes that certain Participants have made to their names and addresses, as set forth in Section I(A) of the UTP Plan and to update the listing of Participant identifying codes set forth in Section VIII(C) of the UTP Plan.

B. Governing or Constituent Documents

Not applicable.

C. Implementation of Amendment

Because the Amendment constitutes a ''Ministerial Amendment'' under Section XVI of the UTP Plan, the Chair of the UTP Plan's Operating Committee may submit the Amendment to the Commission on behalf of the Participants in the UTP Plan. Because the Participants designate the Amendment as concerned solely with the administration of the UTP Plan, the Amendment becomes effective upon filing with the Commission.

[1] 15 U.S.C. 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] *See* Letter from Robert Books, Chairman, Operating Committee, UTP Plan, to Vanessa Countryman, Secretary, Commission, dated October 23, 2019.

[4] The Participants are: Cboe BYX Exchange, Inc., Cboe BZX Exchange, Inc., Cboe EDGA Exchange, Inc., Cboe EDGX Exchange, Inc., Cboe Exchange, Inc., Financial Industry Regulatory Authority, Inc., The Investors' Exchange LLC, Long-Term Stock Exchange, Inc., Nasdaq BX, Inc., Nasdaq ISE, LLC, Nasdaq PHLX, Inc., The Nasdaq Stock Market LLC, New York Stock Exchange LLC, NYSE American LLC, NYSE Arca, Inc., NYSE Chicago, Inc., and NYSE National, Inc. (collectively, the ''Participants'').

[5] 17 CFR 242.608(b)(2).

D. Development and Implementation Phases

Not applicable.

E. Analysis of Impact on Competition

The Amendment does not impose any burden on competition because they simply add LTSE as a Participant to the UTP Plan and effectuates a change in the names and addresses of certain Participants. LTSE has completed the required steps to be added to the Plans, and the Amendment represents the final step to officially add LTSE as a Participant. For the same reasons, the Participants do not believe that the Amendment introduces terms that are unreasonably discriminatory for purposes of Section 1lA(c)(l)(D) of the Act.

F. Written Understanding or Agreement Relating to Interpretation of, or Participating in Plan

Not applicable.

G. Approval by Sponsors in Accordance With Plan

See Item I.C. above.

H. Description of Operation of Facility Contemplated by the Proposed Amendment

Not applicable.

I. Terms and Conditions of Access

Not applicable.

J. Method of Determination and Imposition and Amount of, Fees and Charges

Not applicable.

K. Method and Frequency of Processor Evaluation

Not applicable.

L. Dispute Resolution

Not applicable.

II. Regulation NMS Rule 601(a)

A. Equity Securities for Which Transaction Reports Shall Be Required by the Plan

Not applicable.

B. Reporting Requirements

Not applicable.

C. Manner of Collecting, Processing, Sequencing, Making Available and Disseminating Last Sale Information

Not applicable.

D. Manner of Consolidation

Not applicable.

E. Standards and Methods Ensuring Promptness, Accuracy and Completeness of Transaction Reports

Not applicable.

F. Rules and Procedures Addressed to Fraudulent or Manipulative Dissemination

Not applicable.

G. Terms of Access to Transaction Reports

Not applicable.

H. Identification of Marketplace of Execution

Not applicable.

III. Solicitation of Comments

The Commission seeks comments on the Amendment. Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed Amendment 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 S7–24–89 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 S7–24–89. 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 website (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all written statements with respect to the proposed Amendment that are filed with the Commission, and all written communications relating to the proposed Amendment 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 website viewing and printing at the principal office of the Plan. 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 S7–24–89 and should be submitted on or before December 12, 2019.

By the Commission.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25803 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87595; File No. 4–698]

Joint Industry Plan; Notice of Filing and Immediate Effectiveness of Amendment to the Plan Governing the Consolidated Audit Trail To Add Long-Term Stock Exchange LLC as a Participant

November 22, 2019.

Pursuant to Section 11A(a)(3) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 608 thereunder,[2] notice is hereby given that on October 18, 2019, Long-Term Stock Exchange LLC (''LTSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') an amendment to the Plan Governing the Consolidated Audit Trail (''Plan'').[3] The amendment adds LTSE as a Participant to the Plan. The Commission is publishing this notice to solicit comments on the amendment from interested persons.

I. Description and Purpose of the Amendment

The amendment to the CAT NMS Plan adds LTSE as a Participant.[4] The CAT NMS Plan provides that any Person [5] approved by the Commission as

[1] 15 U.S.C. 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] The Commission approved the CAT NMS Plan on November 16, 2016. *See* Securities Exchange Act Release No. 79318, 81 FR 84695 (November 23, 2016) (order approving the CAT NMS Plan).

[4] Defined in Section 1.1 of the Plan as follows: ''Participant'' means each Person identified as such on Exhibit A hereto, and any Person that becomes a Participant as permitted by this Agreement, in such Person's capacity as a Participant in the Company (it being understood that the Participants shall comprise the ''members'' of the Company (as the term ''member'' is defined in Section 18–101(11) of the Delaware Act)).

[5] Defined in Section 1.1 of the Plan as follows: ''Person'' means any individual, partnership,

Continued

a national securities exchange or national securities association under the Exchange Act may become a Participant by submitting to the Company [6] a completed application in the form provided by the Company.[7] As a condition to admission as a Participant, said Person shall: (i) Execute a counterpart of the CAT NMS Plan, at which time Exhibit A shall be amended to reflect the status of said Person as a Participant (including said Person's address for purposes of notices delivered pursuant to the CAT NMS Plan); and (ii) pay a fee to the Company as set forth in the Plan (the ''Participation Fee'').[8] The amendment to the Plan reflecting the admission of a new Participant shall be effective only when: (x) It is approved by the Commission in accordance with Rule 608 or otherwise becomes effective pursuant to Rule 608; and (y) the prospective Participant pays the Participation Fee.[9]

LTSE has executed a copy of the current CAT NMS Plan, amended to include LTSE in the List of Parties (including the address of LTSE), paid the applicable Participation Fee and provided each current Plan Participant with a copy of the executed and amended Plan.[10]

II. Effectiveness of the Proposed Linkage Plan Amendment

The foregoing Plan amendment has become effective pursuant to Rule 608(b)(3)(iii) [11] because it involves solely technical or ministerial matters. At any time within sixty days of the filing of this amendment, the Commission may summarily abrogate the amendment and require that it be refiled pursuant to paragraph (a)(1) of Rule 608,[12] if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors or the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanisms of, a national market system or otherwise in furtherance of the purposes of the Act.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the amendment 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 4–698 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 4–698. 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 20549–1090 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 4–698 and should be submitted on or before December 12, 2019.

By the Commission.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25802 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

limited liability company, corporation, joint venture, trust, business trust, cooperative or association and any heirs, executors, administrators, legal representatives, successors and assigns of such Person where the context so permits.

[6] The ''Company'' refers to the limited liability company, Consolidated Audit Trail, LLC, which is responsible for conducting the activities of the CAT. *See* Securities Exchange Act Release No. 87149 (September 27, 2019), 84 FR 52905 (October 3, 2019).

[7] *See* Section 3.3 of the CAT NMS Plan. LTSE was approved as a national securities exchange on May 10, 2019. *See* Securities and Exchange Act Release No. 85828, 84 FR 21814 (May 15, 2019).

[8] *See* Section 3.3 of the CAT NMS Plan.

[9] *Id.*

[10] *See* Letter from Howard Steinberg, Chief Regulatory Officer, LTSE, dated October 17, 2019, to Vanessa Countryman, Secretary, Commission.

[11] 17 CFR 242.608(b)(3)(iii).

[12] 17 CFR 242.608(a)(1).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–87597; File No. 4–533]

Joint Industry Plan; Notice of Filing and Immediate Effectiveness of Amendment to the National Market System Plan for the Selection and Reservation of Securities Symbols To Add Long-Term Stock Exchange, Inc. as a Party Thereto

November 22, 2019.

Pursuant to Section 11A(a)(3) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 608 thereunder,[2] notice is hereby given that on October 17, 2019, Long-Term Stock Exchange, Inc. (''LTSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') an amendment to the National Market System Plan for the Selection and Reservation of Securities Symbols (''Symbology Plan'' or ''Plan'').[3] The amendment proposes to add LTSE as a party to the Symbology Plan. The Commission is publishing this notice to solicit comments on the proposed amendment from interested persons.

I. Description and Purpose of the Amendment

The current parties to the Symbology Plan are BOX Options Exchange, LLC (''BOX''), Nasdaq BX, Inc. (''BX''), Cboe BZX Exchange, Inc. (''CboeBZX''), Cboe EDGA Exchange, Inc. (''CboeEDGA''), Cboe EDGX Exchange, Inc. (''CboeEDGX''), Cboe Exchange, Inc. (''Cboe''), CHX, FINRA, Investors Exchange, LLC (''IEX''), Miami International Securities Exchange, LLC (''MIAX''), Nasdaq ISE, LLC (''ISE''), Nasdaq, New York Stock Exchange LLC (''NYSE''), NYSE American LLC (''NYSE American''), NYSE National, NYSE

[1] 15 U.S.C. 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] On November 6, 2008, the Commission approved the Symbology Plan that was originally proposed by the Chicago Stock Exchange, Inc. (''CHX''), The Nasdaq Stock Market, Inc. (n/k/a The Nasdaq Stock Market LLC) (''Nasdaq''), National Association of Securities Dealers, Inc. (''NASD'') (n/k/a Financial Industry Regulatory Authority, Inc. (''FINRA'')), National Stock Exchange, Inc. (''NSX'') (n/k/a NYSE National, Inc. (''NYSE National'')), and Philadelphia Stock Exchange, Inc. (n/k/a Nasdaq PHLX LLC (''Phlx'')), subject to certain changes. *See* Securities Exchange Act Release No. 58904, 73 FR 67218 (November 13, 2008) (File No. 4–533).

Arca, Inc. (''NYSE Arca''), and Phlx.[4] The proposed amendment to the Symbology Plan would add LTSE as a party to the Symbology Plan. A self-regulatory organization (''SRO'') may become a party to the Symbology Plan if it satisfies the requirements of Section I(c) of the Plan. Specifically, an SRO may become a party to the Symbology Plan if: (i) It maintains a market for the listing or trading of Plan Securities[5] in accordance with rules approved by the Commission; (ii) it signs a current copy of the Plan; and (iii) it pays to the other parties a proportionate share of the aggregate development costs, based upon the number of symbols reserved by the new party during the first twelve (12) months of such party's membership.[6]

LTSE has submitted a signed copy of the Symbology Plan to the Commission in accordance with the requirement set forth in the Symbology Plan regarding new parties to the plan. Additionally, LTSE has represented that it maintains a market for the listing or trading of Plan Securities. Finally, LTSE has agreed to pay all costs required by LTSE pursuant to the Symbology Plan, including its proportionate share of the aggregate development costs previously paid by the other parties to the Processor.

II. Effectiveness of the Proposed Symbology Plan Amendment

The foregoing proposed Symbology Plan amendment has become effective pursuant to Rule 608(b)(3)(iii)[7] because it involves solely technical or ministerial matters. At any time within sixty days of the filing of the amendment, the Commission may summarily abrogate the amendment and require that it be refiled pursuant to paragraph (b)(1) of Rule 608,[8] if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors or the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanisms of, a national market system or otherwise in furtherance of the purposes of the Act.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the Amendment 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 4–533 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 4–533. 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 Plan that are filed with the Commission, and all written communications relating to the Plan 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 Parties' principal offices. 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 4–533, and should be submitted on or before December 12, 2019.

By the Commission.

Eduardo A. Aleman,

Deputy Secretary.

[FR Doc. 2019–25800 Filed 11–26–19; 8:45 am]

BILLING CODE 8011–01–P

[4] On November 18, 2008, ISE filed with the Commission an amendment to the Plan to add ISE as a member to the Plan. *See* Securities and Exchange Act Release No. 59024 (November 26, 2008), 73 FR 74538 (December 8, 2008) (File No. 4–533). On December 22, 2008, NYSE, NYSE Arca, and NYSE Alternext (n/k/a NYSE American) (''NYSE Group Exchanges''), and Cboe filed with the Commission amendments to the Plan to add the NYSE Group Exchanges and Cboe as members to the Plan. *See* Securities Exchange Act Release No. 59162 (December 24, 2008), 74 FR 132 (January 2, 2009) (File No. 4–533). On December 24, 2008, BSE (n/k/a BX) filed with the Commission an amendment to the Plan to add BSE as a member to the Plan. *See* Securities Exchange Act Release No. 59187 (December 30, 2008), 74 FR 729 (January 7, 2009) (File No. 4–533). On September 30, 2009, BATS (n/k/a CboeBZX) filed with the Commission an amendment to the Plan to add BATS as a member to the Plan. *See* Securities Exchange Act Release No. 60856 (October 21, 2009), 74 FR 55276 (October 27, 2009) (File No. 4–533). On July 7, 2010, EDGA (n/k/a CboeEDGA) and EDGX (n/k/a CboeEDGX) filed with the Commission an amendment to the Plan to add EDGA and EDGX, each as a party to the Symbology Plan. *See* Securities Exchange Act Release No. 62573 (July 26, 2010), 75 FR 45682 (August 3, 2010) (File No. 4–533). On May 7, 2012, BOX filed with the Commission an amendment to the Plan to add BOX as a member to the Plan. *See* Securities and Exchange Act Release No. 66957 (May 10, 2012), 77 FR 28904 (May 16, 2012). On November 4, 2016, IEX filed with the Commission an amendment to the Plan to add IEX as a member to the Plan. *See* Securities Exchange Act Release No. 79422 (November 29, 2016), 81 FR 87645 (December 5, 2016). On February 26, 2018, MIAX filed with the Commission an amendment to the Plan to add MIAX as a member to the plan. *See* Securities Exchange Act Release No. 82885 (March 15, 2018), 83 FR 12430 (March 21, 2018).

[5] ''Plan Securities'' are defined in the Symbology Plan as securities that: (i) Are NMS securities as currently defined in Rule 600(a)(46) under the Act; and (ii) any other equity securities quoted, traded and/or trade reported through an SRO facility.

[6] Sections I(c) and V(a) of the Plan.

[7] 17 CFR 242.608(b)(3)(iii).

[8] 17 CFR 242.608(b)(1).

DEPARTMENT OF STATE

[Public Notice 10758]

60 Day Notice of Proposed Information Collection: ECA Exchange Student Surveys

ACTION: Notice of request for public comment.

SUMMARY: The Department of State is seeking Office of Management and Budget (OMB) approval for the information collection described below. In accordance with the Paperwork Reduction Act of 1995, we are requesting comments on this collection from all interested individuals and organizations. The purpose of this notice is to allow 60 days for public comment preceding submission of the collection to OMB.

DATES: The Department will accept comments from the public up to January 27, 2020.

ADDRESSES: You may submit comments by any of the following methods:

- *Web:* Persons with access to the internet may comment on this notice by going to *www.Regulations.gov.* You can search for the document by entering ''Docket Number: DOS–2019–0011'' in the Search field. Then click the ''Comment Now'' button and complete the comment form.
- *Email: Parkes-Moscovatm@state.gov.*
- *Mail:* 2200 C Street NW, Washington, DC 20037.

You must include the DS form number (if applicable), information

collection title, and the OMB control number (if any) in any correspondence.

FOR FURTHER INFORMATION CONTACT: Direct requests for additional information regarding the collection listed in this notice, including requests for copies of the proposed collection instrument and supporting documents, to Tiffany Parkes-Moscova who may be reached on (202) 632–6359 or *Parkes-Moscovatm@state.gov.*

SUPPLEMENTARY INFORMATION:

- *Title of Information Collection:* ECA Exchange Student Surveys.
- *OMB Control Number:* 1405–0210.
- *Type of Request:* Revision of a Currently Approved Collection.
- *Originating Office:* Educational and Cultural Affairs (ECA/PE/C/PY).
- *Form Number:* SV2012–0007 (Foreign Exchange students).
- *Respondents:* Exchange students from foreign countries participating in Department of State sponsored programs from 2020–2023.
- *Estimated Number of Respondents:* 1,500 annually.
- *Estimated Number of Responses:* 1,500 annually.
- *Average Time per Response:* 15 minutes.
- *Total Estimated Burden Time:* 375 hours.
- *Frequency:* On occasion.
- *Obligation to Respond:* Voluntary.

We are soliciting public comments to permit the Department to:

- Evaluate whether the proposed information collection is necessary for the proper functions of the Department.
- Evaluate the accuracy of our estimate of the time and cost burden for this proposed collection, including the validity of the methodology and assumptions used.
- Enhance the quality, utility, and clarity of the information to be collected.
- Minimize the reporting burden on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Please note that comments submitted in response to this Notice are public record. Before including any detailed personal information, you should be aware that your comments as submitted, including your personal information, will be available for public review.

Abstract of Proposed Collection

This collection of information is under the provisions of the Mutual Educational and Cultural Exchange Act, as amended, and the Exchange Visitor Program regulations (22 CFR part 62), as applicable. The information collected will be used by the Department to ascertain whether there are any issues that would affect the safety and well-being of exchange program participants.

Methodology

The survey will be sent electronically via the Survey Monkey tool and responses collected electronically. If a respondent requests a paper version of the survey it will be provided.

Robert Ogburn,

Director.

[FR Doc. 2019–25778 Filed 11–26–19; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 10959]

Notice of Determinations; Culturally Significant Objects Imported for Exhibition—Determinations: "Judd" Exhibition

SUMMARY: Notice is hereby given of the following determinations: I hereby determine that certain objects to be exhibited in the exhibition ''Judd,'' imported from abroad for temporary exhibition within the United States, are of cultural significance. The objects are imported pursuant to loan agreements with the foreign owners or custodians. I also determine that the exhibition or display of the exhibit objects at The Museum of Modern Art, in New York, New York, from on or about March 1, 2020, until on or about July 11, 2020, and at possible additional exhibitions or venues yet to be determined, is in the national interest. I have ordered that Public Notice of these determinations be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Chi D. Tran, Paralegal Specialist, Office of the Legal Adviser, U.S. Department of State (telephone: 202–632–6471; email: *section2459@state.gov*). The mailing address is U.S. Department of State, L/PD, SA–5, Suite 5H03, Washington, DC 20522–0505.

SUPPLEMENTARY INFORMATION: The foregoing determinations were made pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.;* 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, and Delegation of Authority No. 236–3 of August 28, 2000.

Marie Therese Porter Royce,

Assistant Secretary, Educational and Cultural Affairs, Department of State.

[FR Doc. 2019–25752 Filed 11–26–19; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 10961]

Notice of Determinations; Culturally Significant Objects Imported for Exhibition—Determinations: "The Great Hall Commission: Kent Monkman, mistikôsiwak (Wooden Boat People)" Exhibition

SUMMARY: Notice is hereby given of the following determinations: I hereby determine that certain objects to be exhibited in the exhibition ''The Great Hall Commission: Kent Monkman, mistikôsiwak (Wooden Boat People)'' imported from abroad for temporary exhibition within the United States, are of cultural significance. The objects are imported pursuant to loan agreement with the foreign owner or custodian. I also determine that the exhibition or display of the exhibit objects at The Metropolitan Museum of Art, in New York, New York, from on or about December 19, 2019, until on or about April 12, 2020, and at possible additional exhibitions or venues yet to be determined, is in the national interest. I have ordered that Public Notice of these determinations be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Chi D. Tran, Paralegal Specialist, Office of the Legal Adviser, U.S. Department of State (telephone: 202–632–6471; email: *section2459@state.gov*). The mailing address is U.S. Department of State, L/PD, SA–5, Suite 5H03, Washington, DC 20522–0505.

SUPPLEMENTARY INFORMATION: The foregoing determinations were made pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.;* 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, and Delegation of Authority No. 236–3 of August 28, 2000.

Marie Therese Porter Royce,

Assistant Secretary, Educational and Cultural Affairs, Department of State.

[FR Doc. 2019–25756 Filed 11–26–19; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 10960]

Notice of Determinations; Culturally Significant Objects Imported for Exhibition—Determinations: ''Alonso Berruguete: First Sculptor of Renaissance Spain'' Exhibition

SUMMARY: On September 5, 2019, notice was published on page 46772 of the **Federal Register** (volume 84, number 172) of determinations pertaining to certain objects to be included in an exhibition entitled ''Alonso Berruguete: First Sculptor of Renaissance Spain.'' Notice is hereby given of the following determinations: I hereby determine that certain additional objects to be exhibited in the exhibition ''Alonso Berruguete: First Sculptor of Renaissance Spain,'' imported from abroad for temporary exhibition within the United States, are of cultural significance. The objects are imported pursuant to loan agreements with the foreign owners or custodians. I also determine that the exhibition or display of the exhibit object at the Meadows Museum, Southern Methodist University, Dallas, Texas, from on or about March 29, 2020, until on or about July 26, 2020, and at possible additional exhibitions or venues yet to be determined, is in the national interest. I have ordered that Public Notice of these determinations be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Chi D. Tran, Paralegal Specialist, Office of the Legal Adviser, U.S. Department of State (telephone: 202–632–6471; email: *section2459@state.gov*). The mailing address is U.S. Department of State, L/PD, SA–5, Suite 5H03, Washington, DC 20522–0505.

SUPPLEMENTARY INFORMATION: The foregoing determinations were made pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), Executive Order 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.;* 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, and Delegation of Authority No. 236–3 of August 28, 2000.

Marie Therese Porter Royce,

Assistant Secretary, Educational and Cultural Affairs, Department of State.

[FR Doc. 2019–25755 Filed 11–26–19; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 10964]

Notice of a Public Meeting, in Preparation for an International Maritime Organization Meeting

The Department of State will conduct an open meeting at 1:00 p.m. on 21 January 2020, in Room 5Y23–21 of the Douglas A. Munro Coast Guard Headquarters Building at St. Elizabeth's, 2703 Martin Luther King Jr. Avenue SE, Washington, DC 20593. The primary purpose of the meeting is to prepare for the seventh session of the International Maritime Organization's (IMO) Sub-Committee on Ship Design and Construction to be held at the IMO headquarters, London, United Kingdom, February 3–7, 2020.

The agenda items to be considered include:

—Adoption of the agenda
—Decisions of other bodies
—Amendments to the explanatory notes to SOLAS chapter II–1, subdivision and damage stability regulations (resolution MSC.429(98))
—Safety measures for non-SOLAS ships operating in polar waters
—Finalization of second-generation intact stability criteria
—Mandatory instrument and/or provisions addressing safety standards for the carriage of more than 12 industrial personnel on board vessels engaged on international voyages
—Development of amendments to SOLAS chapter II–1 to include requirements for water level detectors on non-bulk carrier cargo ships with multiple cargo holds
—Mandatory application of the Performance standard for protective coatings for void spaces on bulk carriers and oil tankers
—Performance standards for protective coatings for void spaces on all types of ships
—Amendments to the 2011 ESP Code
—Unified interpretations to provisions of IMO safety, security and environment-related conventions
—Review of mandatory requirements in SOLAS, MARPOL, and Load Line Conventions and the IBC and IGC Codes regarding watertight doors on cargo ships
—Biennial status report and provisional agenda for SDC 8
—Election of Chairman and Vice-Chairman for 2021
—Any other business
—Report to the Maritime Safety Committee

Members of the public may attend this meeting up to the seating capacity of the room. Upon request to the meeting coordinator, members of the public may also participate via teleconference, up to the capacity of the teleconference phone line. To facilitate the building security process, and to request reasonable accommodation, those who plan to attend should contact the meeting coordinator, LT Dimitrios Wiener, by email at *Dimitrios.N.Wiener@uscg.mil,* or by phone at (202) 372–1414, or in writing at 2703 Martin Luther King Jr. Ave. SE, Stop 7509, Washington, DC 20593–7509 not later than January 14, 2019, seven days prior to the meeting. Requests made after January 14, 2020 might not be able to be accommodated. Please note that due to security considerations, two valid, government issued photo identifications must be presented to gain entrance to the Coast Guard Headquarters building. The building is accessible by taxi, public transportation, and privately owned conveyance (upon request). In the case of inclement weather where the U.S. Government is closed or delayed, a public meeting may be conducted virtually utilizing the teleconference phone line. For those who RSVP, the meeting coordinator will confirm whether the virtual public meeting will be utilized. Members of the public can find out whether the U.S. Government is delayed or closed by visiting *www.opm.gov/status/.*

Jeremy M. Greenwood,

Coast Guard Liaison Officer, Office of Ocean and Polar Affairs, Department of State.

[FR Doc. 2019–25787 Filed 11–26–19; 8:45 am]

BILLING CODE 4710–09–P

SURFACE TRANSPORTATION BOARD

[Docket No. AB 1292X]

Alabama & Tennessee River Railway, LLC—Abandonment Exemption—in Marshall County, Ala.

Alabama & Tennessee River Railway, LLC (ATN), has filed a verified notice of exemption under 49 CFR part 1152 subpart F—*Exempt Abandonments* to abandon an approximately 885-foot rail line beginning approximately 3,670 feet north of milepost 86 in Marshall County, Ala., and continuing to the end of the track (the Line). The Line traverses U.S. Postal Service Zip Code 35976.

ATN has certified that: (1) No local traffic has moved over the Line in the past two years; (2) there is, and can be, no overhead traffic on the Line because it is stub-ended; (3) no formal complaint filed by a user of rail service on the Line (or by a state or local government entity

acting on behalf of such user) regarding cessation of service over the Line either is pending with the Surface Transportation Board (Board) or any U.S. District Court or has been decided in favor of a complainant within the two-year period; and (4) the requirements at 49 CFR 1105.12 (newspaper publication), 49 CFR 1152.50(d)(1) (notice to governmental agencies), and 49 CFR 1105.7 and 1105.8 (environmental and historic report), have been met.

As a condition to this exemption, any employee adversely affected by the abandonment shall be protected under *Oregon Short Line Railroad—Abandonment Portion Goshen Branch Between Firth & Ammon, in Bingham & Bonneville Counties, Idaho,* 360 I.C.C. 91 (1979). To address whether this condition adequately protects affected employees, a petition for partial revocation under 49 U.S.C. 10502(d) must be filed.

Provided no formal expression of intent to file an offer of financial assistance (OFA) [1] has been received, this exemption will be effective on December 27, 2019, unless stayed pending reconsideration. Petitions to stay that do not involve environmental issues must be filed by December 6, 2019.[2] Formal expressions of intent to file an OFA under 49 CFR 1152.27(c)(2) and trail use/rail banking requests under 49 CFR 1152.29 must be filed by December 9, 2019.[3] Petitions to reopen or requests for public use conditions under 49 CFR 1152.28 must be filed by December 17, 2019, with the Surface Transportation Board, 395 E Street SW, Washington, DC 20423–0001.

A copy of any petition filed with the Board should be sent to ATN's representative, Paul R. Hitchcock, Holland & Knight LLP, Suite 3900, 50 North Laura Street, Jacksonville, FL 32202.

If the verified notice contains false or misleading information, the exemption is void ab initio.

ATN has filed a combined environmental and historic report that addresses the potential effects of the abandonment on the environment and historic resources. OEA will issue an environmental assessment (EA) by December 2, 2019. The EA will be available to interested persons on the Board's website, by writing to OEA, or by calling OEA at (202) 245–0305. Assistance for the hearing impaired is available through the Federal Relay Service at (800) 877–8339. Comments on environmental and historic preservation matters must be filed within 15 days after the EA becomes available to the public.

Environmental, historic preservation, public use, or trail use/rail banking conditions will be imposed, where appropriate, in a subsequent decision.

Pursuant to the provisions of 49 CFR1152.29(e)(2), ATN shall file a notice of consummation with the Board to signify that it has exercised the authority granted and fully abandoned the Line. If consummation has not been effected by ATN's filing a notice of consummation by November 27, 2020, and there are no legal or regulatory barriers to consummation, the authority to abandon will automatically expire.

Board decisions and notices are available at *www.stb.gov.*

Decided: November 21, 2019.

By the Board, Allison C. Davis, Director, Office of Proceedings.

Jeffrey Herzig,

Clearance Clerk.

[FR Doc. 2019–25766 Filed 11–26–19; 8:45 am]

BILLING CODE 4915–01–P

[1] Persons interested in submitting an OFA must first file a formal expression of intent to file an offer, indicating the type of financial assistance they wish to provide (*i.e.,* subsidy or purchase) and demonstrating that they are preliminarily financially responsible. *See* 49 CFR 1152.27(c)(2)(i).

[2] The Board will grant a stay if an informed decision on environmental issues (whether raised by a party or by the Board's Office of Environmental Analysis (OEA) in its independent investigation) cannot be made before the exemption's effective date. *See Exemption of Out-of-Serv. Rail Lines,* 5 I.C.C.2d 377 (1989). Any request for a stay should be filed as soon as possible so that the Board may take appropriate action before the exemption's effective date.

[3] Filing fees for OFAs and trail use requests can be found at 49 CFR 1002.2(f)(25) and (27), respectively.

TENNESSEE VALLEY AUTHORITY

Meeting of the Regional Energy Resource Council

AGENCY: Tennessee Valley Authority (TVA).

ACTION: Notice of meeting.

SUMMARY: The TVA Regional Energy Resource Council (RERC) will hold a meeting Wednesday, December 11, 2019, and Thursday, December 12, 2019, to discuss an introduction to TVA, its mission and approaches to managing coal ash.

The RERC was established to advise TVA on its energy resource activities and the priority to be placed among competing objectives and values. Notice of this meeting is given under the Federal Advisory Committee Act (FACA).

DATES: The public meeting will be held on Wednesday, December 11, 2019, from 8:30 a.m. to 12:00 p.m., EST, and 4:30 p.m. EST to 5:30 p.m. EST, and on Thursday, December 12, 2019, from 8:30 a.m. to 12:00 p.m. EST.

ADDRESSES: The meeting will be held at the TVA Knoxville Office Complex, 400 West Summit Hill Drive, Knoxville, Tennessee 37902 and will be open to the public. Anyone needing special access or accommodations should let the contact below know at least a week in advance.

FOR FURTHER INFORMATION CONTACT: Liz Upchurch, 865–632–8305, *efupchurch@tva.gov.*

SUPPLEMENTARY INFORMATION: The meeting agenda includes the following:

1. Introductions
2. Overview of TVA and its Mission
3. Overview of TVA's approach to manage coal ash
4. Public Comments
5. Council Discussion and Advice

The RERC will hear opinions and views of citizens by providing a public comment session starting at 4:30 p.m. EST, lasting up to an hour, on Wednesday, December 11, 2019. Persons wishing to speak are requested to register either at the door between 8:30 a.m. and 3:30 p.m., EST, on Wednesday, December 11, 2019, or in advance by visiting *www.tva.com/About-TVA/Get-Involved-Stay-Involved,* and will be called on during the public comment period. TVA will set time limits for providing oral comments, once registered. Handout materials should be limited to one printed page. Written comments are also invited and may be mailed to the Regional Energy Resource Council, Tennessee Valley Authority, 400 West Summit Hill Drive, WT–9–D, Knoxville, Tennessee 37902.

Dated: November 21, 2019.

Amy Henry,

Senior Manager, Enterprise Relations & Strategic Partnerships, Tennessee Valley Authority.

[FR Doc. 2019–25791 Filed 11–26–19; 8:45 am]

BILLING CODE 8120–08–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. 2019–0640]

Agency Information Collection Activities: Agency Information Collection Activities: Requests for Comments; Clearance of Renewed Approval of Information Collection: Air Taxi and Commercial Operator Airport Activity Survey

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FAA invites public comments about our intention to request the Office of Management and Budget (OMB) approval to renew an information collection. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on August 16, 2019. The collection involves requesting that small on-demand operators voluntarily provide the number of revenue passengers that boarded their aircraft at each airport annually. This information is used in determining an airport's category and eligibility for federal funding on an annual basis. It is not available through any other federal data source.

DATES: Written comments should be submitted by December 27, 2019.

ADDRESSES: Interested persons are invited to submit written comments on the proposed information collection to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments should be addressed to the attention of the Desk Officer, Department of Transportation/FAA, and sent via electronic mail to *oira_submission@omb.eop.gov,* or faxed to (202) 395–6974, or mailed to the Office of Information and Regulatory Affairs, Office of Management and Budget, Docket Library, Room 10102, 725 17th Street NW, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Luis Loarte by email at: *Luis.Loarte@faa.gov;* phone: 202–267–9622.

SUPPLEMENTARY INFORMATION:

Public Comments Invited: You are asked to comment on any aspect of this information collection, including (a) whether the proposed collection of information is necessary for FAA's performance; (b) the accuracy of the estimated burden; (c) ways for FAA to enhance the quality, utility and clarity of the information collection; and (d) ways that the burden could be minimized without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of this information collection.

OMB Control Number: 2120–0067.

Title: Air Taxi and Commercial Operator Airport Activity Survey.

Form Numbers: FAA Form 1800–31.

Type of Review: Clearance of a renewal of an information collection.

Background: The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on August 16, 2019 under FRN document citation number 2019–0640. The data collected through this survey is the only source of data for charter and nonscheduled passenger data by Part 135 operator (air taxis). The data received on the form (either paper or signed electronic copy) is then incorporated into the Air Carrier Activity Information System which is used to determine whether an airport is eligible for Airport Improvement Program funds and for calculating primary airport sponsor apportionment as specified by title 49 United Stated Code (U.S.C.) 47114. The data collected on the form includes passenger enplanements by carrier and by airport. Passengers traveling on air taxis would be overlooked entirely if this passenger survey were not conducted. As a result, many airports would not receive their fair share of funds since there is currently no other source for this type of charter activity. On average, approximately 100 operators respond each year, reporting a total 1.1 million passengers. This data is important to those airports that struggle to meet the 2,500 and 10,000 passenger levels and could not do so without the reporting of the charter passengers.

Respondents: The voluntary survey is sent through the U.S. Postal Service to approximately 190 small on-demand operators (certificated under Federal Aviation Regulation Part 135) that have reported activity in the last three years. The form is also available on the FAA website. Beginning with the calendar year 2019 data, operators will be able to access the form, electronically sign and submit it to the FAA.

Frequency: Annually.

Estimated Average Burden per Response: 1.5 hours per respondent.

Estimated Total Annual Burden: On average, approximately 100 respondents submit an annual response. The cumulative total annual burden is estimated to be 150 hours.

Issued in Washington, DC, on November 20, 2019.

Luis Loarte,

Senior Airport Planner, Office of Airports/Airport Planning and Environmental Division.

[FR Doc. 2019–25702 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. FAA–2019–0819]

Agency Information Collection Activities: Requests for Comments; Clearance of a New Approval of Information Collection: National Sleep Study

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FAA invites public comments about our intention to request the Office of Management and Budget (OMB) approval for a new information collection. The collection involves study on relationships between aircraft noise events and the probability of waking up.

DATES: Written comments should be submitted by January 27, 2020.

ADDRESSES: Please send written comments:

By Electronic Docket: www.regulations.gov (Enter docket number into search field).

By mail: Dr. Natalia Sizov, The FAA Policy, International Affairs and Environment, 800 Independence Ave. SW, Washington, DC 20591.

By fax: 202–267–5594.

FOR FURTHER INFORMATION CONTACT: Dr. Natalia Sizov by email at: *natalia.sizov@faa.gov;* phone: 202–267–3553.

SUPPLEMENTARY INFORMATION:

Public Comments Invited: You are asked to comment on any aspect of this information collection, including (a) Whether the proposed collection of information is necessary for FAA's performance; (b) the accuracy of the estimated burden; (c) ways for FAA to enhance the quality, utility and clarity of the information collection; and (d) ways that the burden could be minimized without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of this information collection.

OMB Control Number: 2120–XXXX.

Title: National Sleep Study.

Form Numbers: None.

Type of Review: Clearance of a new information collection.

Background: The main purpose of the National Sleep Study is to collect nationally representative information on the effects of aircraft noise on sleep and to derive exposure-response relationships between aircraft noise and

its effect on communities around United States civilian airports. This Study will collect information about single aircraft noise events levels and the probability of resident's waking up. The FAA will use the information from this collection to derive the empirical data to inform any potential updates to or validation of the national aviation noise policy.

Respondents: Approximately 4,400 respondents to 25,000 postal surveys (18% response rate). From among these survey respondents, approximately 400 respondents (9.1%) will be recruited into the field study.

Frequency: Response to the postal survey, and participation in the field study, will be a one-time event.

Estimated Average Burden per Response: The postal survey will take an estimated 8.25 minutes to complete. The field study will take an estimated 2 hours and 33 minutes of active participation across 5 study days to complete.

Estimated Total Annual Burden: The estimated total annual burden for the postal survey is 302 hours and 30 minutes in each of the two years of the study, and 510 hours for field study.

Issued in Washington, DC, on November 21, 2019.

Rebecca Cointin,

Executive Director (Acting), FAA Office of Environment & Energy.

[FR Doc. 2019–25714 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Notice of Final Federal Agency Actions of Proposed Highway/Interchange Improvement in Ohio; Statute of Limitations on Claims

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of limitation on claims for judicial review of actions by the Ohio Department of Transportation (ODOT), pursuant to 23 U.S.C. 327.

SUMMARY: The FHWA, on behalf of ODOT, is issuing this notice to announce actions taken by ODOT that are final. The actions relate to the proposed modification of United States Route 62 (US–62) in the County of Stark, State of Ohio. Those actions grant licenses, permits, and approvals for the project.

DATES: By this notice, the FHWA, of behalf of ODOT, is advising the public of final agency actions subject to 23 U.S.C. 139(I)(1). A claim seeking judicial review of the Federal Agency Actions on the highway project will be barred unless the claim is filed on or before April 27, 2020. If the Federal law that authorizes judicial review of a claim provides a time period of less than 150 days for filing such claim, then that shorter period of time still applies.

FOR FURTHER INFORMATION CONTACT: For FHWA: Noel F. Mehlo, Jr., Planning and Environmental Specialist, FHWA Ohio Division Office; HPD–OH, 200 North High Street, Room 328, Columbus, Ohio 43215–2408, 614–280–6841, *Noel.Mehlo@dot.gov*.

SUPPLEMENTARY INFORMATION: Effective December 11, 2015 and as amended June 6, 2018, the Federal Highway Administration (FHWA) assigned, and the Ohio Department of Transportation (ODOT) assumed, environmental responsibilities for this project pursuant to 23 U.S.C. 327. Notice is hereby given that ODOT, has taken final agency actions subject to 23 U.S.C. 139(l)(1) by issuing licenses, permits, and approvals for the following highway project in the State of Ohio. The project will improve the existing 0.9-mile section of US 62 between State Route (SR) 43 (Market Avenue) and the bridge over the Middle Branch of Nimishillen Creek. The project will reconstruct and relocate US 62 to the north of the existing alignment to improve sight distance on the eastbound curve and eliminate many driveways directly accessing US 62. The project will create cul-de-sacs at Gibbs Avenue, Rowland Avenue, and Gross Avenue (north side) and convert Maple Avenue to a right-in/right-out access. Most of the properties along the north side of the existing US 62 alignment and several properties along the south side of US 62 around the Gibbs Avenue and St. Elmo Avenue intersections will be removed by the project. The existing signalized intersections at Rowland Avenue and Maple Avenue will be removed. Direct access to (and across) US 62 for the northern and southern neighborhoods will be provided via a new signalized intersection at St. Elmo Avenue that will include street lighting, Americans with Disabilities Act (ADA) compliant pedestrian cross walks, a median refuge, and pedestrian signal features. The St. Elmo signal will provide access to a two-lane frontage road that will be constructed south of the new US 62 alignment to provide access to the businesses and residences on the south side of US 62 between Gibbs Avenue and St. Elmo Avenue.

US 62 will be reconstructed as a four-lane roadway (two lanes in each direction) with additional auxiliary lanes and turn lanes added to provide an acceptable level of service at the new St. Elmo Avenue signalized intersection. In the eastbound direction, an auxiliary lane will begin at the SR 43 entrance ramp and continue east to tie into the existing Harrisburg intersection right turn lane. Heading westbound, an auxiliary lane will travel from just east of the St. Elmo intersection to 30th Street NE, providing direct access from US 62 to 30th Street NE. With the addition of the auxiliary lanes described above, the majority of proposed US 62 within the project limits will resemble a six-lane roadway with three eastbound lanes and three west bound lanes. Center-left turn lanes will also be provided on both eastbound and westbound US 62 at the signalized intersection with St. Elmo Avenue.

The west and east ends of the project are designed at a 50 mile per hour (mph) design speed transitioning to a 45 mph design speed between Rowland Avenue and Maple Avenue to accommodate the signalized intersection and pedestrian crossing at St. Elmo Avenue. Various design elements will be incorporated into the project between Rowland Avenue and Maple Avenue including reduced shoulder width, landscaping, and signing to comply with the reduced design speed.

A new storm sewer system will be provided to collect the drainage along US 62 and the frontage road to be constructed south of the new US 62 alignment. The project will reconstruct the existing storm water conduit and an outfall to the Middle Branch of Nimishillen Creek south of the existing US 62 roadway embankment and construct a new storm sewer north of US 62 which will also discharge into the Middle Branch of Nimishillen Creek.

Based upon the ability to meet the purpose and need of the project, public comments, and impacts to the natural and human environment, ODOT selected Alternative G1–d3a, presented in the March 2017 Feasibility Study, as the Preferred Alternative selected for the July 2018 Environmental Assessment for the project. The Preferred Alternative meets the safety needs of the project and maintains access to US 62 for the nearby neighborhoods and commercial properties.

Following the Public Hearing and 30-day comment period for the July 2018 Environmental Assessment, the project team conducted further investigation and analyses on the Preferred Alternative (G1–d3a) as part of the public involvement process and consideration of Performance Based Practical Design (PBPD) initiative. Through this exercise, the project team identified design changes that minimize access and right-of-way impacts and

reduce costs to the Preferred Alternative. Sub-alternative G1–d3a–1 incorporates these design changes within the existing project study area footprint and meets the purpose and need for the project to increase safety and decrease congestion while maintaining access to US 62 for the nearby neighborhoods and commercial properties. Based on design changes reflected in Sub-alternative G1–d3a–1 and resulting reductions in anticipated project impacts, no additional assessment and resource agency coordination was warranted for the project.

The actions by the Federal agencies, and the laws under which such actions were taken, are described in the Environmental Assessment (EA), and the Finding on No Significant Impact (FONSI), approved on January 28, 2019. The EA, FONSI, and other project records are available by contacting ODOT at the address provided above. The ODOT EA, and FONSI can be viewed and downloaded from the project website at *http://www.dot.state.oh.us/districts/D04/stark/US62/Pages/default.aspx.* This notice applies to all Federal agency decisions as of the issuance date of this notice and all laws under which such actions were taken, including but not limited to:

(1) Council on Environmental Quality regulations;

(2) National Environmental Policy Act (NEPA);

(3) Moving Ahead for Progress in the 21st Century Act (MAP–21);

(4) Department of Transportation Act of 1966;

(5) Federal Aid Highway Act of 1970;

(6) Clean Air Act Amendments of 1990;

(7) Noise Control Act of 1970;

(8) 23 CFR part 772 FHWA Noise Standards, Policies and Procedures;

(9) Department of Transportation Act of 1966, Section 4(f);

(10) Clean Water Act of 1977 and 1987;

(11) Endangered Species Act of 1973;

(12) Migratory Bird Treaty Act;

(13) National Historic Preservation Act of 1966, as amended;

(14) Historic Sites Act of 1935;

(15) Executive Order 13112, Invasive Species; and

(16) Title VI of the Civil Rights Act of 1964.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Planning and Construction. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal Programs and activities apply to this program.)

Authority: 23 U.S.C. 139(l)(1)

Issued On: November 7, 2019.

Laura S. Leffler,

Division Administrator, Federal Highway Administration, Columbus, Ohio.

[FR Doc. 2019–25792 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2019–0192]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel ANGRY FIN (Motor Vessel); Invitation for Public Comments

AGENCY: Maritime Administration, DOT.

ACTION: Notice.

SUMMARY: The Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirements of the coastwise trade laws to allow the carriage of no more than twelve passengers for hire on vessels, which are three years old or more. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before December 27, 2019.

ADDRESSES: You may submit comments identified by DOT Docket Number MARAD–2019–0192 by any one of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Search MARAD–2019–0192 and follow the instructions for submitting comments.
- *Mail or Hand Delivery:* Docket Management Facility is in the West Building, Ground Floor of the U.S. Department of Transportation. The Docket Management Facility location address is: U.S. Department of Transportation, MARAD–2019–0192, 1200 New Jersey Avenue SE, West Building, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays.

Note: If you mail or hand-deliver your comments, we recommend that you include your name and a mailing address, an email address, or a telephone number in the body of your document so that we can contact you if we have questions regarding your submission.

Instructions: All submissions received must include the agency name and specific docket number. All comments received will be posted without change to the docket at *www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments, see the section entitled Public Participation.

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE, Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel ANGRY FIN is:

—*Intended Commercial Use of Vessel:* ''Carrying of passengers for sightseeing tours''

—*Geographic Region Including Base of Operations:* ''Wisconsin'' (Base of Operations: Port Washington, WI)

—*Vessel Length and Type:* 35′ sail catamaran

The complete application is available for review identified in the DOT docket as MARAD–2019–0192 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the vessel name, state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

Public Participation

How do I submit comments?

Please submit your comments, including the attachments, following the instructions provided under the above heading entitled **ADDRESSES**. Be advised that it may take a few hours or even days for your comment to be reflected on the docket. In addition, your comments must be written in English. We encourage you to provide concise comments and you may attach additional documents as necessary. There is no limit on the length of the attachments.

Where do I go to read public comments, and find supporting information?

Go to the docket online at *http://www.regulations.gov,* keyword search MARAD–2019–0192 or visit the Docket Management Facility (see **ADDRESSES** for hours of operation). We recommend that you periodically check the Docket for

new submissions and supporting material.

Will my comments be made available to the public?

Yes. Be aware that your entire comment, including your personal identifying information, will be made publicly available.

May I submit comments confidentially?

If you wish to submit comments under a claim of confidentiality, you should submit three copies of your complete submission, including the information you claim to be confidential business information, to the Department of Transportation, Maritime Administration, Office of Legislation and Regulations, MAR–225, W24–220, 1200 New Jersey Avenue SE, Washington, DC 20590. Include a cover letter setting forth with specificity the basis for any such claim and, if possible, a summary of your submission that can be made available to the public.

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, to *www.regulations.gov,* as described in the system of records notice, DOT/ALL–14 FDMS, accessible through *www.dot.gov/privacy.* To facilitate comment tracking and response, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. Whether or not commenters identify themselves, all timely comments will be fully considered. If you wish to provide comments containing proprietary or confidential information, please contact the agency for alternate submission instructions.

(Authority: 49 CFR 1.93(a), 46 U.S.C. 55103, 46 U.S.C. 12121)

* * * * *

Dated: November 21, 2019.

By Order of the Maritime Administrator.

T. Mitchell Hudson, Jr.,

Secretary, Maritime Administration.

[FR Doc. 2019–25708 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2019–0194]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel THE NICE BOAT (Motor Vessel); Invitation for Public Comments

AGENCY: Maritime Administration, DOT.

ACTION: Notice.

SUMMARY: The Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirements of the coastwise trade laws to allow the carriage of no more than twelve passengers for hire on vessels, which are three years old or more. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before December 27, 2019.

ADDRESSES: You may submit comments identified by DOT Docket Number MARAD–2019–0194 by any one of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Search MARAD–2019–0194 and follow the instructions for submitting comments.
- *Mail or Hand Delivery:* Docket Management Facility is in the West Building, Ground Floor of the U.S. Department of Transportation. The Docket Management Facility location address is: U.S. Department of Transportation, MARAD–2019–0194, 1200 New Jersey Avenue SE, West Building, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays.

Note: If you mail or hand-deliver your comments, we recommend that you include your name and a mailing address, an email address, or a telephone number in the body of your document so that we can contact you if we have questions regarding your submission.

Instructions: All submissions received must include the agency name and specific docket number. All comments received will be posted without change to the docket at *www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments, see the section entitled Public Participation.

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE, Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel THE NICE BOAT is:

—*Intended Commercial Use of Vessel:* ''Short term chartering, days and long weekends, etc''

—*Geographic Region Including Base of Operations:* ''Massachusetts, Rhode Island, South Carolina, Florida'' (Base of Operations: Newport, RI)

—*Vessel Length and Type:* 52′ motor vessel.

The complete application is available for review identified in the DOT docket as MARAD–2019–0194 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the vessel name, state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

Public Participation

How do I submit comments?

Please submit your comments, including the attachments, following the instructions provided under the above heading entitled **ADDRESSES**. Be advised that it may take a few hours or even days for your comment to be reflected on the docket. In addition, your comments must be written in English. We encourage you to provide concise comments and you may attach additional documents as necessary. There is no limit on the length of the attachments.

Where do I go to read public comments, and find supporting information?

Go to the docket online at *http://www.regulations.gov,* keyword search MARAD–2019–0194 or visit the Docket Management Facility (see **ADDRESSES** for hours of operation). We recommend that you periodically check the Docket for new submissions and supporting material.

Will my comments be made available to the public?

Yes. Be aware that your entire comment, including your personal

identifying information, will be made publicly available.

May I submit comments confidentially?

If you wish to submit comments under a claim of confidentiality, you should submit three copies of your complete submission, including the information you claim to be confidential business information, to the Department of Transportation, Maritime Administration, Office of Legislation and Regulations, MAR–225, W24–220, 1200 New Jersey Avenue SE, Washington, DC 20590. Include a cover letter setting forth with specificity the basis for any such claim and, if possible, a summary of your submission that can be made available to the public.

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, to *www.regulations.gov,* as described in the system of records notice, DOT/ALL–14 FDMS, accessible through *www.dot.gov/privacy.* To facilitate comment tracking and response, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. Whether or not commenters identify themselves, all timely comments will be fully considered. If you wish to provide comments containing proprietary or confidential information, please contact the agency for alternate submission instructions.

(Authority: 49 CFR 1.93(a), 46 U.S.C. 55103, 46 U.S.C. 12121)

* * * * *

Dated: November 21, 2019.

By Order of the Maritime Administrator.

T. Mitchell Hudson, Jr.

Secretary, Maritime Administration.

[FR Doc. 2019–25711 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2019–0195]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel TORTUGA (Motor Vessel); Invitation for Public Comments

AGENCY: Maritime Administration, DOT.

ACTION: Notice.

SUMMARY: The Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirements of the coastwise trade laws to allow the carriage of no more than twelve passengers for hire on vessels, which are three years old or more. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before December 27, 2019.

ADDRESSES: You may submit comments identified by DOT Docket Number MARAD–2019–0195 by any one of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Search MARAD–2019–0195 and follow the instructions for submitting comments.
- *Mail or Hand Delivery:* Docket Management Facility is in the West Building, Ground Floor of the U.S. Department of Transportation. The Docket Management Facility location address is: U.S. Department of Transportation, MARAD–2019–0195, 1200 New Jersey Avenue SE, West Building, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays.

Note: If you mail or hand-deliver your comments, we recommend that you include your name and a mailing address, an email address, or a telephone number in the body of your document so that we can contact you if we have questions regarding your submission.

Instructions: All submissions received must include the agency name and specific docket number. All comments received will be posted without change to the docket at *www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments, see the section entitled Public Participation.

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE, Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel TORTUGA is:

—*Intended Commercial Use of Vessel:* ''Recreational charters''

—*Geographic Region Including Base of Operations:* ''Florida'' (Base of Operations: Fort Lauderdale, FL)

—*Vessel Length and Type:* 82′ motor vessel

The complete application is available for review identified in the DOT docket as MARAD–2019–0195 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the vessel name, state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

Public Participation

How do I submit comments?

Please submit your comments, including the attachments, following the instructions provided under the above heading entitled **ADDRESSES**. Be advised that it may take a few hours or even days for your comment to be reflected on the docket. In addition, your comments must be written in English. We encourage you to provide concise comments and you may attach additional documents as necessary. There is no limit on the length of the attachments.

Where do I go to read public comments, and find supporting information?

Go to the docket online at *http://www.regulations.gov,* keyword search MARAD–2019–0195 or visit the Docket Management Facility (see **ADDRESSES** for hours of operation). We recommend that you periodically check the Docket for new submissions and supporting material.

Will my comments be made available to the public?

Yes. Be aware that your entire comment, including your personal identifying information, will be made publicly available.

May I submit comments confidentially?

If you wish to submit comments under a claim of confidentiality, you should submit three copies of your complete submission, including the information you claim to be confidential business information, to the Department of Transportation, Maritime Administration, Office of Legislation and Regulations, MAR–225, W24–220, 1200 New Jersey Avenue SE, Washington, DC 20590. Include a cover letter setting forth with specificity the basis for any such claim and, if possible, a summary of your submission that can be made available to the public.

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, to *www.regulations.gov,* as described in the system of records notice, DOT/ALL–14 FDMS, accessible through *www.dot.gov/privacy.* To facilitate comment tracking and response, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. Whether or not commenters identify themselves, all timely comments will be fully considered. If you wish to provide comments containing proprietary or confidential information, please contact the agency for alternate submission instructions.

(Authority: 49 CFR 1.93(a), 46 U.S.C. 55103, 46 U.S.C. 12121)

* * * * *

Dated: November 21, 2019.

By Order of the Maritime Administrator.

T. Mitchell Hudson, Jr.,

Secretary, Maritime Administration.

[FR Doc. 2019–25712 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number MARAD–2019–0193]

Waiver Request for Aquaculture Support Operations for the 2020 Calendar Year: COLBY PERCE, RONJA CARRIER, SADIE JANE, MISS MILDRED 1, KC COMMANDER

AGENCY: Maritime Administration, DOT.

ACTION: Notice and request for comments.

SUMMARY: Pursuant to a delegation of authority from the Secretary of Transportation, the Maritime Administrator is authorized to issue waivers allowing documented vessels with registry endorsements or foreign flag vessels to be used in operations that treat aquaculture fish or protect aquaculture fish from disease, parasitic infestation, or other threats to their health when suitable vessels of the United States are not available that could perform those services. A request for such a waiver has been received by the Maritime Administration (MARAD). This notice is being published to solicit comments intended to assist MARAD in determining whether suitable vessels of the United States are available that could perform the required services. If no suitable U.S.-flag vessels are available, the Maritime Administrator may issue a waiver in accordance with USCG regulations on Aquaculture. A brief description of the proposed aquaculture support service is listed in the **SUPPLEMENTARY INFORMATION** section below.

DATES: Submit comments on or before December 27, 2019.

ADDRESSES: You may submit comments identified by DOT Docket Number MARAD–2019–0193 by any of the following methods:

- *On-line via the Federal Electronic Portal: http://www.regulations.gov.* Search using ''MARAD–2019–0193'' and follow the instructions for submitting comments.
- *Mail/Hand-Delivery/Courier:* Docket Management Facility; U.S. Department of Transportation, 1200 New Jersey Avenue SE, Room W12–140, Washington, DC 20590. Submit comments in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing.

Reference Materials and Docket Information: You may view the complete application, including the aquaculture support technical service requirements, and all public comments at the DOT Docket on-line via *http://www.regulations.gov.* Search using ''MARAD–2019–0193.'' All comments received will be posted without change to the docket, including any personal information provided. The Docket Management Facility is open 9:00 a.m. to 5:00 p.m., Monday through Friday, except on Federal holidays.

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE, Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.* If you have questions on viewing the Docket, call Docket Operations, telephone: (800) 647–5527.

SUPPLEMENTARY INFORMATION: As a result of the enactment of the Coast Guard Authorization Act of 2010, codified at 46 U.S.C. 12102, the Secretary of Transportation has the discretionary authority to issue waivers allowing documented vessels with registry endorsements or foreign flag vessels to be used in operations that treat aquaculture fish for or protect aquaculture fish from disease, parasitic infestation, or other threats to their health when suitable vessels of the United States are not available that could perform those services. The Secretary has delegated this authority to the Maritime Administrator. Pursuant to this authority, MARAD is providing notice of the service requirements proposed by Cooke Aquaculture (Cooke) in order to make a U.S.-flag vessel availability determination. Specifics can be found in Cooke's application letter posted in the docket.

To comply with USCG Aquaculture Support regulations at 46 CFR part 106, Cooke is seeking a MARAD Aquaculture Waiver to operate the vessels, COLBY PERCE, RONJA CARRIER, SADIE JANE, MISS MILDRED 1 and the KC COMMANDER as follows:

—*Intended Commercial Use of Vessel:* ''to use highly-specialized foreign-flag vessels referred to as a ''wellboat'' (or ''live fish carrier'') to treat Cooke's swimming inventory of farmed Atlantic salmon in the company's salt-water grow-out pens off Maine's North Atlantic Coast. This treatment prevents against parasitic infestation by sea lice that is highly destructive to the salmon's health.''

—*Geographic Region:* ''off Maine's North Atlantic Coast''

—*Requested Time Period:* ''2020 calendar year, from January 1, 2020 to December 31, 2020''

Interested parties may submit comments providing detailed information relating to the availability of U.S.-flag vessels to perform the required aquaculture support services. If MARAD determines, in accordance with 46 U.S.C. 12102(d)(1) and MARAD's regulations at 46 CFR part 388, that suitable U.S.-flag vessels are available to perform the required services, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria set forth in 46 CFR 388.4.

Privacy Act

In accordance with 5 U.S.C. 553(c), MARAD solicits comments from the public to inform its process to determine the availability of suitable vessels. DOT posts these comments, without edit, to *www.regulations.gov,* as described in the system of records notice, DOT/ALL–14 FDMS, accessible through *www.dot.gov/privacy.* In order to facilitate comment tracking and response, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. Whether or not commenters identify themselves, all timely comments will be fully considered. If you wish to provide comments containing proprietary or confidential information, please contact

the agency for alternate submission instructions.

(Authority: 49 CFR 1.93(w))

* * * * *

Dated: November 21, 2019.
By Order of the Maritime Administrator.

T. Mitchell Hudson, Jr.,

Secretary, Maritime Administration.

[FR Doc. 2019–25710 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

[Docket No. DOT–OST—2019–0167]

Rural Opportunities To Use Transportation for Economic Success: Request for Information

AGENCY: Office of the Secretary, Department of Transportation (DOT).

ACTION: Request for information (RFI).

SUMMARY: On October 28, 2019, the Secretary of Transportation issued an order launching the Rural Opportunities to Use Transportation for Economic Success (ROUTES) initiative. ROUTES will help the Department of Transportation (DOT) address disparities in rural transportation infrastructure to tangibly improve safety and economic competitiveness in all parts of the country. This notice requests comments on unmet transportation infrastructure needs in rural transportation, barriers that rural communities face in addressing these needs, stakeholders' experiences with applying to and using DOT discretionary grant and credit programs, and opportunities for DOT to improve its services and technical assistance to rural communities in relation to these grant and credit programs.

DATES: Comments must be received on or before 30 days from posting of this notice. DOT will consider comments filed after this date to the extent practicable.

ADDRESSES: Comments should refer to the docket number above and be submitted by one of the following methods:

- *Electronic Submission:* Go to *http://www.regulations.gov.* Search by using the docket number (provided above). Follow the instructions for submitting comments on the electronic docket site.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building Ground Floor, Room PL–401, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* 1200 New Jersey Avenue SE, West Building Ground Floor, Room PL–401, Washington, DC, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal Holidays.

Instructions: All submissions must include the agency name and docket numbers.

Note: All comments received, including any personal information, will be posted without change to the docket and will be accessible to the public at *http://www.regulations.gov.* You should not include information in your comment that you do not want to be made public. Input submitted online via *www.regulations.gov* is not immediately posted to the site. It may take several business days before your submission is posted.

FOR FURTHER INFORMATION: Visit *http://www.transportation.gov/rural*, or contact Robert Hyman at *rural@dot.gov* or 202–366–5843.

SUPPLEMENTARY INFORMATION:

Background

The mission of the DOT is to ensure our Nation has the safest, most efficient, and modern transportation system in the world; that improves the quality of life for all American people and communities, from rural to urban; and increases the productivity and competitiveness of American workers and businesses. To accomplish this mission, Congress authorizes and appropriates funds to the DOT, which administers a large portfolio of grant and credit programs to maintain and improve aspects of our transportation network. Each year, DOT awards billions of dollars in discretionary transportation grants using prescribed selection and eligibility criteria.

Rural transportation networks are critically important for domestic uses and export of agriculture, mining, and energy commodities, as well as the quality of life for all Americans. However, rural networks face unique challenges in safety, infrastructure condition, and usage.

To address these issues, on October 28, 2019, the Secretary of Transportation issued an order launching the Rural Opportunities to Use Transportation for Economic Success (ROUTES) initiative. ROUTES will improve how the DOT considers rural project applications in DOT's discretionary grant and credit programs, including ensuring that project costs, local resources, and the benefits to the American people and economy are appropriately considered. It will also provide rural communities with technical assistance for meeting the Nation's transportation infrastructure investment needs in a financially sustainable manner.

DOT seeks information directly from the public and other stakeholders to inform the development and implementation of the ROUTES initiative. DOT seeks comments that illustrate rural communities' needs and experiences with transportation infrastructure, including the condition of that infrastructure, its effect on safety, and how its use affects the community. For the purpose of this notice, ''transportation'' includes road, rail, transit, aviation, maritime, pipelines, and other forms of transportation; ''infrastructure'' includes all capital investment in transportation such as structures, equipment, and rolling stock. This includes comments and data pertaining to current unmet needs in rural transportation, barriers rural communities face in addressing these transportation needs, stakeholders' experiences with applying to and using DOT discretionary grant and credit programs, and opportunities for the DOT to improve its services and technical assistance to rural communities in relation to these grant and credit programs, within the limits of statutory requirements. In addition, DOT specifically requests comments and data in response to the questions below. To the extent possible, DOT seeks relevant technical information, regulatory citations, data, or other evidence to support the comments received.

1. Identifying Unmet Needs in Rural Transportation

A. What infrastructure issues are contributing to high fatality rates on rural roadways and rail-highway grade crossings (*e.g.,* roadway condition or geometry, driver behavior, wildlife collisions)?

B. What unique challenges do rural areas face related to infrastructure condition (*e.g.,* age of infrastructure or equipment, including vehicles, bridge closures or postings, types of freight carried, weather resiliency)?

C. How does infrastructure usage (*e.g.,* access to public transportation, technology deployment) affect the lives of rural Americans?

D. What types of infrastructure projects are most needed in rural communities to meet national transportation priorities such as safety and economic competitiveness?

E. What types of rural transportation projects or services do rural communities find challenging to fund?

F. What additional or alternative methods can be used to identify and prioritize rural transportation projects for funding through discretionary grants?

2. Addressing Unmet Needs Through DOT Discretionary Grant Programs

A. What resources or direct assistance could DOT provide to support rural transportation projects or reach communities that may not be aware of DOT discretionary programs?

B. What challenges do rural communities face when applying for DOT grants and financial assistance (*e.g.,* project prioritization, eligibility requirements, funding match)?

C. What types of technical assistance would be effective for navigating the application process?

Public Comment

DOT invites comments by all those interested in the Rural Opportunities to Use Transportation for Economic Success (ROUTES) initiative. Comments may be submitted and viewed at Docket Number DOT–OST–2019–0167 at *http://www.regulations.gov,* or at the address given above under **ADDRESSES**. Comments must be received on or before 30 days from posting of this notice to receive full consideration by DOT. After 30 days from posting of this notice, comments will continue to be available for viewing by the public.

Issued in Washington, DC, on November 22, 2019, under authority delegated at 49 U.S.C. 1.25a.

Joel Szabat,

Acting Under Secretary of Transportation for Policy.

[FR Doc. 2019–25785 Filed 11–26–19; 8:45 am]

BILLING CODE 4910–9X–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Internal Revenue Service, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on information collections, as required by the Paperwork Reduction Act of 1995. The IRS is soliciting comments concerning the substantiation of charitable contributions (§ 1.170A–13).

DATES: Written comments should be received on or before January 27, 2020. to be assured of consideration.

ADDRESSES: Direct all written comments to Dr. Philippe Thomas, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224.

FOR FURTHER INFORMATION: Requests for additional information or copies of the information collection should be directed to Sara Covington, (202) 317–6038, at Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or through the internet, at *Sara.L.Covington@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Substantiation of Charitable Contributions.

OMB Number: 1545–0754.

Regulation Project Number: TD 8002.

Abstract: This regulation provides guidance relating to substantiation requirements for charitable contributions. Section 1.170A–13 of the regulation requires donors to maintain receipts and other written records to substantiate deductions for charitable contributions.

Current Actions: There is no changes in the paperwork burden previously approved by OMB.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or households, and business or other for-profit organizations.

Estimated Number of Respondents: 26,000,000.

Estimated Time per Respondent: 5 minutes.

Estimated Total Annual Burden Hours: 2,158,000.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: November 18, 2019.

Philippe Thomas,

IRS Supervisory Tax Analyst.

[FR Doc. 2019–25741 Filed 11–26–19; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 4768

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Internal Revenue Service, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on information collections, as required by the Paperwork Reduction Act of 1995. The IRS is soliciting comments concerning Form 4768, Application for Extension of Time To File a Return and/or Pay U.S. Estate (and Generation-Skipping Transfer) Taxes.

DATES: Written comments should be received on or before January 27, 2020 to be assured of consideration.

ADDRESSES: Direct all written comments to Dr. Philippe Thomas, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Sara Covington at Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or at (202) 317–6038, or through the internet at *sara.l.covington@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Application for Extension of Time To File a Return and/or Pay U.S. Estate (and Generation-Skipping Transfer) Taxes.

OMB Number: 1545–0181.

Form Number: 4768.

Abstract: Form 4768 is used to request an extension of time to file an estate

(and generation-skipping) tax return and/or to pay the estate (and generation-skipping) taxes and to explain why the extension should be granted. IRS uses the information to decide whether the extension should be granted.

Current Actions: Section V, notice to applicant—to be completed by Internal Revenue Service was removed. This removal of seven lines, and 52 words, will result in a decrease of burden hours.

Type of Review: Revision of a currently approved collection.

Affected Public: Individuals and business or other for-profit organizations.

Estimated Number of Respondents: 18,500.

Estimated Time per Respondent: 1 hour, 30 minutes.

Estimated Total Annual Burden Hours: 27,565.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: November 18, 2019.

Philippe Thomas,

IRS Supervisory Tax Analyst.

[FR Doc. 2019–25740 Filed 11–26–19; 8:45 am]

BILLING CODE 4830–01–P

FEDERAL REGISTER

Vol. 84 Wednesday,

No. 229 November 27, 2019

Part II

Department of the Treasury

Internal Revenue Service

26 CFR Part 54

Department of Labor

Employee Benefits Security Administration

29 CFR Part 2590

Department of Health and Human Services

45 CFR Subchapter E, Part 147, and Part 158

Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public; Transparency in Coverage; Final Rule and Proposed Rule

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG–118378–19]

RIN 1545–BP47

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AB93

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147 and 158

[CMS–9915–P]

RIN 0938–AU04

Transparency in Coverage

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: Proposed rule.

SUMMARY: These proposed rules set forth proposed requirements for group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee (or his or her authorized representative), including an estimate of such individual's cost-sharing liability for covered items or services furnished by a particular provider. Under these proposed rules, plans and issuers would be required to make such information available on an internet website and, if requested, through non-internet means, thereby allowing a participant, beneficiary, or enrollee (or his or her authorized representative) to obtain an estimate and understanding of the individual's out-of-pocket expenses and effectively shop for items and services. These proposed rules also include proposals to require plans and issuers to disclose in-network provider negotiated rates, and historical out-of-network allowed amounts through two machine-readable files posted on an internet website, thereby allowing the public to have access to health insurance coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending. The Department of Health and Human Services (HHS) also proposes amendments to its medical loss ratio program rules to allow issuers offering group or individual health insurance coverage to receive credit in their medical loss ratio calculations for savings they share with enrollees that result from the enrollee's shopping for, and receiving care from, lower-cost, higher-value providers.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 14, 2020.

ADDRESSES: Written comments may be submitted to the addresses specified below. Any comment that is submitted will be shared with the Department of the Treasury (Treasury Department), Internal Revenue Service (IRS) and the Department of Labor (DOL). Please do not submit duplicates.

All comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the internet exactly as received, and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

In commenting, please refer to file code CMS–9915–P. Because of staff and resource limitations, the Departments of Labor, HHS, and the Treasury (the Departments) cannot accept comments by facsimile (FAX) transmission.

Comments must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9915–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9915–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. The comments are posted on the following website as soon as possible after they have been received *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

FOR FURTHER INFORMATION CONTACT:

Deborah Bryant, Centers for Medicare and Medicaid Services, (301) 492–4293.

Christopher Dellana, Internal Revenue Service, (202) 317–5500.

Matthew Litton or David Sydlik, Employee Benefits Security Administration, (202) 693–8335.

Customer Service Information: Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit DOL's website (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (*www.cms.gov/cciio*) and information on health reform can be found at *http://www.healthcare.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Executive Order

On June 24, 2019, President Trump issued Executive Order 13877, ''Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First.'' [1] Section 3(b) of Executive Order 13877 directs the Secretaries of the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) to issue an advance notice of proposed rulemaking (ANPRM), consistent with applicable law, soliciting comment on a proposal to require health care providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care. The Departments have considered the issue, including by consulting with stakeholders, and have determined that a notice of proposed rulemaking (NPRM), rather than an ANPRM, would allow for more specific and useful feedback from commenters, who would

[1] 84 FR 30849 (June 27, 2019). The Executive Order was issued on June 24, 2019 and was published in the **Federal Register** on June 27, 2019.

be able to respond to specific proposals. Additionally, increases in health care costs and out-of-pocket liability without transparent, meaningful information about health care pricing have left consumers with little ability to make cost-conscious decisions when purchasing health care items and services. An NPRM, rather than an ANPRM, would enable the Departments to more quickly address this pressing issue.

B. Benefits of Transparency in Health Coverage and Past Efforts To Promote Transparency

As explained earlier in this preamble, these proposed rules will fulfill the Departments' responsibility under Executive Order 13877. These proposed rules also would implement legislative mandates under sections 1311(e)(3) of the Patient Protection and Affordable Care Act (PPACA) and section 2715A of the Public Health Service (PHS) Act. The overarching goal of these proposed rules is to support a market-driven health care system by giving consumers the information they need to make informed decisions about their health care and health care purchases. Specifically, the purposes of these proposed rules are to provide consumers with price and benefit information that will enable them to evaluate health care options and to make cost-conscious decisions; reduce surprises in relation to consumers' out-of-pocket costs for health care services; create a competitive dynamic that will begin to narrow price differences for the same services in the same health care markets; foster innovation by providing industry the information necessary to support informed, price-conscious consumers in the health care market; and, over time, potentially lower overall health care costs. The Departments are of the view that this price transparency effort will equip consumers with information to actively and effectively participate in the health care system, the prices for which should be driven and controlled by market forces. For these reasons and those explained in more detail later in this preamble, these price transparency efforts are crucial to providing consumers with information about health care costs and to stabilizing health care spending.

As explained in the report ''Reforming America's Healthcare System through Choice and Competition,'' [2] consumers have an important role to play in controlling costs, but consumers must have meaningful information in order to create the market forces necessary to achieve lower health care costs. Most health care consumers rely on third-party payers, including the government and private health insurance, to reimburse health care providers for a large portion of their health care costs. Third-party payers negotiate prices with health care providers and reimburse the providers on the consumer's behalf, which conceals from consumers the true market price of their care. When consumers seek care, they do not typically know whether they could have received the same service from another provider offering lower prices. Because a large portion of insured consumers' out-of-pocket financial liability has historically, for many consumers, not been dependent on the provider's negotiated rate with the third-party payer, there has been little or no incentive for some consumers to consider price and seek out lower-cost care.[3] However, as health care spending continues to rise, consumers are shouldering a greater portion of their health care costs.[4]

In the private health insurance market, consumers are responsible for a greater share of their health care costs through higher deductibles and shifts from copayments to coinsurance.[5] A deductible is the amount a consumer pays for covered health services before his or her health plan starts to pay.[6] Generally, the amount the consumer pays for a specific item or service furnished by a network provider before the deductible is met is the rate the group health plan or health insurance issuer has negotiated with the provider, also referred to as the negotiated rate. A study of large employer health plans found that the portion of payments paid by consumers for deductibles increased from 20 percent to 51 percent between 2003 and 2017.[7] Furthermore, enrollment in health plans with high deductibles is also increasing. In 2018, the Centers for Disease Control and Prevention estimated that 47 percent of persons under age 65 with private health insurance were enrolled in health plans with high deductibles, up from 25.3 percent in 2010.[8]

Coinsurance is the percentage of costs a participant, beneficiary, or enrollee pays for a covered item or service after he or she has paid his or her deductible.[9] Copayments (sometimes called ''copays'') are a fixed amount ($20, for example) that a consumer pays for a covered item or service, usually when he or she receives the service. Copays can vary for different items or services within the same plan, like prescription drugs, laboratory tests, and visits to specialists.[10] Copayments are both more predictable for consumers, because the copayment amount is set in advance, and often less expensive for consumers than coinsurance amounts. For instance, assuming an individual has met his or her deductible, if a plan or issuer has negotiated the cost of a procedure with a particular provider to be $1,000, and the plan or issuer has a 20 percent coinsurance requirement, the individual would be responsible for paying a $200 coinsurance amount toward the cost of the procedure.

In the health care market, where consumers generally are responsible for paying higher deductibles and have more cost sharing in the form of coinsurance, out-of-pocket liability is often directly contingent upon the reimbursement rate a health plan has negotiated with a provider. The fact that more consumers are bearing greater financial responsibility for the cost of their health care provides the opportunity to establish a consumer-driven health care market. If consumers have better pricing information and can shop for health care items and services more efficiently, they can increase competition and demand for lower prices.[11] Currently, however, consumers

[2] Azar, A.M., Mnuchin, S.T., and Acosta, A. ''Reforming America's Healthcare System Through Choice and Competition.'' December 3, 2018. Available at: *https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.*

[3] *Id.*

[4] Claxton, G., Levitt, L., Long M. ''Payments for cost sharing increasing rapidly over time.'' Peterson-Kaiser Health System Tracker. April 2016. Available at: *https://www.healthsystemtracker.org/brief/payments-for-cost-sharing-increasing-rapidly-over-time/.*

[5] Ray, M., Copeland, R., Cox, C. ''Tracking the rise in premium contributions and cost-sharing for families with large employer coverage,'' Peterson-Kaiser Health System Tracker. August 14, 2019. Available at: *https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/.*

[6] *https://www.healthcare.gov/glossary/deductible/.*

[7] Claxton, G., Levitt, L., Long, M. ''Payments for cost sharing increasing rapidly over time.'' Peterson-Kaiser Health System Tracker. April 2016. Available at: *https://www.healthsystemtracker.org/brief/payments-for-cost-sharing-increasing-rapidly-over-time/.*

[8] Cohen, R., Martinez, M., Zammitti, E. ''Health insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2018.'' August 2018. Available at: *https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf.*

[9] *https://www.healthcare.gov/glossary/co-insurance/.*

[10] *https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf.*

[11] Azar, A.M., Mnuchin, S.T., and Acosta, A. ''Reforming America's Healthcare System Through Choice and Competition.'' December 3, 2018. Available at: *https://www.hhs.gov/sites/default/*

Continued

have little insight into negotiated rates until after services are rendered. As a result, it can be difficult for consumers to estimate potential out-of-pocket costs because of the wide variability in health care prices for the same service.[12]

Without transparency in pricing, there are little to no market forces to drive competition, as demonstrated by significant variations in prices for procedures,[13] even within a local region. For example, a study of price variation in the San Francisco area showed that, even for a relatively commoditized service such as a lower-back MRI, prices ranged from $500 to $10,246.[14] A study on reference pricing in the California Public Employees' Retirement System found a range of $12,000 to $75,000 for the same joint replacement surgery, $1,000 to $6,500 for cataract removal, and $1,250 to $15,500 for arthroscopy of the knee.[15] Variability in pricing, such as in these examples, suggests that there is substantial opportunity for increased transparency to save money by shifting patients from high to lower-cost providers.[16]

Many empirical studies have investigated the impact of price transparency on markets, with most research showing that price transparency leads to lower and more uniform prices, consistent with predictions of standard economic theory. One study notes special characteristics of the health market, including that: (1) Diseases and treatments affect each patient differently, making health care difficult to standardize and making price dispersion difficult to monitor; (2) patients cannot always know what they want or need, and physicians must serve as their agents; and (3) patients are in a poor position to choose a hospital because they do not have a lot of information about hospital quality and costs.[17] This study suggests that these special characteristics of the health care market, among other relevant factors, make it difficult to draw conclusions based on empirical evidence gathered from other markets. Nevertheless, the same study concluded that despite these complications, greater price transparency, such as access to posted prices, might lead to more efficient outcomes and lower prices.

In Kentucky, public employees are provided with a price transparency tool that allows them to shop for health care services and share in any cost-savings realized by seeking lower-cost care. Over a 3-year period, 42 percent of eligible employees used the program to look up information about prices and rewards and 57 percent of those chose at least one more cost-effective provider, saving state taxpayers $13.2 million and resulting in $1.9 million in cash benefits paid to public employees for seeking lower cost care.[18] In 2007, New Hampshire launched a website that allows consumers with private health insurance to compare health care costs and quality.[19] In a recent study of the New Hampshire price transparency tool, researchers found that health care price transparency can shift care to lower-cost providers and save consumers and payers money.[20] The study specifically focused on X-rays, CT scans, and MRI scans; determined that the transparency tool reduced the costs of medical imaging procedures by 5 percent for patients and 4 percent for issuers; and estimated savings of $7.9 million for patients and $36 million for issuers over a 5-year period. At the end of the 5-year period, out-of-pocket costs for these services in New Hampshire were 11 percent lower than for medical imaging services not included in the transparency tool. Individuals who had not yet satisfied their deductible saw almost double the savings, and prices for services listed in the tool became less dispersed over time.[21] The Departments are of the view that health care markets could work more efficiently and provide consumers with lower cost health care if individuals could see an estimate of their out-of-pocket liability prior to making their health care purchases.

A study of enrollees in plans with high deductibles found that respondents wanted additional health care pricing information so they could make more informed decisions about where to seek care based on price.[22] Another study found that 71 percent of respondents said that out-of-pocket spending was either important or very important to them when choosing a doctor.[23]

Currently, the information that consumers need to make informed decisions based on the prices of health care services is not readily available. The 2011 Government Accountability Office (GAO) report, ''Health Care Price Transparency: Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care,'' found that the lack of transparency in health care prices, coupled with the wide pricing disparities for particular procedures within the same market, can make it difficult for consumers to understand health care prices and to effectively shop for value.[24] The report references a number of barriers that make it difficult for consumers to obtain price estimates in advance for health care services. Such barriers include, for example, the difficulty of predicting health care service needs in advance, a complex billing structure resulting in bills from multiple providers, the variety of insurance benefit structures, and the lack of public disclosure of rates negotiated between providers and third-party payers.

The GAO report also explored various price transparency initiatives, including tools that consumers could use to generate price estimates before receiving a health care service. The report notes that pricing information displayed by tools varies across initiatives, in large

files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

[12] Cooper, Z., Craig, S., Gaynor, M., Reenen J. ''The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured.'' 134. Q. J. of Econ 51. September 4, 2018. Available at: *https://academic.oup.com/qje/article/134/1/51/5090426?searchresult=1.*

[13] *Id.*

[14] Pinder, J. ''Why do MRI prices vary so much? And a note about our data.'' Clear Health Costs. July 17, 2014. Available at: *https://clearhealthcosts.com/blog/2014/07/prices-vary-much-mini-case-study-mri/.*

[15] Boynton, A., Robinson, J. ''Appropriate Use of Reference Pricing Can Increase Value.'' Health Affairs Blog. July 7, 2015. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20150707.049155/full/.*

[16] Sinaiko, A., Rosenthal, M. ''Examining a Health Care Price Transparency Tool: Who Uses it, and How They Shop for Care.'' 35 Health Affairs 662. April 2016. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0746.*

[17] Congressional Research Service Report to Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector, July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[18] Rhoads, J. ''Right to Shop for Public Employees: How Health Care Incentives are Saving Money in Kentucky.'' Dartmouth Inst. for Health Pol'y and Clinical Prac. March 8, 2019. Available at: *https://thefga.org/wp-content/uploads/2019/03/RTS-Kentucky-HealthCareIncentivesSavingMoney-DRAFT8.pdf.*

[19] ''Compare Health Costs & Quality of Care in New Hampshire.'' NH HealthCost. *https://nhhealthcost.nh.gov/.*

[20] Brown, Z. ''Equilibrium Effects of Health Care Price Information.'' 100 Rev. of Econ. and Stat. 1. July 16, 2018. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*)

[21] *Id.*

[22] Sinaiko, A., Mehrotra, A., Sood, N. ''Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game.'' 176 JAMA Intern. Med. 395. March 2016. Available at: *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2482348.*

[23] Ateev, M., Dean, K., Sinaiko, A., Neeraj, S. ''Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information.'' 36 Health Affairs. 1392. August 2017. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1471.*

[24] *https://www.gao.gov/products/GAO-11-791.*

part due to limits reported by the initiatives in their access or authority to collect certain necessary price data. According to the GAO report, transparency initiatives that provided consumers with a reasonable estimate of their complete costs integrated pricing data from both providers and plans and issuers. The GAO report, therefore, recommended that HHS determine the feasibility, and the next steps, of making estimates of out-of-pocket costs [25] for health care services available to consumers.[26]

States have been at the forefront of transparency initiatives and some have required disclosure of pricing information for years. More than half of the states have passed legislation establishing price transparency websites or mandating that health plans, hospitals, or physicians make pricing information available to patients.[27] As of early 2012, there were 62 consumer-oriented, state-based health care price comparison websites. Half of these websites were launched after 2006, and most were hosted by a state government agency (46.8 percent) or hospital association (38.7 percent). Most websites reported prices of inpatient care for medical conditions (72.6 percent) or surgeries (71.0 percent). Information about prices of outpatient services such as diagnostic or screening procedures (37.1 percent), radiology studies (22.6 percent), prescription drugs (14.5 percent), or laboratory tests (9.7 percent) were reported less often.[28] However, it is important to note that the state efforts directed at plans are not applicable to self-insured group health plans. As a result, the data collected does not include data from self-insured group health plans and a significant portion of consumers would not have access to information on their plans.

States have adopted a variety of approaches to improve price transparency.[29] In 2012, Massachusetts began requiring issuers to provide, upon request, the estimated amount insured patients would be responsible to pay for proposed admissions, procedures, or services based upon the information available to the issuer at the time, and also began requiring providers to disclose the charge for the admission, procedure, or service upon request by the patient within 2 working days.[30] Sixteen states have implemented all-payer claims databases that include health care prices and quality information; and of these 16 states, 8 states make both price and quality information available to the public through state-based websites.[31]

Health insurance issuers and self-insured group health plans also have moved in the direction of increased price transparency. For example, some group health plans are using price transparency tools to incentivize employees to make cost conscious decisions when purchasing health care services. Most large issuers have embedded cost estimator tools into their enrollee websites, and some provide their enrollees with comparative cost information, which includes rates that the issuers and plans have negotiated with in-network providers and suppliers.

In the HHS 2020 Notice of Benefit and Payment Parameters (2020 Payment Notice) proposed rule,[32] HHS sought input on ways to provide consumers with greater transparency with regard to their own health care data, Qualified Health Plan (QHP) offerings on the Federally-facilitated Exchanges (FFEs),[33] and the cost of health care services. Additionally, HHS sought comment on ways to further implement section 1311(e)(3) of PPACA, as implemented by 45 CFR 156.220(d), under which, upon the request of an enrollee, a QHP issuer must make available in a timely manner the amount of enrollee cost sharing under the enrollee's coverage for a specific service furnished by an in-network provider. HHS was particularly interested in what types of data would be most useful to improving consumers' abilities to make informed health care decisions, including decisions related to their coverage specifications and ways to improve consumer access to information about health care costs.

Commenters on the 2020 Payment Notice overwhelmingly supported the idea of increased price transparency. Many commenters provided suggestions for defining the scope of price transparency requirements, such as providing costs for both in-network and out-of-network health care, and providing health care cost estimates that include an accounting for consumer-specific benefit information, like progress toward meeting deductibles and out-of-pocket limits, as well as remaining visits under visit limits. Commenters expressed support for implementing price transparency requirements across all private markets and for price transparency efforts to be a part of a larger payment reform effort and a provider empowerment and patient engagement strategy. Some commenters advised HHS to carefully consider how such policies should be implemented, warning against federal duplication of state efforts and requirements that would result in group health plans and health insurance issuers passing along increased administrative costs to consumers, and cautioning that the proprietary and competitive nature of payment data should be protected.

In the summer and fall of 2018, HHS hosted listening sessions related to the goal of empowering consumers by ensuring the availability of useable pricing information. Participants included a wide representation of stakeholders from providers, issuers, researchers, and consumer and patient advocacy groups. Participants noted that currently available pricing tools are underutilized, in part because consumers are often unaware that they exist, and even when used, the tools sometimes convey inconsistent and inaccurate information.

Participants also commented that tool development can be expensive, especially for smaller health plans, which tend to invest less in technology because of the limited return on investment. Participants also commented that most tools developed to date do not allow for comparison shopping. Participants stated that existing tools usually use historical claims data, which results in broad, sometimes regional estimates, rather than accurate and individualized prices. In addition, participants noted pricing tools are rarely available when and where consumers are likely to make health care decisions, for example, during interactions with providers. This

[25] GAO defines an estimate of a consumer's complete health care cost as pricing information on a service that identifies a consumer's out-of-pocket cost, including any negotiated discounts, and all costs associated with a service or services.

[26] *https://www.gao.gov/products/GAO-11-791.*

[27] Frakt, A., Mehrotra, A. ''What Type of Price Transparency Do We Need in Health Care?'' 170 Ann. Intern. Med. 561. April 16, 2019. Available at: *https://mfprac.com/web2019/07literature/literature/Misc/HealthTransparency_Frankt.pdf.*

[28] Kullgren, J., Duey, K, Werner, R. ''A Census of State Health Care Price Transparency Websites.'' 309 JAMA 2437. June 19, 2013. Available at: *https://jamanetwork.com/journals/jama/fullarticle/1697957.*

[29] ''2017 Price Transparency & Physician Quality Report Card.'' Catalyst for Payment Reform. Available at: *https://www.catalyze.org/product/2017-price-transparency-physician-quality-report-card/.*

[30] Jenkins, K. ''CMS Price Transparency Push Trails State Initiatives.'' Nat'l L. Rev. February 8, 2019. Available at: *https://www.natlawreview.com/article/cms-price-transparency-push-trails-state-initiatives.*

[31] ''The State Of State Legislation Addressing Health Care Costs And Quality,'' Health Affairs Blog. August 22, 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20190820.483741/full/.*

[32] 84 FR 227 (Jan. 24, 2019).

[33] The term ''Exchanges'' means American Health Benefit Exchanges established under section 1311 of PPACA. *See* section 2791(d)(21) of the PHS Act.

means that patients are not able to consider relevant cost issues when discussing referral options or the tradeoffs of various treatment options with referring providers. In a national study, there was alignment between patients, employers, and providers in wanting to know and discuss the cost of care at the point of service.[34] With access to patient-specific cost estimates for services furnished by particular providers, referring providers and their patients could take pricing information into account when considering treatment options.

In response to this feedback, CMS has pursued initiatives in addition to these proposed rules to improve access to the information necessary to empower consumers to make more informed decisions about their health care costs. These initiatives have included a multi-step effort to implement section 2718(e) of the PHS Act, which was added by section 1001 of PPACA (Pub. L. 111–148), as amended by section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152). Section 2718(e) of the PHS Act requires each hospital operating within the United States to, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act (SSA). In the Fiscal Year (FY) 2015 Hospital Inpatient Prospective Payment Systems and Long Term Care Hospital Prospective Payment Systems (IPPS/LTCH PPS) final rule,[35] CMS reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the PHS Act and provided guidelines for its implementation. At that time, CMS required hospitals to either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry. In addition, CMS stated that it expected hospitals to update the information at least annually, or more often as appropriate, to reflect current charges, and encouraged hospitals to undertake efforts to engage in consumer-friendly communication of their charges to enable consumers to compare charges for similar services across hospitals and to help them understand what their potential financial liability might be for items and services they obtain at the hospital.

In the FY 2019 IPPS/LTCH PPS final rule,[36] CMS again reminded hospitals of their obligation to comply with section 2718(e) of the PHS Act and announced an update to its guidelines. The updated guidelines, which have been effective since January 1, 2019, require hospitals to make available a list of their current standard charges (whether in the form of a ''chargemaster'' or another form of the hospital's choice) via the internet in a machine-readable format and to update this information at least annually, or more often as appropriate. The intent of the guidelines is to improve consumer access to important information regarding the cost of their health care through hospital websites. Price transparency and the ability to compare standard charges across hospitals can empower consumers to be more informed and exercise greater control over their purchasing decisions.

In response to stakeholder feedback and Executive Order 13877, CMS took another important step toward improving health care value and increasing competition in the Calendar Year 2020 Hospital Outpatient Policy Payment System (OPPS) Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates: Price Transparency Requirements for Hospitals to Make Standard Charges Public (CMS–1717–F2) final rule (OPPS Price Transparency final rule) by codifying requirements under section 2718(e) of the PHS Act as well as a regulatory scheme under section 2718(b)(3) of the PHS Act that enables CMS to enforce those requirements.[37] To further improve public access to meaningful hospital charge information, CMS is requiring hospitals to make publicly available their gross charges (as found in the hospital's chargemaster), their payer-specific negotiated charges, their discounted cash prices, and their de-identified minimum and maximum negotiated charges for all items and services they provide through a single online machine-readable file that is updated at least once annually. Additionally, the final rule requires hospitals to display online in a consumer-friendly format the payer-specific negotiated charges, discounted cash prices and de-identified minimum and maximum negotiated charges for as many of the 70 shoppable services selected by CMS that the hospital provides and as many additional hospital-selected shoppable services as are necessary for a combined total of at least 300 shoppable services (or if the hospital provides less than 300 shoppable services, then as many as the hospital provides). CMS defines shoppable services as a service that can be scheduled by a health care consumer in advance, and has further explained that shoppable services are typically those that are routinely provided in non-urgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule such services at times that are convenient for them.

The Departments have concluded that the final rules under section 2718(e) of the PHS Act would not result in consumers receiving complete price estimates for health care items and services because, as the GAO concluded, complete price estimates require pricing information from both providers and health insurance issuers.[38] In addition, because section 2718(e) of the PHS Act applies only to items and services provided by hospitals, the final requirements under that section would not improve the price transparency of items and services provided by other health care entities. Accordingly, the Departments have concluded that additional price transparency efforts are necessary to empower a more price-conscious and responsible health care consumer, promote competition in the health care industry, and lower the overall rate of growth in health care spending.

Despite these price transparency efforts, there continues to be a lack of easily accessible pricing information for consumers to use when shopping for health care services. While there are several efforts across states, many still do not require private market plans and issuers to provide real-time, out-of-pocket cost estimates to participants, beneficiaries, and enrollees.[39] Furthermore, states do not have authority to require such disclosures to participants and beneficiaries of self-insured group health plans, which compose a significant portion of the private market.[40] These proposed rules are meant, in part, to address this lack of easily accessible pricing information,

[34] ''Let's Talk About Money.'' University of Utah. *https://uofuhealth.utah.edu/value/lets-talk-about-money.php.*

[35] 79 FR 49854, 50146, (Aug. 22, 2014).

[36] 83 FR 41144, 41686 (Aug. 17, 2018).

[37] Published elsewhere in this issue of the **Federal Register**.

[38] *https://www.gao.gov/products/GAO-11-791.*

[39] ''2017 Price Transparency & Physician Quality Report Card.'' Catalyst for Payment Reform. Available at: *https://www.catalyze.org/product/2017-price-transparency-physician-quality-report-card/.*

[40] Self-Insured Health Benefit Plans 2019: Based on Filings through Statistical Year 2016. January 7, 2019. Available at: *https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2019-appendix-b.pdf.*

and represent a critical part of the Departments' overall strategy for reforming health care markets by promoting transparency, competition, and choice across the health care industry.

The Departments, therefore, believe that additional rulemaking is necessary and appropriate to ensure consumers can exercise meaningful control over their health care and health care spending. The disclosures that the Departments are proposing to require would ensure consumers have ready access to the information they need to estimate their potential out-of-pocket costs for health care items and services before a service is delivered. These proposed rules would also empower consumers by incentivizing market innovators to help consumers understand how their plan or coverage pays for health care and to shop for health care based on price, which is a fundamental factor in any purchasing decision.

C. Statutory Background and Enactment of PPACA

The Patient Protection and Affordable Care Act was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 was enacted on March 30, 2010 (collectively, PPACA). As relevant here, 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 the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815 to the Internal Revenue Code (Code) to incorporate the provisions of part A of title XXVII of the PHS Act, PHS Act sections 2701 through 2728 into ERISA and the Code, making them applicable to plans and issuers providing health insurance coverage in connection with group health plans.

1. Transparency in Coverage

Section 2715A of the PHS Act provides that group health plans and health insurance issuers offering group or individual health insurance coverage shall comply with section 1311(e)(3) of PPACA, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the state's insurance commissioner, and make such information available to the public. Section 1311(e)(3) of PPACA addresses transparency in health care coverage and imposes certain reporting and disclosure requirements for health plans that are seeking certification as QHPs that may be offered on an Exchange.

Paragraph (A) of section 1311(e)(3) of PPACA requires plans seeking certification as a QHP to submit the following information to state insurance regulators, the Secretary of HHS, and the Exchange and to make that information available to the public:

- Claims payment policies and practices,
- Periodic financial disclosures,
- Data on enrollment,
- Data on disenrollment,
- Data on the number of claims that are denied,
- Data on rating practices,
- Information on cost sharing and payments with respect to any out-of-network coverage, and
- Information on enrollee and participant rights under this title.

Paragraph (A) also requires plans seeking certification as a QHP to submit any ''[o]ther information as determined appropriate by the Secretary.''

Paragraph (C) requires those plans, as a requirement of certification as a QHP, to permit individuals to learn the amount of cost sharing (including deductibles, copayments, and coinsurance) under the individual's coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by an in-network provider in a timely manner upon the request of the individual. Paragraph (C) specifies that, at a minimum, such information shall be made available to such individual through an internet website and such other means for individuals without access to the internet.

On March 27, 2012, HHS issued the Exchange Establishment final rule [41] that implemented sections 1311(e)(3)(A) through (C) of PPACA at 45 CFR 155.1040(a) through (c) and 156.220. The Exchange Establishment final rule created standards for QHP issuers to submit specific information related to transparency in coverage. QHPs are required to post and make data related to transparency in coverage available to the public in plain language and submit this same data to HHS, the Exchange, and the state insurance commissioner. In the preamble to the Exchange Establishment final rule, HHS noted that ''health plan standards set forth under this final rule are, for the most part, strictly related to QHPs certified to be offered through the Exchange and not the entire individual and small group market. Such policies for the entire individual and small and large group markets have been, and will continue to be, addressed in separate rulemaking issued by HHS, and the Departments of Labor and the Treasury.''

2. Medical Loss Ratio (MLR)

Section 2718(a) and (b) of the PHS Act, as added by PPACA, generally requires health insurance issuers to submit an annual MLR report to HHS, and provide rebates to enrollees if the issuers do not achieve specified MLR thresholds. HHS proposes to amend its MLR program rules under section 2718(c) of the PHS Act, under which the methodologies for calculating measures of the activities reported under section 2718(a) of the PHS Act shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans. Specifically, HHS proposes to recognize the special circumstances of a different and newer type of plan for purposes of MLR reporting and calculations when that plan shares savings with consumers who choose lower-cost, higher-value providers. HHS proposes to revise 45 CFR 158.221 to add a new paragraph (b)(9) to allow such shared savings, when offered by an issuer, to be factored into an issuer's MLR numerator calculation beginning with the 2020 MLR reporting year.

II. Overview of the Proposed Rules Regarding Transparency—the Departments of the Treasury, Labor, and Health and Human Services

The Departments propose the price transparency requirements set forth in these proposed rules in new 26 CFR 54.9815–2715A, 29 CFR 2590.715–2715A, and 45 CFR 147.210. Paragraph (a) of the proposed rules sets forth the scope and relevant definitions. Paragraph (b) of the proposed rules includes: (1) A requirement that group health plans and health insurance issuers in the individual and group markets disclose to participants, beneficiaries, or enrollees (or their authorized representatives) upon their request, through a self-service tool made available by the plan or issuer on an internet website, cost-sharing information for a covered item or service from a particular provider or providers, and (2) a requirement that plans and issuers make such information available in paper form. Paragraph (c) of the proposed rules would require that plans and issuers disclose to the public, through two machine-readable files, the negotiated

[41] *https://www.govinfo.gov/content/pkg/FR-2012-03-27/pdf/2012-6125.pdf.*

rates for in-network providers, and unique amounts a plan or issuer allowed for items or services furnished by out-of-network providers during a specified time period.

The Departments request comments on all aspects of these proposed rules. In the preamble discussion that follows, the Departments also solicit comments on a number of specific issues related to the proposed rules where stakeholder feedback would be particularly useful in evaluating whether and how to issue final rules.

Sections III and IV of this preamble include requests for information on topics closely related to this rulemaking. Due to the design and capability differences among the information technology systems of plans and issuers, as well as difficulties consumers experience in deciphering information relevant to health care and health insurance, the Departments seek comment on additional price transparency requirements that could supplement the proposed requirements of paragraphs (b) and (c) of these proposed rules. For example, in section III, the Departments seek comment on whether the Departments should require plans and issuers to disclose information necessary to calculate a participant's, beneficiary's, or enrollee's cost-sharing liability through a publicly-available, standards-based application programming interface (API).

Section IV of this preamble requests comment on how existing quality data on health care provider items and services can be leveraged to complement the proposals in these proposed rules. Although these proposed rules do not include any health care quality disclosure requirements, the Departments appreciate the importance of health care quality information in providing consumers the information necessary to make value-based health care decisions.[42]

A. Proposed Requirements for Disclosing Cost-Sharing Information to Participants, Beneficiaries, or Enrollees

As described earlier in this preamble, the Departments' intention regarding these proposed rules is to enable participants, beneficiaries, and enrollees to obtain an estimate of their potential cost-sharing liability for covered items and services they might receive from a particular health care provider, consistent with the requirements of section 2715A of the PHS Act and section 1311(e)(3)(C) of PPACA. Accordingly, paragraph (b) of these proposed rules would require group health plans and health insurance issuers to disclose certain information relevant to a determination of a consumer's out-of-pocket costs for a particular health care item or service in accordance with specific method and format requirements, upon the request of a participant, beneficiary, or enrollee (or his or her authorized representative).

1. Information Required To Be Disclosed to Participants, Beneficiaries, or Enrollees

Based on significant research and stakeholder input, the Departments conclude that requiring group health plans and health insurance issuers to disclose to participants, beneficiaries, or enrollees cost-sharing information in the manner most familiar to them is the best means to empower individuals to understand their potential cost-sharing liability for covered items and services that might be furnished by particular providers. The Departments, therefore, modeled these proposed price transparency requirements on existing notices that plans and issuers generally provide to participants, beneficiaries, or enrollees after health care items and services have been furnished.

Specifically, section 2719 of the PHS Act requires non-grandfathered plans and issuers to provide a notice of adverse benefit determination[43] (commonly referred to as an explanation of benefits (EOB)) to participants, beneficiaries, or enrollees after health care items or services are furnished and claims for benefits are adjudicated. EOBs typically include the amount billed by a provider for items and services, negotiated rates with in-network providers or allowed amounts for out-of-network providers, the amount the plan paid to the provider, and the individual's obligation for deductibles, copayments, coinsurance, and any other balance under the provider's bill. Consumers are accustomed to seeing cost-sharing information as it is presented in an EOB. This proposal similarly would require plans and issuers to provide the specific price and benefit information on which an individual's cost-sharing liability is based.

The Departments have concluded that proposing to require plans and issuers to disclose to participants, beneficiaries, or enrollees price and benefit information that is analogous to the information that generally appears on an EOB would be the most effective and reasonable way to present cost-sharing information prior to the receipt of care, in a manner that can be understood by these individuals. Providing individuals with access to information generally included in EOBs before they receive covered items and services would enable individuals to understand their cost-sharing liability for the item or service and consider price when choosing a provider from whom to receive the item or service. Cost-sharing liability estimates would be required to be built upon accurate information, including actual negotiated rates, out-of-network allowed amounts, and individual-specific accumulated amounts. This does not mean the Departments would require that the estimate reflect the amount that is ultimately charged to a participant, beneficiary, or enrollee. Instead, the estimate would reflect the amount a participant, beneficiary, or enrollee would be expected to pay for the covered item or service for which cost-sharing information is sought. Thus, these proposed rules would not require the cost-sharing liability estimate to include costs for unanticipated items or services the individual could incur due to the severity of the his or her illness or injury, provider treatment decisions, or other unforeseen events.

In designing this price transparency proposal, the Departments also considered stakeholder input regarding the importance of protecting proprietary information. As explained earlier in this preamble, all of the information that would be required to be disclosed under these proposed rules is currently disclosed in EOBs that plans and issuers provide to individuals as a matter of course after services have been furnished and payment has been adjudicated. Therefore, the Departments are of the view that the proposed requirement that plans and issuers disclose this same information, to the same parties, before services are rendered does not pose any greater risk to plan or issuer proprietary information.

Consistent with how the information for an item or service would typically be presented on an EOB, the Departments propose to allow plans and issuers to provide participants, beneficiaries, and

[42] ''2017 Price Transparency & Physician Quality Report Card.'' Catalyst for Payment Reform. Available at: *https://www.catalyze.org/product/2017-price-transparency-physician-quality-report-card/*.

[43] An adverse benefit determination means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in 29 CFR 2590.715–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). *See* 26 CFR 54.9815–2719, 29 CFR 2590.715–2719 and 45 CFR 147.136. Plans subject to the requirements of ERISA (including grandfathered health plans) are also subject to a requirement to provide an adverse benefit determination under 29 CFR 2560.503–1.

enrollees with cost-sharing information for either a discrete item or service or for items or services for a treatment or procedure for which the plan bundles payment, according to how the plan or issuer structures payment for the item or service. Accordingly, these proposed rules set forth seven content elements that a plan or issuer must disclose, upon request, to a participant, beneficiary, or enrollee (or his or her authorized representative) for a covered item or service, to the extent relevant to the individual's cost-sharing liability for the item or service. These seven content elements generally reflect the same information that is included in an EOB after health care services are provided. The Departments have determined that each of the content elements is necessary and appropriate to implement the mandates of section 2715A of the PHS Act and section 1311(e)(3)(C) of PPACA by permitting individuals under a plan or coverage to learn the amount of their cost-sharing liability for specific items or services under a plan or coverage from a particular provider. The Departments propose that plans and issuers must satisfy these elements through disclosure of actual data relevant to an individual's cost-sharing liability that is accurate at the time the request is made. The Departments acknowledge that plans and issuers may not have processed all of an individual's outstanding claims when the individual requests the information; therefore, plans and issuers would not be required to account for outstanding claims that have not yet been processed.

Furthermore, under these proposals, the cost-sharing information would need to be disclosed to the participant, beneficiary, or enrollee in plain language. The proposed rules define ''plain language'' to mean written and presented in a manner calculated to be understood by the average participant, beneficiary, or enrollee. Determining whether this standard has been satisfied requires an exercise of considered judgment and discretion, taking into account such factors as the level of comprehension and education of typical participants, beneficiaries, or enrollees in the plan or coverage and the complexity of the terms of the plan. Accounting for these factors would likely require limiting or eliminating the use of technical jargon and long, complex sentences, so that the information provided will not have the effect of misleading, misinforming, or failing to inform participants, beneficiaries, or enrollees.

a. First Content Element: Estimated Cost-Sharing Liability

The first content element that plans and issuers would be required to disclose under these proposed rules would be an estimate of the cost-sharing liability for the furnishing of a covered item or service by a particular provider or providers. The calculation of the cost-sharing liability estimate would be required to be computed based on the other relevant cost-sharing information that plans and issuers would be required to disclose, as described later in this section of the preamble.

The proposed rules define ''cost-sharing liability'' to mean the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the plan or coverage. Cost-sharing liability calculations must consider all applicable forms of cost sharing, including deductibles, coinsurance requirements, and copayments. The term cost-sharing liability does not include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered items or services. For QHPs offered through Exchanges, an estimate of cost-sharing liability for a requested covered item or service provided must reflect any cost-sharing reductions the individual would receive under the coverage.

The proposed rules define ''items or services'' to mean all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees), for which a provider charges a patient in connection with the provision of health care. This proposed definition of items or services is intended to be flexible enough to allow plans and issuers to disclose cost-sharing information for either discrete items or services for which an individual is seeking cost-sharing information, or, if the issuer bundles payment for items or services associated with a treatment or procedure, for a set of items or services included in the bundle. These proposed rules further define ''covered items or services'' to mean items or services for which the costs are payable, in whole or in part, under the terms of a plan or coverage. The Departments solicit comment on whether other types of information are necessary to provide an estimate of cost-sharing liability prior to an individual's receipt of items or services from a provider or providers. The Departments also solicit comment on these definitions.

b. Second Content Element: Accumulated Amounts

The second content element would be a participant's, beneficiary's, or enrollee's accumulated amounts. These proposed rules define ''accumulated amounts'' to mean the amount of financial responsibility that a participant, beneficiary, or enrollee has incurred at the time the request for cost-sharing information is made, either with respect to a deductible or an out-of-pocket limit (such as the annual limitation on cost sharing provided in section 2707(b) of the PHS Act, as incorporated into ERISA and the Code, or a maximum out-of-pocket amount the plan or issuer establishes that is lower than the requirement under the PHS Act). In the case where an individual is enrolled in a family plan or coverage (or other-than-self-only coverage), these accumulated amounts would include the financial responsibility a participant, beneficiary, or enrollee has incurred toward meeting his or her individual deductible and/or out-of-pocket limit as well as the amount of financial responsibility that the individuals enrolled under the plan or coverage have incurred toward meeting the other-than-self-only coverage deductible and/or out-of-pocket limit, as applicable.[44] For this purpose, accumulated amounts would include any expense that counts toward the deductible or out-of-pocket limit (such as copayments and coinsurance), but would exclude expenses that would not count toward a deductible or out-of-pocket limit (such as premium payments, out-of-pocket expenses for out-of-network services, or amounts for items or services not covered under a plan or coverage).

Furthermore, to the extent a plan or issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or

[44] The Departments read section 2707(b) as requiring non-grandfathered group health plans to comply with the maximum annual limitation on cost sharing promulgated under section 1302(c)(1) of PPACA, including the HHS clarification that the self-only maximum annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in other-than-self-only coverage. Accordingly, the self-only maximum annual limitation on cost sharing applies to an individual who is enrolled in family coverage or other coverage that is not self-only coverage under a group health plan. *See* 80 FR 10749, 10824–10825 (Feb. 27, 2015); *see also* FAQs About Affordable Care Act Implementation (Part XXVII), Q1, available at *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvii.pdf.*

hours covered in a defined time period) independent of individual medical necessity determinations, the accumulated amounts would also include the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant, beneficiary, or enrollee has used).

The Departments understand that certain cumulative treatment limitations may vary by individual based on a determination of medical necessity and that it may not be reasonable for a plan or issuer to account for this variance as part of the accumulated amounts. Therefore, plans and issuers would be required to provide cost-sharing information with respect to an accumulated amount for a cumulative treatment limitation that reflects the status of the individual's progress toward meeting the limitation, and would not include any individual determination of medical necessity that may affect coverage for the item or service. For example, if the terms of an individual's plan or coverage limit coverage of physical therapy visits to 10 per plan or policy year, subject to a medical necessity determination, and at the time the request for cost-sharing information is made the individual has had claims paid for three physical therapy visits, the plan or coverage would make cost-sharing information disclosures based on the fact that the individual could be covered for seven more physical therapy visits in that plan or policy year, regardless of whether or not a determination of medical necessity has been made at that time.

c. Third Content Element: Negotiated Rate

The third content element under these proposed rules would be the negotiated rate, reflected as a dollar amount, for an in-network provider or providers for a requested covered item or service, to the extent necessary to determine the participant's, beneficiary's, or enrollee's cost-sharing liability. These proposed rules define ''negotiated rate'' to mean the amount a plan or issuer, or a third party (such as a third-party administrator (TPA)) on behalf of a plan or issuer, has contractually agreed to pay an in-network provider for a covered item or service pursuant to the terms of an agreement between the provider and the plan, issuer, or third party on behalf of a plan or issuer. The Departments understand that some provider contracts express negotiated rates as a formula (for example, 150 percent of the Medicare rate), but disclosure of formulas is not likely to be helpful or understandable for many participants, beneficiaries, and enrollees viewing this information. For this reason, these proposed rules would require disclosure of the rate that results from using such a formula, which would be required to be expressed as a dollar amount.

Negotiated rates generally are an essential input for the calculation of a participant's, beneficiary's, or enrollee's cost-sharing liability. For example, cost-sharing liability for a covered service with a 30 percent coinsurance requirement cannot be determined without knowing the negotiated rate of which an individual must pay 30 percent. Additionally, if an individual has not met an applicable deductible and the cost for a covered item or service from an in-network provider is less than the remaining deductible, then the cost-sharing liability will in fact be the negotiated rate. The Departments acknowledge, however, that if the negotiated rate does not impact an individual's cost-sharing liability under a plan or coverage for a covered item or service (for example, the copayment for the item or service is a flat dollar amount or zero dollars and the individual has met a deductible, or a deductible does not apply to that particular item or service), disclosure of the negotiated rate may be unnecessary to calculate cost-sharing liability for that item or service. Therefore, the Departments propose that disclosure of a negotiated rate would not be required under these proposed rules if it is not relevant for calculating an individual's cost-sharing liability for a particular item or service. The Departments seek comment on whether there are any reasons disclosure of negotiated rates should nonetheless be required under these circumstances.

Under these proposed rules, plans and issuers would be required to disclose to participants, beneficiaries, or enrollees an estimate of cost-sharing liability for items and services, including prescription drugs. This would allow individuals to request cost-sharing information for a specific billing code (as described later in this preamble) associated with a prescription drug or by descriptive term (such as the name of the prescription drug), which will permit individuals to learn the estimated cost of a prescription drug obtained directly through a provider, such as a pharmacy or mail order service. In addition to allowing individuals to obtain cost-sharing information by using a billing code or descriptive term, the rules would also permit individuals to learn the cost of a set of items or services that include a prescription drug or drugs that is subject to a bundled payment arrangement for a treatment or procedure. The proposed rules define the term ''bundled payment'' to mean a payment model under which a provider is paid a single payment for all covered items or services provided to a patient for a specific treatment or procedure. However, the Departments acknowledge that outside of a bundled payment arrangement, plans and issuers often base cost-sharing liability for prescription drugs on the undiscounted list price, such as the average wholesale price or wholesale acquisition cost, which frequently differs from the price the plan or issuer has negotiated for the prescription drug.[45] In these instances, providing the individual with a rate that has been negotiated between the issuer or plan and its pharmacy benefit manager could be misleading, as this rate would reflect rebates and other discounts, and could be lower than what the individual would pay—particularly if the individual has not met his or her deductible. However, arguably, requiring the issuer to disclose only the rate upon which the individual's cost-sharing liability estimate is based would perpetuate the lack of transparency around drug pricing.

The Departments seek comment regarding whether a rate other than the negotiated rate, such as the undiscounted price, should be required to be disclosed for prescription drugs, and whether and how to account for any and all rebates, discounts, and dispensing fees to ensure individuals have access to meaningful cost-sharing liability estimates for prescription drugs. The Departments also solicit comment as to whether there are certain scenarios in which drug pricing information should not be included in an individual's estimated cost-sharing liability. For example, would the cost to an individual for a drug outside of a bundled payment arrangement be so impacted by factors beyond the negotiated rate for the drug, and not reasonably knowable by the plan or issuer, that the cost-sharing liability estimate for that drug would not be meaningful for the individual and should not be provided outside of a cost-sharing liability estimate for a bundled payment? Alternatively, should drug costs be required to be included in a cost-sharing liability estimate in all scenarios, including when the consumer

[45] ''Follow the Dollar: How the pharmaceutical distribution and payment system shapes the prices of brand medicines.'' PhRMA. November 2017. Available at *https://www.phrma.org/report/follow-the-dollar-report.*

searches for cost-sharing information for a particular drug by billing code or descriptive term in connection with items and services for which the plan or issuer does not bundle payment? The Departments also seek comment on whether the relationship between plans or issuers and pharmacy benefit managers[46] allows plans and issuers to disclose rate information for drugs, or if contracts between plans and issuers and pharmacy benefit managers would need to be amended to allow plans and issuers to provide a sufficient level of transparency. If those contracts would need to be amended, the Departments seek comment on the time that would be needed to make those changes.

d. Fourth Content Element: Out-of-Network Allowed Amount

The fourth content element would be the out-of-network allowed amount for the requested covered item or service. This element would only be relevant when a participant, beneficiary, or enrollee requests cost-sharing information for a covered item or service furnished by an out-of-network provider. These proposed rules define ''out-of-network allowed amount'' to mean the maximum amount a plan or issuer would pay for a covered item or service furnished by an out-of-network provider. Under these proposed rules, plans and issuers would be required to disclose an estimate of cost-sharing liability for a participant, beneficiary, or enrollee. Therefore, when disclosing an estimate of cost-sharing liability for an out-of-network item or service, the plan or issuer would disclose the out-of-network allowed amount and any cost-sharing liability the participant, beneficiary, or enrollee would be responsible for paying. For instance, if a plan has established an out-of-network allowed amount of $100 for an item or service from a particular out-of-network provider and the participant, beneficiary, or enrollee is responsible for paying 30 percent of the out-of-network allowed amount ($30), the plan would disclose both the allowed amount ($100) and the individual's cost-sharing liability ($30), indicating that the individual is responsible for 30 percent of the out-of-network allowed amount.

Because the proposed definition of cost-sharing liability does not include amounts charged by out-of-network providers that exceed the out-of-network allowed amount, which participants, beneficiaries, or enrollees must pay (sometimes referred to as balance bills), it may be difficult for participants, beneficiaries, or enrollees to determine their likely out-of-pocket costs for covered items and services furnished by an out-of-network provider. Nonetheless, under section 1311(e)(3)(A)(vii) of PPACA and section 2715A of the PHS Act, Congress intended that participants, beneficiaries, enrollees, and other members of the public have access to accurate and timely information on cost sharing and payments with respect to any out-of-network coverage. In the Departments' view, requiring plans and issuers to disclose out-of-network allowed amounts and a participant's, beneficiary's, or enrollee's cost-sharing obligation for covered items and services is necessary and appropriate to fulfill this statutory mandate, and would give individuals information necessary to estimate their out-of-pocket costs if they request additional information from an out-of-network provider about how much the provider would charge for a particular item or service.

e. Fifth Content Element: Items and Services Content List

The fifth content element would be a list of those covered items and services for which cost-sharing information is disclosed. This requirement would be relevant only when a participant, beneficiary, or enrollee requests cost-sharing information for an item or service that is subject to a bundled payment arrangement that includes multiple items or services, rather than one discrete item or service. This requirement would not apply when an individual requests cost-sharing information for an item or service not subject to a bundled payment arrangement. In cases in which an individual requests a cost-sharing liability estimate for a covered item or service that is subject to a bundled payment arrangement, plans and issuers would be required to disclose a list of each covered item and service included in the bundled payment arrangement and the individual's cost-sharing liability for those covered items and services as a bundle, but not a cost-sharing liability estimate separately associated with each covered item or service included in the bundle. In the Departments' view, in order to support consumers' ability to shop for services, consumers need to know precisely what items and services are included in the cost-sharing information provided.

f. Sixth Content Element: Notice of Prerequisites to Coverage

The sixth content element would be a notice, whenever applicable, informing the individual that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage. The proposed rules define the term ''prerequisite'' to mean certain requirements relating to medical management techniques for covered items and services that must be satisfied before a plan or issuer will cover the item or service. Specifically, prerequisites include concurrent review, prior authorization, and step-therapy or fail-first protocols. The definition of prerequisite in these proposed rules is intended to capture medical management techniques that apply to an item or service that require action by the participant, beneficiary, or enrollee before the plan or issuer will cover the item or service. Accordingly, the proposed definition of prerequisite does not include medical necessity determinations generally, or other forms of medical management techniques that do not require action by the participant, beneficiary, or enrollee. The Departments solicit comment on whether there are any additional medical management techniques that should be explicitly included as prerequisites in the final rules.

g. Seventh Content Element: Disclosure Notice

The seventh and final content element would be a notice that communicates certain information in plain language and includes several specific disclosures. First, this notice would include a statement that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between providers' billed charges and the sum of the amount collected from the plan or issuer and the amount collected from the patient in the form of cost sharing (the difference often referred to as balance billing) and that these estimates do not account for those potential additional amounts. The Departments understand that there are numerous state laws that address balance-billing practices such that the notice described in this proposed content element regarding balance bills may be misleading or inaccurate for beneficiaries, participants, or enrollees enrolled in a plan or coverage in certain states. The Departments request comment on whether any modifications to this content element would be appropriate to allow plans and issuers to accurately advise participants,

[46] Pharmacy benefit managers are third-party companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, self-insured group health plans, and other payers.

beneficiaries, or enrollees of their potential exposure to or protection from any balance bills.

Second, the notice would be required to convey that actual charges for the participant's, beneficiary's, or enrollee's covered items and services may be different from those described in a cost-sharing liability estimate, depending on the actual items and services received at the point of care.

Third, the notice would be required to include a statement that the estimated cost-sharing liability for a covered item or service is not a guarantee that coverage will be provided for those items and services.

Finally, under these proposed rules, plans and issuers would be permitted to include any additional information, including other disclaimers that the plan or issuer determines appropriate, as long as the additional information does not conflict with the information required to be provided. Plans and issuers would be permitted to include additional language so long as the language could not reasonably be read to disclaim the plan's or issuer's responsibility for providing a participant, beneficiary, or enrollee with accurate cost-sharing information. For example, plans and issuers may choose to provide a disclaimer that informs consumers who are seeking estimates of cost-sharing liability for out-of-network allowed amounts that they may have to obtain a price estimate from the out-of-network provider in order to fully understand their out-of-pocket cost liability. Plans and issuers may also provide a disclaimer indicating how long the price estimate will be valid, based on the last date of the contract term for the negotiated rate or rates if multiple providers with different contract terms are involved. The Departments are of the view that this type of disclaimer could provide participants, beneficiaries, and enrollees with a better understanding of how their cost estimate may change over time, and seek comment on whether a disclaimer indicating the expiration of the cost estimate should be required. Furthermore, plans and issuers may also include disclaimer information regarding prescription drug cost estimates and whether rebates, discounts, and dispensing fees may impact the actual cost to the consumer.

The Departments have developed model language that plans and issuers could use, but would not be required to use, to satisfy the disclosure notice requirements described above. This model language is being proposed contemporaneously with, but separate from, these proposed rules. The Departments seek comment on the proposed model language and any additional information that stakeholders believe should be included in the proposed model notice or any information that should be omitted from the proposed model notice. As noted later in the preamble, to obtain copies of the proposed model notice, please visit CMS's website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of these proposed rules and identify the rule (CMS–9915–P), the ICR's CFR citation, CMS ID number, and OMB control number.

The Departments further clarify that this proposed disclosure notice would be in addition to the information that QHP issuers are currently required to publish on their websites pursuant to 45 CFR 156.220(a)(7) regarding cost sharing and payments with respect to out-of-network coverage. In addition, some portions of this disclosure may overlap with network adequacy disclosure standards under 45 CFR 156.230(e). That section requires QHP issuers to, notwithstanding 45 CFR 156.130(c), count the cost sharing paid by an enrollee for an out-of-network essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting toward the enrollee's annual limitation on cost sharing or provide a notice to the enrollee that additional costs may be incurred for an EHB, including balance billing charges.

The Departments request comment on the proposed notice disclaimers and whether any additional disclaimers would be necessary or beneficial to consumers' learning about their potential cost-sharing liability for covered items and services. For example, should the Departments require a notice that explains that the cost-sharing information provided may not account for claims an individual has submitted that the plan or issuer has not yet processed?

The Departments are also considering whether to require plans and issuers to provide a participant, beneficiary, or enrollee information regarding non-covered items or services for which the individual requests cost-sharing information. For example, there could be a requirement that a plan or issuer provide a statement, as applicable, indicating that the item or service for which the individual has requested cost-sharing information is not a covered benefit under the terms of the plan or coverage, and expenses charged for that item or service will not be reimbursed by the plan or coverage.

2. Required Methods for Disclosing Information to Participants, Beneficiaries, or Enrollees

Section 1311(e)(3)(C) of PPACA requires that cost-sharing information be made available through an internet website and other means for individuals without access to the internet. Therefore, these proposed rules would require that group health plans and health insurance issuers disclose to participants, beneficiaries, or enrollees (or their authorized representatives) the cost-sharing information described earlier in this preamble in two ways: (1) Through a self-service tool that meets certain standards and is available on an internet website, and (2) in paper form.

a. First Delivery Method: Internet-Based Self-Service Tool

Under these proposed rules, plans and issuers would be required to make available a self-service tool on an internet website for their participants, beneficiaries, or enrollees to use, without a subscription or other fee, to search for cost-sharing information for covered items and services. The tool would be required to allow users to search for cost-sharing information for a covered item or service provided by a specific in-network provider, or by all in-network providers. The tool also would be required to allow users to search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers. The tool would be required to provide users real-time responses that are based on cost-sharing information that is accurate at the time of the request.

In order for plans and issuers to provide accurate cost-sharing information, the Departments understand that the participant, beneficiary, or enrollee will have to input certain data elements into the tool. Therefore, plans and issuers would be required to make available a tool that allows users to search for cost-sharing information: (1) By billing code (for example, CPT Code 87804) or, (2) by a descriptive term (for example, ''rapid flu test''), at the option of the user. The tool also would be required to allow users to input the name of a specific in-network provider in conjunction with a billing code or descriptive term, to produce cost-sharing information and a cost-sharing liability estimate for a covered item or service provided by that in-network provider. With respect to a request for cost-sharing information for all in-network providers, if a plan or issuer utilizes a multi-tiered network,

the tool would be required to produce the relevant cost-sharing information for the covered item or service for each tier. To the extent that cost-sharing information for a covered item or service under a plan or coverage varies based on factors other than the provider, the tool would also be required to allow users to input sufficient information for the plan or issuer to disclose meaningful cost-sharing information. For example, if the cost-sharing liability estimate for a prescription drug depends on the quantity and dosage of the drug, the tool would be required to allow the user to input a quantity and dosage for the drug for which he or she is seeking cost-sharing information. Similarly, to the extent that the cost-sharing liability estimate varies based on the facility at which an in-network provider furnishes a service (for example, at an outpatient facility versus in a hospital setting), the tool would be required to either permit a user to select a facility, or display in the results cost-sharing liability information for every in-network facility at which the in-network provider furnishes the specified item or service. The Departments request comment on whether there are any scenarios under which plans and issuers may not be able to ascertain the in-network facilities at which an in-network provider furnishes services.

As stated previously, the Departments acknowledge that plans and issuers may not have sufficient information on providers outside of their network to provide the participant, beneficiary, or enrollee a complete estimate of out-of-pocket expenses, since the plan or issuer may not know what the out-of-network provider will bill for an item or service. However, if the plan or issuer provides coverage for out-of-network items or services, the plan or issuer generally will have established an out-of-network allowed amount that the participant, beneficiary, or enrollee could use, in conjunction with information he or she may request from the out-of-network provider about what the total bill for services may be, to compute an estimate of his or her out-of-pocket expenses. It is the Departments' understanding that a plan or issuer may require certain information, in addition to the identification of a covered item or service, before it can provide an out-of-network allowed amount for a covered item or service, and that plans and issuers may have different ways of establishing an out-of-network provider's allowed amount for a covered item or service (such as by zip code or state). Therefore, plans and issuers would be required to allow users to search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers by inputting a billing code or descriptive term and the information that is necessary for the plan or issuer to produce the out-of-network allowed amount (such as the zip code for the location of the out-of-network provider).

To the extent a user's search returns multiple results, the tool would be required to have functionalities that would allow users to refine and reorder results (also referred to as sort and filter functionalities) by geographic proximity and the amount of estimated cost-sharing liability to the beneficiary, participant, or enrollee. The Departments solicit comment on whether the tool should be required to have additional refining and reordering functionality, including whether it would be helpful or feasible to refine and reorder by provider subspecialty (such as providers who specialize in pediatric psychiatry), or by the quality rating of the provider, if the plan or issuer has available data on provider quality.

It is the Departments' intention that these proposed rules would require plans and issuers to create a user-friendly internet-based self-service tool, but these proposed rules do not include a definition for ''user-friendly'' since there are a variety of ways a tool can be designed to be user-friendly. The Departments want to preserve plan and issuer flexibility to create tools that are best for their participants, beneficiaries, or enrollees, by soliciting user feedback and consumer-testing in the development of their tools. However, it is the Departments' view that a user-friendly tool would mean a tool that allows intended users to search for the cost-sharing information outlined in paragraph (b)(1) of these proposed rules efficiently and effectively, without unnecessary effort. The Departments are of the view that plans and issuers can look to federal plain language guidelines,[47] the requirements for a Summary Plan Description's method of presentation at 29 CFR 2520.102–2(a), and general industry standards for guidance when designing and developing their consumer tools. The Departments solicit comment on whether there is different or additional guidance that should be consulted.

These proposed rules require that the self-service tool be made available on an internet website to provide consistency with section 1311(e)(3)(C) of PPACA, which uses the term ''internet website.'' However, the Departments seek feedback on whether this term should be interpreted to include other comparable methods of accessing internet-based content. The statute was enacted in 2010 when the primary mode of accessing internet-based content was through a personal computer. Since that time, ownership of mobile devices with internet access and use of internet-based mobile applications has become much more common. The Departments acknowledge that there may be technical differences between a website and other methods of viewing internet-based content, such as mobile applications. However, the Departments also understand that technology evolves over time, and it is the Departments' view that Congress did not intend to limit the ability to access information via alternative methods of viewing internet-based content that may be available now or in the future.

Mobile applications also may provide additional benefits beyond those of traditional websites. Due to the portability of mobile devices, a self-service tool that is similar to the kind required for an internet website under these proposed rules that is made available through a mobile application might provide participants, beneficiaries, enrollees, and their health care providers greater opportunities to use the tool together at the point of care to evaluate treatment options based on price. The Departments further understand that mobile applications may, in certain cases, offer greater privacy and security protections than an internet website for the information protected by applicable privacy and security requirements, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules (45 CFR parts 160 and 164) (HIPAA Rules) that would be accessible through the proposed tool. Accordingly, the Departments seek comment on whether the final rules should permit the proposed disclosure requirements to be satisfied with a self-service tool that is made available through a website or comparable means of accessing the internet, such as a mobile application, or whether multiple means, such as websites and mobile applications, should be required. The Departments also seek comment on the relative resources required for building an internet website versus an internet-based mobile application.

b. Second Delivery Method: Paper Form

With respect to a delivery method that would not require a participant, beneficiary, or enrollee (or his or her authorized representative) to have

[47] *https://www.plainlanguage.gov/guidelines.*

access to the internet, plans and issuers would have to furnish, at the request of the of the participant, beneficiary, or enrollee (or his or her authorized representative), without a fee, all of the information required to be disclosed under paragraph (b)(1) of these proposed rules, as outlined earlier in this preamble, in paper form. A plan or issuer would be required to provide the information in accordance with the requirements under paragraph (b)(2)(i) of these proposed rules and as described earlier in this preamble. That is, the plan or issuer would be required to allow an individual to request cost-sharing information for a discrete covered item or service by billing code or descriptive term, according to the participant's, beneficiary's, or enrollee's request. Further, the plan or issuer would be required to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the participant's, beneficiary's, or enrollee's request, permitting the individual to specify the information necessary for the plan or issuer to provide meaningful cost-sharing liability information (such as dosage for a prescription drug or zip code for an out-of-network allowed amount). To the extent the information the individual requests returns more than one result, the individual would also be permitted to request that the plan or issuer refine and reorder the information disclosed by geographic proximity and the amount of the cost-sharing liability estimates.

This information would be required to be mailed to a participant, beneficiary, or enrollee no later than 2 business days after a participant's, beneficiary's, or enrollee's request is received. This would mean that cost-sharing information must be mailed via the U.S. Postal Service or some other delivery system within 2 business days of receipt of an individual's request. Nothing in these proposed rules prohibits a plan or issuer from providing individuals with the option to request disclosure of the information required under paragraph (b)(1) of these proposed rules through other methods (such as, over the phone, through face-to-face encounters, by facsimile, or by email).

The Departments request comment on these proposed disclosure methods, including whether additional methods of providing information should be required, rather than permitted. The Departments are particularly interested in feedback on whether plans and issuers should be required to provide the information over the phone, or by email, at the request of a participant, beneficiary, or enrollee.

The Departments also are considering requiring all plans and issuers to allow individuals to seek cost-sharing information by inputting a description of a treatment or procedure (such as knee replacement) that often involves the provision of multiple items and services. The Departments are interested in feedback on whether it would be feasible for plans and issuers to allow individuals to request cost-sharing information by such a treatment or procedure if the plan or issuer makes payments based on a discrete billing code for each item and service associated with a treatment or procedure, and not as a bundled payment for all items and services associated with the treatment or procedure. For instance, if an individual requests cost-sharing information for a knee replacement, and the plan or issuer does not bundle payment for multiple items and services provided in connection with a knee replacement, would it be unduly burdensome for a plan or issuer to disclose meaningful cost-sharing information for items and services typically provided in connection with a knee replacement?

3. Special Rule To Prevent Unnecessary Duplication

These proposed rules include a special rule to streamline the provision of the required disclosures and avoid unnecessary duplication of the disclosures with respect to group health coverage. The proposed special rule is similar to the one that applied with respect to the requirement for group health plans and health insurance issuers to provide certificates of creditable coverage before that requirement was generally superseded by PPACA.[48]

The special rule provides that to the extent coverage under a plan consists of group health insurance coverage, the plan would satisfy the requirements of these proposed rules if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and issuer. Accordingly, for example, if there were a plan and an issuer that enter into a written agreement under which the issuer agrees to provide the information required under these proposed rules, and the issuer failed to provide full or timely information, then the issuer, but not the plan, would violate the transparency disclosure requirements.[49]

4. Privacy, Security, and Accessibility

These proposed requirements for group health plans and health insurance issuers to provide cost-sharing liability estimates and related cost-sharing information would operate in tandem with existing state and federal laws governing the privacy, security, and accessibility of the information that would be disclosed under these proposed disclosure requirements. For example, the Departments are aware that the content proposed to be disclosed by plans and issuers may be subject to the privacy, security, and breach notification rules under HIPAA or similar state laws in the hands of a HIPAA covered entity or business associate. Nothing in these proposed rules is intended to alter or otherwise affect plans' and issuers' data privacy and security responsibilities under HIPAA Rules or other applicable state or federal laws.

The Departments also expect that plans and issuers will follow existing applicable state and federal laws regarding persons who must be allowed to access and receive the information that would be disclosed under these proposed rules. These proposed rules refer to such persons as ''authorized representatives'' and do not establish any new class of persons or entities who are authorized to access the information that would be provided through the proposed internet-based, self-service tool. Accordingly, the Departments expect plans and issuers to follow existing laws with regard to persons who may or must be allowed to access the cost-sharing information that would be required to be disclosed under these proposed rules.

[48] As of December 31, 2014, group health plans are generally no longer required to provide HIPAA certificates of creditable coverage. *See* 26 CFR 9801–5 and 29 CFR 2590.701–5. An exception to this general rule is expatriate health plans, which must satisfy the provisions of title XXVII of the PHS Act, Chapter 100 of the Code, and part 7 of subtitle B of title I of ERISA that would otherwise apply if PPACA had not been enacted. *See* section 3(d)(2)(G) of the Expatriate Health Coverage Clarification Act (EHCCA), enacted as Division M of the Consolidated and Further Continuing Appropriations Act of 2015.

[49] Under section 4980D(d)(1) of the Code, the excise tax for group health plans failing to satisfy these proposed rules is not imposed on a small employer (generally fewer than 50 employees) which provides health insurance coverage solely through a contract with an issuer on any failure which is solely because of the health insurance coverage offered by the issuer.

B. Proposed Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services From Out-of-Network Providers

The Departments take the position that health care spending cannot be curbed without more competition in the market, and competition cannot be achieved without greater price transparency. As explained earlier in this preamble, section 2715A of the PHS Act and section 1311(e)(3)(A) of PPACA require group health plans and health insurance issuers to make public certain specified information, as well as other information the Secretary of HHS determines to be appropriate to provide transparency in health coverage. Thus, these provisions evidence Congress' intent that members of the public play a role in using health coverage transparency information to promote consumer interests. Consistent with this authority, the Departments have determined that it would be appropriate to require plans and issuers to make public negotiated rates with in-network providers and data outlining the different amounts a plan or issuer has allowed for covered items or services furnished by out-of-network providers.

The Departments have concluded that public availability of such information would create price transparency for persons who are uninsured, as well as insured persons who are considering coverage alternatives. The proposal would also support meaningful comparisons between plan coverage options and issuer options for all consumers, comparisons that would not be supported through the internet-based consumer tool proposed earlier in this rule. In proposing requirements for public disclosure of negotiated rates and historical out-of-network allowed amounts, the Departments are exercising specific authority under section 1311(e)(3)(A)(vii) and (ix) of PPACA (as applied to plans and issuers in the individual and group markets through section 2715A of the PHS Act), which requires plans and issuers to disclose other information the Secretary of HHS determines to be appropriate to create transparency in health coverage.

As explained later in this preamble, the proposed disclosure requirements would provide consumers, including third-party software developers and health care researchers, information about health care prices that is necessary to make informed health care purchasing decisions. These requirements would also help to expose price differences so that consumers can judge the reasonableness of provider prices and shop for care at the best price. Accordingly, it is the Departments' view that public availability of negotiated rates and historical out-of-network allowed amounts is appropriate and necessary to empower consumers to make informed decisions about their health care, spur competition in health care markets, and to slow or potentially reverse the rising cost of health care items and services.

1. Public Disclosure of Negotiated Rates and Historical Out-of-Network Allowed Amounts Is Necessary To Create Price Transparency for All Consumers and Payers of Health Care Items and Services, as Well as of Benefit to State and Federal Regulators

First, public availability of negotiated rates and historical out-of-network allowed amounts would empower the nation's 28.5 million uninsured consumers [50] to make more informed health care decisions. Uninsured consumers often must pay full cost for health care items and services, such that pricing information is critical to their ability to evaluate their service options and control their health care spending. Uninsured consumers could use publicly-available pricing information to find affordable service providers or providers who offer the lowest price, depending on the consumer's personal needs and priorities. Provider lists of standard charges often do not reflect the true cost of particular items and services.[51] Although a provider's negotiated rates with group health plans and health insurance issuers do not necessarily reflect the prices providers charge to uninsured patients, uninsured consumers could use this information to gain an understanding of the payment amounts a particular provider accepts for a service, which could inform their own negotiations with that provider for the same item or service.

Second, information on negotiated rates and historical out-of-network allowed amounts is critical for any consumer, insured or uninsured, who wishes to evaluate available options for group or individual market coverage. The proposed requirements that plans and issuers disclose negotiated rates and out-of-network allowed amounts to their participants, beneficiaries, or enrollees (or their authorized representatives) through an internet self-service tool or in paper form will make critical pricing information available to consumers with health insurance coverage. However, the Departments are of the view that both insured and uninsured consumers need access to data on negotiated rates and out-of-network allowed amounts across plans and issuers to be able to shop most effectively for their health care coverage.

Public disclosure of plan and issuer negotiated rates and out-of-network allowed amounts would create and promote price transparency in the health care market for all consumers and payers, including insured consumers, uninsured consumers, sponsors of self-insured and fully-insured group health plans, as well as government sponsors and regulators of local, state, and federal health care programs. For any consumer, insured or uninsured, who wishes to evaluate available options for group or individual market coverage, pricing information is also essential.

Specifically, for those uninsured consumers who wish to purchase coverage and become insured, pricing information for different plans or coverage and their in-network providers would be key to consumers' ability to effectively shop for coverage that best meets their needs at prices they can afford. The same is true for insured or uninsured consumers who wish to evaluate coverage options under their employer's plan or shop for coverage in the individual market. Publicly-available negotiated rate data will assist all consumers in choosing the coverage that best meets their needs in terms of deductible requirements, coinsurance requirements, and maximum out-of-pocket limits—all factors directly determined by a plan's or issuer's negotiated rates or out-of-network allowed amounts. Publicly-available historical allowed amount data for covered items and services provided by out-of-network providers would enable consumers who require specialized services to find the best coverage for their circumstances. For instance, the Departments understand that plans and issuers often place limitations on benefits for specialized services. This causes many specialists to reject insurance, making it difficult, if not impossible, for consumers to find in-network providers in their area who are accepting new patients or who have sufficient availability or expertise to meet their needs. The Departments understand, for example, that many speech therapists and pathologists do not accept insurance because of the

[50] Keith, K. ''Two New Federal Surveys Show Stable Uninsured Rate.'' Health Affairs Blog. September 13, 2018. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/.*

[51] Arora, V., Moriates, C., Shah, N. ''The Challenge of Understanding Health Care Costs and Charges.''17 AMA J. Ethics. 1046. November 2015. Available at: *https://journalofethics.ama-assn.org/article/challenge-understanding-health-care-costs-and-charges/2015-11.*

limitations plans and issuers place on coverage for their services. Such limitations may include exclusions from coverage for speech issues that are developmental in nature, and are not due to a specific illness or injury.[52] Moreover, many plans and issuers that do provide coverage for developmental speech issues place annual visit limits on speech therapy services. Accordingly, consumers who have a need for such specialized services often base their coverage choices primarily, if not solely, on a plan's or issuer's out-of-network benefits. Historical data outlining different amounts paid to out-of-network providers will enable consumers who rely on out-of-network providers to compare out-of-network benefits among different plans and issuers.

Third, public disclosure of pricing information is necessary to enable consumers to use and understand price transparency data in a manner that will increase competition, reduce disparities in health care prices, and potentially lower health care costs. The Departments are of the view that true downward pressure on health care pricing cannot be fully achieved without public disclosure of pricing. General economic theory holds that markets work best when there is price competition.[53] When consumers can shop for services and items based on price, providers and suppliers compete to lower price and improve quality.[54]

One of the recognized impediments to increased competition through health care consumerism is widespread knowledge gaps most consumers have when it comes to evaluating health care options. Making this information public would facilitate and incentivize the design, development, and offering of consumer tools and support services that are necessary to address the general inability of consumers to use or otherwise make sense of health care pricing information. The Departments' proposal to make this information publicly available would allow health care software application developers and other innovators to compile, consolidate, and present this information to consumers in a manner that supports meaningful comparisons between different coverage options and providers, and that assists consumers in making informed health care and coverage decisions.[55] One of the primary purposes of these proposals to make price information publicly available is to put price information in the hands of those best equipped to use it in a manner that will support greater consumerism in the health care market (for example, information technology developers who build tools to help consumers make informed health care decisions).

In developing these proposed rules, the Departments considered that, due to the complexity of our health care system and the data that drives plan and issuer payments for health care services, such data is unlikely to be usable by the average consumer. Put plainly, consumers would not (or could not) effectively use pricing information they do not understand or cannot decipher. The Departments understand many consumers do not fully comprehend the basics of health coverage, much less the more complex facets of our health care system that can affect an individual's out-of-pocket cost for items and services, including its specialized billing codes and payment processes; the various specialized terms used in plan and coverage contracts and related documents (such as copayment and coinsurance); and the various billing and payment structures plans and issuers use to compensate providers and assign cost-sharing liability to individuals (bundled payment arrangements, for example).[56] As a result, the Departments have determined that the proposal to make public negotiated rates with in-network providers and historical payment data outlining out-of-network allowed amounts is appropriate because it would encourage innovation that could help consumers understand and effectively use price transparency information. The more consumers use transparent price data effectively to find quality services they need at the best available prices, the greater the rise in consumerism and competition, as well as downward pressure on the costs of health care items and services.

The Departments assume that market actors will be incentivized to innovate in the price transparency and health care consumerism space, once access to pricing information that allows for meaningful evaluation of different options for delivering health care items or services, coverage options, and provider options becomes available. The Departments further assume that technology developers will be incentivized to design and make available web tools and mobile applications that can guide consumers in accessing available price information, increasing the likelihood that consumers will use the information to make informed health care purchasing decisions. Ultimately, improved access and usability of this information has the potential to increase health insurance literacy, consumerism, and competition, resulting in more reasonable, controlled costs for health care items and services. Additionally, the information would provide industry researchers and experts with baseline data to assist them with identifying, designing, and testing new or existing health care delivery and coverage models.

Fourth, along with consumers, sponsors of self-insured and fully-insured group health plans are also disadvantaged by the lack of price transparency. Group health plans bear the increasing cost of their participants' and beneficiaries' health care. Without information related to what other plans or issuers are actually paying for particular items and services, plans currently lack the pricing information necessary to shop or effectively negotiate for the best coverage for their participants and beneficiaries. Public availability of pricing information is appropriate to empower plans to make meaningful comparisons between offers from issuers and evaluate the prices offered by providers who wish to be included in their pool of in-network providers. The pricing information will also assist plans that contract with TPAs or issuers to provide a network of physicians. That information would provide valuable data a plan could use to assess the reasonableness of network access prices offered by TPAs and issuers by evaluating the specific prices members of a TPA's or issuer's network are accepting for their services. Given that, as of 2017, more than 55 percent of the nation's population received

[52] *https://www.asha.org/practice/reimbursement/private-plans/PrivatePlansCoverageSLP/.*

[53] *https://www.consumer.ftc.gov/sites/default/files/games/off-site/youarehere/pages/pdf/FTC-Competition_How-Comp-Works.pdf.*

[54] Kessler, D., McClellan, M. ''Is Hospital Competition Socially Wasteful?'' 115 Q. J. of Econ. 577. May 2, 2000. Available at: *https://www.nber.org/papers/w7266.*

[55] The Departments recognize that implementation of the API discussed in Section III, Request for Information, could go further toward the goal of empowering application developers and other innovators to support price transparency in the health care market.

[56] *See https://www.benefitspro.com/2016/09/30/survey-most-workers-dont-understand-health-insuran/?slreturn=20190803010341* (a UnitedHealthcare Consumer Sentiment Survey found that even though 32 percent of respondents were using websites and mobile apps to comparison shop for health care, only 7 percent had a full understanding of all four basic insurance concepts: Plan premium, deductible, coinsurance, and out-of-pocket maximum; although 60 percent of respondents were able to successfully define plan premium and deductible, respondents were not as successful in defining out-of-pocket maximum (36 percent) and coinsurance (32 percent)).

coverage from their employers,[57] the ability of group health plans to effectively negotiate pricing for coverage and services would be a boon to competition in the health care market.

Fifth, public disclosure of price transparency information is also appropriate because it would assist health care regulators in carrying out their duties to oversee health insurance issuers in their states, as well as in designing and maintaining sustainable health care programs. Public disclosure of pricing information would enable state regulators to monitor actual trends in prices for health care items and services. States would be able to assess whether the trend rates issuers use in their rate filings are reasonable in order to assess whether the rates should be approved. Local, state, and federal agencies responsible for implementing health care programs that rely on issuers to provide access to care would be privy to actual pricing information that would inform their price negotiations with issuers. The Departments understand, however, that some government agencies may already have access to the information proposed to be made public. The Departments, thus, are specifically interested in comments from government stakeholders regarding whether and how the price transparency proposed to be created under these proposed rules would benefit government regulators and health care programs.

For these reasons, the Departments propose, in paragraph (c), to require plans and issuers to make available two machine-readable files (as defined later in this preamble) that include information regarding negotiated rates with in-network providers, allowed amounts for covered items or services furnished by particular out-of-network providers, and other relevant information as defined in accordance with specific method and format requirements. These proposed rules would also require plans and issuers to update this information on a monthly basis to ensure it remains accurate.

2. Information Required To Be Disclosed to the Public

The Departments are of the view that minimum requirements for standardized data elements would be necessary to ensure users would have access to accurate and useful pricing information. Without such baseline requirements, the negotiated rate and allowed amount data for out-of-network services made available by each group health plan and health insurance issuer could vary dramatically, creating a disincentive to health care innovators developing tools and resources to enable consumers to accurately and meaningfully use, understand, and compare pricing information for covered items and services across providers, plans, and issuers. Accordingly, under these proposed rules a plan or issuer would be required to publish two machine-readable files. The first file would include information regarding rates negotiated with in-network providers. The second file would include historical data showing allowed amounts for covered items and services furnished by out-of-network providers. For convenience, these are respectively referred to as the Negotiated Rate File and the Allowed Amount File in this preamble. The files would include the following content elements.

a. First Content Element: Name or Identifier for Each Plan Option or Coverage

The first content element that plans and issuers would be required to include in both the Negotiated Rate File and the Allowed Amount File would be the name and identifier for each plan option or coverage offered by a plan or issuer. For the identifier, the Departments propose that plans and issuers use their Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) IDs, as applicable. The Departments seek comment on whether EINs and HIOS IDs are the appropriate identifiers for this purpose. The Departments also seek comment on whether there are other plan or issuer identifiers that should be considered and adopted.

b. Second Content Element: Billing Codes

The second content element that plans and issuers would be required to include in both files would be any billing or other code used by the plan or issuer to identify items or services for purposes of claims adjudication, or accounting or billing for the item or service, including but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier used by a plan or issuer, such as hospital revenue codes, as applicable.

The Departments propose to require that plans and issuers associate each negotiated rate or out-of-network allowed amount with a CPT or HCPCS code, DRG, NDC, or other common payer identifier, as applicable, because plans, issuers, and providers uniformly understand them and commonly use them for billing and paying claims (including for both individual items and services and service packages). The Departments also propose that plans and issuers must include plain language descriptions for each billing code. In the case of items and services that are associated with common billing codes (such as the HCPCS codes), the plan or issuer could use the codes' associated short text description.

c. Third Content Element: Negotiated Rates or Out-of-Network Allowed Amounts

Negotiated Rate File

The third content element that plans and issuers would be required to include in the Negotiated Rate File would be negotiated rates under a plan or coverage with respect to each covered item or service furnished by in-network providers. To the extent a plan or issuer reimburses providers for an item or service based on a formula or reference based-pricing (such as a percentage of a Medicare reimbursement rate), the plan or issuer would be required to provide the calculated dollar amount of the negotiated rate for each provider. Negotiated rates would have to be associated with the provider's National Provider Identifier (NPI), which is accessible by providers, plans, and issuers.

The Departments understand that some plans and issuers do not vary negotiated rates across in-network providers. For instance, some plans and issuers have a negotiated rate that applies to every provider in a certain network tier. In such a case, the plan or issuer must provide the negotiated rate for a covered item or service separately for every provider that participates in that tier of the network. If the plan or issuer reimburses for certain items and services (for example, maternity care and childbirth) through a bundled payment arrangement, the plan must identify the bundle of items and services by the relevant code.

Plans and issuers would also be required to include in the Negotiated Rate File the last date of the contract term for each provider-specific negotiated rate that applies to each item or service (including rates for both

[57] As of 2017, employer-based coverage was the most common, covering 56.0 percent of the population for some or all of the calendar year. Berchick, E., Hood, E. Barnett, J. ''Health Insurance Coverage in the United States: 2017.'' U.S. Government Printing Office. September 2018. Available at: *https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.*

individual and bundled items and services).

Allowed Amount File

The third content element plans and issuers would be required to include in the Allowed Amount File would be historical out-of-network allowed amounts for covered items and services. These proposed rules would require plans and issuers to include in the Allowed Amount File each unique out-of-network allowed amount in connection with covered items or services furnished by a particular out-of-network provider during the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount File. As with the Negotiated Rate File, where a plan or issuer reimburses providers for an item or service based on a formula or reference based-pricing (such as a percentage of a Medicare reimbursement rate), the plan or issuer would be required to provide the calculated dollar amount of the allowed amount for each provider. Allowed amounts would have to be associated with the provider's NPI, which is accessible by providers, plans, and issuers.

When disclosing an out-of-network allowed amount under this requirement, the plan or issuer would disclose the aggregate of the actual amount the plan or issuer paid to the out-of-network provider, plus the participant's, beneficiary's, or enrollee's share of the cost. For instance, if the out-of-network allowed amount for a covered service is $100, and the plan or issuer paid 80 percent of the out-of-network allowed amount ($80) per the terms of the plan or coverage, the participant, beneficiary, or enrollee was responsible for paying twenty percent of the out-of-network allowed amount ($20), the plan or issuer would report an out-of-network allowed amount of $100. This unique payment amount would be associated with the particular covered item or service (identified by billing code) and the particular out-of-network provider who furnished the item or service (identified by NPI).

As an example, assume Group Health Plan A intends to publish a machine-readable file on July 1 reporting the out-of-network historical allowed amount data the Departments propose to require. Under these proposed requirements, Group Health Plan A's Allowed Amount File must detail each discrete out-of-network allowed amount the plan calculated in connection with a covered item or service furnished by an out-of-network provider between January 1 and April 1. During this 90-day time period, Group Health Plan A paid 23 claims from Provider Z seeking compensation for rapid flu tests (CPT Code 87804), a service covered under the group health plan. Group Health Plan A calculated out-of-network allowed amounts of $100 for three claims, $150 for 10 claims, and $200 for the remaining 10 claims. Under these proposed rules, Group Health Plan A would report in the file published on June 30, that it calculated three different out-of-network allowed amounts of $100, $150, and $200 for rapid flu tests (CPT Code 87804) in connection with covered services furnished by Provider Z from January 1 to April 1. On July 30, Group Health Plan A would update the file to show the unique out-of-network allowed amounts for CPT Code 87804 for Provider Z's services rendered from February through April. On August 30, Group Health Plan A would update the file to show such payments for services rendered from March through May, and so on.

The Departments specifically seek comment on whether the required disclosures of historical out-of-network allowed amounts will provide useful information that can assist consumers in locating services at an affordable cost, or whether there is additional information that is both useful to anticipated users and practical for plans and issuers to disclose for this purpose. For instance, the Departments considered requiring plans and issuers to disclose in the Allowed Amount File amounts out-of-network providers charged participants, beneficiaries, and enrollees for covered services. We understand that such charge amounts would be included in any claim for out-of-network benefits and could be helpful to consumers shopping for services based on price. We seek comment on this data element and other information that would support the transparency goals of these proposed rules.

The Departments designed this reporting requirement to elicit payment data that reflects recent out-of-network allowed amounts in connection with claims for out-of-network covered services. The Departments assume these amounts will provide payment data that is useful to consumers because it is reflective of current reimbursements. Specifically, the Departments propose to require reporting based on dates of service within 180 days of the Allowed Amount File publication date to ensure that data is composed of recent claims (rather than older claims from multiple time periods) and to avoid the reporting of payments from different periods of time. Payment data from defined periods of time will enable users to make meaningful comparisons across plans and coverage options.

The 90-day reporting period ensures that the public has access to reasonable volumes of payment data from which users can make useful and accurate inferences about how much a service would cost if furnished by a particular provider. The Departments are concerned, however, that out-of-network providers may not provide services to participants, beneficiaries, or enrollees on a sufficiently frequent basis during a 90-day period to yield a useful amount of payment data. The Departments seek comment generally on these issues and on whether the Departments should require that reporting of out-of-network allowed amounts cover a longer period of time, such as 120 days, 180 days, or more.

Similarly, the Departments propose to require plans and issuers to report out-of-network allowed amounts for services furnished at least 90 days in the past to help ensure the availability of reasonable volumes of out-of-network allowed amount data in the machine-readable file. The Departments are of the view that a 90-day lag between the end of a reporting period and the publication of required out-of-network allowed amount data will allow plans and issuers sufficient time to adjudicate and pay claims from out-of-network providers for the relevant reporting period. The Departments also understand, however, that claims processing times may vary between plans and issuers, and that external factors may increase processing timelines. For example, the Departments understand that many out-of-network providers do not send claims directly to plans and issuers, but require patients to file out-of-network claims. This could mean that an out-of-network claim may not reach a plan or issuer for 6 to 12 months after a service is rendered. Such delays could negatively affect the volume of out-of-network allowed amount data and the ultimate usefulness of this data. For this reason, the Departments seek comment on whether requiring plans and issuers to report out-of-network allowed amounts for items and services furnished at least 90 days in the past is sufficient to ensure the proposed disclosures will yield sufficient volumes of historical data to be useful to consumers who wish to shop for services based on price. For instance, the Departments seek comment on whether the Departments should require that more time elapses between the end of the reporting period and publication of the data, such as 120 days, 180 days, or more, to increase the likelihood that out-of-network claims

from the relevant reporting period have been adjudicated and paid by the time they must be published.

The Departments are aware that providing this information could raise health privacy concerns. For example, there may be instances (such as in a small group health plan or with respect to an item or service for a rare chronic condition) where, through deduction, disclosing the required payment information may enable users to identify the patient who received the service. There may also be instances when this public disclosure requirement would be inconsistent with federal or state laws governing health information that are more stringent than HIPAA Rules with regard to the use, disclosure, and security of health data that was produced pursuant to a legal requirement, such that plans and issuers would be required to further de-identify data to the extent a patient could be identified through deduction. For example, some of the claims for payment from an out-of-network provider could relate to services provided for substance use disorder, which could implicate disclosure limitations under 42 CFR part 2 governing the confidentiality of substance use disorder patient records. Thus, some of the out-of-network allowed amounts that the Departments propose to make public could be subject to disclosure rules and limitations under 42 CFR part 2.

To address privacy concerns, the Departments propose that plans and issuers would not be required to provide out-of-network allowed amount data in relation to a particular provider and a particular item or service when compliance would require a plan or issuer to report out-of-network allowed amounts to a particular provider in connection with fewer than 10 different claims for payment. Furthermore, the Departments note that disclosure of such information would not be required if compliance would violate applicable health information privacy laws. The Departments are committed to protecting sensitive patient health information. For this reason, in addition to proposing this exemption, the Departments propose under paragraph (c)(1)(ii) to require only unique out-of-network allowed amounts to mask the total episodes of care for a particular provider and item or service. The Departments believe these mitigation strategies, in addition to flexibilities proposed to allow the aggregation of reported data (as described later in this preamble), are sufficient to protect patients from identification based on information in the Allowed Amount File. The Departments solicit comment on whether additional privacy protections are required.

The Departments specifically solicit comment on whether a higher minimum claims threshold, such as a threshold of 20 claims, would better mitigate privacy concerns and minimize complexity in complying with federal or state privacy laws without compromising the integrity of the compiled information. The Departments also seek comment on additional approaches that could decrease the potential for aggregated health information that would be disclosed under these proposed rules to be identified, especially with respect to smaller group health plans.

3. Required Method and Format for Disclosing Information to the Public

The Negotiated Rate and Allowed Amounts Files would be required to be disclosed as machine-readable files. These proposed rules define ''machine-readable file'' to mean a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost. This means that the machine-readable file can be imported or read by a computer system without those processes resulting in alterations to the ways the data and the commands are presented in the machine-readable file. These proposed rules would require each machine-readable file to use a non-proprietary, open format to be identified by the Departments in technical implementation guidance (for example, JSON, XML, CSV). A PDF file, for example, would not meet this definition due to its proprietary nature.

The Departments considered proposing that group health plans and health insurance issuers post negotiated rates and historical out-of-network allowed amount data for all covered items and services using a single standardized, non-proprietary file format, specifically JSON. The Departments understand that this format generally is easily downloadable, and it could simplify the ability of price transparency tool developers to access the data. The Departments seek comment on whether the final rule should require group health plans and health insurance issuers to make the Negotiated Rate and Allowed Amounts Files available as JSON files.

These machine-readable files would also be required to comply with technical, non-substantive implementation guidance to be published following the finalization of these proposed rules. The guidance will provide technical direction that identifies the specific open, non-proprietary file format in which plans and issuers should produce the machine-readable files. It will, among other things, provide the schema for the file, which is a description of the manner in which the data should be organized and arranged. The guidance would ensure consistent implementation of the machine-readable file requirements across all plans and issuers, and would ensure stability, predictability, and reliability for users of the proposed machine-readable file.

The Departments believe that providing such specific technical direction in separate guidance, rather than in this rule, would better enable the Departments to update these specific requirements to keep pace with and respond to technological developments. The Departments will publish a PRA package that will further describe the specific data elements that would be disclosed in the proposed machine-readable files.

The Departments propose to require plans and issuers to publish their negotiated rates and historical allowed amount data in two machine-readable files, one reporting required negotiated rate data with in-network providers, and a second reporting required out-of-network allowed amount data. The Departments considered allowing plans and issuers to have flexibility to publish this information in either one or two machine-readable files. The Departments solicit comment on whether building and updating one file could be less burdensome for plans and issuers than maintaining multiple files, and whether having the data in a single file could facilitate use by market innovators.

The Departments are specifically interested in comments regarding whether a single file for disclosure of all the required information would likely be extremely large, making it less than optimal for anticipated users, such as software application developers and health care researchers. The Departments propose to require plans and issuers to publish data on negotiated in-network rates and data on historical out-of-network allowed amounts in separate machine-readable files to account for the dissimilarity between the static rates paid to in-network providers under contract and the more variable amounts paid to out-of-network providers. The Departments seek comment on the benefits and challenges to providing all the required data in two separate files, as proposed.

4. Required Accessibility Standards for Disclosure of Information to the Public

These proposed rules include provisions intended to address potential barriers that could inhibit the public's ability to access and use the information should it become available. For example, some plans and issuers require consumers to set up a username and password, or require consumers to submit various types of other information, including their email address, in order to access data offered by plans and issuers. The Departments are concerned that these requirements might deter the public from accessing negotiated rate and allowed amount information. Accordingly, these proposed rules would require a plan or issuer to make available on an internet website the information described earlier in this preamble in two machine-readable files that must be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such as a name or email address.

The Departments also considered requiring plans and issuers to submit the internet addresses for the machine-readable files to CMS, and having CMS make the information available to the public. A central location could allow the public to access negotiated rate information and historical data for out-of-network allowed amounts in one centralized location, reducing confusion and increasing accessibility. However, the Departments opted to propose flexible rules allowing plans and issuers to publish the files in the location plans and issuers determine will be most easily accessible by the intended users. The Departments also considered that requiring plans and issuers to notify CMS of the internet address for their machine-readable files would increase burden on plans and issuers. The Departments request comment on whether the proposed requirement to allow issuers to display the flat files in the location of their choice is superior to requiring plans and issuers to report the web addresses of their machine-readable files to CMS for public display. The Departments are specifically interested in whether the burden associated with reporting file locations to CMS is outweighed by the risk that members of the public will be unable to easily locate plans' and issuers' machine-readable files.

5. Required Timing of Updates of Information To Be Disclosed to the Public

These proposed rules would require a group health plan or health insurance issuer to update monthly the information required to be included in each machine-readable file. The Departments recognize, however, that information in Negotiated Rate Files may change frequently and are considering whether to require plans and issuers to update their Negotiated Rate Files more often than proposed to ensure that consumers have access to the most up-to-date negotiated rate information. Accordingly, the Departments also seek comment on whether the final rules should require plans' and issuers' Negotiated Rate Files to be updated more frequently. For instance, the Departments considered requiring plans and issuers to update negotiated rate information within 10 calendar days after the effective date of new rates with any in-network provider, including rates for in-network providers newly added to a plan's provider network and updates made necessary by a provider leaving the plan's or issuer's network. The Departments seek comment on this alternate proposal and on whether the update timelines for negotiated rate information and historical out-of-network payment data should be the same.

The proposed rules would also require plans and issuers to clearly indicate the date of the last update made to the Negotiated Rate and Allow Amount Files in accordance with guidance issued by the Departments. The Departments seek comment on this proposal.

6. Special Rules To Prevent Unnecessary Duplication and Allow for Aggregation

Similar to the proposed cost-sharing information disclosure requirements for participants, beneficiaries, and enrollees, the Departments propose a special rule to streamline the provision of the required disclosures that would be included in the proposed machine-readable files. This special rule has three components—one for insured group health plans where a health insurance issuer offering coverage in connection with the plan has agreed to provide the required information, another for plans and issuers that contract with third parties to provide the information on their behalf, and a special rule allowing aggregation of out-of-network allowed amount data.

a. Insured Group Health Plans

The Departments propose that, to the extent coverage under a group health plan consists of group health insurance coverage, the plan would satisfy the proposed file requirement if the health insurance issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and issuer. Accordingly, if a plan sponsor and an issuer enter into a written agreement under which the issuer agrees to provide the information required under these proposed rules, and the issuer fails to provide full or timely information, then the issuer, but not the plan, would violate the transparency disclosure requirements and be subject to enforcement mechanisms applicable to group health plans under the PHS Act.[58]

b. Use of Third Parties To Satisfy Public Disclosure Requirements

Plans and issuers may wish to engage other entities to assist them in complying with the disclosure requirements under these proposed rules. In particular, it is the Departments' understanding that most health care insurance and coverage claims in the U.S. are processed through health care claims clearinghouses [59] and that these entities maintain and standardize health care information, including information on negotiated rates and out-of-network allowed amounts. As a result, plans and issuers may reduce the burden associated with making negotiated rates and out-of-network allowed amounts available in machine-readable files by entering a business associate agreement and contracting with a health care claims clearinghouse or other HIPAA-compliant entity to disclose these data on their behalf.[60] Accordingly, these proposed rules would permit a plan or issuer to satisfy the public disclosure requirement of paragraph (c) of the

[58] Section 2723 of the PHS Act.

[59] The Departments propose to adopt the definition of health care clearinghouse under 45 CFR 160.103 for purposes of these proposed rules. Under that definition, health care clearinghouse means a public or private entity, including billing services, repricing companies, community health management information systems or community health information systems, and ''value-added'' networks and switches, that does either of the following functions: (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction. (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

[60] *See* 45 CFR 164.502(a)(3) and 164.504(e)(2).

proposed rules by entering into a written agreement under which another party (such as a TPA or health care claims clearinghouse) will make public the required information in compliance with this section. However, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide full or timely information, the plan or issuer would violate the transparency disclosure requirements.

c. Aggregation Permitted for Allowed Amount Files

In order to further mitigate privacy concerns and to eliminate unnecessary duplication, the Departments propose to permit plans and issuers to satisfy the requirement of paragraph (c)(1)(ii) of these proposed rules by making available out-of-network allowed amount data that has been aggregated to include information from more than one plan or policy. As previously discussed, a plan or issuer may satisfy the disclosure requirement by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a service provider, or other party with which the plan or issuer has entered into a written agreement to provide the information. Accordingly, under such circumstances, these proposed rules would permit issuers, service providers, or other parties with which the plan or issuer has contracted to aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract. To the extent a plan or issuer is providing out-of-network allowed amount information in the aggregate, the Departments propose to apply the 10 minimum claims threshold to the aggregated claims data set, and not at the plan or issuer level.

7. Additional Comment Solicitation on the Negotiated Rate and Allowed Amount Files

As discussed earlier in this preamble, the Departments assume that some group health plans and health insurance issuers may store data in different systems, including dated legacy systems, which could make it difficult to accurately and efficiently populate a file as required by these proposed rules. The Departments understand that clearinghouses may provide a solution to plans and issuers in this situation, as many clearinghouses already possess the data that would be required to be disclosed in these proposed rules. The Departments seek feedback on the ways plans and issuers may be able to use a health care claims clearinghouse to fulfill the requirements of this rule and the impact this may have in reducing the burden of satisfying these proposed requirements. The Departments further seek comment on whether plans and issuers similarly could use TPAs to reduce the costs and burden of complying with these proposed requirements.

Although the Departments propose in these rules to require plans and issuers to make price and payment information public through machine-readable files, the Departments considered proposing to require plans and issuers to provide rate information through a publicly accessible API that would comply with standards defined by the Departments. The Departments note that there is currently no standard HIPAA transaction applicable to data that will be made available to members of the public who are not covered entities.[61] The Departments also understand that issuer and plan systems could be designed in a manner that providing API access to information that would be disclosed under these proposed rules could be more efficient and less burdensome than maintaining the information in machine-readable files. The Departments are concerned, however, that many plans and issuers could face significant technical issues in complying with such a requirement. The Departments, therefore, seek comment on whether plans and issuers should have the flexibility to provide access to negotiated rates and out-of-network allowed amounts through a publicly accessible API that conforms to defined standards.

Finally, the Departments recognize that the precise impact of making pricing information public cannot be predicted. As discussed in section VII of the preamble to these proposed rules, the Departments are aware that price transparency could have negative unintended consequences in markets where pricing will become very transparent, including narrowing of prices and increases in average costs. The Departments also recognize that information disclosures allowing competitors to know the rates plans and issuers are charging may dampen incentives for competitors to offer lower prices, potentially resulting in higher prices. Some stakeholders also have expressed concern that without additional legislative or regulatory efforts public availability of negotiated rates may have the unintended consequence of increasing costs for services in highly concentrated markets or result in anticompetitive behaviors. Notwithstanding these concerns, the Departments remain confident that the release of the data will help reduce pricing disparities and potentially drive down health care costs, as discussed earlier in this preamble. The Departments seek comment on these potential concerns and what additional rules would help to mitigate risk of these potential consequences.

Interaction of Proposed Requirements With 45 CFR 156.220

The Departments recognize that group and individual market health insurance issuers that offer QHPs through an Exchange are already subject to reporting requirements under 45 CFR 156.220 that implement the transparency in coverage requirements of section 1311(e)(3) of PPACA. Pursuant to 45 CFR 156.220, issuers of QHPs offered through an individual market Exchange or a Small Business Health Options (SHOP) Exchange, including stand-alone dental plans, must submit specific information about their plans' coverage to the appropriate Exchange, HHS, and the state insurance commissioner, as well as make the information available to the public in plain language.

The Departments acknowledge the similar purposes served by 45 CFR 156.220 and these proposed rules. The Departments, however, do not intend for these proposed rules, if finalized, to alter requirements under section 45 CFR 156.220. Accordingly, if these proposed rules are finalized as proposed, QHP issuers would need to comply with requirements under both rules. If necessary and to the extent appropriate, HHS may issue future guidance to address QHP issuers' compliance with both section 45 CFR 156.220 and these proposed rules once they are finalized.

III. Request for Information: Disclosure of Pricing Information Through a Standards-Based API

The Departments are considering further expanding access to pricing information—both individuals' access to estimates about their own cost-sharing liability, and information about negotiated in-network rates and data for out-of-network allowed amounts in future rulemaking. Specifically, the Departments are considering whether to require, through future rulemaking, that group health plans and health insurance issuers make available as discrete data elements through a standards-based API the cost-sharing information that would be disclosed through the proposed internet-based self-service tool, as well as the in-network negotiated rates and out-of-network allowed amounts that

[61] *See generally* 45 CFR part 162, subparts K–S (describing standard HIPAA transactions).

this rule proposes to be publicly disclosed through machine-readable files. Standards-based APIs are also sometimes referred to as ''open'' APIs to convey that certain technical information for the API is openly published to facilitate uniform use and data sharing in a secure, standardized way.

The availability of patient cost-sharing information prior to the ordering and delivery of services can enable both patients and clinicians to make more informed decisions about the course of treatment and the cost to the patient. Requiring such access through a standards-based API could have a number of benefits for patients, providers, and the public at large. It would help promote the Departments' goal of allowing technology innovators to compile, consolidate and present pricing data in a usable format for consumers, thereby helping to make that data more relevant for consumers. For example, providing real-time access to the pricing information as discrete data elements through this mechanism would enable this information to be incorporated into third-party applications used by health care consumers or into electronic medical records for point-of-care decision-making and referral opportunities by clinicians. Additionally, being able to access these data elements through standards-based APIs would allow health care consumers to use a third-party application of their choice to obtain personalized, actionable health care service price estimates, rather than being required to use a specific application or online tool developed or identified by their plan or issuer. Widespread adoption of published, common, technical, content, and vocabulary standards are an important factor in fostering an environment in which third-party vendors can tailor products and services to better serve consumers through making health information accessible and actionable, including information that can support better financial decisions about their health care.

APIs are messengers or translators that work behind the scenes to ensure that software programs can talk to one another.[62] An API can be thought of as a set of commands, functions, protocols, or tools published by one software developer (''A'') that enable other software developers to create programs (applications or ''apps'') that can interact with A's software without the other software developer needing to know the internal workings of A's software, all while maintaining consumer data privacy standards. This is how API technology enables the seamless user experiences associated with applications familiar from other aspects of many consumers' daily lives, such as travel and personal finance. Standardized, transparent, and procompetitive API technology can similarly benefit consumers of health care services. A standards-based, transparent API's technical requirements are consistent with other system APIs that have been developed to the same standards and are openly published, supporting interoperability. Technical consistency is fundamental to scale API-enabled interoperability and reduce the level of custom development and costs necessary to access, exchange, and use health information. Publishing specific technical and business information, such as how to demonstrate authorization to access specific data, necessary for applications to interact successfully with an API in production, is commonplace in many other industries and has fueled innovation, growth, and competition. In addition, a standards-based API does not allow any and all applications or application developers unfettered access to sensitive information within a database or data system. Instead, a standards-based API can enable an application to securely access a specific set of data based on established technical specifications and authentication and access controls. These controls can be implemented consistent with the organization's identity authentication or access authorization verification processes that comply with all applicable privacy and security laws and regulations.

On March 4, 2019, HHS Office of the National Coordinator for Health Information Technology (ONC) published a proposed rule, ''21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program'' (ONC 21st Century Cures Act proposed rule), which proposed updates to the standards, implementation specifications and certification criteria as well as Condition and Maintenance of Certification requirements for health information technology (health IT) under the ONC Health IT Certification Program. The ONC 21st Century Cures Act proposed rule specifically describes the requirements health IT developers must meet to comply with the API Condition of Certification as established by the 21st Century Cures Act and to be certified as meeting API-focused certification criteria under the ONC Health IT Certification Program. In the proposed rule, ONC proposed a set of technical API standards including the HL7 Fast Healthcare Interoperability Resources (FHIR) standard and complementary security and app registration protocols, OAuth 2.0 and OpenID Connect Core, for adoption by HHS at 45 CFR 170.215. ONC also proposed the adoption of a standard called the ''United States Core Data for Interoperability (USCDI)'' at 45 CFR 170.213 (84 FR 7424), which would establish a set of data classes and constituent data elements to support nationwide interoperability. The USCDI standard also references content and vocabulary standards relevant to included data that are adopted under 45 CFR part 170.

On March 4, 2019, CMS also published a proposed rule, ''Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and Chip Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers'' (CMS Interoperability & Patient Access proposed rule).[63] This rule would require Medicare Advantage organizations, Medicaid and CHIP Fee-for-Service programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers in the FFEs to provide enrollees with access to select data, including claims data, through a standards-based API that conforms to the technical standards proposed for adoption in the ONC 21st Century Cures Act proposed rule at 45 CFR 170.215. If the CMS Interoperability & Patient Access proposed rule is finalized, certain entities, such as FFE QHP issuers and companies that participate in both Medicare (by offering a Medicare Advantage plan) and the individual or group market, would be required to provide certain data through a standards-based API, while also being subject to future rulemaking under section 2715A of the PHS Act.

Sections 13111 and 13112 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) require that federal agencies utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under section 3004 of the PHS Act. Consistent with section 3004 of the PHS

[62] For more information on APIs, see *https://www.healthit.gov/api-education-module/story_html5.html.*

[63] 84 FR 7610 (March 04, 2019).

Act and sections 13111 and 13112 of the HITECH Act, and to limit additional burden, the Departments would align, to the extent possible, any standards adopted in future rulemaking under section 2715A of the PHS Act that rely on standards-based APIs with the standards adopted by HHS under section 3004 of the PHS Act. This would include the technical standards for APIs proposed in the ONC 21st Century Cures Act proposed rule for HHS adoption at 45 CFR 170.215, which are also referenced in the CMS Interoperability & Patient Access proposed rule, though the Departments recognize that the content and vocabulary standards in the CMS Interoperability & Patient Access proposed rule relating to claims and clinical data are not applicable to pricing data.

The API standards proposed for HHS adoption in the ONC 21st Century Cures Act proposed rule are published standards. Notably, the FHIR standard is a consensus technical standard that holds great potential for supporting interoperability and enabling new entrants and competition throughout the health care industry. FHIR leverages modern computing techniques to enable users to access health care information over the internet via a standardized RESTful API. Specifically, FHIR includes both technical specifications for API transport (RESTFul + JSON) and also specifications for API content known as ''resources,'' which are a type of software architecture that provides interoperability between the internet and computer systems. Developers can create tools that interact with FHIR APIs to provide actionable data to their stakeholders. In the short time since FHIR was first created, the health care industry has rapidly embraced the standard through substantial investments in industry pilots, specification development, and the deployment of FHIR APIs supporting a variety of business needs.

The Departments request comment on whether API technical standards, based on the FHIR standard, as aligned with the ONC 21st Century Cures Act proposed rule and the CMS Interoperability & Patient Access proposed rule, should be required in the future across group health plans and health insurance coverage in the group and individual markets.[64] Specifically, the Departments are seeking comment on whether the Departments should propose an approach under which plans and issuers would be required to develop and implement procedures to make data available through APIs using the HL7® FHIR® IG: PSS for Patient Cost Transparency.[65] Recognizing that this IG is currently under development, the Departments could propose a staged approach to the implementation of this API requirement: (1) Starting prior to when the IG is final (for example, starting January 1, 2022), payers could be required to make data available through an API; and (2) starting on or after the final IG publication date (anticipated to be October 1, 2023), plans and issuers could be required to make data available through APIs using the HL7® FHIR® IG: PSS for Patient Cost Transparency. The Departments are considering an approach under which initially plans and issuers would not be required to utilize the FHIR standard for this API, but the Departments would strongly encourage such use. While the IG for Patient Cost Transparency would not yet be finalized during this period, prior iteration(s) of the standard for trial use would be publicly available and could provide a development roadmap for payers wishing to deploy a FHIR-based API. The Departments are soliciting comment on the appropriateness of this proposed approach, the challenges it may present, and whether these suggested timeframes are appropriate.

The Departments request comment on what pricing information should be disclosed through an API, including whether all data elements required to be provided through the internet-based self-service tool and the negotiated in-network rate and allowed amount data for out-of-network providers machine-readable files should be required, whether a more limited set of data elements should be required in future rulemaking, and whether there are additional data elements that should be required.

The Departments recognize that requiring plans and issuers to disclose information related to cost-sharing liability, negotiated rates, and allowed-amounts for items and services furnished by out-of-network providers through a standards-based API would place additional burdens on issuers. The Departments seek comment on the possible scope of this burden. The Departments request comment on the potential operational impact on plans and issuers of using an API standard that aligns with the CMS Interoperability & Patient Access proposed rule to make pricing information more accessible. With adequate time for implementation, the Departments believe an API solution would not only greatly benefit patients, but may prove less burdensome for issuers and plans than requiring that the disclosures be made via machine-readable files. The Departments seek comment on plans' and issuers' readiness to disclose such data elements through an API, and the amount of time plans and issuers would need to implement such standards.

While the Departments expect that such a requirement would be justified by the increase in access to pricing information for consumers and the public, the Departments welcome comment on the utility of providing access via a standards-based API in the future, if a plan or issuer based tool and negotiated in-network rate and historical payments to out-of-network providers files are already available, as proposed elsewhere in this rule. The Departments are of the view that requiring plans and issuers to make pricing data available through a standards-based API would spur competition and reduce the burden on application developers to innovate around providing more user-friendly and effective applications for consumers. The ability to develop an application that can effectively interconnect with multiple APIs based on a single standard rather than having to build for separate proprietary APIs (or machine-readable files) allows application developers to focus development on meeting consumer needs. These applications would then allow consumers to realize the potential associated with greater access to these data. The Departments anticipate that a future rule that would propose the use of a standards-based API consistent with the API technical standards proposed for HHS adoption in the ONC 21st Century Cures Act proposed rule, to the extent such proposals are finalized, would encourage innovation and ensure that the pricing data are standardized in ways that promote interoperability and the use of electronic technological and third-party innovation. Access to pricing data through standards-based APIs would encourage application developers to try out different application features in order to determine what features are most engaging and user friendly for consumers. The Departments are also interested in comments from

[64] The Departments note that there is currently no standard HIPAA transaction applicable to data that will be made available to members of the public who are not covered entities. *See generally* 45 CFR 162.923.

[65] *https://www.hl7.org/special/Committees/projman/searchableProjectIndex.cfm?action=edit&ProjectNumber=1514.*

application developers about potential uses for these data.[66]

If the Departments move forward with a proposal in future rulemaking to require plans and issuers to make pricing information available through an API, the Departments have determined that the specific business and technical documentation necessary to interact with the proposed APIs would need to be made freely and publicly accessible. The Departments understand transparency about API technology is critical to ensuring that any interested application developer could easily obtain information needed to develop applications technically compatible with a plan's or issuer's API. Transparency would also be needed so that application developers would understand how to successfully interact with a plan's or issuer's API, including by satisfying any requirements the organization may establish for verification of developers' identity and their applications' authenticity, consistent with its security risk analysis and related organizational policies and procedures to ensure it maintains an appropriate level of privacy and security protection for data required to be disclosed. The Departments would likely propose to use the documentation requirements for standards-based APIs as defined in the ONC 21st Century Cures Act proposed rule and the CMS Interoperability & Patient Access proposed rule, to the extent those standards are finalized (see 84 FR 7634 through 7635). The Departments request comment on the future applicability of the documentation requirements for standards-based APIs as defined in the ONC 21st Century Cures Act proposed rule and the CMS Interoperability & Patient Access proposed rule, for the purposes of this use case specific to price transparency, and on what other documentation requirements are necessary to ensure transparency and consistency of pricing information.

The CMS Interoperability & Patient Access proposed rule proposed requirements for routine testing and monitoring of standards-based APIs (see 84 FR 7635). The Departments seek comment on whether there are reasons why different testing and monitoring requirements should apply to plans and issuers in the group and individual markets, for use specifically regarding price transparency and, if so, what requirements should apply. The Departments are also interested in comments regarding whether requiring the same testing and monitoring requirements would produce efficiencies for entities subject to both the CMS Interoperability & Patient Access proposed rule and section 2715A of the PHS Act.

The Departments recognize that while a specific standard for the standards-based API would need to be codified in regulation, the need for continually evolving standards development has historically outpaced the Departments' ability to amend regulatory text. In order to address how standards development can outpace agencies' rulemaking schedule, the Departments are considering proposing the approach for permitting stakeholders to utilize updated standards required for the API, as proposed in the CMS Interoperability & Patient Access proposed rule, to the extent it is finalized as proposed (see 84 FR 7630–7631), which references the Standards Version Advancement Process discussed in the ONC 21st Century Cures Act proposed rule (84 FR 7497–7498). However, the Departments are interested in comments regarding the impact on plans and issuers of updating APIs, and the frequency with which such updates should occur for this test case. The Departments also welcome comments on the circumstances in which voluntary use of updated versions of adopted standards set forth in future rulemaking should be allowed, and if the Departments should maintain alignment with the approach described in the CMS Interoperability and Patient Access proposed rule.[67]

The Departments are also interested in comments regarding potential privacy and security risks associated with a requirement that plans and issuers make pricing information available through a standards-based API. In the hands of a HIPAA-covered entity, such as a health care provider or health plan, or its business associate, individually identifiable pricing information about one's health care is PHI as defined at 45 CFR 160.103. As explained in the ONC 21st Century Cures Act proposed rule[68] direct-to-consumer health information technology products and services are a growing sector of the health IT market, but are often not regulated by the HIPAA Rules. Rather, the privacy and security practices of consumer-facing health IT products and services are typically regulated by the Federal Trade Commission Act (FTC Act). However, the FTC Act applies to acts and practices that are unfair and deceptive (15 U.S.C. 45(a)(1)), and does not prescribe privacy requirements to be adopted or followed that can be leveraged for the purpose of recognizing reasonable and necessary privacy-protective practices in these proposed rules.[69]

Although nothing would prevent an enrollee from requesting information through the API that is unrelated to the individual's actual health status or needs, the Departments anticipate that individuals typically would be seeking information related to their own potential health conditions and needs. For example, an individual is more likely to request cost-sharing information with in-network obstetricians if she is pregnant than if she is not. Revealing what information has been requested by individual enrollees could, thus, reveal sensitive information about their health status. Ensuring the privacy and security of these data if they are transmitted through the API would be of critical importance. To the extent that information that could be requested via the API would be considered PHI, covered entities and business associates would be able to disclose that information only to the extent permitted or required by the HIPAA Rules, and other federal and state laws. The Departments request comment on privacy and security standards that would be sufficient to protect the sensitive health data the Departments could propose in future rulemaking to be transmitted via an API, or whether additional privacy and security standards should be required.

If an enrollee directs a covered entity to send his PHI to a third-party application chosen by the individual, and that third-party application developer is neither a covered entity nor business associate under HIPAA Rules, (such as an application developer retained by the covered entity to transmit the PHI to the individual), the PHI to be transmitted through the API would not be protected under HIPAA Rules after being transmitted through the standards-based API and received by the third party, and covered entities would not be responsible for the security of that PHI once it has been received by the third-party application.[70] The Departments

[66] *See* 84 FR 7628–7639.

[67] The Departments direct readers to the ONC 21st Century Cures Act proposed rule for further discussion on the voluntary advancement to updated versions of standards adopted for HHS use: *https://www.federalregister.gov/d/2019-02224/p-1003.*

[68] 84 FR 7424 (March 4, 2019).

[69] *See* HHS, Examining Oversight of the Privacy & Security of Health Data Collected by Entities Not Regulated by HIPAA, available at: *https://www.healthit.gov/sites/default/files/non-covered_entities_report_june_17_2016.pdf.*

[70] HHS Office for Civil Rights, *FAQ on Access, Health Apps and APIs, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access-right-health-apps-apis/index.html* ("Once health

recognize that this could present a risk to sensitive information about enrollees' health status if the third party subsequently misuses the data or has a security breach. Nevertheless, the Departments are of the view that consumers should have access to this information to empower them to make informed health care decisions. To this end, the Departments believe consumers should be able to share such data with third-party applications of their choosing, but that they should understand that they are accepting the potential privacy and security risks that come from using a third-party application that is not required to comply with the HIPAA Rules.

The Departments are committed to maximizing enrollees' access to and control over their health information, including information designed to enable them to be more adept consumers of health care. The use of third-party applications to access pricing information is likely to introduce privacy risks of which consumers may be unaware, particularly if they do not understand that third-party application developers that are not providing an application on behalf of a covered entity are not business associates, and are not bound by the HIPAA Rules. The Departments seek comment regarding what information plans, issuers and third-party application developers should make available to individuals to better help them understand essential information about the privacy and security of their information, and what to do if they believe they have been misled or deceived about an application's terms of use or privacy policy. The Departments also seek comment regarding the manner and timing under which such information should be provided.

The Departments are considering requirements that would specify that consistent with the HIPAA Privacy Rule, plans and issuers generally may not deny access to a third party when an enrollee requests that the information be made accessible as proposed in this rule. As noted in guidance from HHS Office for Civil Rights, disagreement with the individual about the worthiness of the third party as a recipient of PHI, or even concerns about what the third party might do with the PHI, are not grounds for denying an access request.[71] However, a HIPAA covered entity is not expected to tolerate unacceptable levels of risk to the PHI in its systems, as determined by its own risk analysis.[72] Accordingly, it may be appropriate for a plan or issuer to deny or terminate specific applications' connection to its API under certain circumstances in which the application poses an unacceptable risk to the PHI on its systems or otherwise violates the terms of use of the API technology. In the CMS Interoperability & Patient Access proposed rule, CMS proposed that applicable entities could, in accordance with the HIPAA Security Rule, deny access to the API if the entity reasonably determines, based on objective, verifiable criteria that are applied fairly and consistently, that allowing that application to connect or remain connected to the API would present an unacceptable level of risk to the security of PHI on the entity's systems. The Departments are considering proposing a similar standard in future rulemaking for this specific use case. The Departments seek comment on this, as well as whether there are other specific circumstances under which plans and issuers should be permitted to decline to establish or permitted to terminate a third-party application's connection to the entity's API while remaining in compliance with a requirement to offer patients access through standards-based APIs for purposes of this specific use case.

In addition, and to address the concerns related to the risk to PHI within a system, the Departments further note that there are extant best practices and technical specifications for security related to authorization and access to data through APIs, which can be applied to health care use cases. In the ONC 21st Century Cures Act proposed rule, the ONC proposed technical standards for an API including complementary security and app registration protocols—OAuth 2.0 and OpenID Connect Core. Specifically, ONC proposed to adopt the ''OpenID Connect Core 1.0 incorporating errata set 1'' standard in 45 CFR 170.215(b), which complements the SMART Application Launch Framework Implementation Guide Release 1.0.0 [87] (SMART Guide). The OpenID standard is typically paired with OAuth 2.0 implementations and focuses on user authentication. ONC proposed to adopt the SMART Guide in 45 CFR 170.215(a)(5) as an additional implementation specification associated with the FHIR standard. This guide is referenced by the US FHIR Core IG and is generally being implemented by the health IT community as a security layer with which FHIR deployment is being combined (from both a FHIR server and FHIR application perspective). The use of these technical standards creates the ability for plans and issuers to use industry best practices to control authorization and access to the API and establish appropriate technical requirements for the security of third-party application access.

Further, the implementation of OpenID Connect paired with OAuth 2.0 allows organizations to securely deploy and manage APIs consistent with their organizational practices to comply with existing privacy and security laws and regulations. The organization publishing the API retains control over how patients authenticate when interacting with the API. For example, a patient may be required to use the same credentials they created and use to access their health information through the internet-based self-service tool as they do when authorizing an app to access their data. Since patients complete the authentication process directly with the organization, the app would not have access to their credentials. The Departments are of the view that implementing these security controls and safeguards would help to protect health information technology from nefarious actors.

IV. Request for Information: Provider Quality Measurement and Reporting in the Private Health Insurance Market

Quality, in addition to price, is essential for making value-based purchasing decisions.[73] Thus, the Departments are of the view that information relating to the quality of prospective health care services is critical to achieving the objective of increasing the value of health care. The Departments understand that for this

information is received from a covered entity, at the individual's direction, by an app that is neither a covered entity nor a business associate under HIPAA, the information is no longer subject to the protections of the HIPAA Rules. If the individual's app—chosen by an individual to receive the individual's requested ePHI—was not provided by or on behalf of the covered entity (and, thus, does not create, receive, transmit, or maintain ePHI on its behalf), the covered entity would not be liable under the HIPAA Rules for any subsequent use or disclosure of the requested ePHI received by the app.''). See also, 45 CFR 164.524(a)(1), (c)(2)(ii), and (c)(3)(ii).

[71] *See https://www.hhs.gov/hipaa/for-professionals/faq/2037/are-there-any-limits-or-exceptions-to-the-individuals-right/index.html.* See also, 45 CFR 164.524(a)(2), (3) and (4).

[72] *See* 45 CFR 164.524(c)(2) and (3) and 164.308(a)(1), OCR HIPAA Guidance/FAQ–2036: *https://www.hhs.gov/hipaa/for-professionals/faq/2036/can-an-individual-through-the-hipaa-right/index.html,* and OCR HIPAA Guidance/FAQ–2037: *https://www.hhs.gov/hipaa/for-professionals/faq/2037/are-there-any-limits-or-exceptions-to-the-individuals-right/index.html.*

[73] Damberg, C., Sorbero, M., Lovejoy, S., Martsolf, G., Raaen, L., Mandel, D. ''Measuring Success in Health Care Value-Based Purchasing Programs.'' 4 RAND Health, 2014; 4(3); Q. 9. 2014. Available at: *https://www.rand.org/pubs/periodicals/health-quarterly/issues/v4/n3/09.html.*

reason, many existing cost estimator tools display provider quality information along with cost-sharing information.[74] Many of the cost estimator tools use existing provider-level CMS quality measures and data. For instance, in Colorado, pricing information for health care items and services is displayed along with five-star ratings from the CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results.[75] In Maine, consumers are able to compare median provider payments alongside patient experience HCAHPS survey results and other clinical quality measures, such as measures from CMS' Hospital Compare about how well the provider prevents health care associated infections.[76]

Over the years, CMS has made much progress in improving health care quality measurement and making such quality information publicly available through various mechanisms, including public use files on the CMS website.[77] In addition, CMS makes quality of health care information publicly available at *https://data.Medicare.gov* for a number of different health care providers and suppliers, including hospitals, nursing homes, and physicians. As exemplified in both Colorado and Maine, such data are available for the public and could be used by providers and suppliers of health care and pricing tool developers and integrated into cost-estimator tools.

The Departments also understand that many group health plans and health insurance issuers use other provider-level quality metrics as part of their provider directories and cost- estimator tools and are of the view that quality metrics play a large role in helping their participants, beneficiaries, and enrollees utilize these tools. From stakeholder engagement, the Departments know that the quality information included in these tools varies from issuer to issuer. Similar to states discussed earlier, some issuers have also used HCAHPS to provide meaningful information for consumers on patients' overall satisfaction with hospitals. In addition to CMS measures and data, plans and issuers have also used quality metrics information from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS); Bridges to Excellence, Center for Improvement in Healthcare (CIHQ), DNV GL—Healthcare Accreditations and Certifications, Castle Connelly Top Doctors, the Joint Commission on Accreditation of Healthcare Organizations (''the Joint Commission''), the Core Quality Measures Collaborative, and quality based recognition programs (such as from associations like the American Board of Medical Specialties). In addition, some plans and issuers have also relied on including validated consumer reviews, since consumers often select providers through word of mouth or referral from a provider or friend, relative, or neighbor. In general, the Departments understand that plans and issuers have also found it beneficial to include information on providers' accreditation, certification status, education, and professional achievements in their provider directory tools. This may include information from sources such as Leapfrog Hospital Safety Grade, board certification information on providers, health facilities accreditation program, and the Joint Commission.

The Departments are also aware that there are state and private sector efforts to develop and report on provider quality. In Minnesota, MN Community Measurement develops measures that are used in both the public and private sectors to report on provider quality.[78] Nationally recognized accrediting entities, such as NCQA, URAC, The Joint Commission, and National Quality Forum (NQF) have also been at the forefront of providing health care quality measures for both health plan and provider-level reporting.

The Departments are of the view that these public and private sector quality initiatives can be leveraged to complement the price transparency proposals discussed elsewhere in this proposed rule. The Departments are interested in how these public and private sector quality measures might be used to compliment cost-sharing information for plans and issuers in the private health insurance market.

To enhance the Departments' efforts in promoting competition in the health care market that is based on value, the Departments are interested in stakeholder input on a number of quality reporting related issues, including the following:

1. Whether, in addition to the price transparency requirements the Departments propose in these rules, the Departments should also impose requirements for the disclosure of quality information for providers of health care items and services.

2. Whether health care provider quality reporting and disclosure should be standardized across plans and issuers or if plans and issuers should have the flexibility to include provider quality information that is based on metrics of their choosing, or state-mandated measures.

3. What type of existing quality of health care information would be most beneficial to beneficiaries, participants, and enrollees in the individual and group markets? How can plans and issuers best enable individuals to use health care quality information in conjunction with cost-sharing information in their decision making before or at the time a service is sought?

4. Would it be feasible to use health care quality information from existing CMS quality reporting programs, such as the Medicare Quality Payment Program (QPP)[79] or the Quality Measures Inventory (QMI)[80] for in-network providers in the individual and group markets?

5. Could quality of health care information from state-mandated quality reporting initiatives or quality reporting initiatives by nationally recognized accrediting entities, such as NCQA, URAC, The Joint Commission, and NQF, be used to help participants, beneficiaries and enrollees meaningfully assess health care provider options?

6. What gaps are there in current measures and reporting as it relates to health care services and items in the individual and group markets?

7. The Departments are also interested in understanding any limitations plans and issuers might have in reporting on in-network provider quality in the individual and group markets.

8. The Departments seek more information about how and if quality data is currently used within plans' and issuers' provider directories and cost-estimator tools. The Departments also seek information on the data sources for quality information, and whether plans and issuers are using internal claims data or publicly-available data.

The OPPS Price Transparency final rule, discussed elsewhere in this preamble, also included a request for

[74] *http://www.truthinhealthcare.org/consumer-resources/cost-comparison-tools/.*

[75] Center for Improving Value in Health Care. 2019 Public Facility and Quality Reporting. Available here: *https://www.civhc.org/wp-content/uploads/2018/12/Prometheus-and-Imaging-Methodology_FAQs_for-Preview.pdf.*

[76] *https://www.comparemaine.org/?page=methodology.*

[77] *https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html.*

[78] *https://mncm.org/.*

[79] *https://qpp.cms.gov/.*

[80] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measures-Inventory.html#targetText=Quality%20Measures%20Inventory,quality%2C%20reporting%20and%20payment%20programs.&targetText=It%20is%20important%20to%20note,or%20CMS%20Program%2F Measure%20Leads.*

comment on quality measurement relating to price transparency. The Departments intend to review and consider the public input related to quality in response to that rule for future rulemaking.

V. Overview of the Proposed Rule Regarding Issuer Use of Premium Revenue Under the Medical Loss Ratio Program: Reporting and Rebate Requirements—The Department of Health and Human Services

Consumers with health insurance often lack incentives to seek care from lower-cost providers, for example when consumers' out-of-pocket costs are limited to a set copayment amount regardless of the costs incurred by the issuer. Innovative benefit designs can be used to increase consumer engagement in health care purchasing decisions. HHS proposes to allow issuers that empower and incentivize consumers through the introduction of new or different plans that include provisions encouraging consumers to shop for services from lower-cost, higher-value providers, and that share the resulting savings with consumers, to take credit for such ''shared savings'' payments in their medical loss ratio (MLR) calculations. HHS believes this proposal would preserve the statutorily-required value consumers receive for coverage under the MLR program, while encouraging issuers to offer new or different plan designs that support competition and consumer engagement in health care.

Formula for Calculating an Issuer's Medical Loss Ratio (45 CFR 158.221)

Section 2718(b) of the PHS Act requires a health insurance issuer offering group or individual health insurance coverage (including grandfathered health insurance coverage) to provide rebates to enrollees if the issuer's MLR falls below specified thresholds (generally, 80 percent in the individual and small group markets and 85 percent in the large group market). Section 2718(b) of the PHS Act generally defines MLR as the percentage of premium revenue (after certain adjustments) an issuer expended on reimbursement for clinical services provided to enrollees and on activities that improve health care quality. Consistent with section 2718(c) of the PHS Act, the standardized methodologies for calculating an issuer's MLR must be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Several states have recently considered or adopted legislation [81] to promote health care cost transparency and encourage issuers to design and make available plans that ''share'' savings with enrollees who shop for health care services and choose to obtain care from lower-cost, higher-value providers. In addition, at least two states and a number of self-insured group health plans [82] have incorporated such shared savings provisions into their health plans. Under some plan designs, the savings are calculated as a percentage of the difference between the rate charged by the provider chosen by the consumer for a medical procedure and the average negotiated rate for that procedure across all providers in the issuer's network. Under other plan designs, the shared savings are provided as a flat dollar amount according to a schedule that places providers in one or more tiers based on the rate charged by each provider for a specified medical procedure. Under various plan designs, the shared savings may be provided in form of a gift card, a reduction in cost sharing, or a premium credit. HHS is of the view that such unique plan designs would motivate consumers to make more informed choices by providing consumers with tangible incentives to shop for care at the best price. As explained elsewhere in this preamble, there is ample evidence that increased transparency in health care costs would lead to increased competition among providers.[83] HHS is of the view that allowing flexibility for issuers to include savings they share with enrollees in the numerator of the MLR would increase issuers' willingness to undertake the investment necessary to develop and administer plan features that may have the effect of increasing health care cost transparency which in turn would lead to reduced health care costs.

HHS has in the past exercised its authority under section 2718(c) of the PHS Act to take into account the special circumstances of different types of plans by providing adjustments to increase the MLR numerator for ''mini-med'' and ''expatriate'' plans,[84] student health insurance plans,[85] as well as for QHPs that incurred Exchange implementation costs [86] and certain non-grandfathered plans (that is, ''grandmothered'' plans).[87] This authority has also been exercised to recognize the special circumstances of new plans [88] and smaller plans.[89] Consistent with this approach, HHS is proposing to exercise its authority to account for the special circumstances of new and different types of plans that provide ''shared savings'' to consumers who choose lower-cost, higher-value providers by adding a new paragraph 45 CFR 158.221(b)(9) to allow such shared savings payments to be included in the MLR numerator. HHS makes this proposal to ensure, should the proposal be finalized as proposed, that issuers would not be required to pay MLR rebates based on a plan design that would provide a benefit to consumers that is not currently captured in any existing MLR revenue or expense category. HHS proposes that the amendment to 45 CFR 158.221 become effective beginning with the 2020 MLR reporting year (for reports filed by July 31, 2021). HHS invites comments on this proposal.

VI. Applicability

A. In General

The Departments propose to require group health plans and health insurance issuers of individual market and group market health insurance coverage, including self-insured group health plans, to disclose pricing information as discussed in these proposed rules, with certain exceptions as discussed in more detail in this section of the preamble. The Departments are of the view that consumers across the private health

[81] *See, for example,* 24–A Maine Rev. Stat. Ann. sec. 4318–A (adopted June 19, 2017); Neb. Rev. Stat. sec. 44–1401 *et seq.* (adopted Apr. 23, 2018); Utah Code Ann. sec. 31A–22–647 (adopted March 19, 2018); AZ SB 1471 (2018); N.H. HB 1784–FN (2018); MA H2184 (2017).

[82] *See, for example,* the State of New Hampshire employee medical benefit, the Site of Service and Vitals SmartShopper Programs, *https://das.nh.gov/riskmanagement/active/medical-benefits/cost-savings-programs.aspx#vitals-smartshopper;* Utah Public Employees Health Program Cost Comparison Tool, *https://www.pehp.org/general/how-to-use-cost-saving-tools.*

[83] Congressional Research Service Report to Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector, July 24, 2007.

[84] *See* 45 CFR 158.221(b)(3) for ''mini-med'' plans and 45 CFR 158.221(b)(4) for ''expatriate'' plans. *Also see* the Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protections and Affordable Care Act; Interim Final Rule; 75 FR 74863 at 74872 (December 1, 2010).

[85] *See* 45 CFR 158.221(b)(5). *Also see* the Student Health Insurance Coverage; Final Rule, 77 FR 16453 at 16458–16459 (March 21, 2012).

[86] *See* 45 CFR 158.221(b)(7). *Also see* the Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule; 79 FR 30240 at 30320 (May 27, 2014).

[87] *See* 45 CFR 158.221(b)(6). *Also see* 79 FR at 30320 (May 27, 2014).

[88] *See* 45 CFR 158.121. *Also see* 75 FR at 74872–74873 (Dec. 01, 2010) and the HHS Notice of Benefit and Payment Parameters for 2018 Final Rule; 81 FR 94058 at 94153–94154 (Dec. 22, 2016).

[89] *See* 45 CFR158.230 and 158.232. *Also see* 75 FR at 74880 (Dec. 01, 2010).

insurance market will benefit from the availability of pricing information that is sufficient to support informed health care decisions on an element as basic as price. Although the Departments considered making the proposed requirements applicable to a more limited part of the private health insurance market, the Departments are of the view that consumers across the market should come to expect and receive the same access to standardized, meaningful pricing information and estimates. This broader applicability also has the greatest potential to reform health care markets.

The Departments also considered limiting applicability to individual market plans and insured group health plans; but concluded that limiting applicability would be inconsistent with section 2715A of the PHS Act. The Departments are concerned that a more limited approach might encourage plans and issuers to simply shift costs to sectors of the market where these proposed requirements would not apply and where consumers have less access to pricing information. The Departments are of the view that consumers in all private market health plans should be able to enjoy the benefits of greater price transparency and that a broader approach will have the greatest impact toward the goal of controlling the cost of health care industry-wide.

The Departments anticipate that pricing information related to items and services that are subject to capitation arrangements under a specific plan or contract could meet transparency standards by disclosing only the consumer's anticipated liability. For example, some providers participate in accountable care organizations (ACOs) and may be reimbursed based on a capitation payment. ACOs are groups of doctors, hospitals, and other health care providers that come together to provide coordinated care for their patients. The goal of ACOs is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves. Under such arrangements, the group health plan or health insurance issuer may reimburse the providers a set dollar payment per patient per unit of time to cover a specified set of services and administrative costs without regard to the actual number of services provided. The Departments also understand that there may be certain plan benefit structures where full disclosure of these data is not aligned with the goals of these proposed rules, such as a staff model health maintenance organization (HMO). The Departments seek comment on whether there are certain reimbursement or payment models that should be partially or fully exempt from these requirements, or should otherwise be treated differently. Further, the Departments seek comment on how consumers may be more informed about their cost-sharing requirements under these reimbursement or payment models.

By statute, certain plans and coverage are not subject to the transparency provisions under section 2715A of the PHS Act and, therefore, would not be subject to these proposed rules. This includes grandfathered health plans, excepted benefits, and short-term, limited-duration insurance, as discussed later in this section of the preamble.

Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of PPACA, and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules.[90] Under section 1251 of PPACA, section 2715A of the PHS Act does not apply to grandfathered health plans. These proposed rules would not apply to grandfathered health plans (as defined in 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, 45 CFR 147.140).

In accordance with sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code, the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code do not apply to any group health plan (or group health insurance coverage offered in connection with a group health plan) or individual health insurance coverage in relation to its provision of excepted benefits, if certain conditions are satisfied. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code. Section 2715A of the PHS Act is contained in title XXVII of the PHS Act, and, therefore, these proposed rules would not apply to a plan or coverage consisting solely of excepted benefits.

The Departments propose that the proposed rules would not apply to health reimbursement arrangements, or other account-based group health plans, as defined in 26 CFR 54.9815–2711(d)(6)(i), 29 CFR 2590.715–2711(d)(6)(i), and 45 CFR 147.126(d)(6)(i), that simply make certain dollar amounts available, with the result that cost-sharing concepts are not applicable to those arrangements.

These proposed rules also would not apply to short-term, limited-duration insurance. Under section 2791(b)(5) of the PHS Act, short-term, limited-duration insurance is excluded from the definition of individual health insurance coverage and generally is therefore, exempt from requirements of title XXVII of the PHS Act that apply in the individual market, including section 2715A of the PHS Act.[91]

These proposed rules would apply to ''grandmothered'' plans. Grandmothered plans refer to certain non-grandfathered health insurance coverage in the individual and small group markets 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. Under current guidance, such coverage may be renewed 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.[92] While grandmothered plans are not treated as being out of compliance with certain specified market reforms, section 2715A of the PHS Act is not among those specified reforms. Therefore, the Departments propose these rules would apply to ''grandmothered'' plans. The Departments seek comment on whether grandmothered plans may face special challenges in complying with these transparency reporting provisions and whether the proposed rules should or should not apply to grandmothered plans.

Except as otherwise provided for the proposed MLR requirements, the Departments also propose that the requirements discussed in these proposed rules would become effective for plan years (or in the individual market policy years) beginning on or after 1 year after the finalization of this rule. The Departments request feedback about this proposed timing. In particular, the Departments are interested in information and request comment from group health plans, health insurance issuers, and TPAs on the timing necessary to develop cost

[90] 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140.

[91] *See* 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

[92] 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.*

estimation tools and machine-readable files.

B. Good Faith Special Applicability

These proposed rules include a special applicability provision to address circumstances in which a group health plan or health insurance issuer, acting in good faith, makes an error or omission in its disclosures under these proposed rules. Specifically, a plan or issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure, provided that the plan or issuer corrects the information as soon as practicable. Additionally, to the extent such error or omission is due to good faith reliance on information from another entity, these proposed rules include a special applicability provision that holds the plan or issuer harmless, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate. Under these proposed rules, if a plan or issuer has knowledge that such information is incomplete or inaccurate, the plan or issuer must correct the information as soon as practicable in accordance with paragraph (d)(4) of these proposed rules.

Furthermore, these proposed rules also include a special applicability provision to account for circumstances in which a plan or issuer fails to make the required disclosures available due to its internet website being temporarily inaccessible. Accordingly, these proposed rules provide that a plan or issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable. The Departments solicit comments on whether, in addition to these special applicability provisions, additional measures should be taken to ensure that plans and issuers that have taken reasonable steps to ensure the accuracy of required cost-information disclosures are not exposed to liability by virtue of providing such information as required under these proposed rules.

VII. Economic Impact Analysis and Paperwork Burden

A. Summary/Statement of Need

This regulatory action is taken, in part, in light of Executive Order 13877 directing the Departments to issue an ANPRM, soliciting comments consistent with applicable law, requiring health care providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care. As discussed elsewhere in the preamble, the Departments have considered the issue, including consulting with stakeholders, and have determined that an NPRM would allow for greater specificity from commenters, who would be able to respond to specific proposals. In addition, despite the growing number of initiatives and the growing consumer demand for, and awareness of the need for pricing information, there continues to be a gap in easily accessible pricing information for consumers to use for health care shopping purposes. An NPRM enables the Departments to more quickly address this pressing issue. The proposed new requirements added to 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 147 are aimed at addressing this gap, and are a critical part of the Administration's overall strategy for reforming health care markets by promoting transparency and competition, creating choice in the health care industry, and enabling consumers to make informed choices about their health care. By requiring group health plans and health insurance issuers to disclose to participants, beneficiaries, or enrollees (or their authorized representatives) such individual's cost-sharing information for covered items or services furnished by a particular provider, it provides them sufficient information to determine their potential out-of-pocket costs related to needed care and encourage them to consider price when making decisions about their health care.

B. Overall Impact

The Departments have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct 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 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

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 1 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 RIA must be prepared for major rules with economically significant effects ($100 million or more in any 1 year), and a ''significant'' regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments have concluded that this rule is likely to have economic impacts of $100 million or more in at least 1 year, and, therefore, meets the definition of ''significant rule'' under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with this rule. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

These proposed rules aim to enable participants, beneficiaries, or enrollees to obtain information about their potential cost-sharing liability for covered items and services that they might receive from a particular health care provider or providers by requiring plans and issuers to disclose cost-sharing information as described at 26 CFR 54.9815–2715A, 29 CFR 2590.715–2715A, and 45 CFR 147.210. As discussed previously in these proposed rules, there has been a shift in the health care market from copayments to coinsurance, coupled with increases in

plans with high deductibles which generally require sizeable out-of-pocket expenditures prior to receiving coverage under the terms of the plan or policy; therefore, participants, beneficiaries, or enrollees are now beginning to shoulder a greater portion of their health care costs. With access to accurate and actionable pricing information, participants, beneficiaries, and enrollees would be able to consider the costs of an item or service when making decisions related to their health care. The Departments are of the view that disclosure of pricing information is crucial for participants, beneficiaries, and enrollees to engage in informed health care decision-making.

In addition, these proposals would require plans and issuers to make public negotiated rates of in-network providers and historical allowed amounts paid to out-of-network providers for all covered items and services. The Departments are of the view that these requirements would ensure that all consumers have the pricing information they need in a readily accessible format, which could inform their choices and have an impact on the disparities in health care costs. Public availability of information on in-network provider negotiated rates and allowed amounts for out-of-network services would allow consumers who wish to shop between plans to better understand what the cost of their care from a particular provider would be under each plan or policy. Furthermore, the Departments are of the view that the availability of price information to the public would empower the 28.5 million uninsured consumers [93] to make more informed health care decisions. Public availability of this information would also allow third-party developers to provide consumers more accurate information on provider, plan and issuer value and ensure that such information is available to consumers where and when it is needed (for example, via integration into electronic health records, price transparency tools, and consumer mobile applications).

1. Impact Estimates of the Transparency in Coverage Provisions and Accounting Table

This NPRM sets forth proposed requirements for group health plans and health insurance issuers to disclose to a participant, beneficiary, or enrollee, his or her cost-sharing information for covered items or services from a particular provider or providers. This NPRM also includes proposals to require plans and issuers to disclose in-network provider-negotiated rates and historical allowed amounts for out-of-network items and services provided by out-of-network providers through machine-readable files posted on a public internet website. In accordance with OMB Circular A–4, Table 1 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

The Departments are unable to quantify all benefits and costs of these proposed rules. The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs and transfers resulting from the provisions of these proposed rules for plans, issuers, beneficiaries, participants, and enrollees.

TABLE 1—ACCOUNTING TABLE

Benefits

Non-Quantified:

- Provides consumers with a tool to determine their estimated out-of-pocket costs, potentially becoming more informed on the cost of their health care which could result in lower overall costs if consumers choose lower-cost providers or health care services.
- Potential increase in timely payments by consumers of medical bills as a result of knowing their expected overall costs prior to receiving services and having the ability to budget for expected health care needs.
- Potential profit gains by third-party mobile application developers and potential benefits to consumers through the development of mobile applications that may be more user-friendly and improve consumer access to cost information, potentially resulting in reductions in out-of-pocket costs.
- Potentially enable consumers shopping for coverage to understand the negotiated rates for providers in different group and individual health plans available to them and choose a plan that could minimize their out-of-pocket costs.
- States could potentially use the negotiated rate file to determine if premium rates are set appropriately.
- Potential reduction in cross-subsidization, which could result in lower prices as prices become more transparent.
- Public posting of negotiated rates could facilitate the review of anti-trust violations.

Costs:	Low estimate (million)	High estimate (million)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	$231.8	$298.4	2019	7	2020–2024
	224.5	286.5	2019	3	2020–2024

Quantitative:

- Cost to plans and issuers to plan, develop, and build the proposed internet self-service tool and to provide negotiated in-network rates and out-of-network allowed amounts in machine-readable files, maintain appropriate security standards and update the machine-readable files per the proposed rules.
- Increase operating costs to plans and issuers as a result of training staff to use the internet self-service tool, responding to consumer inquiries, and delivering consumer's cost-sharing information and required notices.
- Cost to plans and issuers to review all the requirements in this proposal.

Non-Quantified:

- Potential cost incurred by plans and issuers that wish to develop a mobile accessible version of their internet-based self-service tool. Potential increase in cyber security costs by plans and issuers to prevent data breaches and potential loss of personally identifiable information.
- Potential increase in out-of-pocket costs for consumers if providers increase prices or issuers shift those costs to consumers in the form of increased cost sharing other than increased deductibles.

[93] This is based on 2017 uninsured data from Keith, K. ''Two New Federal Surveys Show Stable Uninsured Rate.'' Health Affairs Blog. September 13, 2018. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/*.

- Potential costs to states to review and enforce provisions of the proposed rules.
- Potential increase in consumer costs if reductions in cross-subsidization are for uncompensated care, as this could require providers finding a new way to pay for those uncompensated care costs.
- Potential increase in health care costs if consumers confuse cost with quality and value of service.
- Potential costs to inform and educate consumers on the availability and functionality of internet self-service tool.
- Potential exposure of consumers to identity theft as a result of breaches and theft of personally identifiable information.
- Potential consumer confusion related to low health care literacy and the potential complexity of internet self-service tools.
- Potential cost to plans and issuers to a conduct quality control review of the information in the negotiated rate and out-of-network allowed amounts machine-readable files.

Transfers:	Estimate (million)	Year dollar	Discount rate (percent)	Period covered
Federal Annualized Monetized ($/year)	$9.3	2019	7	2020–2024
	9.5	2019	3	2020–2024
Other Annualized Monetized ($/year)	150.6	2019	7	2020–2024
	153.7	2019	3	2020–2024

Quantitative:
- Transfers from the federal government to consumers in the form of increased premium tax credits by approximately $12 million per year beginning in 2021 as a result of estimated premium increases by issuers in the individual market to comply with these proposed rules.
- Transfer from consumers to issuers in the form of reduced MLR rebate payments in the individual and group markets by approximately $67 million per year by allowing issuers to take credit for ''shared savings'' payments in issuers' MLR calculations.
- Transfers from providers to consumers and issuers of approximately $128 million per year as a result of lower medical costs for issuers and consumers by allowing issuers to share with consumers the savings that result from consumers shopping for care from lower-cost providers.

Non-Quantified:
- Potential transfer from providers to consumers facing collections to reduce the overall amounts owed to providers if they are able to use competitor pricing as a negotiating tool.
- Potential transfer from providers to consumers if there is an overall decrease in health care costs due to providers reducing prices to compete for customers.
- Potential transfer from consumers to providers if there is an increase in health care costs if providers and services increase their negotiated rates to match those of competitors.
- Potential transfer from issuers to consumers if premiums go down and potential transfer from consumers to issuers if premiums increase.
- Potential transfer from issuers to consumers and the federal government in the form of decreased premiums and premium tax credits as a result of issuers adopting provisions encouraging consumers to shop for services from lower-cost providers and sharing the resulting savings with consumers.

Table 1 provided the anticipated benefits and costs (quantitative and non-quantified) to plans and issuers to disclose cost-sharing information as described at 26 CFR 54.9815–2715A, 29 CFR 2590.715–2715A, and 45 CFR 147.210 and make public negotiated rates of in-network providers and out-of-network allowed amounts paid for covered items and services. The following information describes benefits and costs—qualitative and non-quantified—to plans and issuers separately for these two requirements.

2. Proposed Requirements for Disclosing Cost-Sharing Information to Participant, Beneficiaries, or Enrollees Under 26 CFR 54.9815–2715A(b), 29 CFR 2590.715–2715A(b), and 45 CFR 147.210(b)

Costs

In paragraph (b) of the proposed rules, the Departments are proposing to require group health plans and health insurance issuers to disclose certain relevant information in accordance with a prescribed method and format requirements, upon the request of a participant, beneficiary or enrollee (or an authorized representative on behalf of such individual). Under this requirement, the Departments are proposing seven content elements, which are described in paragraph (b)(1) of the proposed rules and discussed earlier in this preamble. The quantitative cost associated with meeting these requirements are detailed in the corresponding information collection requirement (ICR) that is discussed later in this preamble.

In addition to the costs described in the corresponding ICR, the Departments recognize there may be other costs associated with this requirement that are difficult to quantify given the lack of information and data. For example, while the Departments are of the view that the overall effect of this proposal would lower health care costs, the Departments recognize that price transparency may have the opposite effect because in some markets where pricing is very transparent, pricing can narrow and average costs can increase.[94] Additionally, states may incur additional costs to review and enforce the requirements proposed in this rule.

As described in the corresponding ICR section, the Departments assume most self-insured group health plans would work with a TPA to meet the requirements of these proposed rules. The Departments estimated cost assumes in the high-range estimate that all health insurance issuers and TPAs (on behalf of self-insured group health plans) would need to develop and build their internet-based self-service tools from scratch. However, the Departments also provide a low-range estimate assuming that most plans, issuers, and TPAs would modify an existing web-based tool. The Departments recognize that some plans, issuers, and TPAs may also voluntarily elect to develop a mobile application, which would result in additional costs. Additionally, TPAs generally work with multiple self-insured group health plans, and as a

[94] Kutscher, B. ''Report: Consumers demand price transparency, but at what cost?'' Modern Healthcare. June 2015. Available at: *https://www.modernhealthcare.com/article/20150623/NEWS/150629957/consumers-demand-price-transparency-but-at-what-cost.*

result, the costs for each TPA and self-insured group health plan may be lower to the extent they are able to leverage any resulting economies of scale.

Moreover, health care data breach statistics clearly show there has been an upward trend in data breaches over the past 9 years, with 2018 having more reported data breaches than any other year since records first started being published. Between 2009 and 2018, there have been 2,546 health care data breaches resulting in the theft and exposure of 189,945,874 health care records, equating to more than 59 percent of the United States population. Health care data breaches are now being reported at a rate of more than one per day.[95] Based on this information, the Departments recognize the requirements of these proposed rules provide additional opportunities for health care data breaches. Plans and issuers may incur additional expenses to ensure a consumer's PHI and personally identifiable information (PII) is secure and protected. Additionally, as consumers accessing the internet-based self-service tool may be required to input personal data to access the consumer-specific pricing information, consumers may be exposed to increased risk and experience identity theft as a result of breaches and theft of PII.

Benefits

Informed Consumer. A consumer armed with pricing information could potentially have greater control over their own health care spending, which could foster competition among providers resulting in less disparity in health care prices or a reduction in health care prices. Consumers who use this tool would be able to access their cost sharing paid to date, their progress toward meeting their accumulators such as deductibles and out-of-pocket limits, their estimated cost-sharing liability for an identified item or service, the negotiated rates with in-network providers for covered items and services, and the out-of-network allowed amounts for covered items and services. Additionally, consumers might gain some peace of mind in knowing where they stand financially with regard to their current health care needs and have the ability to plan ahead for any items and services they could require in the near future. The Departments are of the view that access to this information is essential to enable consumers to make informed decisions regarding specific services or treatments, budget appropriately to pay any out-of-pocket expenses, and determine what impact any change in providers or items or services would have on the cost of a particular service or treatment.

Consumers may become more cost conscious. The Departments are of the view that consumers may begin to focus on costs of services because under this proposal, plans and issuers would be required to disclose cost-sharing information that puts consumers' cost-sharing liability in the context necessary for truly cost-conscious decision-making. Consumers may know they have a coinsurance of 20 percent for an item or service, but many are unaware of what dollar amount of which they will be responsible for paying 20 percent. Knowing that dollar amount could motivate consumers to seek lower-cost providers and services. As discussed earlier in the preamble, there has been recent evidence in New Hampshire and Kentucky that supports the Departments' assumption that having access to pricing information, along with currently available information on provider quality and incentives to shop for lower prices, can result in consumers choosing providers with lower costs for items and services, thus lowering overall health care costs. The Departments acknowledge that this may only hold true if cost sharing varies between providers. Cost sharing in HMOs and Exclusive Provider Organizations (EPOs) generally is through fixed copayment amounts regardless of the provider who furnishes a covered item or service and, therefore, the proposed rules would provide little incentive for consumers to choose less costly providers in this context.

Timely Payment of Medical Bills. The Departments anticipate that consumers with access to the information provided in response to the proposed rules would be more likely to pay their bills on time. A recent Transunion survey found that 79 percent of respondents said they would be more likely to pay their bills in a timely manner if they had price estimates before getting care.[96] In addition, a non-profit hospital network, found that the more information they shared with patients, the better prepared those patients are for meeting their responsibilities. They further note that they find it valuable to explain to patients what their benefits are, provide an estimate of what the patient might owe for a service, and discuss any pre-payment requirements so that the patient understands what to expect during the billing process and what their options are. The hospital network reports that providing price estimates to patients has resulted in increased point of service cash collections from $3 million in 2010 to $6 million in 2011.[97]

Increased Competition Among Providers. The Departments are of the view that the requirements of these proposed rules would lead to competition among providers as consumers would be aware of and compare the out-of-pocket cost of a covered item or service prior to receiving that item or service, which might force higher-cost providers to lower their prices in order to compete for the price sensitive consumer.

3. Proposed Requirements for Public Disclosure of In-Network Negotiated Rates and Historical Payments of Out-of-Network Allowed Amounts Through Machine-Readable Files Under 26 CFR 54.9815–2715A(c), 29 CFR 2590.715–2715A(c), and 45 CFR 147.210(c).

Costs

In paragraph (c) of these proposed rules, the Departments are proposing to require that group health plans and health insurance issuers make available to the public on an internet website two digital files in a machine-readable format. The first file (the Negotiated Rate File) would include information regarding rates negotiated with in-network providers. The second file (the Allowed Amount File) would publish data showing allowed amounts for covered items and services furnished by out-of-network providers over a 90-day period. Plans and issuers would be required to make the required information available in accordance with certain method and format requirements described at paragraph (c)(2) of the proposed rules and update the files monthly. The quantitative cost associated with meeting the proposed requirements are detailed in the associated ICR section.

Non-Quantified Costs for Public Disclosure of In-network Negotiated Rates: In addition to the costs described in the associated ICR, the Departments recognize there may be other costs associated with the requirement to make in-network negotiated rates available publicly that are difficult to quantify given the current lack of information and data. While the Departments are of the view that the overall effect of this

[95] *See* Report on Healthcare Data Breach Statistics, available at: *https://www.hipaajournal.com/healthcare-data-breach-statistics/.*

[96] Kutscher, B. ''Report: Consumers demand price transparency, but at what cost?'' Modern Healthcare. June 2015. *https://www.modernhealthcare.com/article/20150623/NEWS/150629957/consumers-demand-price-transparency-but-at-what-cost.*

[97] HFMA Executive Roundtable: Reimagining Patient Access. December 2015. Available at: *https://api.hfma.org/Content.aspx?id=43731.*

proposal would lower health care prices, there are instances in very transparent markets, where pricing can narrow and average costs can increase.[98] The Departments also recognize that plans and issuers may experience additional costs (for example, quality control reviews) to ensure they comply with the requirements of these proposed rules. In addition, the Departments are aware that information disclosures allowing competitors to determine the rates their competitors are charging may dampen each competitor's incentive to offer a low price [99] or result in a higher price equilibrium. While health insurance issuers with the highest negotiated rates may see a decrease in their negotiated rates, as their providers respond to consumer and smaller health insurance issuers' concerns of paying more for the same item and service, issuers with the lowest negotiated rates may see their lower cost providers adjust their rates upward to become equal across the board. However, most research suggests that when better price information is available, prices for goods sold to consumers fall. For example, in an advertising-related study, researchers found that the act of advertising the price of a good or service is associated with lower prices.[100]

A potential additional non-quantified cost could be the cost to remove ''gag clauses'' from contracts between health insurance issuers and providers. Contracts between issuers and providers often include a gag clause, which prevents issuers from disclosing negotiated rates. The Departments recognize that issuers and providers may incur a one-time expense for their attorneys to review and update their provider contracts to remove any relevant gag clause.

Another potential cost is the impact on a plan's or issuer's ability or incentive to establish a robust network of providers. A health insurance provider network is a group of health care providers that have contracted with a group health plan or health insurance issuer to provide care at a specified price the provider must accept as payment in full. Many times, plans and issuers want consumers to use the providers in their network because these providers have met the health plan's quality standards and agreed to accept a negotiated rate for their services in exchange for the patient volume they will receive by being part of the plan's network.[101] Some plans and issuers offer a narrow network. Narrow networks operate with a smaller provider network, meaning a consumer will have few choices when it comes to in-network health care providers but often lower monthly premiums and out-of-pocket costs.[102] The Departments recognize that making negotiated rates public may create a disincentive for plans and issuers to establish a contractual relationship with a provider (including in narrow networks) because providers may be unwilling to give a discount to issuers and plans when that discount will be made public. The requirements of this proposal could also result in a reduction in revenue for those smaller health insurance issuers that are unable to pay higher rates to providers and may require them to narrow their provider networks, which could affect access to care for some consumers. Due to a smaller issuer's potential inability to pay providers with higher rates, smaller issuers may further narrow their networks to include only providers with lower rates, possibly making it more difficult for smaller issuers to fully comply with network adequacy standards described at 45 CFR 156.230 or applicable state network adequacy requirements.

Non-Quantified Cost for Public Disclosure of Out-of-network Allowed Amounts: In addition to the costs described in the associated ICR and the previous analysis related to the public disclosure of negotiated rates, the Departments recognize that there may be other costs associated with the requirement to make historical payments of out-of-network allowed amounts publicly available that are difficult to quantify, given the current lack of information and data. For example, as a result of balance billing by providers, plans and issuers may be forced to increase their allowed amounts (such as the usual and customary and reasonable amount) to meet the demands of the price sensitive consumer.

Furthermore, while plans and issuers must de-identify data (such as claim payment information for a single provider) and ensure certain sensitive data are adequately protected, unauthorized disclosures of PHI and PII may increase as a result of manual preparation and manipulation of the required data.

Benefits

The Departments are of the view that requiring plans and issuers to make available information regarding negotiated in-network provider rates and 90-days of historical allowed amount data for out-of-network allowed amounts for covered items and services to the public would benefit plans and issuers, regulatory authorities, consumers, and the overall health care market.

Group Health Plans and Health Insurance Issuers: Plans and issuers may benefit from these proposals because under these proposed rules a plan or issuer would know the negotiated rates of their competitors. This may allow plans and issuers that are paying higher rates for the same items or services to negotiate with certain providers to lower their rates, thereby lowering provider reimbursement rates. The Departments acknowledge, however, as noted in the costs section earlier in this preamble, that knowledge of other providers' negotiated rates could also drive up rates if a provider discovers it is currently being paid less than other providers by a plan or issuer and, thereby, negotiates higher rates.

In addition, these proposed rules may result in more plans and issuers using a reference pricing structure. Under this structure, participants, beneficiaries, or enrollees who select a provider charging above the reference price (or contribution limit) must pay the entire difference and these differences do not typically count toward that individual's deductible or the annual out-of-pocket limit. Plans and issuers may want to use a reference pricing structure to pass on any potential additional costs associated with what they can identify as higher cost providers to the participant, beneficiary, or enrollee. The Departments recognize that reference pricing might not impact every consumer. For example, CalPERS provides exceptions from reference pricing when a member lives more than 50 miles from a facility that offers the service below the price limit. It also exempts the patient if the patient's physician gives a clinical justification

[98] Kutscher, B. ''Report: Consumers demand price transparency, but at what cost?'' Modern Healthcare. June 2015. Available at: *https://www.modernhealthcare.com/article/20150623/NEWS/150629957/consumers-demand-price-transparency-but-at-what-cost.*

[99] Koslov, T., Jex, E. ''Price transparency or TMI?'' Available at: *https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi.*

[100] Austin, D., Gravelle, J. ''Report: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector.'' CRS Report for Congress. June 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[101] See Davis, E. ''Health Insurance Provider Network Overview'' Verywell Health, August 2019. Available at: *https://www.verywellhealth.com/health-insurance-provider-network-1738750.*

[102] Anderman, T ''What to Know About Narrow Network Health Insurance Plans'', Consumer Reports, November 2018. Available at: *https://www.consumerreports.org/health-insurance/what-to-know-about-narrow-network-health-insurance-plans/.*

for using a high-priced facility or hospital setting. Another example is a business with a self-insured group health plan that exempts laboratory tests for patients with a diagnosis of cancer from its reference pricing program. However, reference pricing has generally been shown to result in price reductions, not merely slowdowns in the rate of price growth. For example, in the first 2 years after implementation, reference pricing saved CalPERS $2.8 million for joint replacement surgery, $1.3 million for cataract surgery, $7.0 million for colonoscopy, and $2.3 million for arthroscopy.[103]

Regulatory Authorities: In many states, health insurance issuers must obtain prior approval for rate changes from the state's Department of Insurance. Regulatory authorities such as state Departments of Insurance might benefit from this proposal because knowledge of provider negotiated rates and historical out-of-network allowed amounts paid to out-of-network providers could support determinations of whether premium rates, including requests for premium rate increases, are reasonable and justifiable.

Consumers: Access to the negotiated rates between plans and issuers and in-network providers and the amount plans and issuers paid out-of-network providers for covered items and services would allow consumers to understand the impact of their choices for health care coverage options and providers on the cost of a particular service or treatment. Introducing this information into the consumer's health care decision-making process would give the consumer a greater degree of control over their own health care costs. Furthermore, having access to publicly available out-of-network allowed amounts would provide consumers who are shopping for coverage the ability to compare the different plan or issuer payments for items and services, including items and services from providers that might be out-of-network. While the Departments are of the view that consumers would benefit from the requirements of this proposal, the Departments recognize that utilizing the required information would not be appropriate or reasonable in an emergency situation.

Overall Health Insurance Market: This proposal may induce an uninsured person to obtain health insurance, depending on premium rates, after learning the actual dollar difference between the usual and customary rates that they pay for items and services as an uninsured consumer and the negotiated rates and out-of-network allowed amounts under the terms of a group health plan or health insurance issuer's policy. In addition, this proposal might force providers to lower their rates for certain items and services in order to compete for the price sensitive consumer or plan; although the immediate payment impact would be categorized as a transfer, any accompanying health and longevity improvements would be considered as benefits (and any accompanying increases in utilization would, thus, be considered costs). And, as discussed elsewhere in this preamble, New Hampshire's HealthCost website was found to reduce the cost of medical imaging procedures by 5 percent. The study further found that patients saved approximately $7.5 million dollars on X-Ray, CT, and MRI scans over the 5 year period studied (dollars are stated in 2010 dollars).[104]

4. Medical Loss Ratio (45 CFR 158.221)

In these proposed rules, HHS proposes to amend § 158.221 to allow health insurance issuers that share with consumers savings that result from consumers shopping for lower-cost, higher-value services, to take credit for such ''shared savings'' payments in issuers' MLR calculations. For this impact estimate, HHS assumed that only relatively larger issuers (with at least 28,000 enrollees) that have consistently reported investment costs in health information technology on the MLR annual reporting form (of at least $6.77 per enrollee, which represents issuers with 70 percent of total reported commercial market health information technology investment) or issuers that operate in states that currently (three states in 2019) or may soon support ''shared savings'' plan designs would initially choose to offer plan designs with a ''shared savings'' component, that such issuers would share, on average, 50 percent of the savings with consumers (which would increase the MLR numerator under the proposed rule), and that issuers whose MLRs were previously below the applicable MLR standards would use their retained portion of the savings to lower consumers' premiums in future years (which would reduce the MLR denominator). Based on 2014–2017 MLR and other data, HHS estimates that this proposal could reduce MLR rebate payments from issuers to consumers by approximately $67 million per year, while facilitating savings that would result from lower medical costs of approximately $128 million per year for issuers and consumers (some of which would be retained by issuers, shared directly with consumers, or used by issuers to reduce future premium rates).

5. Summary of Estimated Transfers

The Departments assume that because 2020 premium rates are nearly finalized, that issuers will not be able to charge for the expenses incurred due to these proposed rules in the 2020 rates. Because issuers will not have had an opportunity to reflect the 2020 development costs in the 2020 premium rates, some issuers may apply margin to the assumed ongoing expenses as they develop premium rates for 2021 and after. The Departments estimate premiums for the fully-insured markets would be $450 billion for 2021, which includes the individual, small group, and large group markets.[105] The Departments estimate that the ongoing expense represents approximately 0.03 percent of premiums for the fully-insured market. Assuming this level of premium increase in the individual market, premium tax credit outlays are estimated to increase by about $12 million per year beginning in 2021. Given that 2021 premium tax credit outlays are expected to be $43 billion, the Departments expect the estimated increase of $12 million to have minimal impacts on anticipated enrollment. The Departments note that any impact of these proposed rules on provider prices has not been estimated, as limited evidence has generally shown not much of an effect on health care prices. As a result, the Departments are assuming that the overall impact will be minimal. However, there is a large degree of uncertainty regarding the effect on prices so actual experience could differ.

C. Regulatory Review Costs

Affected entities will need to understand the requirements of these proposed rules, if finalized, before they can comply. Group health plans and health insurance issuers are responsible for ensuring compliance with these proposed rules. However, as assumed elsewhere, it is expected that issuers and TPAs, and only the largest self-insured plans will likely incur this burden. The issuers and TPAs will then

[103] Boynton, A., Robinson, J. ''Appropriate Use of Reference Pricing Can Increase Value.'' Health Affairs Blog. June 2015. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20150707.049155/full/.*

[104] Brown, Z. ''Equilibrium Effects of Health Care Price Information.'' 100 Rev. of Econ. and Stat. 1. July 16, 2018. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*)

[105] 2017 earned premium data was taken from amounts reported for MLR, and trended forward using overall Private Health Insurance trend rates from the NHE projections.

provide plans with rule compliant services. Therefore, the burden for the regulatory review is estimated to be incurred by the 1,959 issuers and TPAs.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret these proposed rules, if finalized, the Departments should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review and interpret these proposed rules, the Departments assume that the total number of health insurance issuers and TPAs that would be required to comply with these rules would be a fair estimate of the number of entities affected.

The Departments acknowledge that this assumption may understate or overstate the costs of reviewing these proposed rules. It is possible that not all affected entities will review these rules, if finalized, in detail, and may seek the assistance of outside counsel to read and interpret them. For these reasons, the Departments are of the view that the number of health insurance issuers and TPAs would be a fair estimate of the number of reviewers of these proposed rules. The Departments welcome any comments on the approach in estimating the number of affected entities that will review and interpret these proposed rules, if finalized.

Using the wage information from the BLS for a Computer and Information Systems Manager (Code 11–3021) and a Lawyer (Code 23–1011) the Departments estimate that the cost of reviewing this rule is $285.66 per hour, including overhead and fringe benefits.[106] Assuming an average reading speed, the Departments estimate that it would take approximately 4 hours for the staff to review and interpret these proposed rules (2 hours each for a lawyer and an Information Systems Manager), if finalized; therefore, the Departments estimate that the cost of reviewing and interpreting these proposed rules, if finalized, for each health insurance issuer and TPA is approximately $1,142.64. Thus, the Departments estimate that the overall cost for the estimated 1,959 health insurance issuers and TPAs is $2,238,431.76 ($1,142.64 × 1,959 total number of estimated health insurance issuers and TPAs).

D. Regulatory Alternatives Considered

In developing the policies contained in these proposed rules, the Departments considered alternatives to the presented proposals. In the following paragraphs, the Departments discuss the key regulatory alternatives that the Departments considered.

1. Limiting Cost-Sharing Disclosures to Certain Covered Items and Services and Certain Types of Group Health Plans and Health Insurance Issuers

These proposed rules require plans and issuers to disclose cost-sharing information for any requested covered item or service. The Departments considered limiting the number of items or services for which plans and issuers would be required to provide cost-sharing information to lessen the burden on these entities. However, limiting disclosures to a specified set of items and services reduces breadth and availability of useful cost estimates to determine anticipated cost-sharing liability, limiting the impact of price transparency efforts by reducing the incentives to lower prices and provide higher-quality care. The Departments assume that plans (or TPAs on their behalf) and issuers, whether for a limited set of covered items and services or all covered items and services, would be deriving these data from the same data source. Because the data source would be the same, the Departments assume that any additional burden to produce the information required for all covered items and services, as opposed to a limited set of covered items and services, would be minimal. The Departments are of the view that this minimal additional burden is outweighed by the potentially large, albeit unquantifiable, benefit to consumers of having access to the required pricing information for the full breadth of items and services covered by their plan or issuer. For these reasons, in order to achieve lower health care costs and reduce spending through increased price transparency, the Departments propose to require cost-sharing information be disclosed for all covered items and services.

The Departments also considered implementing a more limited approach by imposing requirements only on individual market plans and fully-insured group coverage. However, the Departments are concerned that this limited approach might encourage plans to simply shift costs to sectors of the market where these proposed requirements would not apply and where consumers have less access to pricing information. The Departments are of the view that consumers should be able to enjoy the benefits of greater price transparency and that a broader approach will have the greatest likelihood of controlling the cost of health care industry-wide. Indeed, if the requirements of these proposed rules were limited to only individual market plans, the Departments estimate only 13,700,000 participants, beneficiaries, and enrollees would receive the intended benefits of these rules. In contrast, under these proposed rules, a total of 193,500,000 participants, beneficiaries, and enrollees would receive the intended benefits. The Departments acknowledge that limiting applicability of the requirements of these proposed rules to the individual market would likely reduce the overall cost and hour burden estimates identified in the corresponding ICRs section, but the overall cost and burden estimates per covered life would increase. Further, there is a great deal of overlap in health insurance issuers that offer coverage in both the individual and the group markets. Issuers offering coverage in both markets would be required to comply with the requirements of these proposed rules even if the Department limited the applicability to only the individual market. Because TPAs provide administrative functionality for self-insured group health care coverage, those non-issuer TPA entities would not incur any hourly burden or associated costs because they do not have any overlap between the individual and group markets. The Departments are of the view that the benefits of providing consumer pricing information to an estimated total 193,500,000 participants, beneficiaries, and enrollees outweigh the increased costs and burden hours that a subset of plans and issuers (and TPAs on behalf of self-insured group health plans) that are not active participants in the individual market would incur. The Departments have determined the benefits of expanding the applicability of these proposed rules would not only expand access to health care pricing information to a greater number of individuals, but that any developed economies of scale would have a much greater likelihood of achieving the goal of controlling the cost of health care industry-wide.

2. Requirement To Post Machine-Readable Files of Negotiated Rates and Historical Data for Out-of-Network Allowed Amount Payments Made to Out-of-Network Providers to a Public Website

In proposing the requirement that group health plans and health insurance issuers post their negotiated rates and historical data for out-of-network allowed amount payments made to out-of-network providers on a publicly accessible website, the Departments considered requiring payers to submit

[106] Wage information is available at *https://www.bls.gov/oes/current/oes_nat.htm.*

the internet addresses for the machine-readable files to CMS, and CMS would make the information available to the public. A central location could allow the public to access negotiated rate information and historical data for out-of-network allowed amounts in one centralized location, reducing confusion and increasing accessibility. Posting negotiated rates and historical data for out-of-network allowed amounts in a central location may also make it easier to post available quality information alongside price information. However, to provide flexibility and reduce burden, the Departments are of the view that plans and issuers should determine where to post negotiated rate and out-of-network allowed amount information rather than prescribing the location the information is to be disclosed. Further, requiring payers to submit internet addresses for their machine-readable files to CMS would result in additional burden to the extent plans and issuers already post this information in a different centralized location.

3. Frequency of Updates to Machine-Readable Files

In proposing paragraph (c) of these proposed rules, the Departments considered requiring more frequent updates (within 10 calendar days of new rate finalization) to the negotiated rates and out-of-network allowed amounts. More frequent updates would provide a number of benefits for the patients, providers, and the public at large. Specifically, such a process could ensure the public has access to the most up-to-date rate information so that consumers can make the most meaningful, informed decisions about their health care utilization. Requiring group health plans and health insurance issuers to update the machine-readable files more frequently would result in increased burdens and costs for those affected entities. With respect to the Negotiated Rate File, the Departments estimate that requiring updates within 10 calendar days of rate finalization would result in each plan, issuer, or TPA (on behalf of a self-insured group health plan) incurring an annual hour burden of 1,110 hours with an associated equivalent cost of $110,290. Based on recent data the Departments estimate a total 1,959 entities—1,754 issuers [107] and 205 TPAs [108]—will be responsible for implementing the proposals of these rules. For all 1,754 health insurance issuers and 205 TPAs, the total hour burden would be 2,174,490 hours with and associated equivalent annual cost of $216,057,326. As discussed in the corresponding ICR, requiring a less frequent 30 calendar day update would reduce the annual hour burden for each entity to 360 hours with an associated equivalent cost of $35,770. For all 1,754 health insurance issuers and 205 TPAs, the total hour burden is reduced to 705,240 hours with and associated equivalent annual cost of $70,072,646. With respect to the Allowed Amount File, the Departments estimate that requiring updates within 10 calendar days of rate finalization would result in each plan, issuer, or, TPA (on behalf of a self-insured group health plan) incurring an annual hour burden of 481 hours with an associated equivalent cost of $44,952. For all 1,754 health insurance issuers and 205 TPAs, the total hour burden would be 942,279 hours with and associated equivalent annual cost of $88,061,046. As discussed in the corresponding ICR, requiring a less frequent update would reduce the annual hour burden for each plan, issuer, and TPA to 156 hours with an associated equivalent cost of $14,579 per file. For all 1,754 health insurance issuers and 205 TPAs, the total hour burden is reduced to 305,604 hours with an associated equivalent annual cost of $28,560,339. By proposing monthly updates to the machine-readable files, rather than updates every 10 calendar days, the Departments have chosen to strike a balance between placing an undue burden on plans and health insurance issuers and assuring the availability of accurate information.

4. Proposed File Format Requirements

In 26 CFR 54.9815–2715A(c)(2), 29 CFR 2590.715–2715A(c)(2), and 45 CFR 147.210(c)(2), these proposed rules require payers to post information in two machine-readable files. A machine-readable file is defined as a digital representation of data or information in a file that can be imported or read into a computer system for further processing without human intervention, while no semantic meaning is lost. These proposed rules would require each machine-readable file to use a non-proprietary, open format. The Departments considered requiring payers to post negotiated rates and plan-specific historical charges paid for out-of-network services for all items and services using a specific file format, namely JSON. However, the Departments are of the view that being overly prescriptive in the file type would impose an unnecessary burden on payers despite the advantages of JSON, namely being downloadable and readable for many health care consumers, and the potential to simplify the ability of price transparency tool developers to access the data. Therefore, the Departments have proposed that group health plans and health insurance issuers post the negotiated rate and out-of-network allowed amount information in two distinct machine-readable files using a non-proprietary, open format to be identified by the Departments in future guidance.

In addition, the Departments considered proposing that plans and issuers provide the specific out-of-network allowed amount methodology needed for consumers to determine out-of-pocket liability for services by providers not considered to be in-network by the group health plan or health insurance issuer, rather than historical data on paid out-of-network claims. However, the Departments understand providing a formula or methodology for calculating a provider's out-of-network allowed amount does not provide the data users need in an easy-to-use machine-readable format. The Departments determined that providing monthly data files on amounts paid by plans and issuers over a 90-day period (by date of service with a 90-day lag) for items and services provided by out-of-network providers would enable users to more readily determine what costs a plan or issuer may pay toward items or services obtained out-of-network. Because a plan or issuer does not have a contract with an out-of-network provider that establishes negotiated rates, the plan or issuer cannot anticipate what that provider's charges will be for any given item or service; therefore, the plan or issuer cannot provide an estimate of out-of-pocket costs to the consumer.

Providing data on the costs covered by a plan or issuer for specific items and services allows a consumer to anticipate what their plan or issuer would likely contribute to the costs of items or services obtained from out-of-network providers and allows the consumer to estimate his or her out-of-pocket costs by subtracting that amount from the cost of the out-of-network services. Historical out-of-network allowed amount data will provide increased price transparency for consumers, and the burdens and costs related to producing these data are not considered to be significantly higher than that associated with producing the methodology for determining allowed amounts for payments to out-of-network providers. Given these circumstances, the Departments have proposed that payers provide historical allowed amount data for out-of-network covered

[107] 2018 MLR Data Trends.

[108] Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

items or services furnished by a particular out-of-network provider during the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount File, rather than requiring plans and issuers to report their methodology or formula for calculating the allowed amounts for out-of-network items and services.

5. Proposal To Require Both Disclosure of Cost-Sharing Information to Participants, Beneficiaries, and Enrollees and Publicly-Posted Machine-Readable Files With Negotiated Rates and Out-of-Network Allowed Amounts

The Departments considered whether proposing that group health plans and health insurance issuers be required to disclose cost-sharing information through a self-service tool or in paper form to participants, beneficiaries, or enrollees (or their authorized representatives) so that they may obtain an estimate of their cost-sharing liability for covered items and services and publicly-posted machine-readable files containing data on in-network negotiated rates and historical out-of-network allowed amounts would be duplicative. The requirement to disclose cost-sharing information to participants, beneficiaries, or enrollees proposed in these rules would require plans and issuers to provide consumer-specific information on potential cost-sharing liability to enrolled consumers, complete with information about their deductibles, copays, and coinsurance. However, cost-sharing information for these plans and coverage would not be available or applicable to consumers who are uninsured or shopping for plans pre-enrollment. Data disclosed to participants, beneficiaries, and enrollees would also not be available to third parties who are interested in creating consumer tools to assist both uninsured and insured consumers with shopping for the most affordable items or services. Limiting access to data to a subset of consumers would not promote the transparency goals of these proposed rules, and would reduce the potential for these proposed rules to drive down health care costs by increasing competition.

As discussed in more detail in the corresponding ICR sections of this preamble, the Departments estimate that the high-end average 3-year hour burden and cost to develop only the internet-based self-service tool, including the initial tool build and maintenance, customer service training, and customer assistance burdens and costs. The Departments estimate the total hour burden per group health plan, health insurance issuer, or TPA (on behalf of a self-insured group health plan) would be approximately 956 hours, with an associated equivalent average annual cost of approximately $168,804. For all 1,754 health insurance issuers and 205 TPAs, the Departments estimate the total average annual hour burden, over a 3-year period, to be 1,872,564 hours with an associated equivalent total average annual cost of approximately $161,355,868.

In contrast, and as further discussed in the corresponding ICR sections earlier in this preamble, for implementation of the currently proposed internet-based self-service tool in conjunction with the out-of-network allowed amount and in-network negotiated rate machine-readable files, the Departments estimate that the average annual high-end burden and cost, over a 3-year period, for each group health plan and health insurance issuer or TPA would be approximately 2,127 hours, with an associated equivalent cost of approximately $190,356. For all 1,754 health insurance issuers and 205 TPAs, the Departments estimate the total average high-end annual hour burden and cost, over a 3-year period, to be 4,165,900 hours with an associated equivalent total average annual cost of approximately $372,906,502.

Additionally, as discussed in more detail in the corresponding ICR sections, the Departments estimate that that the low-end average 3-year burden and cost to develop and maintain only the internet-based self-service tool, including the initial tool build and maintenance, customer service training, and customer assistance burdens and costs. The Departments estimate the total hour burden per plan and or TPA would be approximately 392 hours, with an associated equivalent average annual cost of approximately $33,194. For all 1,754 health insurance issuers and 205 TPAs, the Departments estimate the total average annual hour burden, over a 3-year period, to be 767,100 hours with an associated equivalent total average annual cost of approximately $65,027,268.

In contrast, and as further discussed in the corresponding ICR sections earlier in this preamble, for implementation of the currently proposed internet-based self-service tool in conjunction with the out-of-network allowed amount and in-network negotiated rate machine-readable files, the Departments estimate that the average annual low-end hour burden and cost, over a 3-year period, for group health plan and health insurance issuer or TPA would be approximately 1,562 hours, with an associated equivalent average annual cost of approximately $141,183. For all 1,754 health insurance issuers and 205 TPAs the Departments estimate the total average annual low-end hour burden and cost, over a 3-year period, to be 3,060,436 hours with an associated equivalent total average annual cost of approximately $276,577,902.

While the Departments recognize that requiring disclosures through both mechanisms increases the cost and hour burdens for plans and issuers required to comply with the requirements of these proposed rules, the Departments are of the view that these additional costs are outweighed by the benefits accrued to the broader group of consumers (such as the uninsured and individuals shopping for coverage) and other individuals who would benefit directly from the additional information provided through the machine-readable files. Furthermore, as noted earlier in this preamble, researchers and third-party developers would also be able to use the data included in the machine-readable files in a way that could accrue even more benefits to individuals, including those individuals not currently enrolled in a particular plan or coverage. For these reasons, the Departments concluded that, in addition to proposing to require plans and issuers to be required to disclosure cost-sharing information to participants, beneficiaries, or enrollees through an internet-based self-service tool or in paper form, proposing to require plans and issuers to disclose information on negotiated rates and out-of-network allowed amounts would further the goals of price transparency and accrue more benefit to all potentially affected stakeholders.

6. Proposal To Require Machine-Readable Files in Lieu of an API

The Departments considered whether to propose a requirement for group health plans and health insurance issuers to make the information required in these proposed rules to be disclosed through a standards-based API, instead of through the proposed internet-based self-service tool and machine-readable files. Access to pricing information through an API could have a number of benefits for consumers, providers, and the public at large. The Departments believe this information could ensure the public has access to the most up-to-date rate information. Providing real-time access to pricing information through a standards-based API could allow third-party innovators to incorporate the information into applications used by consumers or combined with electronic medical

records for point-of-care decision-making and referral opportunities by clinicians and their patients. Additionally, being able to access these data through a standards-based APIs would allow consumers to use the application of their choice to obtain personalized, actionable health care item or service price estimates, rather than being required to use one developed by their plan or issuer, although those consumers may be required to pay for access to those applications.

While there are many benefits to a standards-based API, it is the Departments' current view that the burden and costs associated with building and maintaining a standards-based API would result in plans, issuers, and applicable TPAs potentially incurring higher burden and costs than estimated for the internet-based self-service tool and machine-readable files proposed in these rules and discussed in the applicable ICR sections. This view is based on the Departments' preliminary estimate that for all 1,754 health insurance issuers and 205 TPAs, the total cost could range from $500 million to $1.5 billion for the first year. Looking at the average burden and cost over a 3-year period for the API for all 1,754 health insurance issuers and 205 TPAs, the Departments estimate an average annual cost that would significantly exceed the estimated annual cost of publishing the proposed internet-based self-service tool and machine-readable files. The Departments recognize that the development of the API may be streamlined through other development activities related to this proposed rule or by leveraging existing APIs currently used by plans, issuers, or TPAs for their own applications, potentially resulting in significantly lower burden and costs. Although not estimated here, the Departments expect any associated maintenance costs would also decline in succeeding years as group health plans, health insurance issuers or TPAs may gain additional efficiencies or may already undertake similar procedures to maintain any currently used internal APIs. Nonetheless, weighing the burden of group health plans, health insurance issuers and TPAs providing this information using machine-readable files against the potential burden of using a standards-based API, and given the timeframe that group health plans, health insurance issuers and TPAs have to meet the requirements of these proposals, the Departments are of the view that in the short-term, requiring machine-readable files is the more sensible approach.

Even though the Departments are of the view that a machine-readable file is appropriate in the short-term, as discussed earlier in this preamble, the Departments recognize that a standards-based API format in the long-term may be more beneficial to consumers because the public would have access to the most up-to-date rate information and would allow health care consumers to use the application of their choice to obtain personalized, actionable health care service price estimates, and third-party developers could utilize the collected data to develop consumer tools. Therefore, the Departments are considering future rulemaking to further expand access to pricing information through standards-based APIs, including individuals' access to estimates about their own cost-sharing liability and information about negotiated in-network rates and historical payment data for out-of-network allowed amounts.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, the Departments are required to provide 60-days' notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. These proposed rules contain information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized in Table 16.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) requires that the Departments solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of each of the Departments.
- The accuracy of the Departments' 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.

The Departments solicit public comment on each of these issues in the following sections of this document in relation to the information collection requirements in these proposed rules.

A. 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 ICRs.[109] Table 2 in these proposed rules 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. The Departments are of the view that doubling the hourly wage to estimate total cost is a reasonably acceptable estimation method.

TABLE 2—ADJUSTED HOURLY WAGES USED IN BURDEN ESTIMATES

Occupation title	Occupational code	Mean hourly wage ($/hour)	Fringe benefits and overhead ($/hour)	Adjusted hourly wage ($/hour)
General and Operations Manager	11–1021	$59.56	$59.56	$119.12
Computer and Information Systems Manager	11–3021	73.49	73.49	146.98
Computer Programmer	15–1131	43.07	43.07	86.14
Computer System Analyst	15–1121	45.01	45.01	90.02
Web Developer	15–1134	36.34	36.34	72.68
Business Operations Specialist	13–1199	37.00	37.00	74.00

[109] *See* May 2018 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates. Available at: *https://www.bls.gov/oes/current/oes_stru.htm.*

TABLE 2—ADJUSTED HOURLY WAGES USED IN BURDEN ESTIMATES—Continued

Occupation title	Occupational code	Mean hourly wage ($/hour)	Fringe benefits and overhead ($/hour)	Adjusted hourly wage ($/hour)
Other Office and Administrative Support Workers	43–9000	17.28	17.28	34.56
Lawyer	23–1011	69.34	69.34	138.68
Chief Executive Officer	11–1011	96.22	96.22	192.44
Information Security Analysts	15–1122	49.26	49.26	98.52
Customer Service Representatives	43–4051	17.53	17.53	35.06

1. ICR Regarding Requirements for Disclosures to Participants, Beneficiaries, or Enrollees (26 CFR 54.9815–2715A(b), 29 CFR 2590.715–2715A(b), and 45 CFR 147.210(b))

The Departments propose to add 26 CFR 54.9815–2715A(b), 29 CFR 2590.715–2715A(b), and 45 CFR 147.210(b), to require group health plans and health insurance issuers in the group and individual markets to disclose, upon request, to a participant, beneficiary, or enrollee (or his or her authorized representative), such individual's cost-sharing information for covered items and services furnished by a particular provider or providers, as well as allowed amounts for covered items and services from out-of-network providers. As discussed previously in this preamble, the Departments propose in paragraphs (b)(1)(i) through (vii) to require plans and issuers to make this information available through a self-service tool on an internet website and, if requested, in paper form.

The Departments propose to require plans and issuers to disclose, upon request, certain information relevant to a determination of a consumer's cost-sharing liability for a particular health care item or service from a particular provider, to the extent relevant to the individual's cost-sharing liability for the item or service, in accordance with seven content elements: The consumer-specific estimated cost-sharing liability, the consumer-specific accumulated amounts, the negotiated rate, the out-of-network allowed amount for a covered item or service, if applicable, the items and services content list when the information is for items and services subject to a bundled payment arrangement, a notice of prerequisites to coverage (such as prior authorization), and a disclosure notice. The Departments propose to require the disclosure notice to include several statements, written in plain-language, which include disclaimers relevant to the limitations of the cost-sharing information disclosed, including: A statement that out-of-network providers may balance bill participants beneficiaries, or enrollees, a statement that the actual charges may differ from those for which a cost-sharing liability estimate is given, and a statement that the estimated cost-sharing liability for a covered item is not a guarantee that coverage will be provided for those items and services. In addition, plans and issuers would also be permitted to add other disclaimers they determine appropriate so long as such information is not in conflict with the disclosure requirements of these proposed rules. The Departments have developed model language that plans and issuers would be able to use to satisfy the requirement to provide the notice statements described earlier in this preamble.

As discussed earlier in this preamble, the Departments propose that plans and issuers would be required to make available the information described in paragraph (b)(1) of these proposed rules through an internet-based self-service tool as described in paragraph (b)(2)(i) of these proposed rules. The information would be required to be provided in plain-language through real-time responses. Plans and issuers would be required to allow participants, beneficiaries, or enrollees (or their authorized representatives) to search for cost-sharing information for covered items and services by billing code, or by descriptive term, per the user's request, in connection with a specific in-network provider, or for all in-network providers. In addition, the internet-based self-service tool would allow users to input information necessary to determine the out-of-network allowed amount for a covered item or service provided by an out-of-network provider (such as zip code). The tool would be required to have the capability to refine and reorder results by geographic proximity, and the amount of cost-sharing liability to the beneficiary, participant, or enrollee.

Under paragraph (b)(2)(ii) of these proposed rules, the Departments would require plans and issuers to furnish upon request, in paper form, the information required to be disclosed under paragraph (b)(1) of these proposed rules to a participant, beneficiary, or enrollee. As discussed in this preamble, under paragraphs (b)(2)(ii)(A) and (B) of these proposed rules, a paper disclosure would be required to be furnished according to the consumer's filtering and sorting preferences and mailed to the participant, beneficiary, or enrollee (or his or her authorized representative) within 2 business days of receiving the request. As noted in these proposed rules, plans or issuers may, upon request, provide the required information through other methods, such as over the phone, through face-to-face encounters, by facsimile, or by email.

The Departments assume fully-insured group health plans would rely on health insurance issuers to develop and maintain the internet-based self-service tool and disclosure in paper form. While the Departments recognize that some self-insured plans might independently develop and maintain the internet-based self-service tool, at this time the Departments assume that self-insured plans would rely on TPAs (including issuers providing administrative services only and non-issuer TPAs) to develop the required internet-based self-service tool. The Departments make this assumption because the Departments understand that most self-insured group health plans rely on TPAs for performing most administrative duties, such as enrollment and claims processing. For those self-insured plans that choose to develop their own internet-based self-service tools, the Departments assume that they will incur a similar hour burden and cost as estimated for health insurance issuers and TPAs, as discussed later in this preamble. In addition, paragraphs (b)(3) and (c)(4) of these proposed rules provide for a special rule to prevent unnecessary duplication of the disclosures with respect to health coverage, which provides that a plan may satisfy the disclosure requirements if the issuer offering the coverage is required to provide the information pursuant to a

written agreement between the plan and issuer. Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the purposes of estimating required changes to IT infrastructure and administrative hourly burden and costs. The Departments estimate approximately 1,754 issuers and 205 TPAs will be affected by this information collection.

The Departments acknowledge that the costs described in these ICRs may vary depending on the number of lives covered, the number of providers and items and services for which cost-sharing information must be disclosed, and the fact that some plans and issuers already have tools that meet most (if not all) of these requirements or can be easily adapted to meet the requirements of these proposed rules. In addition, plans and issuers may be able to license existing cost estimator tools offered by third-party vendors, obviating the need to establish and maintain their own internet-based, self-service tool. The Departments assume that any related vendor licensing fees would be dependent upon complexity, volume, and frequency of use, but assume that such fees would be lower than an overall initial build and associated maintenance costs. Nonetheless, for purposes of the estimates in these ICRs, the Departments assume all 1,959 health insurance issuers and TPAs would be affected by these proposed rules. The Departments also developed the following estimates based on the mean average size, by covered lives, of issuers or TPAs. As noted later in this section of the preamble, the Departments seek comment on the inputs and assumptions that have been made to develop these burden and cost estimates, particularly with regard to existing efficiencies that would reduce these burden and cost estimates.

The Departments estimate that health insurance issuers and TPAs would incur a one-time cost and hour burden to complete the technical build to implement the requirements of paragraph (b) of these proposed rules to establish the internet-based, self-service tool through which disclosure of cost-sharing information (including required notice statements) in connection with a covered item or service under the terms of the plan or coverage must be made. The Departments estimate an administrative burden on health insurance issuers and TPAs to make appropriate changes to information technology (IT) systems and processes to design, develop, implement, and operate the internet-based, self-service tool and to make this information available in paper form, transmitted through the mail. The Departments estimate that the one-time cost and burden each issuer or TPA would incur to complete the one-time technical build would include activities such as planning, assessment, budgeting, contracting, building and systems testing, incorporating any necessary security measures, incorporating disclaimer and model notice language, or development of the proposed model and disclaimer notice materials for those that choose to make alterations. The Departments assume that this one-time cost and burden would be incurred in 2020. As mentioned earlier in this preamble, the Departments acknowledge that a number of health insurance issuers and TPAs have previously developed some level of price estimator tool similar to, and containing some functionality related to, the requirements in these proposed rules. The Departments, thus, seek to estimate an hourly burden and cost range (high-end and low-end) associated with these proposed rules for those health insurance issuers and TPAs. In order to develop the high-end hourly burden and cost estimates, the Departments assume that all health insurance issuers and TPAs would need to develop and build their internet-based self-service tool project from start-up to operational functionality. The Departments estimate that for each issuer or TPA, on average, it would take business operations specialists 150 hours (at $74 per hour), computer system analysts 1,000 hours (at $90.02 per hour), web developers 40 hours (at $72.68 per hour), computer programmers 1,250 hours (at $86.14 per hour), computer and information systems managers 40 hours (at $146.98 per hour), operations managers 25 hours (at $119.12 per hour), a lawyer 2 hours (at $138.68 per hour), and a chief executive officer 1 hour (at $192.44 per hour) to complete this task. The Departments estimate the total hour burden per issuer or TPA would be approximately 2,508 hours, with an equivalent cost of approximately $221,029. For all 1,754 health insurance issuers and 205 TPAs, the total one-time total hour burden is estimated to be 4,913,172 hours with an equivalent total cost of approximately $432,996,203.

TABLE 3A—TOTAL HIGH-END ESTIMATED ONE-TIME COST AND HOUR BURDEN FOR INTERNET-BASED SELF-SERVICE TOOL FOR EACH HEALTH INSURANCE ISSUER OR TPA

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
General and Operations Manager	25	$119.12	$2,978
Computer and Information Systems Manager	40	146.98	5,879
Computer Programmer	1,250	86.14	107,675
Computer System Analyst	1,000	90.02	90,020
Web Developer	40	72.68	2,907
Business Operations Specialist	150	74.00	11,100
Lawyer	2	138.68	277
Chief Executive Officer	1	192.44	192
Total per respondent	2,508		221,029

TABLE 3B—TOTAL HIGH-END ESTIMATED ONE-TIME COST AND HOUR BURDEN FOR INTERNET-BASED SELF-SERVICE TOOL FOR ALL HEALTH INSURANCE ISSUERS AND TPAS

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	1,959	2,508	4,913,172	$432,996,203

The Departments recognize that a significant number of health insurance issuers may already have some form of price estimator tool that allows for comparison shopping and a large number of issuers may currently provide the ability for consumers to obtain their estimated out-of-pocket costs.[110] For those health insurance issuers and TPAs, that currently have some level of functional cost estimator tool that would meet some of the requirements of these proposed rules, the Departments recognize that these entities would incur a lower hour burden and cost. Thus, the Departments have estimated a low-end hour burden and cost to comply with these proposed rules. Assuming that 90 percent of health insurance issuers and TPAs currently provide a cost estimator tool and would only be required to make changes to their current system in order to meet the requirements in these proposed rules, the Departments estimate that 175 health insurance issuers and 21 TPAs would be required to develop an internet-based self-service tool from start-up to operational functionality. The Departments estimate that each issuer or TPA would incur a one-time cost and hour burden of approximately 2,508 hours, with an equivalent cost of approximately $221,029 (as discussed previously in this ICR). For the 196 health insurance issuers and TPAs, the total one-time hour burden is estimated to be 491,317 hours with an equivalent total cost of approximately $43,299,620.

TABLE 4A—LOW-RANGE ONE-TIME COST AND HOUR BURDEN FOR WEB-BASED CONSUMER PRICE TOOL FOR HEALTH INSURANCE ISSUERS AND TPAS REQUIRING A COMPLETE BUILD FROM THE START-UP TO OPERATIONAL FUNCTIONALITY

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
196	196	2,508	491,317	$43,299,620

The Departments estimate that those health insurance issuers and TPAs that would only be required to make changes to their existing systems would already have operational capabilities that meet approximately 75 percent of the requirements in these proposed rules and would only incur a cost and hour burden related to changes needed to fully meet the requirements of these proposed rules. Based on this assumption, the Departments estimate that 1,579 health insurance issuers and 184 TPAs would incur a one-time hour burden of 627 hours and an associated cost of $55,257 to fully satisfy the requirements of these proposed rules. For all 1,763 health insurance issuers and TPAs, the total one-time hour burden would be 1,105,464 hours with an equivalent total cost of approximately $97,424,146.

TABLE 4B—LOW-END ONE-TIME COST AND HOUR BURDEN FOR WEB-BASED CONSUMER PRICE TOOL FOR HEALTH INSURANCE ISSUERS AND TPAS REQUIRING ONLY A PARTIAL BUILD

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,763	11,763	627	1,105,464	$97,424,146

TABLE 4C—TOTAL LOW-END ONE-TIME COST AND HOUR BURDEN FOR WEB-BASED CONSUMER PRICE TOOL FOR HEALTH INSURANCE ISSUERS AND TPAS

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	1,959	815	1,596,781	$140,723,766

In addition to the range of one-time costs and hour burdens estimated in Tables 4B and 4C, health insurance issuers and TPAs would incur ongoing annual costs such as those related to ensuring cost estimation accuracy, providing quality assurance, conducting website maintenance and making updates, and enhancing or updating any needed security measures. The Departments estimate that for each issuer and TPA, on average, it would take business operations specialists 15 hours (at $74.00 per hour), computer systems analysts 50 hours (at $90.02 per hour), web developers 10 hours (at $72.68 per hour), computer programmers 55 hours (at $86.14 per hour), computer and information systems managers 10 hours (at $146.98), and operations managers 5 hours (at $119.12 per hour) each year to perform these tasks. The total annual hour burden for each issuer or TPA would be 145 hours, with an equivalent cost of approximately $13,141. For all 1,754 health insurance issuers and 205 TPAs, the total annual hour burden is estimated to be 284,055 hours with an equivalent total annual cost of approximately $25,743,023. The Departments consider this to be an upper-bound estimate and expect maintenance costs to decline in succeeding years as health insurance issuers and TPAs gain efficiencies and experience in updating and managing their internet-based self-service tool.

[110] *See* AHIP release dated August 2, 2019—AHIP Issues Statement on Proposed Rule Requiring Disclosure of Negotiated Prices. Available at: *https://www.ahip.org/ahip-issues-statement-on-proposed-rule-requiring-disclosure-of-negotiated-prices/*. *See also* Higgins, A., Brainard, N., Veselovskiy, G. ''Characterizing Health Plan Price Estimator Tools: Findings From a National Survey.'' 22 Am. J. Managed Care 126,2016. Available at: *https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_02_2016_Higgins%20(final).pdf*.

TABLE 5A—ESTIMATED ANNUAL COST AND BURDEN FOR MAINTENANCE OF INTERNET-BASED SELF-SERVICE TOOL FOR EACH HEALTH INSURANCE ISSUER OR TPA

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
General and Operations Manager	5	$119.12	$596
Computer and Information Systems Manager	10	146.98	1,470
Business Operations Specialist	15	74.00	1,110
Computer System Analyst	50	90.02	4,501
Web Developer	10	72.68	727
Computer Programmer	55	86.14	4,738
Total per Respondent	145		13,141

TABLE 5B—ESTIMATED ANNUAL HOUR BURDEN FOR MAINTENANCE OF INTERNET-BASED SELF-SERVICE TOOL FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FROM 2021 ONWARDS

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	1,959	145	284,055	$25,743,023

The Departments estimate the high-end average annual total hour burden, for all health insurance issuers and TPAs to develop, build, and maintain an internet-based consumer self-service tool, over three years would be 1,827,094 hours annually with an average annual total equivalent cost of $161,494,083. The Departments acknowledge that the costs described earlier in this section of the preamble may vary depending on the number of lives covered, and the number of providers and items and services incorporated into the internet-based self-service tool. In recognizing that many health insurance issuers and TPAs currently have some form of cost estimator tool in operation that meet most (if not all) of the requirements in these proposed rules, the Departments estimate the low-end average annual total hour burden, for all health insurance issuers and TPAs to develop, build, and maintain an internet-based self-service tool, over a 3-year period would be 721,630 hours annually with an average annual total equivalent cost of $64,069,937. The Departments recognize that group health plans, issuers, and TPAs may be able to license existing online cost estimator tools offered by vendors, obviating the need to establish, upgrade, and maintain their own internet-based self-service tools and that vendor licensing fees, dependent upon complexity, volume and frequency of use, could be lower than the hour burden and costs estimated here.

TABLE 6—ESTIMATED HIGH-END THREE YEAR AVERAGE ANNUAL HOUR BURDEN AND COSTS FOR ALL HEALTH INSURANCE ISSUERS AND TPAS TO DEVELOP AND MAINTAIN THE INTERNET-BASED SELF-SERVICE TOOL

Year	Estimated number of health insurance issuers and TPAs	Responses	Burden per respondent (hours)	Total annual burden (hours)	Total estimated labor Cost
2020	1,959	1,959	2,508	4,913,172	$432,996,203
2021	1,959	1,959	145	284,055	25,743,023
2022	1,959	1,959	145	284,055	25,743,023
3 year Average	1,959	1,959	933	1,827,094	161,494,083

TABLE 7—ESTIMATED LOW-END THREE YEAR AVERAGE ANNUAL HOUR BURDEN AND COSTS FOR ALL HEALTH INSURANCE ISSUERS AND TPAS TO DEVELOP AND MAINTAIN THE INTERNET-BASED SELF-SERVICE TOOL

Year	Estimated number of health insurance issuers and TPAs	Responses	Burden per respondent (hours)	Total annual burden (hours)	Total estimated labor cost
2020	1,959	1,959	815	1,596,781	$140,723,766
2021	1,959	1,959	145	284,055	25,743,023
2022	1,959	1,959	145	284,055	25,743,023
3 year Average	1,959	1,959	368	721,630	64,069,937

In addition to the one-time and annual maintenance costs estimated in Table 7, health insurance issuers and TPAs would also incur an annual burden and costs associated with customer service representative training, consumer assistance, and administrative and distribution costs related to the disclosures required under paragraph (b)(2)(ii) of these proposed rules. The Departments estimate that, to understand and navigate the internet-based self-service tool and be able to provide the appropriate assistance to consumers, each customer service representative would require approximately 2 hours (at $35.06 per hour) of annual consumer assistance training at an associated cost of $70 per hour. The Departments estimate that each issuer and TPA would train, on average, 10 customer service representatives annually, resulting in a total annual hour burden of 20 hours and associated total costs of $701 per issuer or TPA. For all 1,754 health insurance issuers and 205 TPAs, the total annual hour burden is estimated to be 39,180 hours with an equivalent total annual cost of approximately $1,373,651.

TABLE 8A—ESTIMATED ANNUAL COST AND HOUR BURDEN PER HEALTH INSURANCE ISSUER OR TPA TO TRAIN CUSTOMER SERVICE REPRESENTATIVES TO PROVIDE ASSISTANCE TO CONSUMERS RELATED TO THE INTERNET-BASED SELF-SERVICE TOOL

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
Customer Service Representatives	2	$35.06	$70
Total per Respondent	2		70

TABLE 8B—ESTIMATED ANNUAL COST AND HOUR BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FROM 2021 ONWARDS TO TRAIN CUSTOMER SERVICE REPRESENTATIVES TO PROVIDE ASSISTANCE TO CONSUMERS RELATED TO THE INTERNET-BASED SELF-SERVICE TOOL

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	19,590	20	39,180	$1,373,651

The Departments assume that the greatest proportion of beneficiaries, participants, and enrollees who would request disclosure of cost-sharing information in paper form would do so because they do not have access to the internet. However, the Departments acknowledge that some consumers with access to the internet would also contact a plan or issuer for assistance and may request to receive cost-sharing information in paper form.

Recent studies have found that approximately 20 million households do not have an internet subscription [111] and that approximately 19 million Americans (6 percent of the population) lack access to fixed broadband services that meet threshold levels.[112] Additionally, a recent Pew Research Center analysis found that 10 percent of U.S. adults do not use the internet, citing the following major factors: Difficulty of use, age, cost of internet services, and lack of computer ownership.[113] Additional research indicates that an increasing number, 17 percent, of individuals and households are now considered ''smartphone only'' and that 37 percent of U.S. adults mostly use smartphones to access the internet and that many adults are forgoing the use of traditional broadband services.[114] Further research indicates that younger individuals and households, including approximately 93 percent of households with householders aged 15 to 34, are more likely to have smartphones compared to those aged over 65.[115] The Departments are of the view that the population most likely to use the internet-based self-service tool would generally consist of higher-income and younger individuals, who are more likely to have internet access via broadband or smartphone technologies.

The Departments estimate there are 193.5 million [116] beneficiaries, participants, or enrollees enrolled in group health plans or with health insurance issuers required to comply with the requirements under paragraph (b) of these proposed rules. On average, it is estimated that each issuer or TPA would annually administer the benefits for 98,775 beneficiaries, participants, or enrollees.

Assuming that 6 percent of covered individuals lack access to fixed broadband service and, taking into account that a recent study noted that only 1 to 12 percent of consumers that have been offered internet-based or mobile application-based price

[111] *See* 2017 U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates. Available at: *https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S2801&prodType=table.*

[112] *See* Eight Broadband Progress Report. Federal Communications Commission. December 14, 2018. Available at: *https://www.fcc.gov/reports-research/reports/broadband-progress-reports/eighth-broadband-progress-report.* In addition to the estimated 19 million Americans that lack access, they further estimate that in areas where broadband is available approximately 100 million Americans do not subscribe.

[113] *See* Anderson, M., Perrin, A., Jiang, J., Kumar, M. ''10% of Americans don't use the internet. Who are they?'' ((Pew Research Center. April 22, 2019. Available at: *https://www.pewresearch.org/fact-tank/2019/04/22/some-americans-dont-use-the-internet-who-are-they/.*

[114] *See* Anderson, M. ''Mobile Technology and Home Broadband 2019.'' Pew Research Center. June 13, 2019. Available at *https://www.pewinternet.org/2019/06/13/mobile-technology-and-home-broadband-2019/* (finding that overall 17 percent of Americans are now ''smartphone only'' internet users, up from 8 percent in 2013. The study also shows that 45 percent of non-broadband users cite their smartphones as a reason for not subscribing to high-speed internet).

[115] *See* Ryan, C. ''Computer and internet Use in the United States: 2016.'' American Community Survey Reports: United States Census Bureau. August 2016 Available at: *https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-39.pdf.*

[116] EBSA estimates that in 2016 there were 135.7 million covered individuals with private sector and 44.1 million with public sector employer sponsored coverage (*see https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf*). Kaiser Family Foundation reports 13.7 million enrollees in the individual market for the first quarter of 2019 (*see: https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/*).

transparency tools use them,[117] the Departments estimate that on average 6 percent of participants, beneficiaries, or enrollees would seek customer support (a mid-range percentage of individuals that currently use available cost estimator tools) and that an estimated 1 percent of those participants, beneficiaries, or enrollees would request any pertinent information be disclosed to them in paper form. The Departments estimate that each health insurance issuer or TPA, on average, would require a customer service representative to interact with a beneficiary, participant, or enrollee approximately 59 times per year on matters related to cost-sharing information disclosures required by these proposed rules. The Departments estimate that each customer service representative would spend, on average, 15 minutes (at $35.06 per hour) for each interaction, resulting in a cost of approximately $9 per interaction. The Departments estimate that each issuer or TPA would incur an annual hour burden of 15 hours with an associated equivalent cost of approximately $519 for each issuer or TPA, resulting in a total annual hour burden of 29,025 hours with an associated cost of approximately $1,017,617 for all issuers or TPAs.

The Departments assume that all beneficiaries, participants, or enrollees that contact a customer service representative representing their plan or issuer would request non-internet disclosure of the internet-based self-service tool information. Of these, the Departments estimate that 54 percent of the requested information would be transmitted via email or facsimile at negligible cost to the issuer or TPA and that 46 percent would request the information be provided via mail. The Departments estimate that, on average, each issuer or TPA would send approximately 27 disclosures via mail annually. Based on these assumptions, the Departments estimate that the total number of annual disclosures sent by mail for all health insurance issuers and TPAs would be 53,406.

The Departments assume the average length of the printed disclosure would be approximately nine single-sided pages in length, assuming two pages of information (similar to that provided in an EOB) for three providers (for a total of six pages) and an additional three pages related to the required notice statements, with a printing cost of $0.05 per page. Therefore, including postage costs of $0.55 per mailing, the Departments estimate that each health insurance issuer or TPA would incur a material and printing costs of $1.00 ($0.45 printing plus $0.55 postage costs) per mailed request. Based on these assumptions, the Departments estimate that each issuer or TPA would incur an annual printing and mailing cost of approximately $27, resulting in a total annual printing and mailing cost of approximately $53,406 for all health insurance issuers and TPAs.

TABLE 9A—ESTIMATED ANNUAL COST AND HOUR BURDEN PER RESPONSE PER HEALTH INSURANCE ISSUER OR TPA TO ACCEPT AND FULFILL REQUESTS FOR A MAILED DISCLOSURE

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
Customer Service Representatives	0.25	$35.06	$9
Total per Respondent	0.25		9

TABLE 9B—ESTIMATED ANNUAL COST AND HOUR BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FROM 2021 ONWARDS TO ACCEPT AND FULFILL REQUESTS FOR MAILED DISCLOSURES

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total labor cost of reporting	Printing and materials cost	Total cost
1,959	116,100	15	29,025	$1,017,617	$53,406	$1,071,023

The Departments solicit comment for this collection of information request related to the overall estimated costs and hour burdens. The Departments also seek comment related to the technical and labor requirements or costs that may be required to meet the requirements of these proposed rules; for example, what costs may be associated with any potential consolidation of information needed for the internet-based self-service tool functionality. The Departments seek comment on the estimated number of health insurance issuers and TPAs currently in the group and individual markets and the number of self-insured group health plans that might seek to independently develop an internet-based self-service tool, the percentage of consumers who might use the internet-based self-service tool, and the percentage of consumers who might contact their plan, issuer, or TPA requesting information via a non-internet disclosure method. The Departments seek comment on any other existing efficiencies that could be leveraged to minimize the burden on group health plans, issuers, and TPAs, as well as how many or what percentage of plans, issuers, and TPAs might leverage such efficiencies. The Departments seek comment on the proposed model notice and any additional information that stakeholders feel should be included, removed, or expanded upon and its overall adaptability.

In conjunction with these proposed rules, CMS is seeking an OMB control number and approval for the proposed information collection (OMB control number: 0938–NEW (Transparency in Coverage (CMS–10715)). CMS is proposing to require the following information collections to include the following burden. DOL and Treasury will submit their burden estimates upon approval.

[117] *See* Mehrotra, A., Chernew, M., Sinaiko, A. ''Health Policy Report: Promises and Reality of Price Transparency.'' April 5, 2018. 14 N. Eng. J. Med. 378. Available at: *https://www.nejm.org/doi/full/10.1056/NEJMhpr1715229.*

2. ICRs Regarding Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services From Out-of-Network Providers Under 26 CFR 54.9815–2715A(c), 29 CFR 2590.715–2715A(c), and 45 CFR 147.210(c)

The Departments propose to add paragraph (c) of these proposed rules to require group health plans and health insurance issuers to make public negotiated rates with in-network providers and data outlining the different amounts a plan or issuer has paid to particular out-of-network providers for covered items or services. Plans and issuers would be required to disclose for each covered service or item, the negotiated rates for services and items furnished by particular in-network providers and out-of-network allowed amount data for each covered service or item furnished by particular out-of-network provider through two machine-readable files that must conform to guidance issued by the Departments. The list of required data elements that must be included for each file for each covered item or service are discussed previously and enumerated under paragraph (c)(1)(i) for the Negotiated Rate File and paragraph (c)(1)(ii) for the Allowed Amount File of these proposed rules. Under paragraphs (c)(2) and (3) of these proposed rules, the files must be posted on a public internet site with unrestricted access and must be updated monthly.

For the Allowed Amount File required under proposed paragraph (c)(1)(ii), the proposed rules would require plans and issuers to make available a machine-readable file showing the unique amounts a plan or issuer's coverage allowed for items or services furnished by particular out-of-network providers during the 90-day time period that begins 180 days before the publication date of the file. As discussed previously in these proposed rules, to the extent that a plan or issuer has allowed multiple amounts for an item or service to a particular provider at the same rate, the proposed rules would only require a plan or issuer to list the allowed amount once. Additionally, if the plan or issuer would only display allowed amounts in connection with 10 or fewer claims for a covered item or service for payment to a provider during any relevant 90-day period, the plan or issuer would not be required to report those unique allowed amounts.

As discussed in the previous collection of information, the Departments assume fully-insured group health plans would rely on health insurance issuers and most self-insured group health plans would rely on issuers or TPAs to develop and update the proposed machine-readable files. The Departments recognize that there may be some self-insured plans that wish to individually comply with these proposed rules and would incur a similar hour burden and costs as described in the following paragraphs.

The Departments estimate a one-time hour burden and cost to health insurance issuers and TPAs to make appropriate changes to IT systems and processes, to develop, implement and operate the Negotiated Rate File in order to meet the proposed requirements under paragraph (c)(1)(i). The Departments estimate that for each health insurance issuer or TPA, on average, would require business operations specialists 20 hours (at $74 per hour), computer system analysts 500 hours (at $90.02 per hour), computer programmers 600 hours (at $86.14 per hour), computer and information systems managers 50 hours (at $146.98 per hour) and operations managers 20 hours (at $119.12 per hour) to complete this task. The total burden for each issuer or TPA would be approximately 1,190 hours on average, with an equivalent associated cost of approximately $107,905. For all 1,754 health insurance issuers and 205 TPAs, the Departments estimate the total one-time hour burden would be 2,331,210 hours with an associated cost of approximately $211,386,679. The Departments emphasize that these are upper bound estimates that are meant to be sufficient to cover substantial, complex activities that may be necessary for some plans and issuers to comply with these proposed rules due to the manner in which their current systems are designed. Such activities may include such significant activity as the design and implementation of databases that will support the production of the Negotiated Rate Files. The Departments request comment on these estimates and whether they substantially overestimate expected burden.

TABLE 10A—ESTIMATED ONE-TIME COST AND HOUR BURDEN PER HEALTH INSURANCE ISSUER OR TPA FOR THE NEGOTIATED RATES FOR IN-NETWORK PROVIDERS NEGOTIATED RATE FILE

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
General and Operations Manager	20	$119.12	$2,382
Computer and Information Systems Manager	50	146.98	7,349
Business Operations Specialist	20	74.00	1,480
Computer System Analyst	500	90.02	45,010
Computer Programmer	600	86.14	51,684
Total per Respondent	1,190		107,905

TABLE 10B—ESTIMATED ONE-TIME COST AND HOUR BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FOR THE NEGOTIATED RATES FOR IN-NETWORK NEGOTIATED RATE FILE

Number of Respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	1,959	1,190	2,331,210	$211,386,679

In addition to the one-time costs estimated Tables 10A and 10B, health insurance issuers and TPAs would incur ongoing annual burdens and costs to update the proposed Negotiated Rate File monthly as proposed under paragraph (c)(3). The Departments estimate that for each issuer or TPA, on average, it would require a general and

operations manager 3 hours (at $119.12 per hour), computer systems analysts 10 hours (at $90.02 per hour), computer programmers 10 hours (at $86.14 per hour), a computer and information systems manager 5 hours (at $146.98), and a business operations specialist 2 hours (at a rate of $74.00) to make the required updates to the Negotiated Rate File. The Departments estimate that each issuer or TPA would incur a burden of 30 hours with an associated cost of approximately $3,002 to update the Negotiated Rate File. Assuming health insurance issuers and TPAs make changes that would require the file to be updated monthly per the requirements proposed in these rules, an issuer or TPA would need to update the Negotiated Rate File 12 times during a given year, resulting in an ongoing annual hour burden of 360 hours for each issuer or TPA with an associated equivalent cost of approximately $36,022. The Departments estimate the total annual hour burden for all 1,959 health insurance issuers and TPAs would be 705,240 hours, with an associated equivalent cost of approximately $70,567,725. The Departments consider this estimate to be an upper-bound estimate and expect ongoing update costs to decline in succeeding years as health insurance issuers and TPAs gain efficiencies and experience in updating and managing the machine-readable files.

The Departments seek comment on the accuracy of the burden estimates under these proposed rules, as well as any ways to further refine the burden estimates.

TABLE 11A—ESTIMATED ANNUAL ONGOING COST AND BURDEN PER HEALTH INSURANCE ISSUER OR TPA FOR THE NEGOTIATED RATES FOR IN-NETWORK PROVIDERS NEGOTIATED RATE FILE

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
General and Operations Manager	3	$119.12	$357
Computer and Information Systems Manager	5	146.98	735
Business Operations Specialist	2	74.00	148
Computer System Analyst	10	90.02	900
Computer Programmer	10	86.14	861
Total per Respondent	30		3,002

TABLE 11B—ESTIMATED ANNUAL ONGOING COST AND BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FROM 2021 ONWARDS FOR THE IN-NETWORK PROVIDERS NEGOTIATED RATE FILE

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	23,508	360	705,240	$70,567,725

The Departments estimate the total one-time hour burden for all health insurance issuers and TPAs of 2,331,210 hours and an associated equivalent cost of approximately $211,386,679 to develop and build the Negotiated Rate File in a machine-readable format. In subsequent years, the Departments estimate the total annual hour burden of 705,240 hours to maintain and update the Negotiated Rate File with an annual associated equivalent cost of approximately $70,567,725. The Departments estimate the average annual total hour burden, for all health insurance issuers and TPAs, over three years, would be 1,247,230 hours with an average annual associated equivalent total cost of $117,507,376.

TABLE 12—ESTIMATED THREE YEAR AVERAGE ANNUAL HOUR BURDEN AND COSTS FOR ALL ISSUERS AND TPAS TO DEVELOP AND MAINTAIN THE IN-NETWORK PROVIDERS NEGOTIATED RATE FILE

Year	Estimated number of health insurance issuers and TPAs	Responses	Burden per respondent (hours)	Total annual burden (hours)	Total estimated labor cost
2020	1,959	1,959	1,190	2,331,210	$211,386,679
2021	1,959	23,508	360	705,240	70,567,725
2022	1,959	23,508	360	705,240	70,567,725
3 year Average	1,959	16,325	637	1,247,230	117,507,376

The Departments estimate a one-time hour burden and cost to health insurance issuers and TPAs to make appropriate changes to IT systems and processes, to develop, implement, and operate the Allowed Amount File in order to meet the proposed requirements under paragraph (c)(1)(ii) of the proposed rules related to making available a file of certain historical claims paid to out-of-network providers. The Departments estimate that each issuer or TPA, on average, would require business operations specialists 20 hours (at $74 per hour), computer system analysts 500 hours (at $90.02 per hour), computer programmers 600 hours (at $86.14 per hour), computer and information systems managers 50 hours (at $146.98 per hour), information security analysts 100 hours (at $98.52 per hour), and operations managers 20 hours (at $119.12 per hour) to complete this task. The total burden per issuer or TPA would be approximately 1,290 hours on average, with an equivalent associated cost of approximately $117,757. For all 1,754 health insurance issuers and 205 TPAs, the Departments estimate the total one-time hour burden

would be 2,527,110 hours with an equivalent associated cost of approximately $230,686,747.

TABLE 13A—ESTIMATED ONE-TIME COST AND HOUR BURDEN PER HEALTH INSURANCE ISSUER OR TPA FOR THE OUT-OF-NETWORK ALLOWED AMOUNT FILE

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
General and Operations Manager	20	$119.12	$2,382
Computer and Information Systems Manager	50	146.98	7,349
Business Operations Specialist	20	74.00	1,480
Computer System Analyst	500	90.02	45,010
Information Security Analysts	100	98.52	9,852
Computer Programmer	600	86.14	51,684
Total per Respondent	1,290		117,757

TABLE 13B—ESTIMATED ONE-TIME COST AND HOUR BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FOR THE OUT-OF-NETWORK ALLOWED AMOUNT FILE

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	1,959	1,290	2,527,110	$230,686,747

In addition to the one-time costs estimated in Tables 13A and 13B, health insurance issuers and TPAs would incur ongoing annual burdens and costs to update the proposed Allowed Amount File monthly. The Departments estimate that for each issuer or TPA, on average, it would require a computer systems analysts 5 hours (at $90.02 per hour), computer programmers 5 hours (at $86.14 per hour), a computer and information systems manager 1 hour (at $146.98), and an information security analyst 2 hours (at $98.52 per hour) to make the required Allowed Amount File updates. The Departments estimate that each issuer or TPA would incur a monthly burden of 13 hours with an equivalent associated cost of approximately $1,225 to update the Allowed Amount File. Assuming health insurance issuers and TPAs make changes that would require the file to be updated monthly per the requirements in these proposed rules an issuer or TPA would need to update Allowed Amount File 12 times during a given year, resulting in an ongoing annual burden of approximately 156 hours for each issuer or TPA with an equivalent associated cost of approximately $14,698. The Departments estimate the total annual hour burden for all 1,959 health insurance issuers and TPAs would be 305,604 hours with an equivalent associated cost of approximately $28,793,069. The Departments consider this estimate to be an upper-bound estimate and expect ongoing Allowed Amount File update costs to decline in succeeding years as health insurance issuers and TPAs gain efficiencies and experience in updating and managing the Allowed Amount File.

TABLE 14A—ESTIMATED ANNUAL ONGOING COST AND BURDEN PER HEALTH INSURANCE ISSUER OR TPA FOR THE OUT-OF-NETWORK ALLOWED AMOUNT FILE

Occupation	Burden hours per respondent	Labor cost per hour	Total cost per respondent
Computer and Information Systems Manager	1	$146.98	$147
Computer System Analyst	5	90.02	450
Computer Programmer	5	86.14	431
Information Security Analysts	2	98.52	197
Total per Respondent	13		1,225

TABLE 14B—ESTIMATED ANNUAL ONGOING COST AND BURDEN FOR ALL HEALTH INSURANCE ISSUERS AND TPAS FROM 2021 ONWARDS FOR THE OUT-OF-NETWORK ALLOWED AMOUNT FILE

Number of respondents	Number of responses	Burden hours per respondent	Total burden hours	Total cost
1,959	23,508	156	305,604	$28,793,069

The Departments estimate the total one-time hour burden for all health insurance issuers and TPAs of 2,527,110 hours and an equivalent associated cost of approximately $230,686,747 to develop and build the Allowed Amount File to meet the requirements of these proposed rules. In subsequent years, the Departments estimate the total annual hour burden of 305,604 hours to maintain and update the Allowed Amount File with an annual equivalent associated cost of approximately $28,793,069. The Departments estimate the average annual total hour burden,

for all health insurance issuers and TPAs, over three years, would be 1,046,106 hours with an average annual total equivalent associated cost of $96,090,961.

TABLE 15—ESTIMATED THREE YEAR AVERAGE ANNUAL HOUR BURDEN AND COSTS FOR ALL HEALTH INSURANCE ISSUERS AND TPAS TO DEVELOP AND MAINTAIN THE OUT-OF-NETWORK ALLOWED AMOUNT FILE

Year	Estimated number of health insurance issuers and TPAs	Responses	Burden per respondent (hours)	Total annual burden (hours)	Total estimated labor cost
2020	1,959	1,959	1,290	2,527,110	$230,686,747
2021	1,959	23,508	156	305,604	28,793,069
2022	1,959	23,508	156	305,604	28,793,069
3 year Average	1,959	16,325	534	1,046,106	96,090,961

The Departments solicit comment for this collection of information related to all aspects of the estimated hour burden and costs. Specifically, the Departments seek comment related to any technical or operational difficulties associated with maintaining current and up-to-date provider network information or any out-of-network allowed amounts for covered items and services. The Departments also seek comment related to the technical and labor requirements or costs that may be required to meet the requirements proposed in this rule; specifically, any factors that could minimize the frequency of updates that health insurance issuers or TPAs would be required to make to the Allowed Amount File.

The Departments solicit comment for this collection of information related to all aspects of the estimated hour burden and costs. Specifically, the Departments seek comment related to any technical or operational difficulties associated with collecting data and maintaining any out-of-network allowed amounts for covered items and services; including, any difficulties associated with the adjudication of paid claims, incorporating covered items or services furnished by a particular out-of-network provider during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file. The Departments also seek comment related to the technical and labor requirements or costs that may be required to meet the requirements proposed in this rule; specifically, any factors that could minimize the burden and costs associated with updates that health insurance issuers or TPAs would be required to make to the Allowed Amount File.

The Departments also propose that a group health plan may satisfy the proposed requirements by making available the historical amounts paid to out-of-network providers by its health insurance issuer or service provider that includes allowed amounts information on the issuer's or service provider's book of business and a plan or issuer may rely on information provided by its claims clearinghouse in aggregate. To the extent a plan or issuer is providing out-of-network historical payment information in the aggregate, the Departments further propose to apply the 10 minimum claims threshold to the aggregated claims data set, and not at the plan or issuer level.

The Departments acknowledge that as many as 95 percent of group health plans and health insurance issuers might already contract with claims clearinghouses that currently collect some or all of the information required to be disclosed under these proposed rules and might easily be able meet the requirements in these proposed rules, potentially obviating the need for the plan, issuer, or TPA to invest in IT system development. The Departments assume that these plans, issuers, and TPAs would still incur burden, albeit reduced, related to oversight and quality assurance related to any associated clearinghouse activities. The Departments seek comment on existing efficiencies, such as the use of clearinghouses that could be leveraged by plans, issuers, and TPAs related to the development and updating of the required machine-readable files and how many health insurance issuers, TPAs, or self-insured plans may already contract with clearinghouses that collect the information required and may be able to fulfill requirements in these proposed rules.

The Departments understand that plans and issuers may include ''gag clauses'' in their provider contracting agreements, which prevent disclosure of negotiated rates. The Departments seek comment on whether such agreements would need to be renegotiated to remove such clauses, and, if so, seek comment regarding any costs and burden associated with this action. In conjunction with these proposed rules, CMS is seeking an OMB control number and approval for the proposed information collection (OMB control number: 0938–NEW (Transparency in Coverage (CMS–10715)). CMS is proposing to require the following information collections to include the following burden. DOL and Treasury will submit their burden estimates upon approval.

2. ICRs Regarding Medical Loss Ratio (45 CFR 158.221)

HHS proposes to amend § 158.221 to allow issuers to include in the MLR numerator shared savings payments made to enrollees as a result of the enrollee choosing to obtain health care from a lower-cost provider. HHS does not anticipate that implementing this provision would require significant changes to the MLR annual reporting form and the associated burden. The burden related to this collection is currently approved under OMB Control Number 0938–1164 (Exp. 10/31/2020); Medical Loss Ratio Annual Reports, MLR Notices, and Recordkeeping Requirements.

3. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 16—ESTIMATED THREE YEAR AVERAGE PROPOSED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Mailing cost ($)	Total cost ($)
§§ 54.9815–2715A(b)(2)(i); 2590.715–2715A(b)(2)(i); and 147.210(b)(2)(i).	0938–NEW *	1,959	1,959	933	1,827,094	$161,494,083	$0	$161,494,083
§§ 54.9815–2715A(b)(2)(ii); 2590.715–2715A(b)(2)(ii); and 147.210(b)(2)(ii).	0938–NEW	1,306	77,400	10	19,350	678,411	35,604	714,015
§§ 54.9815–2715A(c); 2590.715–2715A(c); and 147.210(c)(1)(i).	0938–NEW	1,959	16,325	637	1,247,230	117,507,376	0	117,507,376
§§ 54.9815–2715A(c)(1)(ii); 2590.715–2715A(c)(1)(ii); and 147.210(c)(1)(ii).	0938–NEW	1,959	16,325	534	1,046,106	96,090,961	0	96,090,961
Total		.....	112,009	2,113	4,139,780	375,770,831	35,604	375,806,435

* High-end three year estimated values are represented in the table and used to determine the overall estimated three-year average.

For PRA purposes the Departments are splitting the burden; where CMS will account for 50 percent of the associated costs and burdens and the Departments of Labor and Treasury will each account for 25 percent of the associated costs and burdens. The hour burden for CMS will be 2,069,890 hours with an equivalent associated cost of approximately $187,886,416 and a cost burden of $17,802. For the Departments of Labor and Treasury, each Department will account for an hour burden of 1,034,945 hours with an equivalent associated cost of approximately $93,942,708 and a cost burden of $8,901.

B. Submission of PRA-Related Comments

The Departments have submitted a copy of these proposed rules to the OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by OMB.

Department of Health and Human Services

To obtain copies of the supporting statement and any related forms for the proposed collections discussed earlier in this preamble, please visit CMS's website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326.

The Departments invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of these proposed rules and identify the rule (CMS–9915–P), the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due January 27, 2020.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act, (5 U.S.C. 601, *et seq.*), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of proposed rules on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit 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.'' HHS uses a change in revenues of more than three to five percent as its measure of significant economic impact on a substantial number of small entities.

These proposed rules propose to require that group health plans and health insurance issuers disclose to a participant, beneficiary, or enrollee (or his or her authorized representative) such individual's cost-sharing information for covered items or services from a particular provider or providers. The Departments are of the view that these issuers generally exceed the size thresholds for ''small entities'' established by the SBA, this, the Departments are not of the view that an initial regulatory flexibility analysis is required for such firms. ERISA covered plans are often small entities. While the Departments' are of the view that these plans would rely on the larger health insurance issuers and TPAs to comply with these proposed rules, they would still experience increased costs due to the requirements as the costs are passed onto them. However, the Departments are not of the view that the additional costs meet the significant impact requirement. These assertions are discussed later in this section of the preamble. In addition, while the requirements of this proposal do not apply to providers, providers may experience a loss in revenue as a result of the demands of price sensitive consumers and plans, and because smaller issuers may be unwilling to continue paying higher rates than larger issuers for the same items and services.

The Departments are of the view that health insurance issuers would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $41.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $35 million or less.[118] The Departments are of the view that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report [119] submissions for the 2017 MLR reporting year, approximately 90 out of 500 issuers of health insurance coverage nationwide had total premium revenue of $41.5 million or less. This estimate may overstate the actual number of small health insurance companies that may be affected, since over 72 percent of these small companies belong to larger holding groups, and most, if not all, of these small companies are likely to have non-health lines of business that will result

[118] ''Table of Small Business Size Standards Matched to North American Industry Classification System Codes.'' U.S. Small Business Administration. Available at: *https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf.*

[119] ''Medical Loss Ratio Data and System Resources.'' CCIIO. Available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

in their revenues exceeding $41.5 million. The Departments are of the view that these same assumptions apply to those TPAs that would be affected by the proposed rules. The Departments do not expect any of these 90 potentially small entities to experience a change in rebates under the proposed amendments to the MLR provisions of these proposed rules in part 158. The Departments acknowledge that it may be likely that a number of small entities might enter into contracts with other entities in order to meet the requirements in the proposed rules, perhaps allowing for the development of economies of scale. Due to the lack of knowledge regarding what small entities may decide to do in order to meet these requirements and any costs they might incur related to contracts, the Departments seek comment on ways that the proposed rules will impose additional costs and burdens on small entities and how many would be likely engage in contracts to meet the requirements.

For purposes of the RFA, the Department of Labor continues to consider a small entity to be an employee benefit plan with fewer than 100 participants.[120] Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments are of the view that assessing the impact of these proposed rules on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the SBA (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631, *et seq.*). Therefore, EBSA requests comments on the appropriateness of the size standard used in evaluating the impact of these proposed rules on small entities. Using this definition of small, about 2,160,743 of the approximately 2,327,339 plans are small entities. Using a threshold approach, if the total costs of the proposed rules were spread evenly across all 1,754 issuers, 205 TPAs, and 2,327,339 ERISA health plans, without considering size, using the three-year average costs, the per-entity costs could be $159.70 ($371,990,734/2,329,298). Instead, if those costs are spread evenly across the estimated 193.5 million[121] beneficiaries, participants, or enrollees enrolled in plans or issuers required to comply with the requirements then the average cost per covered individual would be $1.92 ($371,990,734/193.5 million). Neither the cost per entity nor the cost per covered individual is a significant impact.

In addition, section 1102(b) of the SSA (42 U.S.C. 1302) requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the SSA, the Departments define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. These proposed rules would not affect small rural hospitals. Therefore, the Departments have determined that this would not have a significant impact on the operations of a substantial number of small rural hospitals.

Impact of Regulations on Small Business—Department of the Treasury

Pursuant to section 7805(f) of the Code, these proposed rules have been submitted to the Chief Counsel for Advocacy of the SBA for comment on their impact on small business.

D. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain actions before issuing a proposed rule that includes any federal mandate that may result in expenditures in any one year by a 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.

State, local, or tribal governments may incur cost to enforce some of the requirements of these proposed rules. These proposed rules include instructions for disclosures that would affect private sector firms (for example, health insurance issuers offering coverage in the individual and group markets, and TPAs providing administrative services to group health plans). The Departments acknowledge that state governments could incur costs associated with enforcement of sections within these proposed rules and although the Departments have not been able to quantify all costs, the Departments expect the combined impact on state, local, or Tribal governments and the private sector to be below the threshold.

E. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct costs on state and local governments, preempts state law, or otherwise has federalism implications. Federal agencies promulgating regulations that have 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 regulation.

In the Departments' view, these proposed rules may have federalism implications, because it would have direct effects on the states, the relationship between national governments and states, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers.

Under these proposed rules, all group health plans and health insurance issuers, including self-insured, non-federal governmental group health plans as defined in section 2791 of the PHS Act, would be required to develop an internet-based online tool or non-internet disclosure method to disclose to a participant, beneficiary, or enrollee (or an authorized representative on behalf of such individual), the consumer-specific estimated cost-sharing liability for covered items or services from a particular provider. These proposed rules also include proposals to require plans and issuers to disclose provider negotiated rates and historical data on out-of-network allowed amounts through a digital file in a machine-readable format posted publicly on an internet website. Such federal standards developed under section 2715A of the PHS Act would preempt any related state standards that require pricing information to be disclosed to the participant, beneficiary, or enrollee, or otherwise publicly disclosed to the extent the state disclosure requirements would provide less information to the consumer or the public than what is required under this

[120] The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants.

[121] EBSA estimates that in 2016 there were 135.7 million covered individuals with private sector and 44.1 million with public sector employer sponsored coverage (available at: *https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf*). Kaiser Family Foundation reports 13.7 million enrollees in the individual market for the first quarter of 2019 (available at: *https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/*).

rule and the statutory authority under which it is promulgated.

The Departments are of the view that these proposed rules may have federalism implications based on the required disclosure of pricing information, as the Departments are aware of at least 28 states that have passed some form of price-transparency legislation.[122] Under these state provisions, state requirements vary broadly in terms of the level of disclosure required,[123] some states list the price for each individual service, whereas some states list the aggregate costs across providers and over time to measure the price associated with an episode of illness. States also differ in terms of the dissemination of the information. For example, California mandates that uninsured patients receive estimated prices on request. In contrast, other states use websites or software applications (or apps) that allow consumers to compare prices across providers. Still, only seven states have published the pricing information of health insurance issuers on consumer-facing public websites.[124] Thus, to the extent the disclosure provision these proposed rules required additional information to be disclosed, this proposed rule would require a higher level of disclosure by plans and issuers.

In general, through section 514, ERISA supersedes state laws to the extent that they relate to any covered employee benefit plan, and preserves state laws that regulate insurance, banking, or securities. While ERISA prohibits states from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of PPACA) are not to be ''construed to supersede any provision of states law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a ''requirement'' of a federal standard. The conference report accompanying HIPAA indicates that this is intended to be the ''narrowest'' preemption of states laws (See House Conf. Rep. No. 104– 736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018). States may continue to apply state law requirements to health insurance issuers except to the extent that such requirements prevent the application of PPACA requirements that are the subject of this rulemaking. Accordingly, states have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, the Departments have engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state insurance officials on an individual basis. It is expected that the Departments act in a similar fashion in enforcing PPACA, including the provisions of section 2715A of the PHS Act. While developing this rule, the Departments attempted to balance the states' interests in regulating health insurance issuers with Congress' intent to provide an improved level of price transparency to consumers in every state. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this proposed rule, the Departments certify that the Department of Treasury, Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached proposed rule in a meaningful and timely manner.

F. Congressional Review Act

These proposed rules are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to the Congress and the Comptroller for review.

G. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise issues, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.

The designation of this rule, if finalized, would be informed by public comments received; however, these proposed rules, if finalized as proposed, would be an E.O. 13771 regulatory action.[125]

IX. Statutory Authority

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1135, 1185d and 1191c; and Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are proposed to be adopted pursuant to the authority contained in sections 2701 through 2763, 2791, 2792 and 2794 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 and 300gg–94), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance,

[122] ''Transparency and disclosure of health costs and provider payments: state actions.'' National Conference of State Legislatures. March 2017. Available at: *http://www.ncsl.org/reserach/health/transparency-and-disclosure-health-costs.aspx.*

[123] Mehrotra, A., Chernew, M., Sinaiko, A. ''Promise and Reality of Price Transparency.'' 14 N. Engl. J. Med. 378. April 5, 2018. Available at: *https://www.nejm.org/doi/full/10.1056/NEJMhpr1715229.*

[124] Evans, M. ''One State's Effort to Publicize Hospital Prices Brings Mixed Results.'' Wall Street Journal. June 26, 2019. Available at: *https://www.wsj.com/articles/one-states-effort-to-publicize-hospital-prices-brings-mixed-results-11561555562.*

[125] The Departments estimate cost of approximately $877.31 million in 2020 and annual cost of approximately $127.55 million thereafter. Thus the annualized value of cost, as of 2016 and calculated over a perpetual time horizon with a 7 percent discount rate, is $128.86 million.

Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

Sunita Lough,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed at Washington, DC, this 12th day of November, 2019.

Preston Rutledge,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: November 5, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 7, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 is amended by adding an entry for § 54.9815–2715A in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.9815–2715A is also issued under 26 U.S.C. 9833;

* * * * *

■ **Par. 2.** Section 54.9815–2715A is added to read as follows:

§ 54.9815–2715A Transparency in coverage.

(a) *Scope and definitions*—(1) *Scope.* This section establishes price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage for the timely disclosure of information about costs related to covered items and services under a group health plan or health insurance coverage.

(2) *Definitions.* For purposes of this section, the following definitions apply:

(i) *Accumulated amounts* means:

(A) The amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, either with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other-than-self-only coverage, these accumulated amounts would include the financial responsibility a participant or beneficiary has incurred toward meeting his or her individual deductible and/or out-of-pocket limit, as well as the amount of financial responsibility that the individuals enrolled under the plan or coverage have incurred toward meeting the other-than-self-only deductible and/or out-of-pocket limit, as applicable. Accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but excludes any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket expense for out-of-network services, or amount for items or services not covered under the group health plan or health insurance coverage); and

(B) To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant or beneficiary has used).

(ii) *Beneficiary* has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

(iii) *Billing code* means the code used by a group health plan or health insurance issuer or its in-network providers to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.

(iv) *Bundled payment* means a payment model under which a provider is paid a single payment for all covered items and services provided to a patient for a specific treatment or procedure.

(v) *Cost-sharing liability* means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing liability generally includes deductibles, coinsurance, and copayments, but it does not include premiums, balance billing amounts for out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

(vi) *Cost-sharing information* means information related to any expenditure required by or on behalf of a participant or beneficiary with respect to health care benefits that are relevant to a determination of a participant's or beneficiary's out-of-pocket costs for a particular health care item or service.

(vii) *Covered items or services* means those items or services for which the costs are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.

(viii) *In-network provider* means a provider that is a member of the network of contracted providers established or recognized under a participant's or beneficiary's group health plan or health insurance coverage.

(ix) *Items or services* means all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees), for which a provider charges a patient in connection with the provision of health care.

(x) *Machine-readable file* means a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.

(xi) *Negotiated rate* means the amount a group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer, has contractually agreed to pay an in-network provider for covered items and services, pursuant to the terms of an agreement between the provider and the group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer.

(xii) *Out-of-network allowed amount* means the maximum amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider.

(xiii) *Out-of-network provider* means a provider that does not have a contract under a participant's or beneficiary's group health plan or health insurance coverage to provide items or services.

(xiv) *Out-of-pocket limit* means the maximum amount that a participant or beneficiary is required to pay during a

coverage period for his or her share of the costs of covered items and services under his or her group health plan or health insurance coverage, including for self-only and other-than-self-only coverage, as applicable.

(xv) *Participant* has the meaning given the term under section 3(7) of ERISA.

(xvi) *Plain language* means written and presented in a manner calculated to be understood by the average participant or beneficiary.

(xvii) *Prerequisite* means certain requirements relating to medical management techniques for covered items and services that must be satisfied before a group health plan or health insurance issuer will cover the item or service. Prerequisites include concurrent review, prior authorization, and step-therapy or fail-first protocols. The term prerequisite does not include medical necessity determinations generally or other forms of medical management techniques.

(b) *Required disclosures to participants or beneficiaries.* At the request of a participant or beneficiary (or his or her authorized representative), a group health plan or health insurance issuer offering group or individual health insurance coverage must provide to the participant or beneficiary (or his or her authorized representative) the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section.

(1) *Required cost-sharing information.* The information required under this paragraph (b)(1) is the following cost-sharing information, which is accurate at the time the request is made, with respect to a covered item or service and a particular provider or providers, to the extent relevant to the participant's or beneficiary's cost-sharing liability:

(i) An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service provided by a provider or providers that is calculated based on the information described in paragraphs (b)(1)(ii) through (iv) of this section;

(ii) Accumulated amounts the participant or beneficiary has incurred to date;

(iii) Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service;

(iv) Out-of-network allowed amount for the requested covered item or service, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider;

(v) If a participant or beneficiary requests information for an item or service subject to a bundled payment arrangement that includes the provision of multiple covered items and services, a list of the items and services for which cost-sharing information is being disclosed;

(vi) If applicable, notification that coverage of a specific item or service is subject to a prerequisite; and,

(vii) A notice that includes the following information in plain language:

(A) A statement that out-of-network providers may bill participants or beneficiaries for the difference between a provider's bill charges and the sum of the amount collected from the group health plan or health insurance issuer and from the patient in the form of a copayment or coinsurance amount (the difference referred to as balance billing), and that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for these potential additional amounts;

(B) A statement that the actual charges for a participant's or beneficiary's covered item or service may be different from an estimate of cost-sharing liability provided pursuant to paragraph (b)(1)(i) of this section, depending on the actual items or services the participant or beneficiary receives at the point of care;

(C) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service; and

(D) Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this paragraph (b)(1).

(2) *Required methods and formats for disclosing information to participants or beneficiaries (or their authorized representatives).* The methods and formats for the disclosure required under this paragraph (b) are as follows:

(i) *Internet-based self-service tool.* Information provided under this paragraph (b) must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool allows users to:

(A) Search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

(*1*) A billing code (such as CPT code 87804) or a descriptive term (such as ''rapid flu test''), at the option of the user;

(*2*) The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and

(*3*) Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

(B) Search for an out-of-network allowed amount for a covered item or service provided by out-of-network providers by inputting:

(*1*) A billing code or descriptive term, at the option of the user; and

(*2*) Other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount (such as the location in which the covered item or service will be sought or provided).

(C) Refine and reorder search results based on geographic proximity of providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary (or his or her authorized representative). The group health plan or health insurance issuer is required to:

(A) Provide the cost-sharing information in paper form pursuant to the individual's request, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section; and

(B) Mail the cost-sharing information no later than 2 business days after an individual's request is received.

(3) *Special rule to prevent unnecessary duplication with respect to group health coverage.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan,

violates the transparency disclosure requirements of this paragraph (b).

(c) *Requirements for public disclosure of in-network provider negotiated rates and out-of-network allowed amounts for covered items and services.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraph (c)(1) of this section in two machine-readable files in accordance with the method and format requirements described in paragraph (c)(2) of this section and updated as required under paragraph (c)(3) of this section.

(1) *Required information.* Machine-readable files required under this paragraph (c) that are made available to the public by a group health plan or health insurance issuer must include:

(i) Negotiated rate machine-readable file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Negotiated rates that are:

(*1*) Reflected as dollar amounts, with respect to each covered item or service under the plan or coverage that is furnished by an in-network provider;

(*2*) Associated with the National Provider Identifier (NPI) for each in-network provider; and

(*3*) Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.

(ii) Out-of-network allowed amount file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Unique out-of-network allowed amounts with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this paragraph (c)(1)(ii)(C) would require the group health plan or health insurance issuer to report payment of out-of-network allowed amounts in connection with fewer than 10 different claims for payments). Consistent with paragraph (d)(3) of this section, nothing in this paragraph (c)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service under the plan or coverage that is furnished by an out-of-network provider; and

(*2*) Associated with the National Provider Identifier (NPI) for each out-of-network provider.

(2) *Required method and format for disclosing information to the public.* The machine-readable files that must be made available under paragraph (c) of this section in a form and manner determined by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. The first machine-readable file must include information regarding rates negotiated for in-network providers with each of the required elements described in paragraph (c)(1)(i) of this section. The second machine-readable file must include information related to the historical data showing allowed amounts for covered items and services furnished by out-of-network providers and include the required elements described in paragraph (c)(1)(ii) of this section. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

(3) *Timing.* A group health plan or health insurance issuer must update the machine-readable files and information required by this paragraph (c) monthly. The group health plan or health insurance issuer must clearly indicate the date that the files were most recently updated.

(4) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (c) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (c) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (c).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (c) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (c) in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (c), the group health plan or health insurance issuer violates the transparency disclosure requirements of this paragraph (c).

(iii) *Aggregation permitted for out-of-network allowed amounts.* Nothing in this section prohibits a group health plan or health insurance issuer from satisfying the disclosure requirement described in paragraph (c)(1)(ii) of this section by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, a health insurance issuer, a service provider, or other party with which the plan or issuer has entered into a written agreement to provide the information. Under such circumstances, health insurance issuers, service providers, or other parties with which the group health plan or health insurance issuer has contracted may aggregate out-of-network allowed amounts for more than one group health plan or insurance policy or contract.

(d) *Applicability.* (1) The provisions of this section apply for plan years beginning on or after [1 year after effective date of the final rule]. As provided under § 54.9815–1251, this section does not apply to grandfathered health plans.

(2) This section does not apply to health reimbursement arrangements or other account-based group health plans defined in § 54.9815–2711(d)(6).

(3) Nothing in the section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant or beneficiary information held by group health plans and health insurance issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) or (c) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 3. 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; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 4. Section 2590.715–2715A is added to read as follows:

§ 2590.715–2715A Transparency in coverage.

(a) *Scope and definitions*—(1) *Scope.* This section establishes price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage for the timely disclosure of information about costs related to covered items and services under a group health plan or health insurance coverage.

(2) *Definitions.* For purposes of this section, the following definitions apply:

(i) *Accumulated amounts* means:

(A) The amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, either with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other-than-self-only coverage, these accumulated amounts would include the financial responsibility a participant or beneficiary has incurred toward meeting his or her individual deductible and/or out-of-pocket limit, as well as the amount of financial responsibility that has been incurred toward meeting the other-than-self-only deductible and/or out-of-pocket limit, as applicable. Accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but excludes any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket expense for out-of-network services, or amount for items or services not covered under the group health plan or health insurance coverage); and

(B) To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant or beneficiary has used).

(ii) *Billing code* means the code used by a group health plan or health insurance issuer or its in-network providers to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.

(iii) *Bundled payment* means a payment model under which a provider is paid a single payment for all covered items and services provided to a patient for a specific treatment or procedure.

(iv) *Cost-sharing liability* means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing liability generally includes deductibles, coinsurance, and copayments, but it does not include premiums, balance billing amounts for out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

(v) *Cost-sharing information* means information related to any expenditure required by or on behalf of a participant or beneficiary with respect to health care benefits that are relevant to a determination of a participant's or beneficiary's out-of-pocket costs for a particular health care item or service.

(vi) *Covered items or services* means those items or services for which the costs are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.

(vii) *In-network provider* means a provider that is a member of the network of contracted providers established or recognized under a participant's or beneficiary's group health plan or health insurance coverage.

(viii) *Items or services* means all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees), for which a provider charges a patient in connection with the provision of health care.

(ix) *Machine-readable file* means a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.

(x) *Negotiated rate* means the amount a group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer, has contractually agreed to pay an in-network provider for covered items and services, pursuant to the terms of an agreement between the provider and the group health plan or health insurance issuer, or a third-party on behalf of a group health plan or health insurance issuer.

(xi) *Out-of-network allowed amount* means the maximum amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider.

(xii) *Out-of-network provider* means a provider that does not have a contract under a participant's or beneficiary's group health plan or health insurance coverage to provide items or services.

(xiii) *Out-of-pocket limit* means the maximum amount that a participant or beneficiary is required to pay during a coverage period for his or her share of the costs of covered items and services under his or her group health plan or health insurance coverage, including for self-only and other-than-self-only coverage, as applicable.

(xiv) *Plain language* means written and presented in a manner calculated to be understood by the average participant or beneficiary.

(xv) *Prerequisite* means certain requirements relating to medical management techniques for covered items and services that must be satisfied before a group health plan or health insurance issuer will cover the item or service. Prerequisites include concurrent review, prior authorization, and step-therapy or fail-first protocols. The term prerequisite does not include medical necessity determinations generally or other forms of medical management techniques.

(b) *Required disclosures to participants or beneficiaries.* At the request of a participant or beneficiary (or his or her authorized representative), a group health plan or health insurance issuer offering group coverage must provide to a participant or beneficiary (or his or her authorized representative) the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section.

(1) *Required cost-sharing information.* The information required under this paragraph (b)(1) is the following cost-sharing information, which is accurate at the time the request is made, with respect to a covered item or service and a particular provider or providers, to the extent relevant to the participant's or beneficiary's cost-sharing liability:

(i) An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service provided by a provider or providers that is calculated based on the information described in paragraphs (b)(1)(ii) through (iv) of this section;

(ii) Accumulated amounts the participant or beneficiary has incurred to date;

(iii) Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service;

(iv) Out-of-network allowed amount for the requested covered item or service, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider;

(v) If a participant or beneficiary requests information for an item or service subject to a bundled payment arrangement that includes the provision of multiple covered items and services, a list of the items and services for which cost-sharing information is being disclosed;

(vi) If applicable, notification that coverage of a specific item or service is subject to a prerequisite; and,

(vii) A notice that includes the following information in plain language:

(A) A statement that out-of-network providers may bill participants or beneficiaries for the difference between a provider's bill charges and the sum of the amount collected from the group health plan or health insurance issuer and from the patient in the form of a copayment or coinsurance amount (the difference referred to as balance billing), and that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for these potential additional amounts;

(B) A statement that the actual charges for a participant's or beneficiary's covered item or service may be different from an estimate of cost-sharing liability provided pursuant to paragraph (b)(1)(i) of this section, depending on the actual items or services the participant or beneficiary receives at the point of care;

(C) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service; and

(D) Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this paragraph (b)(1).

(2) *Required methods and formats for disclosing information to participants or beneficiaries (or his or her authorized representative).* The methods and formats for the disclosure required under this paragraph (b) are as follows:

(i) *Internet-based self-service tool.* Information provided under this paragraph (b) must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool allows users to:

(A) Search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

(*1*) A billing code (such as CPT code 87804) or a descriptive term (such as ''rapid flu test''), at the option of the user;

(*2*) The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and

(*3*) Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

(B) Search for an out-of-network allowed amount for a covered item or service provided by out-of-network providers by inputting:

(*1*) A billing code or descriptive term; and

(*2*) Other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount (such as the location in which the covered item or service will be sought or provided).

(C) Refine and reorder search results based on geographic proximity of providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary. The group health plan or health insurance issuer is required to:

(A) Provide the cost-sharing information in paper form pursuant to the individual's request, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section; and

(B) Mail the cost-sharing information no later than 2 business days after an individual's request is received.

(3) *Special rule to prevent unnecessary duplication with respect to group health coverage.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide

the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(c) *Requirements for public disclosure of in-network provider negotiated rates and out-of-network allowed amounts for covered items and services.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraph (c)(1) of this section in two machine-readable files in accordance with the method and format requirements described in paragraph (c)(2) of this section and updated as required under paragraph (c)(3) of this section.

(1) *Required information.* Machine-readable files required under this paragraph (c) that are made available to the public by a group health plan or health insurance issuer must include:

(i) Negotiated rate machine-readable file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Negotiated rates that are:

(*1*) Reflected as dollar amounts, with respect to each covered item or service under the plan or coverage that is furnished by an in-network provider;

(*2*) Associated with the National Provider Identifier (NPI) for each in-network provider; and

(*3*) Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.

(ii) Out-of-network allowed amount file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Unique out-of-network allowed amounts with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this paragraph (c)(1)(ii)(C) would require the group health plan or health insurance issuer to report payment of out-of-network allowed amounts in connection with fewer than 10 different claims for payments. Consistent with paragraph (d)(3) of this section, nothing in this paragraph (c)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service under the plan or coverage that is furnished by an out-of-network provider; and

(*2*) Associated with the National Provider Identifier (NPI) for each out-of-network provider.

(2) *Required method and format for disclosing information to the public.* The machine-readable files that must be made available under paragraph (c) of this section in a form and manner determined by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. The first machine-readable file must include information regarding rates negotiated for in-network providers with each of the required elements described in paragraph (c)(1)(i) of this section. The second machine-readable file must include information related to the historical data showing allowed amounts for covered items and services furnished by out-of-network providers and include the required elements described in paragraph (c)(1)(ii) of this section. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

(3) *Timing.* A group health plan or health insurance issuer must update the machine-readable files and information required by this paragraph (c) monthly. The group health plan or health insurance issuer must clearly indicate the date that the files were most recently updated.

(4) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (c) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (c) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (c).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (c) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (c) in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (c), the group health plan or health insurance issuer violates the transparency disclosure requirements of this paragraph (c).

(iii) *Aggregation permitted for out-of-network allowed amounts.* Nothing in this section prohibits a group health plan or health insurance issuer from satisfying the disclosure requirement described in paragraph (c)(1)(ii) of this section by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, a health insurance issuer, a service provider, or other party with which the plan or issuer has entered into a written agreement to provide the information. Under such circumstances, health insurance issuers, service providers, or other parties with which the group health plan or health insurance issuer has contracted may aggregate out-of-network allowed amounts for more than one group health plan or insurance policy or contract.

(d) *Applicability.* (1) The provisions of this section apply for plan years beginning on or after [1 year after effective date of the final rule]. As provided under § 2590.715–1251, this section does not apply to grandfathered health plans.

(2) This section does not apply to health reimbursement arrangements or other account-based group health plans defined in § 2590.715–2711(d)(6).

(3) Nothing in the section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant or beneficiary information held by group health plans and health insurance issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) or (c) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 147 and 158 as set forth below:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 5. The authority citation for part 147 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.

■ 6. Section 147.210 is added to read as follows:

§ 147.210 Transparency in coverage.

(a) *Scope and definitions*—(1) *Scope.* This section establishes price transparency requirements for group health plans and health insurance issuers in the individual and group markets for the timely disclosure of information about costs related to covered items and services under a group health plan or health insurance coverage.

(2) *Definitions.* For purposes of this section, the following definitions apply:

(i) *Accumulated amounts* means:

(A) The amount of financial responsibility a participant, beneficiary, or enrollee has incurred at the time a request for cost-sharing information is made, either with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other-than-self-only coverage, these accumulated amounts would include the financial responsibility a participant, beneficiary, or enrollee has incurred toward meeting his or her individual deductible and/or out-of-pocket limit, as well as the amount of financial responsibility that the individuals enrolled under the plan or coverage have incurred toward meeting the other-than-self-only deductible and/or out-of-pocket limit, as applicable. Accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but excludes any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket expense for out-of-network services, or amount for items or services not covered under the group health plan or health insurance coverage); and

(B) To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant, beneficiary, or enrollee has used).

(ii) *Beneficiary* has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

(iii) *Billing code* means the code used by a group health plan or health insurance issuer or its in-network providers to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.

(iv) *Bundled payment* means a payment model under which a provider is paid a single payment for all covered items and services provided to a patient for a specific treatment or procedure.

(v) *Cost-sharing liability* means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing liability generally includes deductibles, coinsurance, and copayments, but it does not include premiums, balance billing amounts for out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

(vi) *Cost-sharing information* means information related to any expenditure required by or on behalf of a participant, beneficiary, or enrollee with respect to health care benefits that are relevant to a determination of a participant's, beneficiary's, or enrollee's out-of-pocket costs for a particular health care item or service.

(vii) *Covered items or services* means those items or services for which the costs are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.

(viii) *Enrollee* means an individual who is covered under an individual health insurance policy as defined under section 2791(b)(5) of the PHS Act.

(ix) *In-network provider* means a provider that is a member of the network of contracted providers established or recognized under a participant's, beneficiary's, or enrollee's group health plan or health insurance coverage.

(x) *Items or services* means all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees), for which a provider charges a patient in connection with the provision of health care.

(xi) *Machine-readable file* means a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.

(xii) *Negotiated rate* means the amount a group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer, has contractually agreed to pay an in-network provider for covered items and services, pursuant to the terms of an agreement between the provider and the group health plan or health insurance issuer, or a third-party on behalf of a group health plan or health insurance issuer.

(xiii) *Out-of-network allowed amount* means the maximum amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider.

(xiv) *Out-of-network provider* means a provider that does not have a contract under a participant's, beneficiary's, or enrollee's group health plan or health insurance coverage to provide items or services.

(xv) *Out-of-pocket limit* means the maximum amount that a participant, beneficiary, or enrollee is required to pay during a coverage period for his or her share of the costs of covered items and services under his or her group health plan or health insurance coverage, including for self-only and other-than-self-only coverage, as applicable.

(xvi) *Participant* has the meaning given the term under section 3(7) of ERISA.

(xvii) *Plain language* means written and presented in a manner calculated to be understood by the average participant, beneficiary, or enrollee.

(xviii) *Prerequisite* means certain requirements relating to medical management techniques for covered items and services that must be satisfied before a group health plan or health insurance issuer will cover the item or service. Prerequisites include concurrent review, prior authorization, and step-therapy or fail-first protocols. The term prerequisite does not include medical necessity determinations generally or other forms of medical management techniques.

(xix) *Qualified Health Plan* (QHP) has the meaning given the term in 42 U.S.C. 18021.

(b) *Required disclosures to participants, beneficiaries, or enrollees.* At the request of a participant, beneficiary, or enrollee (or his or her authorized representative), a group health plan or health insurance issuer offering group or individual health insurance coverage must provide to the participant, beneficiary, or enrollee (or his or her authorized representative) the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section.

(1) *Required cost-sharing information.* The information required under this paragraph (b)(1) is the following cost-sharing information, which is accurate at the time the request is made, with respect to a covered item or service and a particular provider or providers, to the extent relevant to the participant's, beneficiary's, or enrollee's cost-sharing liability:

(i) An estimate of the participant's, beneficiary's, or enrollee's cost-sharing liability for a requested covered item or service provided by a provider or providers which must reflect any cost-sharing reductions the enrollee would receive that is calculated based on the information described in paragraphs (b)(1)(ii) through (iv) of this section;

(ii) Accumulated amounts the participant, beneficiary, or enrollee has incurred to date;

(iii) Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service;

(iv) Out-of-network allowed amount for the requested covered item or service, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider;

(v) If a participant, beneficiary, or enrollee requests information for an item or service subject to a bundled payment arrangement that includes the provision of multiple covered items and services, a list of the items and services for which cost-sharing information is being disclosed;

(vi) If applicable, notification that coverage of a specific item or service is subject to a prerequisite; and,

(vii) A notice that includes the following information in plain language:

(A) A statement that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between a provider's bill charges and the sum of the amount collected from the group health plan or health insurance issuer and from the patient in the form of a copayment or coinsurance amount (the difference referred to as balance billing), and that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for these potential additional amounts;

(B) A statement that the actual charges for a participant's, beneficiary's, or enrollee's covered item or service may be different from an estimate of cost-sharing liability provided pursuant to paragraph (b)(1)(i) of this section, depending on the actual items or services the participant, beneficiary, or enrollee receives at the point of care;

(C) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service; and

(D) Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this paragraph (b)(1).

(2) *Required methods and formats for disclosing information to participants, beneficiaries, or enrollees (or their authorized representative).* The methods and formats for the disclosure required under this paragraph (b) are as follows:

(i) *internet-based self-service tool.* Information provided under this paragraph (b) must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool allows users to:

(A) Search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

(*1*) A billing code (such as CPT code 87804) or a descriptive term (such as ''rapid flu test''), at the option of the user;

(*2*) The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and

(*3*) Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

(B) Search for an out-of-network allowed amount for a covered item or service provided by out-of-network providers by inputting:

(*1*) A billing code or descriptive term, at the option of the user; and

(*2*) Other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount (such as the location in which the covered item or service will be sought or provided).

(C) Refine and reorder search results based on geographic proximity of providers, and the amount of the participant's, beneficiary's, or enrollee's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for

covered items or services returns multiple results.

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant, beneficiary, or enrollee (or his or her authorized representative). The group health plan or health insurance issuer is required to:

(A) Provide the cost-sharing information in paper form pursuant to the individual's request, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section; and

(B) Mail the cost-sharing information no later than 2 business days after an individual's request is received.

(3) *Special rule to prevent unnecessary duplication with respect to group health coverage.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(c) *Requirements for public disclosure of in-network provider negotiated rates and out-of-network allowed amounts for covered items and services.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraph (c)(1) of this section in two machine-readable files in accordance with the method and format requirements described in paragraph (c)(2) of this section and updated as required under paragraph (c)(3) of this section.

(1) *Required information.* Machine-readable files required under this paragraph (c) that are made available to the public by a group health plan or health insurance issuer must include:

(i) Negotiated rate machine-readable file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Negotiated rates that are:

(*1*) Reflected as dollar amounts, with respect to each covered item or service under the plan or coverage that is furnished by an in-network provider;

(*2*) Associated with the National Provider Identifier (NPI) for each in-network provider; and

(*3*) Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.

(ii) Out-of-network allowed amount file:

(A) The name and Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan;

(B) A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code; and

(C) Unique out-of-network allowed amounts with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this paragraph (c)(1)(ii)(C) would require the group health plan or health insurance issuer to report payment of out-of-network allowed amounts in connection with fewer than 10 different claims for payments. Consistent with paragraph (d)(3) of this section, nothing in this paragraph (c)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service under the plan or coverage that is furnished by an out-of-network provider; and

(*2*) Associated with the National Provider Identifier (NPI) for each out-of-network provider.

(2) *Required method and format for disclosing information to the public.* The machine-readable files that must be made available under paragraph (c) of this section in a form and manner determined by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. The first machine-readable file must include information regarding rates negotiated for in-network providers with each of the required elements described in paragraph (c)(1)(i) of this section. The second machine-readable file must include information related to the historical data showing allowed amounts for covered items and services furnished by out-of-network providers and include the required elements described in paragraph (c)(1)(ii) of this section. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

(3) *Timing.* A group health plan or health insurance issuer must update the machine-readable files and information required by this paragraph (c) monthly. The group health plan or health insurance issuer must clearly indicate the date that the files were most recently updated.

(4) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (c) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (c) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (c).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (c) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (c) in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide

the information in compliance with this paragraph (c), the group health plan or health insurance issuer violates the transparency disclosure requirements of this paragraph (c).

(iii) *Aggregation permitted for out-of-network allowed amounts.* Nothing in this section prohibits a group health plan or health insurance issuer from satisfying the disclosure requirement described in paragraph (c)(1)(ii) of this section by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, a health insurance issuer, a service provider, or other party with which the plan or issuer has entered into a written agreement to provide the information. Under such circumstances, health insurance issuers, service providers, or other parties with which the group health plan or health insurance issuer has contracted may aggregate out-of-network allowed amounts for more than one group health plan or insurance policy or contract.

(d) *Applicability.* (1) The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after [1 year after effective date of the final rule]. As provided under § 147.140, this section does not apply to grandfathered health plans.

(2) This section does not apply to health reimbursement arrangements or other account-based group health plans defined in § 147.126(d)(6).

(3) Nothing in the section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant, beneficiary, or enrollee information held by group health plans and health insurance issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) or (c) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 7. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended.

■ 8. Section 158.221 is amended by adding paragraph (b)(9) to read as follows:

§ 158.221 Formula for calculating an issuer's medical loss ratio.

* * * * *

(b) * * *

(9) Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR any shared savings payments the issuer has made to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider.

* * * * *

[FR Doc. 2019–25011 Filed 11–15–19; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subchapter E

[CMS–1717–F2]

RIN 0938–AU22

Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule establishes requirements for hospitals operating in the United States to establish, update, and make public a list of their standard charges for the items and services that they provide. These actions are necessary to promote price transparency in health care and public access to hospital standard charges. By disclosing hospital standard charges, we believe the public (including patients, employers, clinicians, and other third parties) will have the information necessary to make more informed decisions about their care. We believe the impact of these final policies will help to increase market competition, and ultimately drive down the cost of health care services, making them more affordable for all patients.

DATES: This final rule is effective on January 1, 2021.

FOR FURTHER INFORMATION CONTACT:

Price Transparency of Hospital Standard Charges, contact Dr. Terri Postma or Elizabeth November, (410) 786–8465 or via email at *PriceTransparencyHospitalCharges@cms.hhs.gov.*

Quality Measurement Relating to Price Transparency, contact Dr. Reena Duseja or Dr. Terri Postma via email at *PriceTransparencyHospitalCharges@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov/.* Follow the search instructions on that website to view public comments.

Current Procedural Terminology (CPT) Copyright Notice

Throughout this final rule, we use CPT codes and descriptions to refer to a variety of services. We note that CPT codes and descriptions are copyright 2018 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.

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Regulation Text

I. Summary and Background

A. Executive Summary

1. Purpose

In this final rule, we establish requirements for all hospitals (including hospitals not paid under the Medicare Outpatient Prospective Payment System (OPPS)) in the United States for making hospital standard charges available to the public pursuant to section 2718(e) of the PHS Act, as well as an enforcement scheme under section 2718(b)(3) of the PHS Act to enforce those requirements. These requirements, as well as the enforcement scheme, are additionally authorized by section 1102(a) of the Social Security Act.

This final rule also addresses comments we received on our proposals to implement section 2718(b) and (e), as well as a request for information on quality measurement relating to price transparency included in the ''Medicare Program; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals'' (84 FR 39398 through 39644), herein referred to as the ''CY 2020 OPPS/ASC proposed rule,'' which was displayed in the **Federal Register** on July 29, 2019, with a comment period that ended on September 27, 2019.

The final rule with comment period titled ''Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity to Apply for Available Slots,'' referred to hereinafter as the ''CY 2020 OPPS/ASC final rule with comment period,'' was displayed in the **Federal Register** on November 1, 2019. In that final rule with comment period, we explained our intent to summarize and respond to public comments on the proposed requirements for hospitals to make public their standard charges in a forthcoming final rule. This final rule is being published as a supplement to the CY 2020 OPPS/ASC final rule with comment period.

2. Summary of the Major Provisions

We are adding a new Part 180—Hospital Price Transparency to Title 45 of the Code of Federal Regulations (CFR) that will codify our regulations on price transparency that implement section

2718(e) of the PHS Act. In this final rule, we are finalizing the following policies: (1) A definition of ''hospital''; (2) definitions for five types of ''standard charges'' (specifically, gross charges and payer-specific negotiated charges, as proposed, plus the discounted cash price, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge) that hospitals would be required to make public; (3) a definition of hospital ''items and services'' that would include all items and services (both individual and packaged) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit; (4) federally owned/operated facilities are deemed to have met all requirements; (5) requirements for making public a machine-readable file that contains a hospital's gross charges and payer-specific negotiated charges, as proposed, plus discounted cash prices, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge for all items and services provided by the hospital; (6) requirements for making public payer-specific negotiated charges, as proposed, plus discounted cash prices, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge, for 300 ''shoppable'' services that are displayed and packaged in a consumer-friendly manner, plus a policy to deem hospitals that offer internet-based price estimator tools as having met this requirement; (7) monitoring hospital noncompliance with requirements for publicly disclosing standard charges; (8) actions that would address hospital noncompliance, which include issuing a written warning notice, requesting a corrective action plan (CAP), and imposing civil monetary penalties (CMPs) on noncompliant hospitals and publicizing these penalties on a CMS website; and (9) appeals of CMPs.

3. Summary of Costs and Benefits

We estimate the total burden for hospitals to review and post their standard charges for the first year to be 150 hours per hospital at $11,898.60 per hospital for a total burden of 900,300 hours (150 hours × 6,002 hospitals) and total cost of $71,415,397 ($11,898.60 × 6,002 hospitals), as discussed in section V of this final rule. We estimate the total annual burden for hospitals to review and post their standard charges for subsequent years to be 46 hours per hospital at $3,610.88 per hospital for a total annual burden for subsequent years of 276,092 hours (46 hours × 6,002 hospitals) and total annual cost of $21,672,502 ($3,610.88 × 6,002 hospitals).

B. Statutory Basis and Current Guidance

Section 1001 of the Patient Protection and Affordable Care Act (ACA) (Pub. L. 111–148), as amended by section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), amended Title XXVII of the PHS Act, in part, by adding a new section 2718(e) of the PHS Act. Section 2718 of the PHS Act, entitled ''Bringing Down the Cost of Health Care Coverage,'' requires each hospital operating within the United States for each year to establish (and update) and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis related groups (DRGs) established under section 1886(d)(4) of the Social Security Act (SSA).

In the FY 2015 inpatient prospective payment system (IPPS)/long-term care hospital (LTCH) prospective payment system (PPS) proposed and final rules (79 FR 28169 and 79 FR 50146, respectively), we reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the PHS Act and provided guidelines for its implementation. At that time, we required hospitals to either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry. In addition, we stated that we expected hospitals to update the information at least annually, or more often as appropriate, to reflect current charges. We also encouraged hospitals to undertake efforts to engage in consumer-friendly communication of their charges to enable consumers to compare charges for similar services across hospitals and to help consumers understand what their potential financial liability might be for items and services they obtain at the hospital.

In the FY 2019 IPPS/LTCH PPS proposed rule and final rule (83 FR 20164 and 83 FR 41144, respectively), we again reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the PHS Act and updated our guidelines for its implementation. The announced update to our guidelines became effective January 1, 2019, and took one step to further improve the public accessibility of standard charge information. Specifically, we updated our guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually, or more often as appropriate. We subsequently published two sets of Frequently Asked Questions (FAQs) [1] that provided additional guidance to hospitals, including a FAQ clarifying that while hospitals could choose the format they would use to make public a list of their standard charges, the publicly posted information should represent their standard charges as reflected in the hospital's chargemaster. We also clarified that the requirement applies to all hospitals operating within the United States and to all items and services provided by the hospital.

II. Requirements for Hospitals To Make Public a List of Their Standard Charges

A. Introduction and Overview

1. Background

As healthcare costs continue to rise, healthcare affordability has become an area of intense focus. Healthcare spending is projected to consume almost 20 percent of the economy by 2027.[2] One reason for this upward spending trajectory is the lack of transparency in healthcare pricing.[3 4 5 6] Numerous studies suggest that consumers want greater healthcare pricing transparency. For example, a study of high deductible health plan enrollees found that respondents wanted additional healthcare price information so they could make more informed decisions about where to seek

[1] Available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf* and *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-internet.pdf.*

[2] CMS. National Health Expenditures Projections, 2018–2027: Forecast Summary. Available at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf.*

[3] Scheurer D. Lack of Transparency Plagues U.S. Health Care System. *The Hospitalist.* 2013 May; 2013(5). Available at: *https://www.the-hospitalist.org/hospitalist/article/125866/health-policy/lack-transparency-plagues-us-health-care-system.*

[4] Bees J. Survey Snapshot: Is Transparency the Answer to Rising Health Care Costs? *New England Journal of Medicine* Catalyst. March 20, 2019. Available at: *https://catalyst.nejm.org/health-care-cost-transparency-answer/.*

[5] Wetzell S. Transparency: A Needed Step Towards Health Care Affordability. *American Health Policy Institute.* March, 2014. Available at: *http://www.americanhealthpolicy.org/Content/documents/resources/Transparency%20Study%201%20-%20The%20Need%20for%20Health%20Care%20Transparency.pdf.*

[6] Robert Wood Johnson Foundation. How Price Transparency Can Control the Cost of Health Care. March 1, 2016. Available at: *https://www.rwjf.org/en/library/research/2016/03/how-price-transparency-controls-health-care-cost.html.*

care based on price.[7] Health economists and other experts state that significant cost containment cannot occur without widespread and sustained transparency in provider prices.[8] We believe there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs. We believe healthcare markets could work more efficiently and provide consumers with higher-value healthcare if we promote policies that encourage choice and competition.[9] As we have stated on numerous occasions, we believe that transparency in healthcare pricing is critical to enabling patients to become active consumers so that they can lead the drive towards value.[10]

Many empirical studies have investigated the impact of price transparency on markets, with most research, consistent with predictions of standard economic theory, showing that price transparency leads to lower and more uniform prices.[11] Traditional economic analysis suggests that if consumers were to have better pricing information for healthcare services, providers would face pressure to lower prices and provide better quality care.[12] Falling prices may, in turn, expand consumers' access to healthcare.[13]

Presently, however, the information that healthcare consumers need to make informed decisions based on the prices of healthcare services is not readily available. The Government Accountability Office (GAO) report (2011), ''Health Care Price Transparency: Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care,'' [14] found that healthcare price opacity, coupled with the often wide pricing disparities for particular procedures within the same market, can make it difficult for consumers to understand healthcare prices and to effectively shop for value. The report references a number of barriers that make it difficult for consumers to obtain price estimates in advance for healthcare services. Such barriers include the difficulty of predicting healthcare service needs in advance, a complex billing structure resulting in bills from multiple providers, the variety of insurance benefit structures, and concerns related to the public disclosure of rates negotiated between providers and third party payers. The GAO report goes on to explore various price transparency initiatives, including tools that consumers could use to generate price estimates in advance of receiving a healthcare service. The report notes that pricing information displayed by tools varies across initiatives, in large part due to limits reported by the initiatives in their access or authority to collect certain necessary price data. According to the GAO report, transparency initiatives with access to and integrated pricing data from both providers and insurers were best able to provide reasonable estimates of consumers' complete costs.

The concept of making healthcare provider charges and insurance benefit information available to consumers is not new; some States have required disclosure of pricing information by providers and payers for a number of years. More than half of the States have passed legislation establishing price transparency websites or mandating that health plans, hospitals, or physicians make price information available to consumers.[15] As of early 2012, there were 62 consumer-oriented, State-based healthcare price comparison websites.[16] Half of these websites were launched after 2006, and most were developed and funded by a State government agency (46.8 percent) or hospital association (38.7 percent).[17] Most websites report prices of inpatient care for medical conditions (72.6 percent) or surgeries (71.0 percent). Information about prices of outpatient services such as diagnostic or screening procedures (37.1 percent), radiology studies (22.6 percent), prescription drugs (14.5 percent), or laboratory tests (9.7 percent) are reported less often.[18]

Since the early 2000s, California-licensed hospitals have been required to annually submit to the State, for public posting on a State website: The charge description master (CDM, also known as a ''chargemaster''); a list of the hospital's average charges for at least 25 common outpatient procedures, including ancillary services; and the estimated percentage increase in gross revenue due to price changes.[19] The information is required to be submitted in plain language using easily understood terminology.[20] In 2012, Massachusetts began requiring insurers to provide, upon request, the estimated amount insured patients will be responsible to pay for proposed admissions, procedures, or services based upon the information available to the insurer at the time, and also began requiring providers to disclose the charge for the admission, procedure, or service upon request by the patient within 2 working days.[21] Since 2015, Oregon has offered pricing data for the top 100 common hospital outpatient procedures and top 50 common inpatient procedures on its *OregonHospitalGuide.org* website, which displays the median negotiated amount of the procedure by hospital and includes patient paid amounts such as deductibles and copayments. The data are derived from State-mandated annual hospital claims collection by the State's all payer claims database (APCD) and represent the service package cost for each of the procedures, including ancillary services and elements related to the procedure, with the exception of professional fees which are billed separately.[22] More recently, in 2018, Colorado began requiring hospitals to post the prices of the 50 most used DRG codes and the 25 most used outpatient CPT codes or healthcare services

[7] Sinaiko AD, et al. Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game. *JAMA Intern Med.* March 2016; 176(3), 395–397. Available at: *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2482348.*

[8] Boynton A, and Robinson JC. Appropriate Use Of Reference Pricing Can Increase Value. *Health Affairs.* July 7, 2015. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20150707.049155/full/.*

[9] Azar AM, Mnuchin ST, and Acosta A. ''Reforming America's Healthcare System Through Choice and Competition.'' December 3, 2018. Available at: *https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.*

[10] Bresnick J. Verma: Price Transparency Rule a ''First Step'' for Consumerism. January 11, 2019. Available at: *https://healthpayerintelligence.com/news/verma-price-transparency-rule-a-first-step-for-consumerism.*

[11] Congressional Research Service Report for Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector, July 24, 2007 (updated April 29, 2008). Available at: *https://crsreports.congress.gov/product/pdf/RL/RL34101.*

[12] Ibid.

[13] Ibid.

[14] GAO. Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care. Publicly released October 24, 2011. Available at: *https://www.gao.gov/products/GAO-11-791.*

[15] Desai S, et al. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA.* 2016;315(17):1874–1881. Available at: *https://jamanetwork.com/journals/jama/fullarticle/2518264.*

[16] Kullgren JT, et al. A census of state health care price transparency websites. *JAMA.* 2013;309(23):2437–2438. Available at: *https://jamanetwork.com/journals/jama/fullarticle/1697957.*

[17] Ibid.

[18] Ibid.

[19] Available at: *https://oshpd.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/2018-chargemasters/.*

[20] Jenkins K. *CMS Price Transparency Push Trails State Initiatives.* The National Law Review. February 8, 2019. Available at: *https://www.natlawreview.com/article/cms-price-transparency-push-trails-state-initiatives.*

[21] Ibid.

[22] Available at: *http://oregonhospitalguide.org/* and *http://oregonhospitalguide.org/understanding-the-data/procedure-costs.html.*

procedure codes with a ''plain-English description'' of the service, which must be updated at least annually.[23]

Not only have States taken an interest in price transparency, but insurers and self-funded employers have also moved in this direction. For example, some self-funded employers are using price transparency tools to incentivize their employees to make cost-conscious decisions when purchasing healthcare services. Most large insurers have embedded cost estimation tools into their member websites, and some provide their members with comparative cost and value information, which includes rates that the insurers have negotiated with in-network providers and suppliers.

Research suggests that making such consumer-friendly pricing information available to the public can reduce healthcare costs for consumers. Specifically, recent research evaluating the impact of New Hampshire's price transparency efforts reveals that providing insured patients with information about prices can have an impact on the out-of-pocket costs consumers pay for medical imaging procedures, not only by helping users of New Hampshire's website choose lower-cost options, but also by leading to lower prices that benefited all patients, including those in the State that did not use the website.[24] [25]

Despite the growing consumer demand and awareness of the need for healthcare pricing data, there continues to be a gap in easily accessible pricing information for consumers to use for healthcare shopping purposes. Specifically, there is inconsistent (and many times nonexistent) availability of provider charge information, among other limitations to understanding data made available or barriers to use of the data. We believe this information gap can, in part, be filled by the new requirements we are finalizing in this final rule, under section 2718(e) of the PHS Act, as described below. As we explained in the CY 2020 OPPS/ASC proposed rule, we believe that ensuring public access to hospital standard charge data will promote and support current and future price transparency efforts. We believe that this, in turn, will enable healthcare consumers to make more informed decisions, increase market competition, and ultimately drive down the cost of healthcare services, making them more affordable for all patients.

2. Summary of Proposals and General Comments

In the CY 2020 OPPS/ASC proposed rule (84 FR 39398), we indicated that health care consumers continue to lack the meaningful pricing information they need to choose the healthcare services they want and need despite our prior requirements for hospitals to publicly post their chargemaster rates online. Based on feedback from hospitals and consumers following the January 1, 2019 implementation of the revised guidelines, and in accordance with President's Executive Order on ''Improving Price and Quality Transparency in American Healthcare to Put Patients First'' (June 24, 2019), we proposed an expansion of hospital charge display requirements to include charges and information based on negotiated rates and for common shoppable items and services, in a manner that is consumer-friendly. We also proposed to establish a mechanism for monitoring and the application of penalties for noncompliance.

Specifically, we proposed to add a new Part 180—Hospital Price Transparency to title 45 CFR which would contain our regulations on price transparency for purposes of section 2718(e) of the PHS Act. We made proposals related to: (1) A definition of ''hospital''; (2) different reporting requirements that would apply to certain hospitals; (3) definitions for two types of ''standard charges'' (specifically, gross charges and payer-specific negotiated charges) that hospitals would be required to make public, and a request for public comment on other types of standard charges that hospitals should be required to make public; (4) a definition of hospital ''items and services'' that would include all items and services (both individual and packaged) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit; (5) requirements for making public a machine-readable file that contains a hospital's gross charges and payer-specific negotiated charges for all items and services provided by the hospital; (6) requirements for making public payer-specific negotiated charges for select hospital-provided items and services that are ''shoppable'' and that are displayed and packaged in a consumer-friendly manner; (7) monitoring for hospital noncompliance with requirements for publicly disclosing standard charges; (8) actions that would address hospital noncompliance, which include issuing a written warning notice, requesting a CAP, and imposing CMPs on noncompliant hospitals and publicizing these penalties on a CMS website; and (9) appeals of CMPs.

Comment: Commenters included individual consumers, patient advocates, hospitals and health systems, private insurers, employers, medical associations, health benefits consultants, health information technology (IT) organizations and organizations with price transparency expertise, and academic institutions, among others. The majority of commenters expressed broad support for our proposed policies (in whole or in part) or agreed with the objectives we seek to accomplish through these requirements. Many of these commenters stated that the disclosure of hospital standard charges would serve to increase competition, drive down healthcare prices, and allow consumers to compare healthcare costs across facilities and to have better control over their budgets and the financing of their healthcare needs.

Many commenters shared personal stories and examples of their experiences, illustrating their desire to shop and learn healthcare service prices in advance, and expressed frustration at their current inability to prospectively access medical costs. Commenters also provided specific examples of the ways that knowledge of healthcare pricing in advance would benefit consumers and empower them to make lower cost choices. Many commenters stated that consumers have a ''right to know'' or ''right to understand'' healthcare costs in advance of receiving treatment.

Individual consumers that submitted comments generally praised the proposals. One commenter stated it is the ''best attempt [thus] far to provide price transparency to the American public.'' But other commenters who supported hospital disclosure of charge information as a necessary first step also recognized that such disclosure would still fall, as one commenter stated, ''far short of the full price and cost transparency we need in every part of our healthcare system.''

By contrast, many organizations, including those representing hospitals and insurers, that submitted comments expressed strong concerns with the proposals and generally questioned

[23] Jenkins K. *CMS Price Transparency Push Trails State Initiatives.* The National Law Review. February 8, 2019. Available at: *https://www.natlawreview.com/article/cms-price-transparency-push-trails-state-initiatives.*

[24] Brown ZY. What would happen if hospitals openly shared their prices? *The Conversation.* January 30, 2019. Available at: *https://theconversation.com/what-would-happen-if-hospitals-openly-shared-their-prices-110352.*

[25] Brown ZY. An Empirical Model of Price Transparency and Markups in Health Care. August 2019. Available at: *http://www-personal.umich.edu/~zachb/zbrown_empirical_model_price_transparency.pdf.*

whether hospital charge disclosures would effectively reduce healthcare costs. Many of these entities commented on the practicalities and usefulness of displaying hospital standard charges and asserted that the proposal would not ''directly'' and ''materially'' serve the stated interest of improving consumer access to healthcare pricing information to help drive down healthcare costs.

Commenters that objected to the proposals also pointed out that disclosure of hospital charges would be insufficient to permit a consumer to obtain an out-of-pocket estimate in advance because consumers with insurance need additional information from payers. Some commenters generally indicated that the proposed disclosures would be of little benefit or use to consumers. Further, several commenters suggested that, for patients with health insurance, insurers, not hospitals, should be the primary source of price information, and that insurers should inform and educate their members on potential out-of-pocket costs in advance of elective services. Some expressed concerns that patients could be confused by hospital charge information and misinterpret the standard charge data the hospital is required to display.

Response: We thank the many commenters for their support of CMS' price transparency initiative in general, and our proposals to require hospitals to make public their standard charge information in particular, which, for reasons articulated in the CY 2020 OPPS/ASC proposed rule, we agree can improve consumer knowledge of the price of healthcare items and services in advance. For example, disclosure of payer-specific negotiated charges can help individuals with high deductible health plans (HDHPs) or those with co-insurance determine the portion of the negotiated charge for which they will be responsible for out-of-pocket. We believe that regulations we are finalizing in this final rule, implementing section 2718(e) of the PHS Act, requiring hospitals make public standard charges, are imperative for several reasons, including that consumers currently do not have the information they need in a readily usable way or in context to inform their healthcare decision-making. Further, we believe that greater transparency will increase competition throughout the market and address healthcare costs. For instance, disclosure of pricing information will allow providers, hospitals, insurers, employers and patients to begin to engage each other and better utilize market forces to address the high cost of medical care in a more widespread fashion.

While we understand the commenters' concerns that disclosure of hospital standard charges may not be used by all consumers, we disagree that the availability of such data would be of little benefit to consumers generally. We continue to believe there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs. We believe healthcare markets could work more efficiently and provide consumers with higher-value healthcare if we promote policies that encourage choice and competition. As we noted in the CY 2020 OPPS/ASC proposed rule, and restated in section II.A.2 of this final rule, numerous studies suggest that consumers want greater transparency and price information so that they can make more informed decisions about where to seek care based on price (84 FR 39572).

We do, however, agree with commenters who indicated that disclosure of hospital charge information alone may be insufficient or does not go far enough for consumers to know their out-of-pocket costs in advance of receiving a healthcare service. As we indicated in the CY 2020 OPPS/ASC proposed rule (84 FR 39574), there are many barriers to obtaining an out-of-pocket estimate in advance and to make price comparisons for healthcare services, including that the data necessary for such an analysis are not available to the general public for personal use. Necessary data to make out-of-pocket price comparisons depends on an individual's circumstances. For example, a self-pay individual may simply want to know the amount a healthcare provider will accept in cash (or cash equivalent) as payment in full, while an individual with health insurance may want to know the charge negotiated between the healthcare provider and payer, along with additional individual benefit-specific information such as the amount of cost-sharing, the network status of the healthcare provider, how much of a deductible has been paid to date, and other information. We therefore agree with commenters who recognize that these policies to require hospitals to make public their standard charges are merely a necessary first step. We discuss the importance and necessity of specific types of hospital standard charges in section II.D of this final rule.

In response to commenters suggesting that insurers should be the primary source of price information, we disagree that insurers alone should bear the complete burden or responsibility for price transparency. At least one key reason that insurers cannot alone bear the burden is that, in numerous instances, they are not participants in the transaction; for example, as discussed in section II.D of this final rule, self-pay patients and insured patients who are considering paying in cash have an interest in understanding hospitals' cash prices, or for employers who want to contract directly with hospitals. We also note that the proposed rule entitled Transparency in Coverage (file code CMS–9915–P) would place complementary transparency requirements on most individual and group market health insurance issuers and group health plans.

Comment: A few commenters asked CMS not to move forward with the final rule, stating that price transparency should be done only at the state level. These commenters expressed concern that CMS moving forward in this area would either limit price transparency to a ''one size fits all'' approach or complicate or undercut efforts already ongoing in several states. These commenters suggested that instead of federal mandates, CMS could work with hospitals to provide meaningful information to patients about their out-of-pocket costs for their hospital care by improving financial counseling, or provide grant dollars for states to improve their own price transparency programs.

More generally, many commenters asserted that several hospitals already respond to consumer requests for actionable healthcare pricing information in advance of receiving care, such as through existing tools, publicizing how and from whom patients can obtain price estimates, providing individualized financial counseling, or a combination of these methods.

Response: We believe it is appropriate to promulgate regulations pursuant to section 2718(e) of the PHS Act.

We further believe that transparency in pricing is a national issue, which Congress has recognized by enacting hospital price transparency statutory requirements.

We appreciate the commenters' concerns about the possible interactions between new federal requirements for hospitals to make public standard charges and existing State price transparency initiatives, or hospital initiatives. As we discussed in the CY 2020 OPPS/ASC proposed rule, we have sought ways to ensure sufficient flexibility in the new requirements, particularly around the form and

manner of making public hospital price information, as well as the frequency of making public this information. As with the proposed requirements, we continue to believe that the requirements we are finalizing in this final rule will align with and enhance ongoing State and hospital efforts for the display of hospital charge information. We note that while many States have made progress in promoting price transparency, most State efforts continue to fall short. For example, a group that tracks State progress found in their most recent report that all but seven States scored an ''F'' on price transparency.[26] States that excel at promoting price transparency (for example, New Hampshire and Maine, the only two States to receive an ''A'' rating) are also States where the price of shoppable services has reportedly decreased [27] or fostered a more competitive market.[28] We believe these final rules will provide a national framework upon which States can either begin or continue to build.

We commend those hospitals that are already publicly releasing their standard charges and providing patients individualized assistance to help them understand their projected costs in advance of receiving care. However, not all hospitals are prioritizing providing such assistance. Moreover, we do not believe that such existing hospital initiatives diminish the need to, and benefits of, establishing consistent, nationwide requirements for hospitals to make public standard charges. We encourage efforts to provide consumers with additional price information (beyond the requirements established in this final rule) and for hospitals to continue to educate and provide prospective out-of-pocket information to patients. By doing so, hospitals can help consumers gain an understanding of hospital standard charge information and thereby support consumers in making cost conscious decisions regarding their care in advance.

Comment: Some commenters generally indicated that the proposals for hospitals to disclose their standard charges would be very burdensome to implement. Several commenters also suggested that the proposed price transparency requirements are contrary to the Patients over Paperwork initiative, which is a CMS initiative that aims to remove regulatory obstacles that get in the way of providers spending time with patients.

Response: The Patients over Paperwork initiative is in accord with President Trump's Executive Order that directs federal agencies to ''cut the red tape'' to reduce burdensome regulations. Through ''Patients over Paperwork,'' CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience.[29] Generally, we believe the final requirements will increase transparency in hospital charge information and will achieve one of our primary goals of putting patients first and empowering them to make the best decisions for themselves and their families.[30] Efficiencies could also be gained through implementation of these requirements for markets, providers and patients.[31] [32] [33] To implement section 2718(e) of the PHS Act and to achieve these goals, some burden on hospitals is necessary. However, we have sought through rulemaking to minimize the burden wherever possible.

We acknowledge commenters' concerns related to burden. However, we believe that the burdens placed on hospitals to make public their standard charge data is outweighed by the benefit that the availability of these data will have in informing patients regarding healthcare costs and choices and improving overall market competition. Since we believe that transparency is necessary to improve healthcare value and empower patients, we believe the need justifies the additional burden. While the burdens hospitals may incur to implement these requirements might be administrative in nature, we believe that the benefits to consumers, and to the public as a whole, justify this regulatory action and that we are thereby prioritizing patients through this regulatory action.

Comment: A few commenters offered suggestions for how to improve hospital price transparency in general, including the following:

- Presenting pricing data with quality, health outcomes, and other relevant data.
- Encouraging shared decision-making and cost of care conversations between patients and clinicians at the point of care.
- Addressing unexpected costs of care and providing consumer protections from unexpected and unnecessary out-of-pocket spending, such as those resulting from incidents where the patient is billed at rates that are inconsistent with publicly posted prices for their payer (referred to by a few commenters as ''price surprise''), or billed by out-of-network providers that provided treatment at an in-network facility, or the practice where the provider bills the patient for the balance between the amount the patient's health insurance plan covers and the amount that the provider charges (''balance billing'').

Response: We acknowledge that additional barriers have to be overcome to allow consumers to identify appropriate sites of care for needed healthcare services, determine out-of-pocket costs in advance, and utilize indicators of quality of care to make value-based decisions. As we have previously described, we believe the policies we are finalizing in this final rule requiring hospitals to make public standard charges are a necessary and important first step in ensuring transparency in healthcare prices for consumers, but that the release of hospital standard charge information is not sufficient by itself to achieve our ultimate goals for price transparency. We also note that our final policies do not preclude hospitals from undertaking additional transparency efforts beyond making public their standard charges. HHS continues to explore other authorities to further advance the Administration's goal of enhancing consumers' ability to choose the healthcare that is best for them, to make fully informed decisions about their healthcare, and to access both useful price and quality information and

[26] de Brantes F, et al. Price Transparency & Physician Quality Report Card 2017. Catalyst for Payment Reform. Available at: *https://www.catalyze.org/wp-content/uploads/2017/11/Price-Transparency-and-Physician-Quality-Report-Card-2017_0-1.pdf.*

[27] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics.* Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*

[28] Gudiksen KL, et al. The Secret of Health Care Prices: Why Transparency Is in the Public Interest. California Health Care Foundation. July 2019. Available at: *https://www.chcf.org/wp-content/uploads/2019/06/SecretHealthCarePrices.pdf.*

[29] *CMS.gov* website, Patients Over Paperwork, at *https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html.*

[30] *CMS.gov*, Patients Over Paperwork webpage, available at *https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html;* see also 84 FR 27021 (RFI describing CMS' top priority as putting patients first and empowering them to make the best decisions for themselves and their families).

[31] Kim M. The Effect of Hospital Price Transparency in Health Care Markets. 2011. Available at: *https://repository.upenn.edu/dissertations/AAI3475926/.*

[32] CRS Report to Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector. July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[33] Santa J. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. 2010. Available at: *https://www.ncbi.nlm.nih.gov/books/NBK53921/.*

provide incentives to find low-cost, high-quality care.

We agree that cost-of-care conversations at the point of care are important. National surveys show that a majority of patients and physicians want to have these conversations, but often the information necessary for actionable conversations is unavailable.[34] A recent supplemental issue of the Annals of Internal Medicine [35] highlighted this issue and identified best practices for integrating cost-of-care conversations at the point of care. We believe that disclosure of hospital standard charges along with the disclosure of payer information is the first step to ensuring patients and practitioners have actionable data to support meaningful cost-of-care conversations. We encourage these conversations and the disclosure of additional relevant information to support patient decisions about their care.

We also agree that ''surprise billing'' is an issue of great concern to consumers and of great interest to both federal and state lawmakers. The policies finalized in this final rule will not resolve that issue entirely, although it is possible that disclosure of hospital standard charges could help mitigate some surprise billing experienced by consumers.

Comment: One commenter suggested that Medicare and Medicaid beneficiaries need an easy way to report fraud and balance billings by providers.

Response: There already exist multiple avenues by which anyone suspecting healthcare fraud, waste, or abuse in Medicare and/or Medicaid may readily report it to oversight authorities. For example, the HHS Office of Inspector General (OIG) Hotline accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS' programs (see *https://oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP* for instructions). Additionally, anyone wishing to report instances of potential Medicare fraud may contact Medicare's toll-free customer service operations at 1–800–MEDICARE (1–800–633–4227), and obtain additional information at *www.medicare.gov/fraud.* Anyone suspecting Medicaid fraud, waste, or abuse is encouraged to report it to the Program Integrity contact of the respective State Medicaid Agency (see *https://www.medicaid.gov/about-us/contact-us/contact-state-page.html* for the 50 United States, the District of Columbia, the US Virgin Islands, and Puerto Rico).

B. Definition of ''Hospital'' and Hospitals Regarded as Having Met Requirements

1. Definition of ''Hospital''

Section 2718(e) of the PHS Act does not define ''hospital.'' Initially, we considered proposing to adopt a definition of ''hospital'' that is used either in other sections of the PHS Act or in the SSA, but we found that no single or combined definition was suitable because those other definitions were applicable to specific programs or Medicare participation and therefore had program-specific requirements that made them too narrow for our purposes. For example, we considered referencing the definition of ''hospital'' at section 1861(e) of the SSA because that definition is well understood by institutions that participate as hospitals for purposes of Medicare. However, we were concerned that doing so could have had the unintentional effect of limiting the institutions we believe should be covered by section 2718(e) of the PHS Act. Even so, we believe that the licensing requirement described at section 1861(e)(7) of the SSA captures the institutions that we believe should be characterized as hospitals for purposes of this section.

Accordingly, we proposed to define a ''hospital'' as an institution in any State in which State or applicable local law provides for the licensing of hospitals and that is: (1) Licensed as a hospital pursuant to such law; or (2) approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing (which we proposed to codify in new 45 CFR 180.20).

We believe this proposed definition is the best way to ensure that section 2718(e) of the PHS Act applies to each hospital operating within the United States. First, in addition to applying to all Medicare-enrolled hospitals (that, by definition, must be licensed by a State as a hospital, or otherwise approved by the State or local licensing agency as meeting hospital licensing standards), the proposed definition would also capture any institutions that are, in fact, operating as hospitals under State or local law, but might not be considered hospitals for purposes of Medicare participation. As discussed in section XVI.A.2. of the CY 2020 OPPS/ASC proposed rule (84 FR 39572 through 39573), many States have promoted price transparency initiatives, and some require institutions they license as hospitals to make certain charges public as a part of those initiatives. Therefore, defining a hospital by its licensure (or by its approval by the State or locality as meeting licensing standards) may carry the advantage of aligning the application of Federal and State price transparency initiatives to the same institutions.

We also proposed that, for purposes of the definition of ''hospital,'' a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. We stated that this proposed definition of State would be consistent with how that term is defined under section 2791(d)(14) of the PHS Act. We further stated that we believed that adopting this definition of ''State'' for purposes of section 2718(e) of the PHS Act is appropriate because, unlike the other provisions in section 2718 which apply to health insurance issuers, section 2718(e) applies to hospitals. Therefore, it is distinguishable from the approach outlined in the July 2014 letters [36] to the Territories regarding the PHS Act health insurance requirements established or amended by Public Law 111–148 and Public Law 111–152.

Our proposed definition focused on whether or not the institution is licensed by the State or under applicable local law as a hospital, or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. As such, a ''hospital'' under our proposed definition includes each institution that satisfies the definition, regardless of whether that institution is enrolled in Medicare or, if enrolled, regardless of how Medicare designates the institution for its purposes. Thus, we noted that the proposed definition includes critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), sole community hospitals (SCHs), and inpatient rehabilitation facilities (IRFs), which we previously identified in our guidelines as being hospitals for the purposes of section 2718(e) of the PHS Act,[37] as well as any other type of institution, so long as it is licensed as

[34] University of Utah Health website, Let's Talk About Money, *https://uofuhealth.utah.edu/value/lets-talk-about-money.php.*

[35] Fostering Productive Health Care Cost Conversations: Sharing Lessons Learned and Best Practices. May 2019 Vol: 170, Issue 9_Supplement. *Annals of Internal Medicine.* Available at: *https://annals.org/aim/issue/937992.*

[36] The July 2014 letters are available at: *https://www.cms.gov/CCIIO/Resources/Letters/index.html#Health%20Market%20Reforms.*

[37] Available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-internet.pdf.*

a hospital (or otherwise approved) as meeting hospital licensing standards.

Finally, we noted that the proposed definition of ''hospital'' did not include entities such as ambulatory surgical centers (ASCs) or other non-hospital sites-of-care from which consumers may seek healthcare items and services. We discussed that, for example, non-hospital sites may offer ambulatory surgical services, laboratory or imaging services, or other services that are similar or identical to the services offered by hospital outpatient departments. In the interest of increasing opportunities for healthcare consumers to compare prices for similar services and promoting widespread transparency in healthcare prices, we encouraged non-hospital sites-of-care to make public their lists of standard charges in alignment with the proposed requirements so that consumers could make effective pricing comparisons.

We invited public comments on our proposed definition of ''hospital,'' which we proposed to codify at 45 CFR 180.20.

Comment: A few commenters requested that CMS finalize the definition of hospital as proposed and applauded the agency's effort to provide a standard definition of hospital for the purposes of making standard charges public. One commenter agreed that the definition of hospital should not be limited to only those hospitals that participate in Medicare.

Several commenters suggested that the proposed definition of hospital is too limited, and suggested that CMS expand the definition to include other providers, such as physicians, ASCs, clinics, community health centers, and skilled nursing facilities, in order to better educate consumers on prices for services furnished by all provider types. A few commenters generally suggested that CMS extend price transparency policies to all service providers and all places of service, not just hospitals or hospital settings. One commenter suggested that CMS expand the definition of hospital to include any facility that conducts surgery with anesthesia.

In particular, a few commenters explained the need for ASCs to be transparent with their prices. One commenter noted that federally mandated payment and other policies continue to emphasize patients obtaining care in an outpatient setting instead of an inpatient acute care hospital and therefore the definition of hospital should reflect the greater role ASCs are taking in the healthcare system. Commenters also noted that ASCs provide similar services to hospitals and may therefore compete with hospitals. On the other hand, one commenter urged CMS to apply price transparency standards to ASCs to minimize incentives for hospitals to defer surgeries to new ASCs formed for the purpose of circumventing disclosure of the hospital's charges.

Commenters took diverging positions on whether IRFs should be required to make public standard charges. A few commenters urged that IRFs be included among the entities required to make public standard charges. On the other hand, as described and addressed in Section II.B.2 of this final rule, a few commenters suggested that IRFs be exempt from the reporting requirements.

Response: We thank the commenters that supported our proposed definition of hospital. We believe that our proposed definition of hospital, which we are finalizing, is a broad definition that will encompass all institutions recognized by a State as a hospital. Because section 2718(e) of the PHS Act applies to each hospital operating within the United States, we do not believe we have the authority to apply the price transparency requirements to non-hospital sites of care. For this reason, we decline to adopt commenters' suggestions that we expand the definition of hospital to include all service providers and places of service, including to all places of service that provide surgical services requiring anesthesia. We also decline the commenters' suggestions to narrow the scope of the definition of hospital, for instance to exclude IRFs where the IRFs otherwise meet the definition of hospital we are finalizing. We believe such an approach would not be consistent with section 2718(e) of the Act, which applies to each hospital operating in the United States. Given the importance of making public standard charge data to inform consumer healthcare decision-making, we believe it is important to not overly constrict the definition of hospital, which might permit subsets of hospitals that meet the definition we are finalizing to avoid public disclosure of their standard charges.

We defer to States' or localities' hospital licensing standards for the determination of whether an entity falls within the definition of hospital for the purposes of new 45 CFR part 180. Any facility licensed by a State or locality as a hospital, or that is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing, would be considered a ''hospital'' for the purposes of section 2718(e) of the Act and therefore required to comply with the requirements to make public their standard charges in the form and manner required by this final rule. For this reason, we cannot provide an exhaustive list of institution types encompassed within State or locality hospital licensing laws.

Regarding specific types of entities, however, we note that healthcare providers such as ASCs, physicians, or community health centers would not likely satisfy our specified definition of ''hospital'' since they are not likely to be licensed by a State or locality as a hospital or to be approved by the agency of such State or locality responsible for licensing hospitals as meeting the standards established for such licensing. We recognize that ASCs provide many of the same services as hospitals and note that many ASCs already engage in price transparency efforts of their own. We have no knowledge that existing price transparency initiatives (those in states that already require hospitals to make public standard charges and our existing guidance that hospitals make public standard charges pursuant to section 2718(e) of the PHS Act) have engendered any shifts in business between hospitals and ASCs. However, we believe it is reasonable to assume that shifts to the most appropriate care setting may occur as referring providers and their patients seek out the highest value setting for their care.

Comment: A few commenters requested clarification on how the requirements to make standard charges public and CMS compliance actions would apply to hospital outpatient services that are provided off-campus, or in hospital-affiliated or hospital-owned clinics. One commenter asked whether all hospital locations under one CMS Certification Number (CCN) are a single hospital for the purpose of the proposal or whether they are considered separate locations. The commenter expressed concern that there is an absence of any connection between the CY 2020 OPPS/ASC proposed rule's definition of ''hospital'' and the CCN. The commenter expressed concern that this lack of clarity would hinder compliance with the proposal if finalized and lessen the impact of the proposed penalty.

Response: We did not propose to define the term ''hospital'' with reference to the CCN, which is the hospital identification system we use for purposes of Medicare and Medicaid. As we discussed in the CY 2020 OPPS/ASC proposed rule, we declined to base the definition of hospital on Medicare participation, as the statute states all hospitals operating within the United

States must make available a list of their standard charges.

As discussed in section II.E.6 of this final rule, each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location, as stated in 45 CFR 180.50. All hospital location(s) operating under the same hospital license (or approval), such as a hospital's outpatient department located at an off-campus location (from the main hospital location) operating under the hospital's license, are subject to the requirements in this rule.

Final Action: We are finalizing our proposal to define ''hospital'' to mean an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. We are finalizing our proposal to set forth the definition of ''hospital'' in the regulations at new 45 CFR 180.20.

2. Special Requirements That Apply to Certain Hospitals

In the CY 2020 OPPS/ASC proposed rule (84 FR 39575 through 39576), we proposed that hospital standard charge disclosure requirements would not apply to federally-owned or operated hospitals, including Indian Health Service (IHS) facilities (including Tribally-owned and operated facilities), Veterans Affairs (VA) facilities, and Department of Defense (DOD) Military Treatment Facilities (MTFs), because, with the exception of some emergency services, these facilities do not provide services to the general public and the established payment rates for services are not subject to negotiation. Instead, each of these facility types is authorized to provide services only to patients who meet specific eligibility criteria. For example, individuals must meet the requirements enumerated at 42 CFR 136.22 through 136.23 to be eligible to receive services from IHS and Tribal facilities. Similarly, under 38 CFR 17.43 through 17.46, VA hospitals provide hospital, domiciliary, and nursing home services to individuals with prior authorization who are discharged or retiring members of the Armed Forces and, upon authorization, beneficiaries of the PHS, Office of Workers' Compensation Programs, and other Federal agencies (38 CFR 17.43). In addition, federally-owned or operated hospitals such as IHS and Tribal facilities [38] impose no cost-sharing, or, in the case of VA hospitals [39] and DOD MTFs,[40] little cost-sharing. With respect to such facilities where there is cost-sharing, the charges are publicized through the **Federal Register**, Federal websites, or direct communication and therefore known to the populations served by such facilities in advance of receiving healthcare services. Only emergency services at federally-owned or operated facilities are available to non-eligible individuals. Because these hospitals do not treat the general public, their rates are not subject to negotiation, and the cost sharing obligations for hospital provided services are known to their patients in advance, we believe it is appropriate to establish different requirements that apply to these hospitals.

Specifically, we proposed to deem federally owned or operated hospitals that do not treat the general public (except for emergency services) and whose rates are not subject to negotiation, to be in compliance with the requirements of section 2718(e) of the PHS Act because their charges for hospital provided services are publicized to their patients (for example, through the **Federal Register**) (proposed new 45 CFR 180.30(b)). We also requested public comments on whether exceptions to our proposed requirements might be warranted for hospitals (for example, hospitals located in rural areas, CAHs, or hospitals that treat special populations) that are not federally owned or operated, while also ensuring that charges for the services provided by such hospitals are available to the public.

Comment: Commenters diverged as to whether additional exceptions should be made for providers that meet the proposed definition of ''hospital,'' such that these providers would not be required to make standard charges public. One commenter strongly recommended that CMS not allow any exceptions to requirements for entities that meet the proposed definition of ''hospital.''

Other commenters requested that CMS exempt CAHs, rural hospitals, and SCHs from part or all requirements to make standard charges public. The commenters stated that the requirements would be challenging for small facilities and cited several justifications for this possible exemption, including that CAHs are already at a disadvantage when negotiating rates with third-party payers; they lack the implementation resources due to their size and reimbursement structure; and the likelihood of their experiencing operational disruptions as a result of diverting staff time and other resources to comply with the proposed requirements. On the other hand, one commenter specified that patients receiving care in CAHs and rural hospitals deserve to know how much services cost in advance.

A few commenters argued that LTCHs and IRFs ought to be excluded or exempted from the requirement of having to make public their standard charges for a variety of reasons, including: (1) Commenters' belief that patients are unable to schedule LTCH and IRF services in advance; (2) patients treated in LTCHs and IRFs are there for follow-up care after a short-term acute stay in a hospital and the critical nature of the patients' condition, and the need for tailored treatment plans for complex conditions, would not lend itself to being shoppable; (3) imposing price transparency requirements on LTCHs will not serve the objectives of increased market competition or quality improvement since sometimes there is only one LTCH in a single market and there are fewer than 400 total LTCHs nationwide.

One commenter requested that CMS exempt institutions and hospitals that are not enrolled in Medicare and which are not reimbursed under a prospective payment system.

Response: Our definition of ''hospital'' is any institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. As we explained in section II.B.1 of this final rule, we defer to States' or localities' hospital licensing standards for the determination of whether an entity falls within the definition of hospital for the purposes of new 45 CFR part 180. We continue to believe this definition provides the best way to ensure that section 2718(e) of the PHS Act applies to each hospital operating

[38] Section 1680r(b) of the Indian Health Care Improvement Act (25 U.S.C. 1680r).

[39] VA cost-sharing information available at: *https://www.va.gov/HEALTHBENEFITS/cost/copays.asp.*

[40] MTF cost-sharing information available at: *https://tricare.mil/Costs/Compare* and *https://comptroller.defense.gov/Portals/45/documents/rates/fy2019/2019_ia.pdf.*

within the United States. It also may help align the application of these requirements with State price transparency initiatives to the same institutions.

We appreciate the operational, resource, and other concerns raised by commenters, however, to the extent that IRFs, CAHs, LTCHs, rural hospitals, and SCHs (among others) fall within our proposed definition of hospital, we believe this is appropriate because patients, or their caregivers, should have the opportunity to know in advance (as their circumstances permit) standard charges for these entities' items and services, to inform their healthcare decision-making. We decline to either exempt such hospitals from making public standard charges, or deem such hospitals as having met requirements for making public their standard charges.

We recognize that some small hospitals, and rural hospitals, including CAHs and SCHs may face challenges in implementing these requirements, but we do not believe that such challenges are insurmountable.

We also disagree with the commenters that suggest that services provided by LTCHs and IRFs are not shoppable. Patients, and their caregivers, seeking long term care or rehabilitation services may have the opportunity to shop for these services in advance, and we believe patients and caregivers should have access to consumer-friendly charge information for such facilities. We believe that such information could be used by patients or their caregivers to better inform their decision-making when a patient transfers from an acute care facility (that falls within our definition of ''hospital'') to a post-acute care facility (that also falls within our definition of ''hospital'').

Further, we believe that patients with complex conditions, their caregivers, or both, may have a particular interest in using price data to inform healthcare decision-making. We believe that the data we are requiring hospitals to make public could inform healthcare decision-making by patients with complex conditions, their caregivers, or both, even though they may require additional, or specialized treatment.

We do not believe that the absence of competition for items or services in a market should excuse hospitals from making public standard charges that consumers may need to inform the cost of their care. We believe transparency in hospital prices is important to consumers' healthcare decision-making, regardless of the number of facilities in a particular market or nationwide.

We also decline the commenter's suggestion to exempt institutions and hospitals from the requirements to make public standard charges if they are not enrolled in Medicare. As we explained in the CY 2020 OPPS/ASC proposed rule, we believe that such an approach would unduly limit the applicability of the policies for hospitals to make public standard charges under section 2718(e) of the PHS Act (84 FR 39575).

Final Action: We are finalizing as proposed to specify at 45 CFR 180.30 provisions on the applicability of the requirements for making public standard charges. We are finalizing as proposed to specify in 45 CFR 180.30(a) that the requirements to make public standard charges apply to hospitals as defined at 45 CFR 180.20.

We received no comments on our proposal to deem federally owned or operated hospitals to be in compliance with the requirements to make public standard charges. Therefore, we are finalizing, as proposed, to specify in 45 CFR 180.30(b) that federally owned or operated hospitals are deemed by CMS to be in compliance with the requirements for making public standard charges, including but not limited to:

- Federally owned hospital facilities, including facilities operated by the U.S. Department of VA and MTF operated by the U.S. Department of Defense.
- Hospitals operated by an Indian Health Program as defined in section 4(12) of the Indian Health Care Improvement Act.

We received no comments on our proposal that hospital charge information must be made public electronically via the internet. We are finalizing this requirement as proposed at 45 CFR 180.30(c).

C. Definition of ''Items and Services'' Provided by Hospitals

Section 2718(e) of the PHS Act requires that hospitals make public a list of the hospital's standard charges for items and services provided by the hospital, including for DRGs. We proposed that, for purposes of section 2718(e) of the PHS Act, ''items and services'' provided by the hospital are all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples of these items and services include, but are not limited to, supplies, procedures, room and board, use of the facility and other items (generally described as facility fees), services of employed physicians and non-physician practitioners (generally reflected as professional charges), and any other items or services for which a hospital has established a charge.

Our proposed definition included both individual items and services as well as ''service packages'' for which a hospital has established a charge. Every hospital maintains a file system known as a chargemaster, which contains all billable procedure codes performed at the hospital, along with descriptions of those codes and the hospitals' own list prices. The format and contents of the chargemaster vary among hospitals, but the source codes are derived from common billing code systems (such as the AMA's CPT system). Chargemasters can include tens of thousands of line items, depending on the type of facility, and can be maintained in spreadsheet or database formats.[41] For purposes of section 2718(e) of the PHS Act, we proposed to define ''chargemaster'' to mean the list of all individual items and services maintained by a hospital for which the hospital has established a standard charge (at proposed new 45 CFR 180.20). Each individual item or service found on the hospital chargemaster has a corresponding ''gross'' charge (84 FR 39578 through 39579). Each individual item or service may also have a corresponding negotiated discount, because some hospitals negotiate with third party payers to establish a flat percent discounted rate off the gross charge for each individual item and service listed on the chargemaster; for example, a hospital may negotiate a 50 percent discount off all chargemaster gross rates with a third party payer.

In contrast to the chargemaster, or so-called ''fee-for-service'' (FFS) price list, hospitals also routinely negotiate rates with third party payers for bundles of services, or ''service packages,'' in lieu of charging for each and every imaging study, laboratory test, or alcohol swab found on the chargemaster.[42] Such service packages may have charges established on, for example, the basis of a common procedure or patient characteristic, or may have an established per diem rate that includes all individual items and services furnished during an inpatient stay. Some hospitals present ''self-pay package pricing'' for prompt same-day payment from healthcare consumers.

[41] Tompkins C, et al. The Precarious Pricing System For Hospital Services. *Health Affairs.* January/February 2006; 25(1). Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.25.1.45.*

[42] Nichols LM, and O'Malley AS. Hospital Payment Systems: Will Payers Like The Future Better Than The Past? *Health Affairs.* January/February 2006; 25(1). Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.25.1.81.*

The hospital's billing and accounting systems maintain the negotiated charges for service packages which are commonly identified in the hospital's billing system by recognized industry standards and codes. For example, a DRG system may be used to define a hospital product based on the characteristics of patients receiving similar sets of [itemized] services.[43] Medicare and some commercial insurers have adopted DRG classifications as a method of inpatient hospital payment. Other codes (for example, payer-specific codes, CPT or Healthcare Common Procedure Coding System (HCPCS) codes) are used by hospitals and payers to identify service packages based on procedures.

For purposes of section 2718(e) of the PHS Act, we proposed to define a ''service package'' to mean an aggregation of individual items and services into a single service with a single charge (proposed new 45 CFR 180.20). In the CY 2020 OPPS/ASC proposed rule, we explained our belief that this was appropriate and consistent with section 2718(e) of the PHS Act because we believe the inclusion of DRGs as an item or service in section 2718(e) recognizes that hospital services can be provided, and charges billed, based on the service's individual component parts or as a more inclusive service package. While section 2718(e) of the PHS Act specifically includes items and services grouped into DRGs as an example of the items and services for which hospitals must list their standard charges, we explained that our proposed definition of ''items and services'' should include not just all DRGs (as established under 1886(d)(4) of the SSA) but also all other service packages provided by the hospital, including, for example, service packages the hospital provides in an outpatient setting for which a hospital may have established a standard charge. Therefore, our proposed definition of ''items and services'' includes both individual items and services and service packages.

We also included in our proposed definition of ''items and services'' provided by the hospital the services furnished by physicians and non-physician practitioners who are employed by the hospital. We explained our belief that the services the hospital provides through its employed physicians and non-physician practitioners are items and services provided by the hospital because such clinicians are employed by the hospital specifically so it can offer such services to its patients. In addition, the hospital establishes and negotiates the charges for the employed physician and non-physician services and then bills and retains the payment for the professional services of employed physicians and non-physician practitioners. We therefore proposed to include these services in our proposed definition of items and services provided by the hospital under section 2718(e) of the PHS Act, and for hospitals to make public the charges for the services of their employed physicians and non-physician practitioners.

We also considered including in our proposed definition of items and services the services provided by physicians and non-physician practitioners who are not employed by the hospitals, but who provide services at a hospital location. For example, a procedure performed in a hospital setting may involve anesthesiology services provided by a non-employed physician who has established his or her own charge for the service provided at a hospital location. These physicians and non-physician practitioners may send a bill that is separate from the hospital bill, or they may elect to reassign their billing rights to the hospital that will send a single bill that includes both hospital charges and professional service charges. Often, healthcare consumers are not expecting an additional charge or are otherwise surprised when they receive bills from entities other than the hospital, or when charges for non-employed physicians and non-physician practitioners are higher than expected (for example, when a non-employed physician is out-of-network and the consumer's third party payer declines payment for those services for that reason). We explained our belief that the provision of such additional charge information would be exceptionally valuable to give consumers a more complete picture of the total amount they might be charged in connection with an inpatient admission or an outpatient department visit at a hospital location, potentially helping to address the widely recognized ''surprise billing'' issue. However, because physicians and non-physician practitioners who are not employed by the hospital are practicing independently, establish their own charges for services, and receive the payment for their services, we indicated we did not believe their charges for their services would fall within the scope of section 2718(e) of the PHS Act as they are not services ''provided by the hospital.''

We welcomed comments on these proposals.

Comment: A few commenters agreed with the proposed definition of ''items and services'' including service packages. Many commenters, however, questioned the feasibility of providing standard charges for service packages, as they believe that it is neither feasible, nor technically possible, for a hospital to report data from its chargemaster as service packages. A few commenters also expressed concern that pricing for service packages as proposed presents a challenge because service packages are often unique to each payer, and the reimbursements negotiated with payers are not necessarily associated with a HCPCS code, DRG, National Drug Code (NDC), or Ambulatory Payment Classification (APC) as the proposed regulation anticipates.

A few commenters stated that they believe CMS needs to provide guidance or a framework to help hospitals define outpatient service packages and attribute ancillary services to specific primary services. Another commenter asked if the definition of ''items and services'' was flexible enough to allow for different payment models ranging from episodic care that has a guarantee of follow-up care being included if a complication happens, to care models that include subscription-based contracts.

Response: We thank commenters for their input on the proposal. We are finalizing the definition of ''items and services'' as proposed.

As we explained in the CY 2020 OPPS/ASC proposed rule, some hospitals routinely negotiate rates with third party payers for bundles of services or ''service packages.'' We agree with commenters that the standard charge for a service package is not typically found on the hospital's chargemaster, which simply lists out all the individual items and services. Standard charges for service packages are negotiated between the hospital and payer and are identified by common billing codes (for example, DRGs or APCs) or other payer-specific identifiers that provide context to the type and scope of individualized items and services that may be included in the package. As explained in more detail in section II.D.3 of this final rule, the payer-specific charge the hospital has negotiated for a service package (also referred to as the 'base rate') can be found in other parts of the hospital billing and accounting systems than the chargemaster, or in rate tables or the rate sheets found in hospital in-network

[43] Mistichelli J. Diagnosis Related Groups (DRGs). Georgetown University. June, 1984. Available at: *https://repository.library.georgetown.edu/handle/10822/556896.*

contracts with third party payers indicating the agreed upon rates for the provision of various hospital services.

We decline to define outpatient service packages and attributed ancillary services because we believe this would be too prescriptive and each hospital may provide different outpatient service packages and ancillary services. We note, however, that we provide some additional guidance for how hospitals should display of payer-specific negotiated charges for hospital items and services (including service packages) and their ancillary services, as applicable, in sections II.F of this final rule.

We also note that the definition of items and services that we are finalizing gives hospitals flexibility to display their standard charges for service packages that are unique to each of their payer-specific contracts. Thus, a service package that has been negotiated with a third party payer to include treatment for complications or follow up care is included in our definition of hospital items and services.

Comment: One commenter sought clarification on whether CMS is retaining the requirement in current CMS guidelines that PPS hospitals post a list of their standard charges for each Medicare Severity (MS)–DRG.

Response: We are finalizing policies that would supersede the current guidance, and require hospitals to make public their payer-specific charges for items and services, including service packages as identified by DRG, APC, or other common billing code. CMS previously issued guidelines specifying that only hospitals paid under the Medicare IPPS (referred to as subsection (d) hospitals) would be required to establish (and update) and make public a list of their standard charges for each DRG established under section 1886(d)(4) of the SSA.[44] In retrospect, we recognize that this guidance unnecessarily limited the reporting of DRGs by hospitals according to section 2718(e) of the PHS Act, which specifies that a hospital make public a list of the hospital's standard charges for items and services provided by the hospital, including for DRGs established under section 1886(d)(4) of the SSA. As indicated in our proposed definition of ''items and services,'' we interpret the statute to apply to not just individualized items and services, but also to service packages. We believe such service packages are identified by common billing codes (for example, DRG or APCs), not just MS–DRGs. We are therefore implementing new policies in these regulations. Additionally, as discussed in more detail in section II.D.3, we clarify that the standard charge associated with the DRG would be the base rate the hospital has negotiated with third party payers.

Comment: A few commenters supported a definition of items and services that would include services of employed physicians and non-physician practitioners (generally reflected as professional charges). A few commenters supported a more expansive definition of items and services that would require hospitals to post charges for all practitioners who affiliate with a hospital. Commenters who favored this approach typically stated that CMS should place hospitals in a position to be fully responsible for transparency around the entire bill, citing concerns about surprise billing where patients received a separate bill from medical practitioners not employed by the hospital.

Response: We appreciate commenters support for the proposed definition of items and services which would include services of employed physicians and non-physician practitioners (generally reflected as professional charges). We also appreciate comments encouraging the adoption of an even broader definition of items and services that includes services for physicians and non-physician practitioners who are affiliated with the hospital. As stated in the CY 2020 OPPS/ASC proposed rule, because physicians and non-physician practitioners who are not employed by the hospital are practicing independently, establish their own charges for services, and receive the payment for their services, we do not believe the charges for their services fall within the scope of section 2718(e) of the PHS Act as they are not services ''provided by the hospital.'' We note that in section II.F.2 of this final rule, we require hospitals to display their standard charges for shoppable services in a consumer-friendly manner, and we provided an example template for the format hospitals could use for this purpose. In section II.F of this final rule, we require hospitals to group the primary shoppable service with the ancillary services customarily provided by the hospital. We also strongly encourage and recommend that hospitals, for the sake of consumer-friendly presentation, indicate any additional ancillary services that are not provided by the hospital but that the patient is likely to experience as part of the primary shoppable service. We recommend and encourage hospitals to indicate that such services may be billed separately by other entities involved in the patient's care. We believe such disclosure may be helpful to enable consumers to identify when services of physicians or non-physician practitioners not employed by the hospital may be separately charged.

Comment: Several commenters sought clarification on the term ''employment,'' noting there are various relationships and employment arrangements (including, for example, full time employment by a hospital, or independent contractor arrangements). A few commenters described these arrangements. For example, one commenter stated that large academic medical centers may have faculty who are housed in a business entity affiliated with the hospital, but not necessarily employed by that hospital. The commenter also stated there may be instances where independent practices assign billing rights to the hospitals entity, but those practitioners are not considered employed by the hospital. A few commenters explained that in many instances, the employment of physicians and non-physician practitioners represent complicated legal organizational structures. Another commenter explained that it could be difficult to understand in what scenarios physicians are employed based on looking at the billing entity for professional services.

Response: We appreciate the commenters' suggestions identifying examples of the variation and complexity in employment models and possible contracting relationships that may exists between hospitals and physicians, or entities employing physicians. Given such variation and complexity, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure, and we decline at this time to codify a definition of ''employment.''

Comment: Several commenters disagreed that services provided by physicians and non-physician practitioners employed by hospitals should be included in the definition of items and services. These commenters suggested that, under the proposed approach, hospitals that employ physicians and non-physician practitioners would be providing displaying prices that would not be comparable with prices of hospitals that do not employ, and therefore need not disclose, physician and non-physician practitioner prices, and expressed

[44] Available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-internet.pdf.*

concern that this would result in consumer confusion. A few commenters believed hospitals that employ physicians and non-physician practitioners would be at a disadvantage under the proposed definition of ''items and services,'' as their standard charges would appear higher than hospitals that do not. One comment suggested that an unanticipated consequence of requiring price transparency only for employed providers could be hospitals moving capital and services into ''partnerships'' in order to take advantage of the hidden pricing that such a partnership would enable.

Response: We disagree with commenters who suggest that services for employed physicians should be excluded from the definition of items and services as we believe this information will be valuable to give consumers a complete picture of the total amount they might be charged by a hospital.

We disagree with comments suggesting that hospital price transparency requirements would disadvantage those hospitals that employ physicians and non-physician practitioners as compared to hospitals that do not. As further discussed in section II.F. of this final rule, with respect to the requirement to make public certain standard charges for shoppable services in a consumer-friendly format, hospital employed physicians' and non-physician practitioners' services may be charged as ancillary services to a primary shoppable service. Under such circumstances, hospitals would list such ancillary services separately from the primary shoppable service. In Table 2, in section II.F of this final rule, we include an example for how hospitals could format and display their shoppable services. We also note that our final policies require that the standard charges for each shoppable service (including ancillary services) be listed separately, not summed (see section II.F. of this final rule). We therefore believe consumers, comparing shoppable services for multiple hospitals, will be able to distinguish whether or not the hospital standard charges include charges for services of physicians and non-physician practitioners.

We also do not have sufficient information to conclude that a requirement for hospitals to disclose standard charges for services of employed physicians and non-physician practitioners is likely to result in a systematic change from the practice of employing physicians and non-physician practitioners to favoring other types of partnerships and employment arrangements. In developing our proposals for hospital price transparency, we drew from similar requirements of States and we are not aware that such price transparency requirements altered the mode by which hospitals employ physicians and non-physician practitioners.

Comment: A few commenters suggested that CMS lacked the legal basis to establish a definition of hospital items and services that includes services of employed physicians and non-physician practitioners.

Response: Section 2718(e) of the PHS Act requires hospitals to make public the hospital's standard charges for items and services provided by the hospital, including for DRGs. The term ''standard charges for items and services'' is not defined in section 2718. We believe the Secretary has the authority to define ''items and services.'' Since hospitals charge patients for the services of their employed physicians and non-physician practitioners, we believe it is reasonable for the Secretary to define items and services as including their services.

Comment: One commenter expressed concern with requiring hospitals to make public standard charges for services of employed emergency room physicians, urging a cautious approach so as to not undermine the patient protections in place under the Emergency Medical Treatment and Labor Act (EMTALA). The commenter explained that EMTALA stipulates that a hospital may not place any signs in the emergency department regarding the prepayment of fees or payment of co-pays and deductibles that may have the chilling effect of dissuading patients from coming to the emergency department. That, the commenter said, could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status. The commenter expressed concern that if the hospital attempts to provide pricing information to patients prior to stabilizing them, it would not only constitute an EMTALA violation, but it could also potentially cause the patient's health to deteriorate since it could delay the patient from receiving critical care. While the commenter noted that the penalties for violating EMTALA are steep, their larger concern was that if price transparency for emergency care is not approached carefully, a hospital could inadvertently put patients in the position of making life-or-death healthcare decisions based on costs.

Several other commenters stressed how important it is that consumers know the cost of emergency services in non-life threatening circumstances. One commenter explained that he or she might have used price data (if available) to determine which hospital emergency room to go to for treatment of a non-life threatening condition. One commenter noted that in the case of an emergency, people would not have time for comparison of shoppable healthcare services.

Response: We appreciate the comment expressing concern about potential interaction between EMTALA, or section 1867 of the SSA (42 U.S.C. 1395dd), and the requirements for hospitals to make public standard charges under section 2718(e) of the PHS Act. However, we believe that the policies we finalize here that require hospitals to make public standard charges online are distinct from EMTALA's requirements and prohibitions and that the two bodies of law are not inconsistent and can harmoniously co-exist. To be clear, the price transparency provisions that we are finalizing do not require that hospitals post any signage or make any statement at the emergency department regarding the cost of emergency care or any hospital policies regarding prepayment of fees or payment of co-pays and deductibles. But we do believe that the policies we are finalizing, for hospitals to make public standard charges, offer consumers opportunities for informed decision-making by providing them with information about the cost of care which, for example, they might consider prior to visiting a hospital emergency department for treatment of a non-life threatening condition.

Comment: One commenter believed that there should be better patient education to go along with the requirements for listing standard charges related to items and services and service packages.

Response: We note that this rule does not preclude hospitals from taking additional measures to educate their patient populations on the data they make publicly available.

Final Action: We are finalizing, as proposed, the meaning of ''items and services'' at new 45 CFR 180.20. In the CY 2020 OPPS/ASC proposed rule, we had included several examples of items and services within the definition; for clarity, we are finalizing a technical change to enumerate these examples at 45 CFR part 180.20.

Accordingly, items and services means all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection

with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples include, but are not limited to the following:

(1) Supplies and procedures.

(2) Room and board.

(3) Use of the facility and other items (generally described as facility fees).

(4) Services of employed physicians and non-physician practitioners (generally reflected as professional charges).

(5) Any other items or services for which a hospital has established a standard charge.

D. Definitions for Types of ''Standard Charges''

1. Overview and Background

Under our current guidelines related to section 2718(e) of the PHS Act (as discussed in the FY 2019 IPPS/LTCH PPS proposed rule and final rule (83 FR 20164 and 41144, respectively)), a hospital may choose the format it uses to make public a list of its standard charges, so long as the information represents the hospital's current standard charges as reflected in its chargemaster.

As we explained in the CY 2020 OPPS/ASC proposed rule, we received feedback from several commenters in response to the 2018 requests for information (RFIs), including hospitals and patient advocacy organizations, who indicated that gross charges as reflected in hospital chargemasters may only apply to a small subset of consumers; for example, those who are self-pay or who are being asked to pay the chargemaster rate because the hospital is not included in the patient's insurance network. We explained that stakeholders also noted that the charges listed in a hospital's chargemaster are typically not the amounts that hospitals actually charge to consumers who have health insurance because, for the insured population, hospitals charge amounts reflect discounts to the chargemaster rates that the hospital has negotiated with third party payers. Further, with respect to patients who qualify for financial assistance or who pay in cash, commenters on the RFIs pointed out that some hospitals will charge lower amounts than the rates that appear on the chargemaster. Adding to the complexity, a few commenters noted that hospitals often package items and services and charge a single discounted negotiated amount for the packaged service. For example, as discussed in II.C. of this final rule, instead of itemizing and charging for each individual hospital item or service found on the chargemaster, a hospital may identify a primary common condition or procedure and charge a single negotiated or ''cash'' amount for the primary common condition or procedure that includes all associated items and services that are necessary for treatment of the common condition or to perform the procedures. We stated that we believed these comments illustrated a fundamental challenge of making healthcare prices transparent in general, and specifically with respect to the issue of how we should best implement section 2718(e) of the PHS Act; simply put, hospitals do not offer all consumers a single ''standard charge'' for the items and services they furnish. Rather, the ''standard charge'' for an item or service (including service packages) varies depending on the circumstances particular to the consumer (84FR 39577 through 39578).

As discussed in the CY 2020 OPPS/ASC proposed rule, in developing our proposals in this rulemaking we took into account the comments we received from the 2018 RFIs responding to our question about how ''standard charges'' should be defined. We indicated in the CY 2020 OPPS/ASC proposed rule that we believed the variety of suggested definitions reflected and supported our assessment that hospitals can have different standard charges for various groups of individuals. We stated that, in general, for purposes of 2718(e) of the PHS Act, we believed a standard charge could be identified as a charge that is the regular rate established by the hospital for the items and services provided to a specific group of paying patients. Therefore, we considered what types of standard charges may reflect certain common and identifiable groups of paying patients and we proposed to define standard charges to mean ''gross charges'' and ''payer-specific negotiated charges,'' and to codify this definition in proposed new 45 CFR 180.20. As explained in the CY 2020 OPPS/ASC proposed rule, our proposal to define standard charges as gross charges and payer-specific negotiated charges reflects the fact that a hospital's standard charge for an item or service is not typically a single fixed amount, but, rather, depends on factors such as who is being charged for the item or service, and particular circumstances that apply to an identifiable group of people, including, for example, healthcare consumers that are insured members of third party insurance products and plans that have negotiated a rate on its members' behalf.

Further, in the CY 2020 OPPS/ASC proposed rule, we acknowledged that the proposed definition of hospital ''standard charges'' would be limited to only two of the many possibilities that exist for defining types of hospital ''standard charges,'' and we discussed other potential definitions that we considered, and sought public input and comment on the alternatives and additional types of standard charges that may be useful to consumers.

Comment: Many commenters, in particular, individuals and those representing independent medical practices, expressed frustration related to the opacity of healthcare prices, stating that hospital charges are often unreasonable. Commenters described hospital billing practices as a ''shell game'' and asserted that the use of overly inflated chargemaster rates to negotiate with payers is an unfair practice that leads patients to get ''gouged.'' One commenter noted that the ''lack of price transparency circumvents market forces that seek to keep prices within reasonable limits [which has] resulted in the creation of a dysfunctional market with rapidly increasing and excessive charges for which the consumer is ultimately responsible.'' Others similarly asserted that the lack of availability of healthcare costs leads to ''predatory pricing'' on the part of hospitals and insurance companies, and noted that millions of Americans have gone bankrupt because they get ''stuck with bills that are beyond reasonable.''

Many commenters asserted that hospital disclosure of standard charges would be critical to bring accountability and increased value to the healthcare industry; however, many other commenters stated that they believed the movement toward value-based care could or would be harmed by hospital disclosure of standard charges, specifically, as a result of disclosure of payer-specific negotiated charges.

Many commenters were highly supportive of our proposals and, in particular, of the proposals to require hospitals to make public both gross and payer-specific negotiated charges. Many commenters asserted that such disclosure is informative and necessary for consumers and will improve the value of healthcare for consumers. For example, commenters indicated that knowing the rate the insurer had negotiated on their behalf would be essential for patients with co-insurance and HDHPs to help determine their out-of-pocket cost estimates in advance. Other commenters indicated that the gross charge or cash rate was important for self-pay patients (with or without insurance) to compare facility prices.

Many other commenters, however, disagreed with our proposals,

questioning the legal authority for requiring disclosure of more than one type of hospital standard charge as proposed, with objections focused mainly on the proposed definition and requirement to disclose payer-specific negotiated charges.

Many commenters supported the addition of, or offered alternative suggestions for, necessary types of standard charges such as the discounted cash price and variations of the de-identified minimum, median, or maximum negotiated charge.

Response: Hospital bills can be mystifying, even to those who have been in healthcare-related professions for years; some hospital charges are market-based, while others are not. There are three broad types of hospital rates, depending on the patient and payer: (1) Medicaid and Medicare FFS rates; (2) Negotiated rates with private insurers or health plans; and (3) Uninsured or self-pay.

Medicaid FFS rates are dictated by each State and tend to be at the lower end of market rates. Medicare FFS rates are determined by CMS and those rates tend to be higher than Medicaid rates within a state. Privately negotiated rates vary with the competitive structure of the geographic market and usually tend to be somewhat higher than Medicare rates, but in some areas of the country the two sets of rates tend to converge.

Chargemaster (gross) rates charged to self-pay individuals bear little relationship to market rates, are usually highly inflated,[45] and tend to be an artifact of the way in which Medicare used to reimburse hospitals. Under the old system, the more services a hospital provided and longer a patient's stay, the greater the reimbursement. Congress, recognizing that the reimbursement system created disincentives to provide efficient care, enacted in 1983 a prospective payment system. The primary objective of the prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs in delivering necessary care to Medicare beneficiaries.

To partly compensate hospitals for certain overly costly hospitalizations, hospitals may receive an ''outlier'' payment which is based on the hospital's billed charges, adjusted to cost, in comparison to the payment that would otherwise be received and an outlier threshold. See 42 CFR 412.84. To determine whether an individual case would qualify for an outlier payment, the hospital's cost-to-charge ratio is applied to the covered charges to estimate the costs of the case. In the late 1990s, many hospitals began manipulating or gaming that ratio to make it easier to qualify for outlier payments. The larger the charges, the smaller the ratio, but it takes time for the ratio to be updated. Thus, by way of example, if a hospital had a cost-to-charge ratio 1 to 5, or 20 percent, then a pill which cost the hospital $1 to purchase might be billed to a patient at $5. However if the hospital doubled the charge to the patient to $10, the corresponding change in its ratio would take time to be updated. Its costs might look like $2 instead of $1 in the interim. Rule changes have reduced such manipulation. Nevertheless, some hospitals' charges do not reflect market rates, and these can come into play when a hospital bills a self-pay patient. Hospital bills that are generated off these chargemaster rates can be inherently unreasonable when judged against prevailing market rates.

As premiums under the ACA have become less affordable,[46] many individuals, both with and without insurance, have large unpaid hospital bills. Some hospitals, including some that are categorized as charitable, have responded by instituting collection actions against those patients. As the number of these suits have proliferated, many states courts have had to grapple with hospital charging systems in order to judge whether a given set of charges was reasonable. There are several potential metrics for assessing reasonableness of a hospital's charge in a given case as an alternative to the chargemaster (gross) rates described above. These include the rate Medicare would have paid for those same services, the amount hospitals are supposed to charge needy patients who lack insurance ''not more than the amounts generally billed to individuals who have insurance covering such care'' (see IRC 501(r)(5)(A) or the amounts billed consistent with the financial assistance policy each non-profit hospital is requires to have (see IRC 501(r)(4)).

We continue to believe that the public posting of hospital standard charge information will be useful to the public, including consumers who need to obtain items and services from a hospital, consumers who wish to view hospital prices prior to selecting a hospital, clinicians who use the data at the point of care when making referrals, and other members of the public who may develop consumer-friendly price transparency tools or perform analyses and make policy to drive value-based care. In the CY 2020 OPPS/ASC proposed rule, we stated that we believed these proposed requirements would represent an important step towards putting healthcare consumers at the center of their healthcare and ensuring they have access to the hospital standard charge information they need. Additionally, as stated in the CY 2020 OPPS/ASC proposed rule, we believe that requiring transparency of hospital charges will drive competition, which, in turn, may have the effect of not only lowering hospital charges for the most vulnerable consumers and those with the least market power to negotiate prices, but also for consumers who have access to charges negotiated on their behalf by a third party payer.

We also continue to believe that price transparency will lead to lower costs for consumers and better quality of care. As stated in the CY 2020 OPPS/ASC proposed rule, many empirical studies have investigated the impact of price transparency on markets, with most research showing that price transparency leads to lower and more uniform prices, consistent with predictions of standard economic theory. Further, evidence shows that healthcare quality is not often correlated with price.[47] Traditional economic analysis suggests that if consumers have better pricing information for healthcare services, providers would face pressure to either lower prices or to provide better quality of care for the prices they charge.[48] Much of the research evidence we considered in the development of these requirements and in the CY 2020 OPPS/ASC proposed rule are reprised in sections II.A, II.D.3, and in our Regulatory Impact Analysis (RIA) (section V). Because the drive towards value depends on access to both quality and cost information, we believe that disclosure of hospital standard charges fully aligns with and supports our drive

[45] Richman BD, et al. Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care. *Am J Manag Care.* 2017;23(4):e100–e105. Available at: *https://www.ajmc.com/journals/issue/2017/2017-vol23-n4/battling-the-chargemaster-a-simple-remedy-to-balance-billing-for-unavoidable-out-of-network-care.*

[46] NCSL website, Health Insurance: Premiums and Increases, at *http://www.ncsl.org/research/health/health-insurance-premiums.aspx.*

[47] Hussey P, et al. The Association Between Health Care Quality and Cost A Systematic Review. *Ann Intern Med.* January 2013; 158(1): 27–34. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4863949/.*

[48] Ginsburg P. Shopping For Price In Medical Care. *Health Affairs.* 2007. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.26.2.w208.*

toward value care as one half of the value proposition. In other words, whereas hospital quality information is readily available to the public,[49] [50] hospital standard charge information is not. Disclosure of hospital standard charge information will therefore complement quality information so that consumers can make high value decisions about their care.

Section 2718 of the PHS Act provides authority to require disclosure of hospital standard charges. Specifically, section 2718(e) of the PHS Act requires each hospital operating within the United States for each year to establish (and update) and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the SSA. In addition to section 2718(e) and section 2718(b)(3) (regarding enforcement), section 1102 of the SSA supports the requirements in this rule. Section 1102(a) of the SSA requires the Secretary to ''make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which [he or she] is charged'' under the SSA. By its terms, this provision authorizes regulations that the Secretary determines are necessary to administer these programs. In our view, as discussed further below, there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs. In addition, these requirements also promote the efficient administration of the Medicare and Medicaid programs.

Since the PHS Act does not define ''standard charges'' for purposes of implementation of section 2718(e) of the PHS Act, we proposed to define standard charges by the regular rate established by the hospital for an item or service provided to a specific group of paying patients. The term ''rate'' is defined in the Oxford dictionary as ''a fixed price paid or charged for something, especially goods or services.'' We therefore use the terms ''rate'' and ''charge'' interchangeably throughout this final rule. We believe that reading the statute to permit disclosure of several types of charges (or ''rates'') that are standard for different identifiable groups of people is reasonable for several reasons. First, while there is a definition of ''charge'' in the SSA that is used for purposes of Medicare (as commenters noted and as discussed in more detail in II.D.2), there is not a definition of 'standard charges' in either the PHS Act or the SSA. We believe that had Congress intended us to use the SSA definition of ''charges,'' Congress would have referenced that definition of ''charges'' and included this provision in the SSA, as opposed to the PHS Act. Alternatively, Congress could have indicated that hospitals make public their ''charges'' and not qualified the term by inserting ''standard'' in front of it. Moreover, we believe the statute contemplates disclosure of changes other than the hospital chargemaster rates because the statute requires hospitals to disclose their ''standard charges'' for items and services, *including for diagnosis related groups* (italicized for emphasis). This suggests that the statute contemplates disclosure of charges other than the list prices as found in the hospital chargemaster because the hospital chargemaster contains only list prices for individual items and services. Hospital chargemasters do not include list prices for service packages represented by common billing codes such as DRGs. Instead, ''standard charges'' for service packages are determined as a result of negotiations with third party payers.[51] For these reasons and others articulated in the CY 2020 OPPS/ASC proposed rule, we believe the term ''standard charges'' for purposes of implementing section 2718(e) of the PHS Act may be defined to mean the standard charges as they relate to different identifiable groups of people and to include charges other than those found in the hospital chargemaster.

As there are many different identifiable groups of paying patients (some that are self-pay and others that are members of third party payer insurance plans), in the CY 2020 OPPS/ASC proposed rule, we defined two types of standard charges, specifically, the gross (chargemaster) charges and the payer-specific negotiated charges. As explained in section II.A. of this final rule, we continue to believe that gross charges found in the chargemaster as well as negotiated charges are both informative and necessary for consumers to understand their potential out-of-pocket cost obligations, but such information is not readily available to consumers. These two specific types of standard charges have the potential to inform two large identifiable groups of healthcare consumers who do not currently have ready access to hospital charge information, specifically those who have limited power to negotiate charges (for example, self-pay individuals) and those who rely on third party payers to negotiate charges on their behalf. We also continue to believe that hospital face only a limited burden to make publicly available these types of standard charges because good business practices necessitate that these charges be available, maintained, and in use in hospital billing and accounting systems.

Section 2719 of the PHS Act requires non-grandfathered plans and issuers to provide a notice of adverse benefit determination [52] (commonly referred to as an explanation of benefits (EOB)) to participants, beneficiaries, and enrollees after healthcare items or services are furnished and claims for benefits are adjudicated. We note that presentation of both gross charges and payer-specific negotiated charges is consistent with the standard charges found in a patient's EOB that health insurance plans are required to provide to patients following a healthcare service. EOBs include such data points as: The type of service provided; the amount the hospital billed for the service (which we define as the gross charge for purposes of implementing section 2718(e) of the PHS Act); any discount the patient received for using an in-network provider (which we define as the payer-specific negotiated charge for purposes of implementing section 2718(e) of the PHS Act) or the allowed amount for out-of-network providers; the portion or amount the plan paid the hospital; and the remaining amount owed out-of-pocket and any portion of that amount applied toward the deductible. It is evident that while the first two sets of charge data are necessary for a consumer to understand their out-of-pocket obligations, that data are insufficient as the consumer must obtain additional information from his or her third party payer related to the circumstances of their particular insurance plan (for example, what portion of the payer-specific negotiated charges would be paid by the plan and

[49] *https://www.medicare.gov/hospitalcompare/search.html.*

[50] AHRQ website, Comparative Reports on Hospitals, at *https://www.ahrq.gov/talkingquality/resources/comparative-reports/hospitals.html.*

[51] Office of Attorney General, Commonwealth of Massachusetts. *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17.* (October 11, 2018). Available at: *https://www.mass.gov/files/documents/2018/10/11/AGO%20Cost%20Trends%20Report%202018.pdf.*

[52] An adverse benefit determination means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in 29 CFR 2590.715–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). See 26 CFR 54.9815–2719, 29 CFR 2590.715–2719 and 45 CFR 147.136. Plans subject to the requirements of ERISA (including grandfathered health plans) are also subject to a requirement to provide an adverse benefit determination under 29 CFR 2560.503–1.

other plan dependencies such as the patient's co-insurance obligations or where the patient is in their deductible for the year). Both gross charges and payer-specific negotiated charges are therefore necessary starting points for patients with third party payer insurance to understand their out-of-pocket cost obligations, and hospitals have ready access to both. By making these two important types of standard charges public, consumers could have the information necessary to create what could be considered an EOB in advance of a service, rather than having to wait for months after services were rendered to understand the extent of their healthcare costs. We address the gross charges as a type of standard charge in section II.D.2 of this final rule. We address the payer-specific negotiated charge in section II.D.3 of this final rule.

Finally, we appreciate commenter support and suggestions for alternative types of standard charges and are finalizing three additional types of standard charges in response to comments. Specifically, we are finalizing the discounted cash price (as discussed in section II.D.4.c of this final rule), as well as the de-identified minimum negotiated charge and the de-identified maximum negotiated charge which are discussed in section II.D.4.d of this final rule.

Final Action: After considering the public comments, we are finalizing as proposed our definition of standard charges at 45 CFR 180.20 to mean the regular rate established by the hospital for an item or service provided to a specific group of paying patients. We are also finalizing two types of standard charges, gross charges and payer-specific negotiated charges (as discussed in more detail in sections II.D.2 and II.D.3 of this final rule). Further, as a result of broad stakeholder support for the discounted cash price as an alternative type of standard charge because of its greater applicability to self-pay individuals, we are adding the discounted cash price as a third type of standard charge (as discussed in more detail in section II.D.4.c of this final rule). In response to the many commenters who supported variations of the de-identified minimum, median and maximum negotiated charges, we are finalizing modifications to define the de-identified minimum negotiated charge, and de-identified maximum negotiated charge as a fourth and fifth type of standard charge (as discussed in more detail in section II.D.4.d of this final rule). Each of these types of standard charges (the gross charge, the payer-specific negotiated charge, the discounted cash price, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge) and the comments received are discussed in more detail in sections II.D.2, II.D.3, and II.D.4.c and II.D.4.d of this final rule, respectively.

2. Definition of ''Gross Charges'' as a Type of Standard Charge

We proposed that, for purposes of the first type of ''standard charge,'' a ''gross charge'' would be defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts (at new 45 CFR 180.20). As we explained in the CY 2020 OPPS/ASC proposed rule (84 FR 39576 through 39577), the hospital chargemaster contains a list of all individual items and services the hospital provides. The gross charges reflected in the chargemaster often apply to a specific group of individuals who are self-pay, but do not reflect charges negotiated by third party payers. We also noted that the chargemaster does not include charges that the hospital may have negotiated for service packages, such as per diem rates, DRGs or other common payer service packages, and therefore this type of standard charge would not include standard charges for service packages.

We proposed to require hospitals to make public their gross charges because, in addition to applying to a specific group of individuals, based on research and stakeholder input, we believe gross charges are useful to the general public, necessary to promote price transparency, and necessary to drive down premium and out-of-pocket costs for consumers of healthcare services. For example, studies suggest that the gross charge plays an important role in the negotiation of prices with third party insurance products that are subsequently sold to consumers.[53] Specifically, as hospital executives and others familiar with hospital billing cycles often note, hospitals routinely use gross charges as a starting point for negotiating discounted rates with third party payers, and higher gross charges have been found to be associated with both higher negotiated rates and, in turn, higher premiums and out-of-pocket costs for insured individuals.[54] [55] As such, gross charges are relevant to all consumers, including those with insurance coverage. We stated in the CY 2020 OPPS/ASC proposed rule that we believe that requiring transparency of hospital gross charges may drive competition, which, in turn, might have the effect of not only lowering hospital charges for the most vulnerable consumers and those with the least market power to negotiate prices, but also for consumers who have access to charges negotiated on their behalf by a third party payer.

Additionally, we indicated in the CY 2020 OPPS/ASC proposed rule that third party developers of consumer price transparency tools can use gross charges in conjunction with additional information (such as an individual's specific insurance and benefit information and quality data) to develop and make available consumer-friendly out-of-pocket cost estimates that allow consumers to compare healthcare service prices across hospitals and other nonhospital settings of care. Moreover, we noted in the CY 2020 OPPS/ASC proposed rule (84 FR 39572 through 39573) that research suggests that making such consumer-friendly information available to the public has been demonstrated to reduce consumer healthcare costs. As such, we concluded that public access to hospital gross charges is critical to inform all patients (both self-pay and insured) of their choices and drive transparency in prices and proposed to codify the proposed definition of ''gross charges'' at new 45 CFR 180.20. We invited public comment on our proposal to define a type of ''standard charge'' as a ''gross charge'' and on our proposed definition of ''gross charge.''

Comment: Several commenters specifically agreed with our proposal to include gross charges as a type of standard charges. A few commenters also stated that they believed gross charges should be the only definition of ''standard charge.'' Several commenters, however, disagreed with the proposed inclusion of gross charges as a type of standard charge due to their belief that the definition conflicts with the definition of ''charges'' used in CMS's Provider Reimbursement Manual Part 1 (PRM1). Several commenters emphasized the importance of CMS remaining consistent with its definitions of ''charges'' due to their belief that deviating from these definitions would undermine the accuracy of hospital cost

[53] Bai G and Anderson GF. Market Power: Price Variation Among Commercial Insurers for Hospital Services. *Health Affairs.* Oct 2018; 37(10): 1615–1622. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0567.*

[54] Bai G and Anderson GF. Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios. *Health Affairs.* Jun 2015; 34(6): 922–928. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1414.*

[55] Batty M and Ippolito B. Mystery of The Chargemaster: Examining The Role Of Hospital List Prices in What Patients Actually Pay. *Health Affairs.* April 2017; 36(4): 689–696. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0986.*

reports which is fundamental to the Medicare rate-setting process.

Response: We thank commenters for their support of a definition of the first type of standard charge to be the ''gross charge'' and disagree with commenters who state that the gross charge should be the only standard charge. As further explained in section II.D.1 of this final rule, we believe the statute contemplates standard charges other than those found in the hospital chargemaster. Additionally, we sought comment last year on a definition of ''standard charges'' and, as a result of comments, we were persuaded a singular ''standard'' that applies to all identifiable groups of patients is not possible because groups of patients with third party payer insurance have different standard charges that apply to them than do patients without third party payer coverage. We therefore decline to adopt the several commenters' suggestions that we finalize the gross charge as the only type of hospital standard charge.

Further, we do not believe our proposed definition of ''gross charges'' for purposes of implementing section 2718(e) of the PHS Act conflicts with definitions of ''charges'' found in the PRM1, which states ''Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; *i.e.,* charges before the application of allowances and discounts deductions.'' [56] In fact, we believe our definition of ''gross charge'' as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts, is the same as the charges referenced in the PRM1 and that hospitals use to create cost reports for Medicare purposes. We further do not believe that the term ''charges'' as used in the PRM is in conflict because the term is defined for a specific purpose and use, that is, for purposes of Medicare cost reporting. For this reason, we disagree with commenters that our definition of ''gross charges'' as a type of standard charge in any way undermines the accuracy of hospital Medicare cost reports.

[56] Part I, Chapter 22, Section 2202.4 of the Medicare Provider Reimbursement Manual *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html.*

Additionally, gross charges may also sometimes be referred to as ''billed charges'' or ''billed amounts'' and appear on a patient's EOB as the first charge listed, and are the first step in explaining the patient's out-of-pocket obligations. When the consumer has no insurance and is self-pay, there is no EOB and the hospital often applies the gross charges to the consumer if no other pre-arrangement has been worked out (for example, if the consumer has not taken advantage of a discounted cash price offered by the hospitals).

Comment: Regarding the need for and usefulness of gross charges as a type of standard charge, several commenters asserted that gross charge data would be meaningful to the public and necessary for full price transparency. A few commenters emphasized the positive difference this information would make if people had the ability to see information, for example one commenter stated that they would like to see the different levels of room charges on a list, stating that it would make a big difference for most people. A few commenters added that by seeing costs up front they could make an informed decision before receiving care, in order to both anticipate their bill and potentially shop around. A few commenters also expressed that by seeing all charges up front, consumers could determine whether ''self-pay'' would be a better deal for them than paying the insurance copay and deductible. By contrast, several commenters disagreed that gross charges would be applicable or useful to the public, because they believe that they do not represent what most consumers would actually pay (particularly those with third party payer coverage) and would not be meaningful to the public. One commenter stated that even in the hands of app developers, this data may have little relevance to insured individuals because the data wouldn't be presented in the context of the individual's health plan. One commenter disagreed with hospitals posting gross charges because they believe that in rural areas, the appearance of high prices may deter a consumer from seeking care.

Response: We thank the commenters for their input. We agree with stakeholders who suggested that while the gross charge may be applicable to some self-paying patients, it is not the standard charge that applies to groups of insured patients. Even some self-paying patients may find that some hospitals offer a cash discounted price off their chargemaster rates (as discussed in more detail in section II.D.4.c of this final rule). Because of this, we are finalizing definitions for several types of standard charges that would be applicable to both self-pay patients as well as consumers with third party payer coverage. As we outlined in more detail in the CY 2020 OPPS/ASC proposed rule (84 FR 39578 through 39579), research suggests that gross charges appear to play an important role in prices paid by consumers with third-party insurance products because higher gross charges are associated with higher negotiated rates, premiums, and consumer out-of-pocket costs. For consumers who are self-pay or who lack insurance, such information can be useful in advance of selecting a provider of healthcare services to help patients determine potential out-of-pocket cost obligations. This information may also have high value for researchers and other academics who can assess regional and national cost trends to determine the effectiveness of price transparency efforts, and for lawmakers to determine policy improvements that are necessary to drive toward value in healthcare. As noted in II.D.1 in this final rule, the presentation of gross charges is the starting point for insured patient's EOBs, which contain multiple charge and other data points necessary for patients to understand their out-of-pocket cost obligations. We therefore believe that disclosure of gross charges are useful to the general public and necessary to promote price transparency and reduce premiums and out-of-pocket costs for consumers of healthcare.

We recognize the unique challenges that rural hospitals face, but disagree that rural hospitals making standard charges public would deter patients from seeking necessary care, especially where there is already minimal competition with a CAH or sole community hospital. We believe instead that this information would allow consumers to include price considerations in their treatment plan for elective procedures, which may result in selecting the most appropriate setting for their care and increased patient satisfaction.

Final Action: At new 45 CFR 180.20, we are finalizing as proposed a definition of gross charge, as a type of standard charge, to mean the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

3. Definition of ''Payer-Specific Negotiated Charge'' as a Type of Standard Charge

As noted in section II.D.1. of this final rule, in general, for purposes of 2718(e), we believe a standard charge can be identified as a regular rate established

by the hospital for the items and services provided to a specific group of paying patients. We proposed that, for purposes of the second type of ''standard charge,'' the ''payer-specific negotiated charge'' would be defined as the charge that the hospital has negotiated with a third party payer for an item or service. We further proposed to define ''third party payer'' for purposes of section 2718(e) of the PHS Act as an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service, and to codify this definition at new 45 CFR 180.20. As the reference to ''third party'' suggests, this definition excludes an individual who pays for a healthcare item or service that he or she receives (such as self-pay patients).

We proposed to focus on a second type of ''standard charge'' related to negotiated rates because most consumers (over 90 percent [57]) rely on a third party payer to cover a portion or all of the cost of healthcare items and services, including a portion or all of the cost of items and services provided by hospitals (in accordance with the terms and conditions of the third party payer's contract agreement with that consumer). Some third party payers (for example, FFS Medicare and Medicaid) currently make public the maximum rate they pay for a hospital item or service. However, many third party payers do not reveal their negotiated rates, even to individuals on behalf of whom they pay. Additionally, many contracts between third party payers and hospitals contain so-called ''gag clauses'' that prohibit hospitals from disclosing the rates they have negotiated with third party payers.[58] Because consumers are not generally part of the negotiations or privy to the resulting negotiated rates, consumers often find it difficult to learn in advance of receiving a healthcare service the rate their third party payers may pay and subsequently what the individual's portion of the cost will be. Having insight into the charges negotiated on one's behalf is necessary for insured healthcare consumers to determine and compare their potential out-of-pocket obligations prior to receipt of a healthcare service. For example, if a healthcare consumer knows that he or she will be responsible for a co-pay of 20 percent of the charges for a hospital service, he or she can compare the charges that the third party negotiated with hospital A and hospital B and, from that, the consumer can determine his or her expected out-of-pocket costs at hospital A versus hospital B.

In the CY 2020 OPPS/ASC proposed rule, we explained that knowing a negotiated charge is also important because a growing number of insured healthcare consumers are finding that some services are more affordable if the consumer chooses to forego utilizing their insurance product and simply pays out-of-pocket. For example, stakeholders and reports indicate that an increasing number of consumers are discovering that sometimes providers' cash discounts can mean paying lower out-of-pocket costs than paying the out-of-pocket costs calculated after taking into account a third party payer's higher negotiated rate.[59] [60] [61] [62] However, consumers cannot make such determinations without knowing the rate their third party payer has negotiated.

For the reasons discussed above, we indicated that we agreed with 2018 RFI commenters that gross charges (as a type of standard charge) could be applicable to one identifiable group of consumers (for example, self-pay) but are not enough for another large and identifiable group of consumers (for example, those with third party insurance) to know their charges for hospital items. Thus, we proposed that a type of ''standard charge'' is the ''payer-specific negotiated charge'' that would be defined as the charge (or rate) that a hospital has negotiated with a third party payer for an item or service. We stated that we decided to focus on negotiated rates rather than all payer rates because charges that are not negotiated (for example, FFS Medicare or Medicaid rates) are often already publicly available.

In the CY 2020 OPPS/ASC proposed rule, we stated that it is clear that such data is necessary for consumers to be able to determine their potential out-of-pocket costs in advance, and that we believe the release of such data would help drive down healthcare costs (as discussed above and supported by recent price transparency research). However, we also stated we recognized that the impact resulting from the release of negotiated rates is largely unknown and that some stakeholders had expressed concern that the public display of negotiated rates, at least without additional legislative or regulatory efforts, may have the unintended consequence of increasing healthcare costs of hospital services in highly concentrated markets or as a result of anticompetitive behaviors.[63]

Moreover, we recognized in the CY 2020 OPPS/ASC proposed rule that requiring release of all payer-specific negotiated charges for all hospital items and services (both individual items and services as well as service packages) would mean releasing a large amount of data. To get a sense for the number of potential negotiated rates a hospital may have, we conducted an internal analysis of plans in the regulated individual and small group insurance markets under the ACA. Our analysis indicated that the number of products or lines of service per rating area ranges from approximately 1 to 200 in the individual market (averaging nearly 20 products or lines of service in each rating area), while in the small market group, the number ranges from 1 to 400 (averaging nearly 40 products or lines of service in each rating area). We further noted our belief that most, if not all, hospitals maintain such data electronically because these data are used routinely for billing, and concluded that disclosure of such large amounts of charge information would present little burden for a hospital to electronically pull and display online in a machine-readable format (as discussed in more detail in the CY 2020 OPPS/ASC proposed rule at 84 FR 39581 through 39585). We went on to explain that ensuring display of such a large amount of data in a consumer-friendly manner may pose greater challenges.

In the CY 2020 OPPS/ASC proposed rule, we noted that, in displaying the payer-specific negotiated charges, hospitals would display all negotiated charges, including, for example, charges

[57] Berchick E, et al. Health Insurance Coverage in the United States: 2017. United States Census Bureau, September 2018. Available at: *https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.*

[58] King JS, Muir MA, Alessi SA. Clarifying Costs Can Increased Price Transparency Reduce Healthcare Spending? 4 William & Mary Policy Review 319 (2013). Available at: *https://pdfs.semanticscholar.org/f604/1a0484c65c593525d0c07e040cf655697f2d.pdf.*

[59] Beck M. How to Cut Your Health-Care Bill: Pay Cash. *The Wall Street Journal.* February 15, 2016. Available at: *https://www.wsj.com/articles/how-to-cut-your-health-care-bill-pay-cash-1455592277.*

[60] Rosato D. How Paying Your Doctor in Cash Could Save You Money. *Consumer Reports.* May 4, 2018. Available at: *https://www.consumerreports.org/healthcare-costs/how-paying-your-doctor-in-cash-could-save-you-money/.*

[61] Terhune C. Many hospitals, doctors offer cash discount for medical bills. *Los Angeles Times.* March 27, 2012. Available at: *https://www.latimes.com/business/healthcare/la-fi-medical-prices-20120527-story.html.*

[62] Weissmann D. 'An Arm And A Leg': Can You Shop Around For A Lower-Priced MRI? *Kaiser Health News.* June 19, 2019. Available at: *https://khn.org/news/an-arm-and-a-leg-can-you-shop-around-for-a-lower-priced-mri/.*

[63] King JS, Muir MA, Alessi SA. Clarifying Costs Can Increased Price Transparency Reduce Healthcare Spending? 4 William & Mary Policy Review 319 (2013). Available at: *https://pdfs.semanticscholar.org/f604/1a0484c65c593525d0c07e040cf655697f2d.pdf.*

negotiated with Medicare Advantage plans because such rates are negotiated. Conversely, hospitals would not include payment rates that are not negotiated, such as rates set by certain healthcare programs that are directly government-financed, for example, those set by CMS for FFS Medicare. We indicated, however, that we believed the display of a non-negotiated rate (for example, display of a Medicare and Medicaid FFS rate for an item or service) in conjunction with the gross charge and the payer-specific negotiated charges for the same item or service could be informative for the public and that the proposals would not preclude hospitals from displaying them.

Finally, we proposed to codify the definition of ''payer-specific negotiated charge'' and ''third party payer'' at new 45 CFR 180.20. We invited public comment on our proposal to define a type of ''standard charge'' as a ''payer-specific negotiated charge.'' We also sought public comment on whether and how the release of such specific charge information could result in unintended consequences and on whether and how there may be different methods for making such information available to individuals who seek to understand what their out-of-pocket cost obligations may be in advance of receiving a healthcare service.

Comment: Many individual commenters and organizations, including patient/consumer advocates, IT and tool developers, medical associations, and small business plan entities, were strongly in favor of the release of payer-specific negotiated charges, indicating that such information is essential for individual decision-making. One commenter stated that the Administration's goal to improve the value of care relies on the disclosure of negotiated rates.

By contrast, many commenters, including commenters from hospitals and large insurers, indicated that the release of gross charges or payer-specific negotiated charges would not be helpful or meaningful to consumers who want to know their individual out-of-pocket estimates. Many commenters noted that the release of gross and payer-negotiated charges is not sufficient by itself, highlighting consumers' need for additional information (such as co-pay, deductible, etc.) to get an individualized out-of-pocket estimate. Several commenters stated their belief that identification of the payer was not necessary for negotiated charges to be useful to the public. Several commenters raised concern related to the potential for patient confusion over the posting of negotiated charges, including if they try to determine how it impacts their financial obligation or over potential discrepancies between the amount the hospital makes public and the amount the insurer indicates to the patient in EOBs sent after the fact. Many commenters stated that they do not believe consumers will use this information.

Response: We appreciate the response from stakeholders who expressed support for our proposed definition of a type of standard charge as the payer-specific negotiated charge. We agree for the policy reasons indicated in the CY 2020 OPPS/ASC proposed rule (84 FR 39579 through 39580) and by commenters that public disclosure of payer-specific negotiated charge (also known as negotiated rates) is essential for insured individuals' decision-making. For the reasons we have indicated, we disagree with commenters who indicated that payer-specific negotiated charges are meaningless to consumers, but we do agree that a payer-specific negotiated charge does not, in isolation, provide a patient with an individualized out-of-pocket estimate. As explained in the GAO report we describe in section II.A. of this final rule, payer-specific negotiated charges are a critical piece of information necessary for patients to determine their potential out-of-pocket cost estimates in advance of a service. As explained in section II.D.1 of this final rule, EOBs are designed to communicate provider charges and resulting patient cost obligations, taking third party payer insurance into account, and the payer-specific negotiated charge is a standard and critical data point found on patient's EOB. When a consumer has access to payer-specific negotiated charge information prior to receiving a healthcare service (instead of sometimes weeks or months after the fact when the EOB arrives), in combination with additional information from payers, it can help him or her determine potential out-of-pocket cost. Knowing a negotiated charge is also important because a growing number of insured healthcare consumers are finding that some services are more affordable when they elect to forego utilizing their health insurance product and, instead, pay out-of-pocket. We further agree that consumers may be able to get a general sense of the cost of healthcare services by viewing de-identified negotiated rates, and we address this issue in more detail in section II.D.4.d of this final rule. However, we believe that having hospitals disclose payer-specific negotiated charges would provide consumers with more specific information for their particular circumstance and insurance plan.

We disagree that there will be confusing discrepancies between the posted hospital charges and the patient's EOB because payer-specific negotiated rates are agreed upon, and, therefore, known in advance by both hospitals and third party payers. We suggest that hospitals access and review the rate sheets (also referred to as rate tables or fee schedules) that are typically included in the contracts hospitals have with third party payers in order to ensure the information they make public is consistent with their contracted rates.

Finally, based on the multitude of comments we received from patient advocates and individual consumers, we believe that patients will use the charge information that hospitals make public. Additionally, hospital charge information can inform shared decision-making and patient-centric referrals at the point of care. Recent research suggests that an increasing number of patients are seeking information from their providers about the anticipated costs of healthcare services. For example, in a recent national survey, a majority of patients, physicians, and employers are ready, or feel a responsibility, to have cost of healthcare conversations.[64] Such conversations depend on the availability of standard charge information.

Comment: Many commenters, including hospital associations and large insurers, questioned CMS' legal authority to require disclosure of payer-specific negotiated charges. For example, many commenters believed that payer-specific negotiated rates are proprietary and requiring their disclosure would infringe upon intellectual property rights recognized by Congress through the Defend Trade Secrets Act of 2016 (DTSA).[65] A few commenters indicated that disclosure of payer-specific negotiated charges was likely limited under the Freedom of Information Act (FOIA). Commenters argued that the FOIA protects trade secrets and confidential commercial or financial information against broad public disclosure. These commenters further asserted that the requirement to disclose payer-specific negotiated charges would violate the First Amendment, and, therefore, compelling disclosure would be unconstitutional. Several commenters pointed out that

[64] University of Utah Health website, Let's Talk About Money, *https://uofuhealth.utah.edu/value/lets-talk-about-money.php.*

[65] 18 U.S.C. 1836.

some contracts between hospitals and payers include non-disclosure clauses, prohibiting the hospital from disclosing the rates they negotiated with third party payers.

Response: We believe that we have authority to define ''standard charges'' to mean the regular rate established by the hospital for an item or service provided to a specific group of paying patients, and that one type of standard charges is payer-specific negotiated charges. As explained in section II.D.2 of this final rule, the term ''standard charges'' is not defined in either the SSA or the PHS Act. We are also not aware of any historical usage of the term by the industry, and note that its association with the rates in a hospital chargemaster appears to have originated with our guidelines that took effect on January 1, 2019. Additionally, we note that many stakeholders (including hospitals) have provided feedback that our current guidelines are neither sufficient to inform consumers (particularly those with insurance) what their charges for a hospital item or service will be, nor reflective of the financial liability that they will actually incur. We therefore concluded it would be reasonable to define payer-specific negotiated charges as a type of ''standard charge.''

We do not believe that the payer-specific negotiated charges hospitals would be required to disclose are proprietary or would constitute trade secrets. To the contrary, this information is already generally disclosed to the public in a variety of ways, for example, through State databases and patient EOBs. For example, New Hampshire has released payer and provider specific negotiated rates in its state operated HealthCost database. Maine has also been releasing negotiated rate information for over a decade. Additionally, the rates are routinely available to patients through EOBs. As noted elsewhere, that presentation of both gross charges and payer-specific negotiated charges is consistent with the standard charges found in a patient's EOBs that health insurance plans are required to provide to patients following a healthcare service. EOBs include such data points as: The type of service provided; the amount the hospital billed for the service (which we define as the gross charge for purposes of these requirements); any in-network discount an insured patient received (which we define as the payer-specific negotiated charge for purposes of these requirements); and the remaining amount owed out-of-pocket and any portion of that amount applied toward the patient's deductible. Additionally, negotiated rates are relatively easy to access, for example, by competitors in a local market, by price transparency vendors who use reverse engineering to determine negotiated rates for their tools, and by private entities that use crowdsourcing efforts to collect the standard charge information found on EOBs and display them online to assist the public in price shopping.[66]

With respect to the Defend Trade Secrets Act of 2016, we do not believe it is applicable here, as it applies only to trade secrets that are ''misappropriated,'' which is defined by reference to, among other things, ''improper means,'' where there was a ''duty to maintain the secrecy,'' or ''accident or mistake.'' We do not believe any of the meanings of the term ''misappropriation'' under the Defend Trade Secrets Act apply to a circumstance where an agency rule requires disclosure of certain information. 18 U.S.C. 1836 *et seq.*

Finally, to the extent commenters intended to cite the Trade Secrets Act, we note that it applies only to disclosures ''not authorized by law,'' in contrast to the circumstance here, where this final rule requires disclosure of certain information. 18 U.S.C. 1905. We would also note that, as a threshold matter, the Trade Secrets Act contemplates disclosure by a federal actor (''an officer or employee of the United States or of any department or agency thereof . . . ''), and not disclosures by private entities, as contemplated by this final rule.

Consistent with price transparency and economics research (discussed in section II.D.1 and elsewhere in this final rule), we believe that the disclosure of payer-specific negotiated charges would serve a greater public interest and that ''concealing negotiated price information serves little purpose other than protecting dominant providers' ability to charge above-market prices and insurers' ability to avoid paying other providers those same elevated rates.''[67] For Maine, one State official indicated that ''to date, there is no evidence that the release of [Maine Health Data Organization] claims data has resulted in an anticompetitive market. In fact, quite the opposite. Transparency is what fosters a competitive market.''[68] Similarly, disclosure of claims data in New Hampshire has resulted in increased competition and reduced prices for healthcare services.[69] Additionally, even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law.

With respect to FOIA, while Exemption 4 does protect confidential trade secrets or confidential commercial information, it does not apply to disclosures by private entities such as hospitals as contemplated by this rule.

Finally, requiring hospitals to make public standard charges is consistent with First Amendment jurisprudence. Rules, such as this one, that require certain factual commercial disclosures pass muster under the First Amendment where the disclosure advances a government interest and does not unduly burden speech. When the government requires accurate disclosures in the marketing of regulated products under appropriate circumstances, it does not infringe on protected First Amendment interests. As the United States Supreme Court recognized in *Zauderer* v. *Office of Disciplinary Counsel,* 471 U.S. 626 (1985) and recently confirmed in *Nat'l Inst. of Family and Life Advocates* v. *Becerra,* 138 S. Ct. 2361, 2372, 2376 (2018) (''NIFLA''), required disclosures of factual, noncontroversial information in commercial speech may be subject to more deferential First Amendment scrutiny. Under the approach articulated in *Zauderer,* courts have upheld required disclosures of factual information in the realm of commercial speech where the disclosure requirement reasonably relates to a government interest and is not unjustified or unduly burdensome such that it would chill protected speech.[70] As further discussed below, and cited elsewhere in this final rule, the required disclosures here advance the

[66] *https://clearhealthcosts.com/pricecheck-share-form/.*

[67] Catalyst for Payment Reform. ''Report Card on State Price Transparency Laws,'' July 2015. Available at: *https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2017/04/2015-Report-Card-on-State-Price-Transparency-Laws.pdf.*

[68] Gudiksen KL, et al. The Secret of Health Care Prices: Why Transparency Is in the Public Interest. California Health Care Foundation. July 2019. Available at: *https://www.chcf.org/wp-content/uploads/2019/06/SecretHealthCarePrices.pdf.*

[69] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics.* Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*

[70] See *Zauderer,* 471 U.S. at 651; *Milavetz* v. *United States,* 559 U.S. 229, 250, 252–53 (2010); *NIFLA,* 138 S. Ct. at 2376 (''[W]e do not question the legality of . . . purely factual and uncontroversial disclosures about commercial products.'').

government's substantial interest in providing consumers with factual price information to facilitate more informed health care decisions, as well as the government's substantial interest in lowering healthcare costs, as further discussed below.[71] As discussed elsewhere in this final rule, each of the standard charges we have chosen specifically because they are relevant to a specific group of consumers. For example, the negotiated charges are directly relevant to patients covered by a payer's specific insurance product. We note that hospitals regularly use their payer-specific negotiated charges to determine insured patient out-of-pocket costs, and payer-specific negotiated charges are also regularly supplied to consumers on EOBs.

Furthermore, these disclosures would neither ''drown[ ] out the [speaker's] own message'' or ''effectively rule[ ] out'' a mode of communication.[72] Indeed, the requirement to provide standard charge information is not unduly burdensome where, as here, the hospital has the ability to convey other information of its choosing in the remainder of the website and other interactions with the public.

Some comments assert that the rule should be evaluated under the intermediate scrutiny test for commercial speech articulated in *Central Hudson Gas & Elec. Corp.* v. *Pub. Serv. Comm'n,* 447 U.S. 557 (1980). Under that test, agencies can regulate speech where the regulation advances a substantial government interest and the regulation is no more extensive than necessary to serve that interest. Although many of these comments failed to offer any explanation as to why the more deferential review under *Zauderer* would not apply, one comment asserted that the *Zauderer* test is limited to disclosures that appear in advertising. We disagree. ''Although the Court in *Zauderer* may have referred repeatedly to advertising . . . , these references were contextual and not the sine qua non of *Zauderer's* reasoning. *Zauderer* did not base its holding on any notion of estoppel or equity, but on the lack of a significant constitutional interest in not disclosing factual and noncontroversial information to consumers.'' *CTIA—Wireless Ass'n* v. *City of Berkeley,* 158 F. Supp. 3d 897, 903 (N.D. Cal. 2016), *aff'd,* 928 F.3d 832, 842 (9th Cir. 2019).

In any event, although we believe that *Zauderer* provides the appropriate framework for review, the rule also satisfies the elements of the *Central Hudson* test. The government interest here is clear. As discussed above, the required disclosures here advance the government's substantial interest in providing consumers with factual price information to facilitate more informed health care decisions. In addition, these disclosures advance the government's substantial interest in lowering healthcare costs. Healthcare costs continue to rise, and healthcare spending is projected to consume almost 20 percent of the economy by 2027.[73] Hospital spending accounts for a substantial share of overall healthcare spending, and hospital charges for similar procedures can vary significantly from hospital to hospital. It is well-documented that the lack of transparency in hospital prices is a barrier that prevents consumers from understanding what their financial liability will be for hospital items and services, and that lack of knowledge not only affects their ability to shop for value, but also gives them no ability to proactively make decisions that could impact that financial liability. Additionally, as discussed in section II.D.1, these rising costs impact the Medicare Trust Funds and the amount paid to hospitals by Medicare.

We note further that public comments received for this rule, healthcare consumers resoundingly expressed support for having access to hospital pricing information. This public sentiment is echoed in numerous studies and surveys show that consumers are concerned about the high cost of healthcare, want to be able to know prices prior to purchasing a healthcare service, and are frustrated by the lack of access to information on medical costs before receiving medical services.[74] [75] [76] [77] [78] Employers are also actively seeking healthcare pricing information for initiatives that drive reductions in healthcare costs[79] [80] [81] and once they have access, they are able to drive healthcare value.[82]

The rule is also narrowly tailored to achieve the government's interest because there is a direct connection between the disclosure of hospital standard charge information and reduced healthcare costs and increased patient satisfaction. As we have described elsewhere in this final rule, we believe the regulations we are establishing are an important first step in providing information to consumers to support their healthcare decision-making. Although some States have made progress in promoting price transparency, most State efforts fall short. Further, existing hospital initiatives to make public their gross charges are not sufficient to provide insured consumers with the information applicable to them. Specifically, insured consumers need to understand the rates third party payers have negotiated (payer-specific negotiated charges) on their behalf for hospital items and services. There is emerging evidence that when healthcare consumers use healthcare pricing information, cost savings results for both inpatient and outpatient care without sacrificing

[71] See generally, *Pharm. Care Mgmt. Ass'n* v. *Rowe,* 429 .3d 294, 310 (1st Cir. 2005) (recognizing that the government interest in cost-effective health care justified disclosure of financial interests of pharmacy benefit managers); *N.Y. State Rest. Ass'n* v. *N.Y. City Bd. Of Health,* 556 F.3d 114, 134 (2d Cir. 2009) (recognizing that the government interest in ''promot[ing] informed consumer decision-making'' justified posting of calories on menus in chain restaurants).

[72] *NIFLA,* 138 S. Ct. at 2378.

[73] CMS. National Health Expenditures Projections, 2018–2027: Forecast Summary. Available at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf.*

[74] Sinha SL, et al. ''The Demographics of Healthcare Price Transparency.'' Accenture Consulting, 2017. Available at: *https://www.accenture.com/_acnmedia/pdf-69/accenture-health-the-demographics-of-healthcare-price-transparency-infographic.pdf.*

[75] Foundation for Government Accountability. ''Poll: Voters Want The Right To Shop For Health Care.'' January 29, 2018. Available at: *https://thefga.org/poll/right-to-shop-poll/.*

[76] Schleifer D, et al. ''Still Searching: How People Use Health Care Price Information in the United States.'' Public Agenda, April 2017. Available at: *https://www.publicagenda.org/wp-content/uploads/2019/09/PublicAgenda_StillSearching_Brief_2017.pdf.*

[77] ''News Reports about a Weakening Economy Impacting How Some Patients Seek Medical Treatment.'' TransUnion. September 17, 2019. Available at: *https://newsroom.transunion.com/news-reports-about-a-weakening-economy-impacting-how-some-patients-seek-medical-treatment/.*

[78] Shih YT, and Chien C. A review of cost communication in oncology: Patient attitude, provider acceptance, and outcome assessment. *Cancer,* 123: 928–39. Available at: *https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.30423.*

[79] Livingston S. Setting the bar for hospital prices: NC aims to tie reimbursement to Medicare for state employees. *Modern Healthcare.* March 2, 2019. Available at: *https://www.modernhealthcare.com/hospitals/setting-bar-hospital-prices.*

[80] Prager E. Consumer Responsiveness to Simple Health Care Prices: Evidence from Tiered Hospital Networks. September 21, 2017. Available at: *https://pdfs.semanticscholar.org/053e/218f13dcd7f21002c623268151918fa708f0.pdf?_ga=2.190709035.1212076034.1563994376-1742025875.1563994376.*

[81] Wu S, et al. Price Transparency for MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition. *Health Affairs.* August 2014; 33(8). Available at: *https://doi.org/10.1377/hlthaff.2014.0168.*

[82] Sachdev G, et al. Self-Insured Employers Are Using Price Transparency To Improve Contracting With Health Care Providers: The Indiana Experience. *Health Affairs.* October 7, 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20191003.778513/full/.*

quality.[83 84 85 86 87] Moreover, cost savings drive competition [88 89] and create a 'spillover' effect benefitting all regional consumers.[90 91 92] Additionally, providers are discovering that providing price estimates ahead of a healthcare service results in fewer billing-related complaints, decreased revenue losses for the provider, and overall increased patient satisfaction.[93 94] Finally, we are not aware of any alternatives to the policies in this final rule that would be as effective in achieving these results. As discussed above and elsewhere in this final rule, hospital chargemaster disclosures do not include the charges applicable to insured consumers; and relying on individual hospitals for voluntary disclosures may not allow consumers to make comparisons between hospitals or sufficiently drive competition or create ''spillover'' effects. Similarly, relying on state-by-state initiatives would only benefit consumers in some states.

Comment: Many commenters expressed confusion related to the term payer-specific negotiated charge, indicating that such a hospital charge does not exist, or that the term is in conflict with terminology used within the healthcare industry, such as ''negotiated rates'' or the ''allowed amount.'' Several commenters asserted that hospitals do not negotiate ''payment rates,'' ''methodologies'' or ''allowed amounts'' with third party payers. Additionally, many commenters suggested in general usage (and according to one commenter, as defined by *dictionary.com*), the definition of ''standard'' means ''usual, common, or customary'' and asserted that payer-specific negotiated charges are not usual, common, or customary because they vary from payer to payer.

Other commenters seemed to suggest that payer-specific charges could not be identified because, as one commenter noted, rates associated with DRGs can have three levels of payments based on the types of co-morbidities and can change based on change in a patient's condition or treatment plan.

Response: As explained in the CY 2020 OPPS/ASC proposed rule, we could not identify an existing definition of ''standard charges,'' nor do we believe that a single ''standard charge'' can be identified for purposes of implementing section 2718(e) of the PHS Act, since factors such as insured status and the particular third-party payer plan drive the hospital charges borne by consumers. Therefore, we proposed a new definition for ''standard charges'' (which can also be called ''rates'') that could apply to certain identifiable groups of individuals—specifically, individuals that are self-pay and individuals that have third party payer coverage. Thus, the charges the hospital has negotiated with a specific payer for a hospital item or service are the standard charges that apply to consumers with a specific plan through a specific insurer—in other words, the rate is the usual or common rate for the members of that plan. Therefore, one type of ''standard charge'' is the gross rate or charge found in the hospital chargemaster (which aligns with the PRM1's definition of ''charges'') while another ''standard charge'' is the charge or rate that the hospital has negotiated with a third party payer for an item or service.

When hospitals contract with a third party payer to be included in the plan's network, the hospital and insurer agree to specific, often discounted, prices that will apply to items or services furnished by the hospital. Best practice according to healthcare financial management experts and revenue cycle managers dictates that these payer-specific negotiated charges should be included in hospital contracts and listed in associated rate sheets (also called rate tables or fee schedules). Rate sheets include a list of all hospital items and services for which the hospital and payer have established regular rates (for example, the payer-specific negotiated charges that apply to hospital items and services). Hospitals also routinely keep and maintain such rate sheets to police and validate their reimbursements from payers as part of their revenue management cycle, holding payers accountable for the rates they have negotiated with the hospital. Such rates tables are also used by hospitals to compare against benchmarks (such as Medicare FFS rates) to determine where it is advantageous to renegotiate for higher amounts at the next opportunity. The contracted rate, sometimes called the ''negotiated rate,'' ''in-network amount,'' ''allowed charges'' or ''negotiated discount'' can be significantly lower than what the hospital would charge an individual who did not have an insurance company negotiating discounts on his or her behalf, and this contracted rate is reflected in the patient's EOB after the healthcare service has been provided. As such, we do not believe the term ''payer-specific negotiated charges'' conflicts with any particular defined industry term or with the term ''charges'' as defined by Medicare. We further clarify that the payer-specific negotiated charge is the charge the hospital has negotiated with a third party for an item or service and does not refer to the amount the hospital is ultimately paid by the insurer or patient for an item or service. We believe that it is unlikely such amounts could be considered hospital standard charges and that it would prove very difficult for a hospital to make such amounts public in advance, given that, as commenters point out, the actual paid amounts are dependent on information that the hospital does not have without

[83] Robinson JC and Brown TT. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. *Health Affairs.* August 2013; 32(8). Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0188.*

[84] Blase B. ''How Price Transparency Would Revolutionize Healthcare.'' *New York Post.* October 12, 2019. Available at: *https://nypost.com/2019/10/12/how-price-transparency-would-revolutionize-healthcare/.*

[85] Rhoads J. Right to Shop for Public Employees: How Health Care Incentives are Saving Money in Kentucky. Foundation for Government Accountability. March 8, 2019. Available at: *https://thefga.org/wp-content/uploads/2019/03/RTS-Kentucky-HealthCareIncentivesSavingMoney-DRAFT8.pdf*

[86] Lieber EMJ. ''Does It Pay to Know Prices in Health Care?'' *American Economic Journal.* 2017, 9(1): 154–179. Available at: *https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.20150124.*

[87] Whaley C, et al. ''Association Between Availability of Health Service Prices and Payments for These Services.'' *JAMA.* 2014; 312(16):1670–1676. Available at *https://jamanetwork.com/journals/jama/fullarticle/1917438.*

[88] Boynton A, and Robinson JC. Appropriate Use Of Reference Pricing Can Increase Value. *Health Affairs.* July 7, 2015. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20150707.049155/full/.*

[89] Wu S, et al. Price Transparency for MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition. *Health Affairs.* August 2014; 33(8). Available at: *https://doi.org/10.1377/hlthaff.2014.0168.*

[90] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics.* Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*

[91] Wu S, et al. Price Transparency for MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition. *Health Affairs.* August 2014; 33(8). Available at: *https://doi.org/10.1377/hlthaff.2014.0168.*

[92] Blase B. ''How Price Transparency Would Revolutionize Healthcare.'' *New York Post.* October 12, 2019. Available at: *https://nypost.com/2019/10/12/how-price-transparency-would-revolutionize-healthcare/.*

[93] Otero HJ, et al. The Cost-Estimation Department: A Step Toward Cost Transparency in Radiology. *JACR.* February 2019; 16(2): 194–95. Available at: *https://www.jacr.org/article/S1546-1440(18)30981-5/fulltext.*

[94] Hammer DC. ''Adapting customer service to consumer-directed health care: by implementing new tools that provide greater transparency in billing, hospitals can decrease collection costs while improving consumer satisfaction.'' *Healthcare Financial Management.* September 2006; 60(9). Available at: *https://go.galegroup.com/ps/anonymous?id=GALE%7CA151440927&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=073507328&p=AONE&sw=w.*

contacting the insurer to determine the specifics of the patient's obligations under the patient's contract with the insurer.

We note that the payer-specific negotiated charge for a DRG is the rate the hospital has negotiated for the DRG as a service package. We clarify that the requirement to make public the payer-specific negotiated charge for a DRG would mean the base rate that is negotiated by the hospital with the third party payer, and not the adjusted or final payment received by the hospital for a packaged service.

Comment: In response to CMS' request for comment on the potential unintended consequences of releasing payer-specific charge information, many commenters asserted such disclosure would be confusing or even harmful to patients. For example, many commenters raised patient-specific concerns that the policy would impact patients negatively by creating reliance on published rates when they could potentially be required to pay a higher out-of-pocket amount after the service, or could impact their health by confusing them or causing them to seek out cheaper care rather than the most effective or best quality care. One commenter expressed concern that display of payer-specific negotiated charges would shift the burden of understanding the costs of care from the hospitals/payers to consumers.

Response: We thank the commenters for their input. We continue to believe that the public posting of hospital standard charge information will be beneficial to healthcare consumers who need to obtain items and services from a hospital, healthcare consumers who wish to view hospital prices prior to selecting a hospital, clinicians who use the data at the point of care when making referrals, and other members of the public who may develop consumer-friendly price transparency tools. This belief is supported by the many commenters who asserted the desire to have better access to, and understanding of, hospital charges. While we cannot discount the possibility that some consumers may find required hospital data disclosures confusing, we believe that the vast majority will find the increased availability of data, especially as it may be reformatted in consumer-friendly price transparency tools, overwhelmingly beneficial. Additionally as noted in section II.D.1 of this final rule, patients already receive this information in the form of EOBs, so we do not believe that advance notice of such standard charges would cause confusion beyond the confusion and frustration that currently exists for lack of such knowledge as expressed by commenters who feel they are ''flying blind.'' We also note that nothing in this final rule would prevent a hospital from engaging in patient education or otherwise assisting patients in understanding potential hospital charges in advance of receiving a hospital service, including articulating factors that may influence ultimate patient out-of-pocket costs or displaying quality information along with hospital charge information.

Moreover, we strongly disagree that the display of payer-specific negotiated charges would effect some shift from hospitals/payers to consumers of the burden of understanding the costs of care, and we pointedly note that research,[95] vast amounts of media reports,[96] as well as many commenters to the CY 2020 OPPS/ASC proposed rule make clear that consumers already bear, and are exceptionally frustrated at the lack of publicly available data to help ease, that burden. We believe that requiring disclosure of hospital standard charges is a necessary first step to begin to alleviate consumers' frustration in understanding their potential cost of care in advance of the receipt of services.

Finally, as noted by commenters, knowing the payer-specific negotiated charges can be highly beneficial for consumers in HDHPs and in plans where the consumer is responsible for a percentage (that is, co-insurance) of the negotiated rate. The most common coinsurance arrangement is 20/80 where the consumer is responsible for 20 percent of the payer-negotiated charges and the insurer covers the remaining 80 percent. Both HDHPs and co-pays are becoming more common[97] [98] and create a great deal of uncertainty for consumers who can't access the rates hospitals and insurers have negotiated.

Comment: Many commenters cautioned that disclosure of payer-specific negotiated charges would increase, not decrease, healthcare costs in certain markets due to anticompetitive behaviors or increases in prices as a result of hospital knowledge of better rates negotiated by neighboring hospitals. Specifically, many commenters stated that disclosure of payer-specific negotiated charges could encourage price fixing and facilitate hospital collusion, causing prices to rise and thus harming consumers. Others raised concerns that publicly displaying insurer contract information would make it easier for insurers to circumvent antitrust safeguards, negatively affecting competition. Several commenters also argued that the inclusion of payer-specific negotiated charges as a standard charge would result in adverse market impacts on published rates and hamper hospitals' ability to negotiate fair and competitive payment rates with payers. One commenter more specifically argued that if all payer rates are disclosed, then every payer paying above the lowest rate would renegotiate to the lowest rate for every service, leaving hospitals with very little power to object. One commenter specifically suggested that CMS conduct a pilot study in only a few markets to determine the impact of the policy on negotiated prices before finalizing.

Response: As indicated in our literature review and Economic Analyses (84 FR 39630 through 84 FR 39634), we concluded that implementing our proposals, most of which we are finalizing in this final rule, would yield many benefits with particular benefits for consumers who we believe have a right to know the cost of hospital services before committing to them and to be able to shop for the best value care and for employers who purchase healthcare for their employees.

In general, our belief that accessible pricing information would reduce healthcare costs by encouraging providers to offer more competitive rates is consistent with predictions of standard economic theory.[99] Economists have long concluded that markets work best when consumer prices reflect the actual cost to create and deliver the product.[100] And a number of empirical

[95] Aliferis L. Variation in Prices for Common Medical Tests and Procedures. *JAMA Intern Med.* 2015; 175(1):11–12. Available at: *https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/1935935.*

[96] CBS News, Medical Price Roulette: CBS News investigates the lack of transparency in America's health care system. September 20, 2019. Available at: *https://www.cbsnews.com/news/medical-price-roulette-cbs-news-investigates-the-lack-of-transparency-in-americas-health-care-system/.*

[97] Cohen RA, et al. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2018. National Center For Health Statistics. Available at: *https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf.*

[98] Miller EG, et al. High-Deductible Health Plan Enrollment Increased From 2006 To 2016, Employer-Funded Accounts Grew In Largest Firms. *Health Affairs.* August 2018. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0188.*

[99] CRS Report for Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector. July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[100] Murray R. Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience.

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studies on price transparency in other markets shows that transparency initiatives tend to lead to more consistent, lower prices.[101] [102] However, some economists do not believe that healthcare price transparency will prevent rising costs due to the unique characteristics of the healthcare market.[103]

In our discussion of available research and market impacts (84 FR 39579 through 84 FR 39580, we took into account the potential for unintended consequences. Specifically, we noted that at minimum, our policy to require disclosure of payer-specific negotiated charges would release data necessary to better understand how the level of price dispersion in various healthcare markets impacts healthcare spending and consumer out-of-pocket costs. As noted in the CY 2020 OPPS/ASC proposed rule, negotiated charges for various procedures varies widely within and across geographic regions on the United States.[104] Some factors associated with the level of hospital price dispersion in a geographic area are the hospital's size, healthcare demand, labor costs, and technology, although it was the hospital's market power (level of competition) that was most positively associated with high price dispersion.[105] [106] One researcher found that variation in prices across hospital referral regions is the primary driver of variation in spending per enrollee for those privately insured, while the quantity of care provided across hospital referral regions is the primary driver of variation in spending per beneficiary for Medicare.[107] One major barrier to fully understanding healthcare price variation (and understanding the impact of transparency of healthcare pricing in general) is the lack of availability of negotiated charges to researchers and the public.[108] We noted that our proposals would make hospital charge information available, which would generate a better understanding of (1) hospital price dispersion, and (2) the relationship between hospital price dispersion and healthcare spending. Understanding these relationships through release of pricing data could lead to downward price pressure on healthcare prices and reductions in overall spending system-wide, particularly in markets where there is insurer and hospital competition,[109] or to considerable spending reductions and reduction of price dispersion.[110]

In their comprehensive analysis of the impact of regulations across more than 30 States requiring public access to the prices of hospital procedures, some researchers found that regulations lowered the price of shoppable procedures such as hip replacements by approximately five percent overall compared to prices for non-shoppable procedures such as appendectomies. They further found that half of the observed price reduction in charges was due to hospitals lowering their prices to remain competitive. This was particularly true for high priced hospitals and for hospitals in competitive urban areas.[111] Research has also indicated that price transparency initiatives can decrease prices paid by consumers and insurers. One study found that following the introduction of a State-run website providing out-of-pocket costs for a subset of shoppable outpatient services reduced the charges for these procedures by approximately 5 percent for consumers, in part by shifting demand to lower cost providers.[112] In addition, the study found that, following the introduction of the website, insurers over time experienced a 4-percent reduction in administrative costs for imaging services.

Another possibility we considered was that transparency in payer-specific negotiated charges could narrow the dispersion of prices in a market, meaning that knowledge of payer-specific charges may not only result in lowering prices for payers currently paying rates above the median, but could also increase prices for payers that are currently paying rates below the median. We considered whether making payer-specific negotiated prices public could risk disrupting the ability for certain payers to extract aggressive discounts in the future, especially from providers in markets with limited competition. For example, a hospital providing an aggressive discount to a particular payer may become motivated to withdraw such discount to avoid divulging such information to other payers with whom they contract.

Several studies of mandated price transparency in non-healthcare commodity markets have shown suppliers can use the information to their advantage in maximizing the prices they can charge in markets with limited competition or where commodities are not easily transferable across geographies.[113] We noted that although there are no definitive conclusions on the effects of price transparency on markets, one study found that it can either increase or decrease prices depending on the strength of the bargainers and the size of the market.[114] While price transparency gives buyers and sellers important information about the value of items and services, the effect may result in price increases by changing the incentives for buyers and sellers may also enable traders to observe deviations

Health Affairs. September/October 2009; 28(5). Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.28.5.1395.*

[101] CRS Report for Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector. July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[102] Kim M. The Effect of Hospital Price Transparency in Health Care Markets. 2011. Available at: *https://repository.upenn.edu/dissertations/AAI3475926/.*

[103] King JS, Muir MA, Alessi SA. Clarifying Costs Can Increased Price Transparency Reduce Healthcare Spending? 4 William & Mary Policy Review 319 (2013). Available at: *https://pdfs.semanticscholar.org/f604/1a0484c65c593525d0c07e040cf655697f2d.pdf.*

[104] Kennedy K, et al. Health Care Cost Institute. Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area. Healthy Marketplace Index. April 30, 2019. Available at: *https://www.healthcostinstitute.org/blog/entry/hmi-2019-service-prices.*

[105] Cooper Z, et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics.* December 2015. Available at: *https://pdfs.semanticscholar.org/cb9c/f90786cc39ddac6d88f3ba1074a7c2d5f0a5.pdf.*

[106] Bai G and Anderson GF. Market Power: Price Variation Among Commercial Insurers For Hospital Services. *Health Affairs.* Oct 2018; 37(10): 1615–1622. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0567.*

[107] Cooper Z, et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics.* December 2015. Available at: *https://pdfs.semanticscholar.org/cb9c/f90786cc39ddac6d88f3ba1074a7c2d5f0a5.pdf.*

[108] Ibid.

[109] Ho K and Lee RS. Insurer Competition and Negotiated Hospital Prices. August 2013. Available at: *https://pdfs.semanticscholar.org/b6e9/11d7e171d3074b473439f93d377f4a4202bf.pdf.*

[110] Brown ZY. An Empirical Model of Price Transparency and Markups in Health Care. August 2019. Available at: *http://www-personal.umich.edu/~zachb/zbrown_empirical_model_price_transparency.pdf.*

[111] Christensen HB, Floyd E, and Maffett M. ''The Effects of Price Transparency Regulation on Prices in the Healthcare Industry.'' Available at: *https://www.bakerinstitute.org/media/files/event/01ce2e80/HPF-paper-AHEC-Floyd.pdf.*

[112] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics.* Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf.*

[113] See for example, Congressional Research Service Report for Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector. July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

[114] Congressional Research Service Report for Congress: Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector. July 24, 2007. Available at: *https://fas.org/sgp/crs/secrecy/RL34101.pdf.*

from collusive practices. Allowing weaker bargainers to see prices negotiated by stronger bargainers will change incentives facing buyers and sellers, and can lead to price increases.

In the absence of a national model, we looked to two States that previously enacted price transparency laws, California and New Hampshire. California enacted a requirement for hospitals to post their CDM in 2004, and in 2003, New Hampshire created an all-payer claims database, later publishing the data in 2007 in a statewide, web-based price transparency comparison tool. Studies assessing the impact of the New Hampshire State law have found that the efforts focused on the wide variation of provider prices, which in turn created opportunities for new benefit design that incentivized consumer choice of lower costs providers and sites of service.[115] In California, the link between hospital chargemaster data and patient cost was validated through a 10-year study of the chargemaster data which found that each dollar in a hospital's list price was associated with an additional 15 cents in payment to a hospital for privately insured patients (versus publicly insured patients).[116] We indicated that this effort to improve the availability of charge data could open up the possibility to States to further regulate hospital charges—examples seen in both California and New Hampshire that took further legislative action to reduce price dispersion, reduce surprise billing and to place limits on charges for the uninsured and for out-of-network providers.

In addition to economic effects described above, we analyzed consumer impact and concluded that consumers may feel more satisfied with their care when they are empowered to make decisions about their treatment. A recent survey [117] indicated a strong desire for price transparency and openness. Eighty-eight percent of the population polled, demanded improved transparency with respect to their total financial responsibility, including co-pays and deductibles. Another study suggests that improving a patient's financial experience served as the biggest area to improve overall customer satisfaction.[118] According to a 2011 GAO report, transparent healthcare price information may help consumers anticipate their healthcare costs, reduce the possibility of unexpected expenses, and make more informed choices about their care, including for both shoppable services as defined in this rule and other hospital items and services in both outpatient and inpatient settings.[119]

A large part of the literature on consumer use of price information comes from studies of price transparency tools, particularly those offered by third party payers and for shoppable services. Some studies of consumer use of price information through web-based tools, such as those offered by self-insured employers or plans, indicate that they may help consumers save money on shoppable services. One study examined consumer use of an employer-sponsored, private price transparency tool and its impact on claims payments for three common medical services: Laboratory tests; advanced imaging services; and clinician office visits.[120] That study found that those who used the tool had lower claims payments by approximately 14 percent for laboratory tests; 13 percent for advanced imaging services; and approximately 1 percent for office visits compared to those who did not use the tool. Another study found that those employed by a large corporation who used a healthcare price transparency tool were able to reduce their costs by 10 to 17 percent compared to nonusers.[121] Those using the tool mainly searched for information on shoppable services and also tended to have more limited insurance coverage. However, one study of the use of price transparency tools by consumers with an employer-based, high deductible health plan found that consumers' likely perception that higher price is a proxy for higher quality care may lead them to select higher-cost options.[122] This study found a spending drop between 11.8 and 13.8 percent occurring across the spectrum of healthcare service categories at the health plan level; the majority of spending reductions were due to consumer quantity reductions across a broad range of services, including both high and low value care. Another study of the use of price transparency tools by consumers found that only 10 percent of consumers who were offered a tool with price information utilized it, and that there was a slight relative increase in their out-of-pocket health spending on outpatient services compared to the patient group that was not offered the tool.[123]

Although we are not requiring that hospitals develop a price comparison tool, we encourage innovation in this area by making standard charges available in a machine-readable format to third-party tool developers as well as the general public. We continue to believe that the use of a third-party tool would enhance public access to pricing data, but we do not believe the absence of one would cause confusion among consumers on how to use the available standard charge data made public by the hospital because we are also proposing requirements for hospitals to make public their payer-specific charges for a set of shoppable services in a consumer-friendly manner. A large part of consumer buy-in and understanding may depend on providers' willingness and ability to make public, and to have conversations with consumers about, their standard charge data to allow for price comparison and decisions about upcoming medical treatment. As consumers' healthcare costs continue to rise, clinicians are in a unique position to discuss the financial impacts of healthcare decisions with their patients. One study found that patients will often choose services based on clinician referral rather than consideration of

[115] Tu H, and Gourevitch R. California HealthCare Foundation and Robert Wood Johnson Foundation. Moving Markets, Lessons from the New Hampshire Price Transparency Experiment. April 2014. Available at: *https://www.chcf.org/wp-content/uploads/2017/12/PDF-MovingMarkets NewHampshire.pdf.*

[116] Batty M and Ippolito B. Mystery Of The Chargemaster: Examining The Role Of Hospital List Prices In What Patients Actually Pay. *Health Affairs.* April, 2017; 36(4): 689–696. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0986.*

[117] See Gruessner V. Consumer Satisfaction Dips When Payers Lack Price Transparency. *Private Payers News* (October 3, 2016). Available at: *https://healthpayerintelligence.com/news/consumer-satisfaction-dips-when-payers-lack-price-transparency.*

[118] Experian Health, Improve the healthcare financial journey. *Patient Engagement* (June 21, 2018). Available at: *https://www.experian.com/blogs/healthcare/2018/06/healthcare-financial-journey/.*

[119] Government Accountability Office. September 2011. Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care. Available at: *https://www.gao.gov/assets/590/585400.pdf.*

[120] Whaley C, et al. ''Association Between Availability of Health Service Prices and Payments for These Services.'' *JAMA.* 2014; 312(16):1670–1676. Available at *https://jamanetwork.com/journals/jama/fullarticle/1917438.*

[121] Lieber EMJ. ''Does It Pay to Know Prices in Health Care?'' *American Economic Journal.* 2017, 9(1): 154–179. Available at: *https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.20150124.*

[122] Brot-Goldberg ZC, et al. What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. Cambridge, MA: National Bureau of Economic Research; Working Paper, October 2015. Available at: *https://www.nber.org/papers/w21632.pdf.*

[123] Desai S, et al. Association between availability of a price transparency tool and outpatient spending. *JAMA.* 2016;315(17):1874–1881. doi:10.1001/jama.2016.4288. Available at: *https://jamanetwork.com/journals/jama/fullarticle/2518264.*

cost.[124] We believe that the pricing information made available as a result of this final rule will help ensure that clinicians have relevant pricing data to counsel patients on financial options. A systematic review found that clinicians and their patients believe communication about healthcare costs is important and that they have the potential to influence health and financial outcomes, but that discussions between clinicians and patients about costs are not common,[125] even though a majority of patients and physicians express a desire to have such cost-of-care conversations.[126] In our review, we found evidence that physicians were open to having these conversations, and that they were occurring more frequently, but providers have also identified the need for price information as a barrier to discussing costs with patients.[127] [128] In addition, a literature review of 18 studies measuring the effects of charge display on cost and practice patterns found that having prospective access to prices for radiology and laboratory services changed physician's ordering behavior, and in 7 of the 9 studies on cost reported statistically significant cost reduction when charges were displayed.[129]

Employers can also benefit from transparency in provider pricing and disclosure of payer-specific negotiated charges in particular. Some employers are seeking and implementing innovative ways using transparency in healthcare pricing to reduce healthcare costs and are using healthcare pricing information effectively to do so.[130] Some employers, particularly self-insured employers, are using knowledge of payer-specific negotiated charges in their discussions with providers and health plans to drive referrals to high value care settings which is driving down the cost of healthcare for both employer and employee. For example, self-insured employers in Indiana are effectively using knowledge of hospital charges to improve contracting with providers.[131] [132] Additionally, based on our review of economics research, we believe the healthcare market will become more effective and efficient as a result of transparency in healthcare pricing. For example, one study found that when the State of California adopted a reference pricing model for their employees, usage of lower priced facilities increased by 9 to 14 percent and facilities in California responded by reducing their prices by 17 to 21 percent.[133] The California and the New Hampshire initiatives (described earlier) were both demonstrated to produce ''spillover'' effects, meaning that changing market prices as a result of consumer shopping benefited even those who were not actively shopping.[134]

In summary, we concluded that transparency in pricing is necessary and can be effective to help bring down the cost of healthcare services, reduce price dispersion, and benefit consumers of healthcare services, including patients and employers. In light of this, we do not believe additional testing needs to be done prior to finalizing this rule. We further note that the federal government has laws and processes to investigate and act when entities engage in collusive or other anticompetitive practices.

Comment: Many commenters indicated that it would be a challenge and burden for hospitals to access and display their payer-specific negotiated charges. For example, many commenters asserted that such information is either ''non-existent'' (specifically that it does not exist in hospital accounting systems) or is not available to be reported by hospitals without significant manual effort, while several others indicated that consumers should pursue information on out-of-pocket obligations from insurers as opposed to hospitals. Several others indicated that the data is not available electronically and would require manual entry or require hospitals to purchase prohibitively expensive software. Several commenters stated that charges on the chargemaster are not always associated with negotiated charges due to billing complexities such as per diem rates and bundled payment arrangements and that the CY 2020 OPPS/ASC proposed rule relied on the mistaken assumption that payer-specific rates can be expressed in a static matrix. One commenter explained that hospital managed care agreements do not typically set forth simple dollar amounts for each service; instead, they specify payment methodologies, which are in essence negotiated payment algorithms rather than static matrices. The commenter also noted that the appropriate payment amount for a particular service package cannot be calculated until the delivery of care, and the assignment of any dollar amount prior to the delivery of care would risk overstating or understating the applicable payment amount for that case.

Response: As noted above, hospital payer-specific negotiated charges or rates can be found within the in-network contracts that hospitals have signed with third party payers. Such contracts often include rates sheets that contain a list of hospital items and services (including service packages) and the corresponding negotiated rates. If the rate sheets are not in electronic form, we suggest that the hospital request an electronic copy of their contract and corresponding rate sheet from the third party payer. Additionally, we note that we are concurrently issuing a proposed rule entitled Transparency in Coverage (file code CMS–9915–P) that would require most issuers of individual and group market health insurance and group health plans to make public, in an electronic machine-readable format, negotiated rate and unique out-of-network allowed amount information that hospitals, including

[124] Chernew M, et al. ''Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans.'' National Bureau of Economic Research, Working Paper No. 24869. Issued July 2018, revised January 2019. Available at: *https://www.nber.org/papers/w24869.*

[125] Meluch AL, and Oglesby WH. (2015). Physician-patient communication regarding patients' healthcare costs in the US: A systematic review of the literature. *Journal of Communication in Healthcare,* 8(2), 151–160. Available at: *https://www.tandfonline.com/doi/full/10.1179/1753807615Y.0000000010?scroll=top&needAccess=true.*

[126] University of Utah: The State of Value in U.S. Healthcare. Available at: *https://uofuhealth.utah.edu/value/.*

[127] Schiavoni KH, et al. How Primary Care Physicians Integrate Price Information into Clinical Decision-Making, *J Gen Intern Medicine.* 2017 January; 32(1): 81–87. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5215149/.*

[128] Alexander GC, et al. Barriers to Patient-physician Communication About Out-of-pocket Costs, *J Gen Intern Med.* 2004 August; 19(8): 856–860. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492500/.*

[129] Goetz C, et al. The effect of charge display on cost of care and physician practice behaviors: a systematic review, *Journal Gen Intern Med.* 2015 Jun; 30(6):835–42. Available at: *https://www.ncbi.nlm.nih.gov/pubmed/25691240.*

[130] Woods L, et al. Employers are fixing health care. *Harvard Business Review.* March 2019. Available at: *https://hbr.org/cover-story/2019/03/how-employers-are-fixing-health-care.*

[131] Sachdev G. Using RAND 2.0 Hospital Pricing Report to Achieve High Value. Employers' Forum of Indiana. July 31, 2019. Available at: *https://employersforumindiana.org/media/2019/07/Using-RAND-2.0-Hospital-Prices-to-Achieve-Value-presented-by-Gloria-Sachdev-7-31-19.pdf.*

[132] Sachdev G, et al. Self-Insured Employers Are Using Price Transparency To Improve Contracting With Health Care Providers: The Indiana Experience. *Health Affairs.* October 7, 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20191003.778513/full/*

[133] Robinson JC and Brown TT. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. *Health Affairs.* August 2013; 32(8). Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0188.*

[134] Blase B. Transparent Prices Will Help Consumers and Employers Reduce Health Spending. Galen Institute. September 27, 2019. Available at: *https://galen.org/assets/Blase_Transparency_Paper_092719.pdf.*

CAHs, and others could use. Access to these data may be a benefit to less resourced hospitals which indicated that payers may take advantage of small hospitals that don't diligently maintain their contracts or contracted rates.

We agree that payer-specific negotiated charges are not found in a hospital's chargemaster because such charges are typically found in other parts of the hospital's billing and accounting systems or in their payer contracts. We also agree that such charges are often negotiated for service packages rather than for individualized items and services as listed in the hospital chargemaster, and that negotiated contracts often include methodologies that would apply to payment rates, often leading to payments to hospitals that are different than the base rates negotiated with insurers for hospital items and services. However, we do not agree that these issues represent barriers to making public payer-specific negotiated charges because as clarified above, the negotiated rates we are requiring to be made public are the base rates, not the payment received. Additionally, we offer suggestions for developing the comprehensive machine-readable file in section II.E of this final rule and the display of payer-specific charges for the set of shoppable services in a low-cost consumer-friendly format in section II.F of this final rule.

Finally, we recognize that some hospitals may have negotiated charges with many payers representing hundreds of plans. We believe the burden to hospitals for making public all payer-specific negotiated charges is outweighed by the public's need for access to such information. However, after consideration of the comments received, we are responding to concerns about burden by finalizing a policy to delay the effective date of these final rules to January 1, 2021 (see section II.G.3 of this final rule for more details). We believe that by extending this final rule effective date, hospitals will have sufficient time to collect and display the standard charge information as required under this rule. Additionally, we are finalizing a policy to regard hospitals that offer internet-based price estimator tools as having met the requirements for making public their consumer-friendly list of shoppable services (section II.F.5 of this final rule) which will relieve some burden for hospitals that are already displaying consumer-friendly charge information.

Comment: Several commenters specifically noted that although the CY 2020 OPPS/ASC proposed rule exempts the publication of Medicaid FFS arrangements, payer-specific negotiated charges would include Medicaid managed care organizations (MCOs) and the information published would have little value to Medicaid beneficiaries since their out-of-pocket obligations are limited by federal and state cost-sharing requirements and the information may intimidate families from seeking necessary care due to the confusion caused by the charges.

Response: Under this final rule, hospitals would be required to make public their standard charges for payer-specific negotiated charges. As noted by commenters and as we explained in the proposed rule, such payer-specific negotiated charges would not include non-negotiated payment rates (such as those payment rates for FFS Medicare or Medicaid). However, hospitals will be required to make public the payer-specific negotiated charges that they have negotiated with third party payers, including charges negotiated by third party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans. Based on research cited previously, as well as patient and patient advocate comments, we disagree that the display of payer-specific negotiated rates will have little value to individuals enrolled in Medicaid MCOs or other Medicaid managed care plans in which third parties negotiate charges with hospitals. We believe that all consumers, including, for example, beneficiaries enrolled in Medicaid MCOs, should have the advantage of a full line of sight into their healthcare pricing. We are therefore finalizing as proposed our definition of payer-specific negotiated charges which would include Medicare and Medicaid plans managed by third party payers who negotiate charges with providers.

Final Action: We are finalizing as proposed a definition of payer-specific negotiated charge as a type of standard charge at new 45 CFR 180.20 to mean the charge that a hospital has negotiated with a third party payer for an item or service. We are also finalizing as proposed a definition of ''third party payer'' for purposes of section 2718(e) of the PHS Act as an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service.

4. Alternative Definitions for Types of Standard Charges That We Considered

In addition to the two types of standard charges (gross charges and payer-specific negotiated charges) that we proposed and are finalizing for purposes of section 2718(e) of the PHS Act, we sought public comment on whether we should instead, or additionally, require the disclosure of other types of charges as standard charges. We considered several alternatives for types of standard charges related to groups of individuals with third party payer coverage and also for types of standard charges that could be useful to groups of individuals who are self-pay.

a. Volume-Driven Negotiated Charge

As a variant of the definition of the ''payer-specific negotiated charge,'' we considered defining a type of ''standard charge'' based on the volume of patients to whom the hospital applies the standard charge. Specifically, we considered defining a type of ''standard charge'' as the ''modal negotiated charge.'' The mode of a distribution represents the number that occurs most frequently in a set of numbers. Here, we considered defining ''modal negotiated charge'' as the most frequently charged rate across all rates the hospital has negotiated with third party payers for an item or service. We indicated that we believed that this definition could provide a useful and reasonable proxy for payer-specific negotiated charges and decrease burden for the amount of data the hospital would have to make public and display in a consumer-friendly format. We sought public comment on whether the modal negotiated charge would be as informative to consumers with insurance and whether it should be required as an alternative or in addition to the payer-specific negotiated charges.

Comment: A few commenters supported volume-driven negotiated charges, such as the modal-negotiated charge, or a similar variation of such a charge based on volume, as a type of standard charge, stating that hospitals should publish chargemaster and negotiated amounts based on the billing volume. One commenter noted that developing and communicating a volume-driven average charge could be challenging, given that hospitals and insurers often negotiate charges for non-standardized bundled services and service packages. A few commenters disagreed with further defining negotiated charges based on volume, stating that they believe the information would be both incorrect and confusing to consumers and onerous for hospitals required to report the information. Additionally, one commenter strongly objected to use of a volume-driven charge, stating that they believe such an alternative standard charge would perpetuate the idea that insurers have been able to drive prices lower based on volume-driven negotiations.

Response: After consideration of the comments received, we agree with the commenters who stated that volume-driven charge information could be confusing to consumers, and we believe it is less useful than the types of standard charges we are finalizing. Because the modal negotiated rate, or similar volume-driven variations, would combine rates the hospital has negotiated with all third party payers for all items or services and weigh that number based on the volume of patients (a number unknown to the public), we agree it could be misleading for consumers who are trying to combine the volume-driven rate with their specific benefit information to determine their potential out-of-pocket obligations in advance, as it does not represent what their specific payer has negotiated. This type of standard charge may have utility in certain circumstances, however, after consideration of the public comments we received, we are not defining ''modal negotiated charges'' as a type of volume-driven ''standard charge'' at this time.

b. All Allowed Charges

We also considered defining a type of ''standard charge'' as the charges for all items and services for all third party payer plans and products, including charges that are non-negotiated (such as FFS Medicare rates), which we would call ''all allowed charges.'' As we explained in the CY 2020 OPPS/ASC proposed rule, this option would have required hospitals to provide the broadest set of charge information for all individuals with health insurance coverage because it would have the advantage of including all identified third party payer charges (including third party payer rates that are not negotiated). Additionally, every consumer would have access to charge information specific to his or her insurance plan. We considered, but did not propose, this alternative because we stated we believed consumers with non-negotiated healthcare coverage already have adequate and centralized access to non-negotiated charges for hospital items and services and are largely protected from out-of-pocket costs which may make them less sensitive to price shopping. However, we sought public comment on whether increasing the data hospital would be required to make public would pose a burden, particularly for smaller or rural hospitals that may not keep such data electronically available.

Comment: We received a few comments related to all allowed charges. One commenter supported the inclusion of the ''Medicare allowable'' charge in particular as a type of standard charge in order to provide a meaningful benchmark using existing data. One commenter objected to including all allowed charges as a type of standard charges due to their belief that consumers whose insurance plans are non-negotiated already have access to the information that would be required.

Response: We agree with commenters who indicated there is no need to include all allowed charges because the allowed amounts of plans that are not negotiated (for example, FFS Medicare and Medicaid) are already publicly disclosed. Moreover, such publicly disclosed allowed amounts make a benchmark available to those who wish to use it; nothing in this final rule would prevent a hospital or third party payer from displaying a Medicare FFS rate as a benchmark. However, we believe it would be redundant to require hospitals to re-disclose already public rates and create an unnecessary burden. After consideration of the public comments we received, we are not finalizing a requirement for hospitals to re-disclose ''all allowed charges'' at this time.

c. Definition of Discounted Cash Price as a Type of ''Standard Charge''

As discussed in the CY 2020 OPPS/ASC proposed rule (84 FR 39577 through 39579), hospital gross charge information may be most directly relevant to a group of self-pay consumers who do not have third party payer insurance coverage or who seek care out-of-network. Such consumers would not need information in addition to hospital gross charges in order to determine their potential out-of-pocket cost obligations because the gross charge would represent the totality of their out-of-pocket cost estimate. However, stakeholders have indicated that hospitals often offer discounts off the gross charge or make other concessions to individuals who are self-pay. Thus, we considered defining a type of ''standard charge'' as the ''discounted cash price,'' defined as the price the hospital would charge individuals who pay cash (or cash equivalent) for an individual item or service or service package. We considered this alternative definition because there are many consumers who pay in cash (or cash equivalent) for hospital items and services.

As we explained in the CY 2020 OPPS/ASC proposed rule, the first subgroup of self-pay consumers that we believed could benefit from knowing the discount cash price would be those who are uninsured. The number of uninsured individuals in the United States rose to 27.4 million in 2017.[135] These individuals' need for hospital price transparency differs from patients with insurance who generally are otherwise shielded from the full cost of hospitalization and hospital items and services. Uninsured individuals do not have the advantage of having access to a discounted group rate that has been negotiated by a third party payer. Therefore, individuals without insurance may face higher out-of-pocket costs for healthcare services.

The second subgroup of self-pay consumers we indicated may benefit from knowing the discounted cash price are those who may have some healthcare coverage but who still bear the full cost of at least certain healthcare services. For example, these may be individuals who: Have insurance but who go out of network; have exceeded their insurance coverage limits; have high deductible plans but have not yet met their deductible; prefer to pay through a health savings account or similar vehicle; or seek non-covered and/or elective items or services. We noted that many hospitals offer discounts to these groups of individuals, either as a flat percentage discount off the chargemaster rate or at the insurer's negotiated rate, while some hospitals offer consumers a cash discount if they pay in full on the day of the service.[136] Other hospitals have developed and offer standardized cash prices for service packages for certain segments of the population that traditionally pay in cash for healthcare services.[137] We recognized that currently, it is difficult for most consumers to determine in advance of receiving a service what discount(s) the hospital may offer an individual because cash and financial need discounts and policies can vary widely among hospitals.

We therefore specifically considered an option that would require hospitals to make public the cash discount that would apply for shoppable services and service packages that would include all ancillary services, similar to our proposals for consumer-friendly display

[135] Kaiser Family Foundation. The Number of Uninsured People Rose in 2017, Reversing Some of the Coverage Gains Under the Affordable Care Act. December 2018. Available at: *https://www.kff.org/uninsured/press-release/the-number-of-uninsured-people-rose-in-2017-reversing-some-of-the-coverage-gains-under-the-affordable-care-act/.*

[136] Beck M. How to Cut Your Health-Care Bill: Pay Cash. *The Wall Street Journal.* February 15, 2016. Available at: *https://www.wsj.com/articles/how-to-cut-your-health-care-bill-pay-cash-1455592277.*

[137] Hempstead K and White C. Plain Talk about Price Transparency. *Health Affairs.* March 25, 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20190319.99794/full/.*

of payer-specific negotiated charges (84 FR 39585 through 39591). In this case, the discounted cash price would represent the amount a hospital would accept as payment in full for the shoppable service package from an individual. Such charges could be lower than the rate the hospital negotiates with third party payers because it would not require many of the administrative functions that exist for hospitals to seek payment from third party payers (for example, prior authorization and billing functions). However, we recognized that many hospitals have not determined or maintain, a standard cash discount that would apply uniformly to all self-pay consumers for each of the items and services provided by the hospital or for service packages, unlike they do for negotiated charges. We sought comment on this option, specifically, how many shoppable services for which it would be reasonable to require hospitals to develop and maintain, and make public a discounted cash price.

In addition, in the CY 2020 OPPS/ASC proposed rule we noted that many hospitals offer cash discounts on a sliding scale according to financial need. In such instances, we acknowledged that it may be difficult for a hospital to establish and make public a single standardized cash rate for such groups of consumers. For this reason, we also considered a different definition that would take sliding scale cash discounts into account by defining a standard charge as the median cash price. The median cash price would be the midpoint of all cash discounts offered to consumers, including prices for self-pay patients and those qualifying for financial assistance. We indicated that for uninsured patients who may qualify for financial assistance, the value of making a median cash price public could raise awareness of their available options, including the ability to apply for financial assistance, however, we also stated that we believed such a rate would be less useful to the public than a single standard cash price that the hospital would accept as payment in full as discussed above.

Comment: Many commenters, including individual consumers, patient advocates, clinicians, and insurers, strongly supported including a definition of standard charges to reflect the discounted cash price that would be offered to a self-pay consumer because they believe this information would be beneficial and relevant to consumers, including consumers with third party payer coverage. A few commenters suggested that CMS redefine this type of ''standard charge'' as hospital walk-in rates, meaning the rates a hospital will typically charge to a patient without insurance, and one commenter suggested that hospitals post the ''Amounts Generally Billed,'' an IRS-defined term for the maximum amount individuals under a hospital's financial assistance plan would pay.

By contrast, several commenters, mostly hospital representatives, disagreed with defining standard charges as the discounted cash price due to their belief that the cash price is often reflective of after-the-fact charity discounts due to the patient's inability to pay or as a result of lack of insurance. One commenter disagreed with defining a cash rate as a type of standard charge because they believe CMS cannot require or force hospitals to have discounted cash prices, and therefore cannot require their disclosure.

Response: We thank the commenters for their strong support and their input on the utility of the discounted cash price for all consumers. We considered this alternative definition because there are many consumers who may wish to pay in cash (or cash equivalent) for hospital items and services, whether insured or uninsured, for a variety of reasons. We agree with commenters who indicated that the discounted cash price is important for many self-pay consumers. Many hospitals have already developed and offer standardized cash prices for service packages for certain segments of the population who traditionally pay in cash for healthcare services and who pay cash (or cash equivalent) in advance of receiving a healthcare service.[138] Such prices and services are typically offered as a consumer-friendly packaged service that negates the need for hospitals to expend administrative time and resources billing third party payers and resubmitting charges when payment is denied.[139] Moreover, we agree with commenters who indicated that up-front knowledge of pricing can increase patient satisfaction and reduce bad debt and could help mitigate ''surprise billing.''

As discussed in the CY 2020 OPPS/ASC proposed rule, we made a distinction between the discounted cash price (the price a hospital agrees to accept from a self-pay consumer as payment in full) versus a median cash price that would take into account any and all cash prices accepted by hospitals, including cash payments accepted following sliding scale discounts as a result of charity care. We clarify that the ''discounted cash price'' would reflect the discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a particular individual's bill. Thus, the discounted cash price is a standard charge offered by the hospital to a group of individuals who are self-pay. The discounted cash price may be generally analogous to the ''walk-in'' rate referred to by commenters, however, we do not want to take a position as to whether it is the same as the cash discount price because the cash discounted price would apply to all self-pay individuals, regardless of insurance status.

We are therefore finalizing a definition of discounted cash price as a type of standard charge. We note that we agree with commenters who indicate that some hospitals may not have determined a discounted cash price for self-pay consumers. For some hospitals, the cash price is the undiscounted gross charges as reflected in the hospital chargemaster as previously discussed. In that case, under our definition of discounted cash price, the hospital's discounted cash price would simply be its gross charges as reflected in the chargemaster.

Final Action: We are finalizing the definition of discounted cash price that we discussed in the CY 2020 OPPS/ASC proposed rule. Specifically, we are finalizing a definition of cash discounted price to mean the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross charges as found in the hospital chargemaster. We are finalizing this definition at 45 CFR 180.20.

d. Definitions of ''De-Identified Minimum Negotiated Charge'' and ''De-Identified Maximum Negotiated Charge'' as Two Types of Standard Charges

In the CY 2020 OPPS/ASC proposed rule, we also considered defining a type of ''standard charge'' as the de-identified minimum, median, and maximum negotiated charge. Under this definition, the hospital would be required to make public the lowest, median, and highest charges of the distribution of all negotiated charges across all third party payer plans and products. We indicated that this

[138] Hempstead K and White C. Plain Talk about Price Transparency. *Health Affairs.* March 25, 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20190319.99794/full/.*

[139] Bai G, et al. Providing Useful Hospital Pricing Information To Patients: Lessons From Voluntary Price Disclosure. *Health Affairs.* April 2019. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20190416.853636/full/.*

information could provide healthcare consumers with an estimate of what a hospital may charge, because it conveys the range of charges negotiated by all third party payers. We also indicated that as a replacement for the payer-specific negotiated charge, this definition had the advantage of lowering reporting burden and could relieve some concerns by stakeholders related to the potential for increased healthcare costs in some markets as a result of the disclosure of third party payer negotiated charges. At the time, we did not propose to define the de-identified minimum, median, and maximum negotiated charges as types of standard charges because we believed the payer-specific negotiated charges would provide much more useful and specific information for consumers. However, we sought comment on this issue as an alternative type of standard charge.

Comment: Many commenters supported a definition of standard charges to require hospitals to post a de-identified range of negotiated rates, including the minimum, median, and maximum negotiated rates or all-inclusive range, quartiles or a median range (that is, the 25th and 75th percentile or the 25th through the 75th percentiles), another specific percentile within the range of negotiated charges, ''usual and customary'' (which are based on a regional percentile), or average rate. Commenters supported these alternatives in addition to payer-specific negotiated charges because they believe de-identified negotiated rate information would be relevant and beneficial to consumers. Commenters noted that many consumer-facing price transparency tools display the minimum and maximum negotiated charges for healthcare services already, or display regional average charges. One commenter stated that providing such alternative charges in addition to providing the payer-specific negotiated charges can be helpful as it provides a ''meaningful anchor'' for the patient when they are comparing options. Other commenters echoed this sentiment, indicating that such charges, in addition to payer-specific negotiated charges, are useful for consumers such as patients and employers.

Several commenters indicated they believed these types of standard charges could provide a suitable substitute for the payer-specific negotiated charges. A few commenters indicated that the substitution could protect the identification of individual payers in smaller markets which they said would reduce any legal or market risk that could be associated with compelling the release of negotiated rates, although one commenter expressed concern that display of a de-identified maximum may have an adverse effect on the ability to negotiate lower rates. By contrast, patient advocates and consumers strongly opposed the substitution of any type of de-identified negotiated charge, stating such charges would provide a far less accurate indicator of a patient's potential financial obligations compared to knowledge of the consumer's own payer-specific negotiated charges. For example, one commenter said that substitution for payer-specific negotiated charges for a more general or informational charge may leave patients feeling misled and delays the country from moving closer to a patient-focused system. Another indicated that limiting standard charge information to a median or range would reduce utility of the information and serve to frustrate innovators who seek to provide consumers with an unbiased view of provider cost and quality.

Several commenters specifically indicated that a range (for example, the minimum and maximum negotiated charges) of de-identified charges would be useful to the public because it would make it easier for consumers to quickly understand the range of prices across all insurance plans that might apply. One commenter noted that requiring hospitals to make public a range instead of all payer-specific negotiated charges would not likely reduce burden.

Additionally, a few commenters recommended the use of regional or market averages or median rates, or the ''usual and customary'' which stated that displaying a market (not hospital) median, or the ''usual and customary'' which is defined by the National Council of Insurance Legislators (NCIL) as the 80th percentile of physician charges in a geographic region based on an independent unbiased benchmarking charge database. One commenter noted that such rates would serve as a basic benchmark for vendors and prevent the prices paid by insurers from being known.

A few commenters, however, disagreed with defining a standard charge based on the hospital's minimum, median, and maximum negotiated rate (or a variation of these) due to their belief that this data would be of limited value or not be beneficial to consumers and may cause confusion. One commenter specifically requested that the median cash price not be finalized as a type of standard charge.

Response: We thank commenters for their support and innovative suggestions on variations of the potential definition of a type of ''standard charge'' as the de-identified minimum, median, and maximum negotiated charge. We agree with commenters that information related to several types of de-identified negotiated rates could be useful and beneficial to consumers in conjunction with payer-specific negotiated charges, together as a range, or as separate types of standard charges.

First, we agree with commenters who suggested that the de-identified minimum negotiated charge and the de-identified maximum negotiated charge could each provide a benchmark for determining the value of a hospital item or service for referring providers or employers. For example, for a consumer with insurance who is obligated to pay a percentage of the negotiated charge, knowing the maximum would be more helpful and informative than not having any reference point at all and would relieve consumers of the fear and uncertainty due to the lack of knowledge. Disclosure of the minimum de-identified negotiated charge by itself could also provide a benchmark that could have an impact on market forces, as some commenters suggested. Therefore, we believe that each value, independent of the other, could be helpful in providing some standard hospital charge information to consumers.

We further agree with commenters who asserted that knowing both the minimum and the maximum (that is, the range) of negotiated rates could benefit consumers. As noted by commenters, many consumer facing pricing tools make use of ranges in their displays. For example, consumers without third party payer coverage could use the range to negotiate a charge with the hospital that is more reasonable than the gross charges a hospital might otherwise bill them. The range would also be useful for consumers with insurance, for example, someone obligated to pay a percentage of the negotiated rate would be able to determine both their minimum and maximum financial obligation for an item or service to compare across hospital settings.

Finally, however, we agree with commenters who indicated that the most beneficial hospital standard charge information for consumers (including patients and employers) would include requiring disclosure of payer-specific negotiated charges along with disclosure of the de-identified minimum negotiated charges and de-identified maximum negotiated charges. We agree with commenters who indicated that this set of information, taken together, can provide consumers with an even more complete picture of hospital

standard charges and drive value. For example, by knowing one's payer-specific negotiated charges in addition to the minimum and maximum negotiated charges for a hospital item or service, consumers with third party payer coverage could determine whether their insurer has negotiated well on their behalf by assessing where their payer-specific negotiated charge falls along the range. Such information would serve to promote value choices in obtaining a healthcare services, and may also promote value choices in obtaining a healthcare insurance product. Additionally, we agree with commenters that presenting such information aligns with current consumer-friendly tools and displays and supports innovation.

We are therefore finalizing with modification to define a fourth type of standard charge as the ''de-identified minimum negotiated charge'' to mean the lowest charge that a hospital has negotiated with all third party payers for an item or service. We are also finalizing with modification to define a fifth type of standard charge as the ''de-identified maximum negotiated charge'' to mean the highest charge that a hospital has negotiated with all third party payers for an item or service. To identify the minimum negotiated charge and the maximum negotiated charge, the hospital considers the distribution of all negotiated charges across all third party payer plans and products for each hospital item or service. We note that this distribution would not include non-negotiated charges with third party payers. The hospital must then select and display the lowest and highest de-identified negotiated charge for each item or service the hospital provides.

We appreciate the many additional innovative suggestions for how a range of de-identified negotiated charges could be displayed by a hospital. We note that we have interpreted section 2718(e) of the PHS Act to require each hospital to disclose its own standard charges, and not the charges that are standard in a particular region or market as some commenters suggested. However, if commenters believe such data to be valuable, nothing would prevent hospitals or other users of the information to include such ranges when presenting it to consumers.

Final Action: We are therefore finalizing with modification to define a fourth and fifth type of standard charge as the ''de-identified minimum negotiated charge'' to mean the lowest charge that a hospital has negotiated with all third party payers for an item or service. We are also finalizing with modification to define a fifth type of standard charge as the ''de-identified maximum negotiated charge'' to mean the highest charge that a hospital has negotiated with all third party payers for an item or service. In response to comments and in the interest of minimizing hospital burden, we are not finalizing the inclusion of the median negotiated charge as a type of standard charge. We are finalizing these definitions at 45 CFR 180.20. As discussed above, we believe these additional types of standard charges could be useful and beneficial to consumers.

We intend for the de-identified minimum negotiated charge and de-identified maximum negotiated charge to be severable, one from the other, and from payer-specific negotiated charge, such that each of these three types of standard charges could stand-alone as a type of standard charge.

We believe it is reasonable to consider the de-identified minimum negotiated charge and the de-identified maximum negotiated charge as severable from payer-specific negotiated charge because these values represent the lowest or highest charge (along a distribution) that a hospital has negotiated across all third party payers for an item or service, and do not identify the third party payer with which these rates are negotiated. We also believe these types of standard charges are severable from each other because the de-identified minimum negotiated charge and the de-identified maximum negotiated charge are separate values in the distribution.

Further, we believe it is feasible for hospitals to separately identify each type of ''standard charge'', which according to the definition we are finalizing in 45 CFR 180.20 includes: Gross charge, payer-specific negotiated charge, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and discounted cash price. As discussed elsewhere in section II.D of this final rule, we believe each type of standard charge is a reasonable, and necessary aspect of hospital price transparency, to ensure consumers have as complete information as possible to inform their healthcare decision-making. We therefore believe that all five charges (gross charge, payer-specific negotiated charge, de-identified minimum negotiated, charge, de-identified maximum negotiated charge, and discounted cash price) provide value to consumers for the reasons discussed in this section. Accordingly, we intended for all five definitions to be severable, such that if a court were to invalidate the inclusion of an individual definition, the remaining definitions would remain defined as types of standard charges.

We believe, when made public in combination (according to the requirements we are finalizing), these types of standard charges will be most effective in achieving meaningful transparency in prices of hospital items and services. We also recognize that each type of standard charge alone, if made public nationwide, could also further hospital price transparency in the United States.

E. Requirements for Public Disclosure of All Hospital Standard Charges for All Items and Services in a Comprehensive Machine-Readable File

1. Overview

Section 2718(e) of the PHS Act requires hospitals to make their standard charges public in accordance with guidelines developed by the Secretary. Therefore, we proposed that hospitals make public their standard charges in two ways: (1) A comprehensive machine-readable file that makes public all standard charge information for all hospital items and services (84 FR 39581 through 39585), and (2) a consumer-friendly display of common ''shoppable'' services derived from the machine-readable file (84 FR 39585 through 39591). In the CY 2020 OPPS/ASC proposed rule, we explained our belief that these two different methods of making hospital standard charges public are necessary to ensure that such data is available to consumers where and when it is needed (for example, via integration into price transparency tools, electronic health records (EHRs), and consumer apps), and also directly available and useful to consumers that search for hospital-specific charge information without use of a developed price transparency tool.

For purposes of displaying all standard charges for all items and services in a comprehensive machine-readable file, we proposed requirements for the file format, the content of the data in the file, and how to ensure the public could easily access and find the file. We agree with commenters who indicate that the machine-readable file would contain a large amount of data, however, we believe that a single data file would be highly useable by the public because all the data would be in one place. By ensuring accessibility to all hospital standard charge data for all items and services, these data will be available for use by the public in price transparency tools, to be integrated into EHRs for purposes of clinical decision-making and referrals, or to be used by

researchers and policy officials to help bring more value to healthcare.

Comment: A few commenters (particularly hospitals) noted concerns that the chargemaster data they already make public online appears to be accessed less by consumers and more by insurance brokers, competitors, and reporters. Additionally, many commenters believed that the proposed data to be made public would be too complex, voluminous, and time consuming for consumers to navigate and understand. Specifically, commenters expressed concern that: The data files would be comprised of thousands of lines of data that consumers would have to sift through; the volume of files could crash personal computers; the information could add to confusion for consumer who may not understand a chargemaster, coding, or the differences between ancillary services, gross charges, and payer-specific negotiated charges; providing large and complex datasets (even if standardized) would not achieve CMS's stated goal of transparency; and consumers may not be able to derive actual costs from standard charge information. Some commenters indicated that the machine-readable file should be made consumer-friendly and searchable.

Response: We believe that requiring hospitals to make public all standard charges for all items and services they provide is consistent with the mandate of section 2718(e) of the PHS Act. We agree with commenters who indicate that the machine-readable file would contain a large amount of data, however, we believe that a single data file would be highly useable by the public because all the data would be in one place. By ensuring accessibility to all hospital standard charge data for all items and services, these data will be available for use by the public in price transparency tools, to be integrated into EHRs for purposes of clinical decision-making and referrals, or to be used by researchers and policy officials to help bring more value to healthcare. In order to ensure hospital standard charge data is more directly useful to the average patient, we proposed and are finalizing an additional requirement for hospitals to make a public standard charges for a set of shoppable services in a consumer-friendly manner (see section II.F of this final rule). We believe the shorter data set presented in a consumer-friendly manner is more likely to be directly useful to consumers who seek to compare costs for common shoppable services hospital-by-hospital.

We note that many machine-readable data sets that are made available for public use can be quite large. For example, Medicare Provider Utilization and Payment Data files include information for common inpatient and outpatient services, all physician and other supplier procedures and services, and all Part D prescriptions.[140] These files are freely available to the public and contain hundreds of thousands of data points in .xlsx and .csv format. We therefore believe it is possible for hospitals to make public all their standard charges for all the items and services they provided in a similar manner. Additionally, we have not heard that large Medicare data files of data derived from claims causes any confusion for healthcare consumers, and healthcare consumers do not typically use the information in the data files directly. Instead, voluminous Medicare data is used by a variety of stakeholders, some of whom take the information and present it to users in a consumer-friendly manner.[141] Similarly, we do not believe that making public a comprehensive machine-readable file with all standard charges for all items and services would create patient confusion. Finally, we note that by definition, machine-readable files are searchable.

2. Standardized Data Elements for the Comprehensive Machine-Readable File

In the CY 2020 OPPS/ASC proposed rule (84 FR 39582 through 39583), we proposed that hospitals disclose their list of standard charges for all items and services online in a single digital file that is machine-readable. Without specifying a minimum reporting standard for the machine-readable file, the standard charges data made publicly available by each hospital could vary, making it difficult for the users of the data to compare items and services. For example, some hospitals currently post a single column of gross charges without any associations to CPT or HCPCS codes or other identifying descriptions of the items and services to which the gross charge applies. A similar example would be a hospital that displays a list of gross charges that is correlated with a list of item numbers that are meaningful to the hospital billing personnel, but not understandable to the general public. By contrast, some hospitals list their gross charges along with a brief description of the item or service to which each gross charge applies and the corresponding standardized identifying codes (typically HCPCS or CPT codes).

We expressed our concern that the lack of uniformity leaves the public unable to meaningfully use, understand, and compare standard charge information across hospitals. Therefore, for the comprehensive machine-readable file of all standard charges for all items and services, we made proposals to ensure uniformity of the data made publicly available by each hospital. To inform these proposals, we considered the data elements that are typically included in a hospital's billing system and which of those elements would result in hospital standard charge data being most transparent, identifiable, meaningful, and comparable. Specifically, we proposed that the list of hospital items and services include the following corresponding information, as applicable, for each item and service:

- Description of each item or service (including both individual items and services and service packages).
- The corresponding gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding payer-specific negotiated charge that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each list of payer-specific charges must be clearly associated with the name of the third party payer.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier.
- Revenue code, as applicable.

We proposed to codify these requirements at proposed new 45 CFR 180.50(b). We stated that we believe that these elements would be necessary to ensure that the public would be able to compare standard charges for the same or similar items and services provided by different hospitals.

We proposed that hospitals associate each standard charge with a CPT or HCPCS code, DRG, NDC, or other common payer identifier, as applicable, because hospitals uniformly understand them and commonly use them for billing items and services (including both individual items and services and service packages). We also proposed

[140] CMS.gov website, Medicare Provider Utilization and Payment Data. Available at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html.*

[141] Wei S, et al. Surgeon Scorecard. ProPublica. Updated July 15, 2015. Available at: *https://projects.propublica.org/surgeons/.*

that hospitals include item descriptions for each item or service. In the case of items and services that are associated with common billing codes (such as HCPCS codes), the hospital could use the code's associated short text description.

In addition, based on stakeholder feedback suggesting hospital charge information should include revenue codes to be comparable, we proposed to require that the hospital include a revenue code where applicable and appropriate. Hospitals use revenue codes to associate items and services to various hospital departments. When a hospital charges differently for the same item or service in a different department, we proposed that the hospital associate the charge with the department represented by the revenue code, providing the public some additional detail about the charges they may expect for hospital services provided in different hospital departments.

In developing this proposal, we also considered whether the following data elements, which are commonly included in hospital billing systems, might be useful to the public:

- Numeric designation for hospital department.
- General ledger number for accounting purposes.
- Long text description.
- Other identifying elements.

However, we determined that, for various reasons, these data elements may not be as useful as the data elements that we proposed to require hospitals to make public. For example, data elements such as general ledger numbers are generally relevant to the hospital for accounting purposes but may not add value for the public, while data elements such as alternative code sets (such as International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD–10) codes) or long text descriptions associated with CPT codes, while useful, might be difficult to associate with a single item or service or be otherwise difficult to display in a file that is intended mainly for further computer processing. Because of this, we stated that while long text descriptions might benefit healthcare consumers and be appropriate for the consumer-friendly display of shoppable services (as discussed in the CY 2020 OPPS/ASC proposed rule, 84 FR 39585 through 39591), we believe they may add unnecessary burden for hospitals when such descriptions are not readily electronically available, or when the display of such data is not easily formatted into a machine-readable file. Therefore, we did not propose to require these additional elements for the machine-readable data file that contains a list of all standard charges for all hospital items and services. We invited public comment on the proposed data elements for the comprehensive machine-readable file of all standard charges for all items and services that hospitals would be required to make public. We also sought public comment on the other data elements that, as we detail above, we considered but did not propose to require, and on any other standard charge data elements that CMS should consider requiring hospitals to make public.

Comment: A few commenters sought clarification on how to make public charges for various hospital items and services. For example, one commenter stated that gross charges are not established for several codes using surgical procedure codes, but rather are listed as unit of time. Others pointed out that charges for hospitals and physicians may be maintained separately, with some indicating that employed physician charges are not included in their hospital chargemaster.

Response: In its comprehensive machine-readable file, the hospital must include all standard charges for all items and services for which it has established a charge, which includes time-based gross charges. For items and services and associated gross charges found in the hospital chargemaster, the hospital could list, for example, the gross charge associated with supplies or amount charges per unit of time. An example of how a hospital could list its time-based gross charges for various items and services can be viewed in Table 1.

We understand that some hospitals may have several locations operating under a consolidated hospital license, and each location may have its own chargemaster. Some hospitals may have a chargemaster for hospital items and services (for example, supplies, procedures, or room and board charges) and one for hospital services provided by employed professionals, although more often all gross charges for all items and services provided by the hospital (including services of employed practitioners) are kept in a single hospital chargemaster. Moreover, we agree with commenters that often the charges for employed practitioners are not associated with specific CPT/HCPCS codes until after a service has been provided to a patient. However, the gross charge for the employed professional would still be present in the chargemaster. The last several rows of Table 1 illustrates one way a hospital could incorporate standard charges for professional services into their comprehensive machine-readable file. Additionally, we note that gross charges for some supplies, such as gauze pads, found in the hospital chargemaster may not have a corresponding common billing code. Therefore, we clarify that that common billing codes as a required data element be included as applicable.

TABLE 1—SAMPLE DISPLAY OF GROSS CHARGES [142]

Hospital XYZ Medical Center Prices Posted and Effective [month/day/year] Notes: [insert any clarifying notes]					
Description	CPT/HCPCS code	NDC	OP/Default gross charge	IP/ER gross charge	ERx Charge quantity
HB IV INFUS HYDRATION 31–60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		251.13	383.97	
HB IV INFUSION THERAPY 1ST HR	96365		1,061.85	1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	251.13	383.97	12 Each.
PHENYLEPHRINE HCL 10% OP DROP		17478020605	926.40	1,264.33	5 mL.
MULTIVITAMIN PO TABS		10135011501	0.00	0.00	100 Each.
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		185.00		
GENETIC COUNSEL 15 MINS	S0265		94.00		
DIALYSIS TRAINING/COMPLETE	90989		988.00		
ANESTH, PROCEDURE ON MOUTH	170		87.00		

Comment: One commenter provided a chart as an example of how to disclose price transparency information broken down by Medicare, Medicaid, commercial non-contracted in-network and commercial non-contracted out-of-network providers. Another commenter recommended that any publicly-available report of hospital negotiated prices be preceded by efforts to create standardized data definitions and formats across hospitals and ensure alignment with insurer reporting standards, which is critical to achieving consumer-friendly, useful, ''apples-to-apples'' information.

Response: We appreciate these comments and agree that standardization is important to ensure that hospital charge information can be compared across and between hospitals. Based on a review of state requirements and a sampling of hospitals that are currently making their charges public, we chose the specific data elements we are finalizing, which are included in hospital billing and accounting systems, as the ones that would result in hospital standard charge data being transparent, identifiable, meaningful, and comparable. For example, we believe that the billing codes present a common data element that provides an adequate cross-walk between hospitals for their items and services. Such codes serve as a common language between providers and payers to describe the medical, surgical and diagnostic services provided by the healthcare community.

We agree that defining elements in a data dictionary or more specificity in data file formats could make it easier for IT personnel to use hospital charge data and will take it under consideration for future rulemaking.

For reasons we discussed earlier in section II.D.3. of this final rule, data on FFS Medicare and Medicaid is not included as a type of standard charge and would not be required to be included in the comprehensive machine-readable file. Because such data is publicly available, however, it could readily be included by a hospital that so chooses, or it could be added by those who use the hospital standard charge information. We further agree that additional data related to commercial non-contracted in-network and commercial non-contracted out-of-network providers could be useful for consumers and note that we are concurrently publishing a price transparency proposed rule entitled Transparency in Coverage (file code CMS–9915–P) focused on disclosure of negotiated rates and unique out-of-network allowed amounts from most individual and group market health insurance issuers and group health plans. We believe that by doing so we are aligning expectations and incentives across the healthcare system and helping to ensure alignment with reporting standards applicable to issuers and group health plans.

Comment: A few commenters expressed concern that this proposal falls short of achieving its goal of informing patients about the cost of care in a meaningful way to choose among hospital providers. One commenter asserted that even when hospitals use the same or similar terminology to describe specific services, some services can be very specific in ways that patients may not understand and associated out-of-pocket costs can vary a great deal, and that unless patients are familiar with coding and standard descriptors, it is likely that many will compare cost estimates for services that are substantially different from what they will receive. Several commenters asserted that hospitals do not have adequate, timely health plan information related to patient benefit plans, bundled payments, and adjudication rules to provide patients with accurate out-of-pocket cost estimates prior to services. One commenter expressed concern with the ability for an accurate estimate to be ''published in a file'' due to the myriad ways that payers structure and adjudicate providers' claims. The commenter noted that third-party payers have processing systems that determine ''allowables'', adjustments, payments, patient responsibility, etc., and that address unique plan design constructs (at the employer's discretion) based on each unique contract. Another commenter asserted that there is significant complexity in negotiated contracts and many other nuances in

[142] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

contract arrangements that would means that each hospital would need to provide data on literally thousands of service bundle combinations.

Response: We are clarifying the requirements for making public all standard charges for all items and services in a comprehensive machine-readable file and have included an example of the format and structure the list of gross charges could take (see Table 1). We agree that standardization in some form is important to ensure high utility for users of the hospital standard charge information, and we have proposed and are finalizing certain requirements (such as the data elements and file formats) that would be standardized across hospitals. We decline at this time to be more prescriptive in our approach; however, we may revisit these requirements in future rulemaking should we find it is necessary to make improvements in the display and accessibility of hospital standard charge information for the public. Regarding the display of payer-specific negotiated charges, we recommend hospitals consult their rate sheets or rate tables within which the payer-specific negotiated charges are often found. Such rate sheets typically contain a list of common billing codes for items and services provided by the hospital along with the associated payer-specific negotiated charge or rate. We believe it is possible to make this information public in a single comprehensive machine-readable file by, for example, using multiple tabs in an XML format. For example, one tab could show a list of individualized items and services and associated gross charges derived from the hospital's chargemaster while another tab could display the individualized items and services and service packages for a specific payer's plan based on the rate sheet derived from the hospital's contract with the payer. We also note that service packages can often be associated with a common billing code such as a DRG or APC or other payer modifier that is identified on the rate sheet. We clarify that for service packages, we do not intend each and every individual item or service within the service package to be separately listed. For example, if a hospital has a payer-specific negotiated charge (base charge) for a DRG code, the hospital would list that payer-specific negotiated charge and associated DRG code as a single line-item on its machine-readable file.

Further, as described in more detail in section II.D.1 of this final rule, we disagree with commenters who indicated that standard charges are meaningless to consumers. We agree, however, that for insured patients, the payer-specific negotiated charge does not in isolation provide a patient with an individualized out-of-pocket estimate. Because the additional details of a consumer's benefit structure (for example, the copay or deductible) are not standard charges maintained by hospitals, we did not propose that hospitals would be required to make these data elements public. However, as we explained, the hospital standard charges, specifically, the gross charge and the payer-specific negotiated charges, are critical data points found on patient EOBs which are designed to communicate provider charges and resulting patient cost obligations, taking third party payer insurance into account. When a patient has access to payer-specific negotiated charge information prior to obtaining a healthcare service (instead of sometimes weeks or months after the fact when the EOB arrives), combined with additional information the patient can get from payers, it can help the individual determine his or her potential out-of-pocket information for a hospital item or service in advance. As previously noted, we agree with commenters who indicate that the machine-readable file would contain a large amount of data, however, we believe that a single data file would be highly useable by the public because all the data would be in one place. By ensuring accessibility to all hospital standard charge data for all items and services, these data will be available for use by the public in price transparency tools, to be integrated into EHRs for purposes of clinical decision-making and referrals, or to be used by researchers and policy officials to help bring more value to healthcare.

Comment: One commenter suggested that the machine-readable file include the ''claim allowable,'' which is comprised of the sum of the co-pay, coinsurance, deductible and health insurance company payment. A few commenters indicated CPT codes and ICD procedure codes should be included to facilitate apples-to-apples comparisons and ensure so inpatient facilities do not have a way to extend charges to cash-pay patients and inflate patient charges.

Response: We thank the commenters for their input. We believe the ''claim allowable'' referred to by the commenter is analogous to the payer-specific negotiated charge, which is the rate negotiated by hospitals that includes both the payer and patient portion. In other words, as explained in section II.D.3 of this final rule, the payer-specific negotiated charge is the discounted rate that the hospital has negotiated with the third party payer and is typically displayed as the second charge listed on the patient's EOB. As expressed by commenters, additional information from the payer is necessary to determine how the ''negotiated rate'' or ''allowed amount'' is apportioned between the payer and the patient. As explained in the CY 2020 OPPS/ASC proposed rule, we do not believe that ICD procedure codes should be included because, while useful, such information might be difficult to associate with a single item or service or be otherwise difficult to display in a file that is intended mainly for further computer processing. In summary, we believe the proposed data elements represent the necessary elements (standard charges, service description, and code) to ensure hospital charge information is relevant to consumers, usable, and comparable, so we are finalizing as proposed.

Comment: Several commenters stated that there can be multiple revenue codes for a single service, leading to consumer confusion and repetitive information. One commenter recommended that CMS eliminate revenue code as a standardized data element because some procedures have the same charge, but the revenue code differs.

Response: We believe the revenue code is an important data element for the reasons described in the CY 2020 OPPS/ASC proposed rule, but we are sympathetic to commenters who indicated that including such a code may exponentially increase the number of fields in the comprehensive machine-readable file and make the file difficult to manage. We believe the commenter indicated this because the revenue center code is specific to each hospital department which may offer the same or similar items and services to other hospital departments. If a hospital were to list out each item or service provided in each revenue center separately, the list of items and services could be replicated many times over. We are therefore not finalizing this data element as a requirement, but continue to encourage its inclusion and use by hospitals where appropriate to improve the public's understanding of hospital standard charges. For example, if an item or service has a different charge when provided in a different revenue center (that is, department), the hospital could list just that one item twice—once for the revenue center that has the different standard charge and once for the standard charge that applies to all other revenue centers.

Comment: Several commenters suggested alternatives to the standard

data elements for reporting all items and services. For example, some suggested including ICD–10 procedure codes, one suggested posting separate charges for administrative cost of government and insurance regulations, and another suggested hospitals make public the costs related to cost-shifting and uncompensated care, the availability of providers, whether the provider takes all forms of payment. One commenter suggested leveraging a group of various stakeholders to develop and validate these standards. One commenter also suggested that a healthcare consumer should have the right to view a line itemized medical bill before and after the time of service, which would contain the full name (no abbreviations) of each medical test as spelled out in the AMA CPT manual for which a medical provider wants paid accompanied by the five (5) digit CPT billing code as per the AMA CPT manual. Two commenters asserted that failure to provide an easy to understand fee schedule in advance, combined with hospitals failure to provide an itemized bill, results in the unfair and unethical practice known as surprise medical billing.

Response: We appreciate the commenters' alternative suggestions and interest in reducing the risk of surprise billing by providing consumers with an advance itemized bill of each medical service. We note that this final rule would not constrain hospitals from providing an itemized bill in advance, ICD–10 codes, or other information that consumers may find helpful to understand the cost of their care. At this time, however, we believe that the common data requirements we are finalizing provide sufficient information for consumers to compare hospital standard charges.

Final Action: We are finalizing with modifications our proposals for common data elements that must be included in the comprehensive machine-readable file that contains all standard charges for all items and services provided by the hospital. Specifically, we are finalizing a requirement that the machine-readable list of hospital items and services include the following corresponding information, as applicable, for each item and service:

- Description of each item or service (including both individual items and services and service packages).
- The corresponding gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding payer-specific negotiated charge that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.
- The corresponding de-identified minimum negotiated charge that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding de-identified maximum negotiated charge that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding discounted cash price that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier.

We are codifying these requirements at new 45 CFR 180.50(b). We believe that these elements are necessary to ensure that the public can compare standard charges for similar or the same items and services provided by different hospitals. We are not finalizing the revenue center code as a required data element, but we continue to encourage its inclusion and use by hospitals where appropriate to improve the public's understanding of hospital standard charges.

3. Machine-Readable File Format Requirements

To make public their standard charges for all hospital items and services, we proposed to require that hospitals post the charge information in a single digital file in a machine-readable format. We proposed to define a machine-readable format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats. A Portable Document Format (PDF) would not meet this definition because the data contained within the PDF file cannot be easily extracted without further processing or formatting. We proposed to codify these format requirements at proposed new 45 CFR 180.50(c) and the definition of machine-readable at proposed new 45 CFR 180.20. We explained our belief that making public such data in a machine-readable format would pose little burden on hospitals because many, if not all, hospitals already keep these data in electronic format in their accounting systems for purposes of, for example, ensuring accurate billing. However, we sought comment on this assumption and the burden associated with transferring hospital charge data into a machine-readable format.

As an alternative, we considered proposing to require that hospitals post their list of all standard charges for all items and services using a single standardized file format, specifically .XML only, because this format is generally easily downloadable and readable for many healthcare consumers, and it could simplify the ability of price transparency tool developers to access the data. However, we did not want to be overly prescriptive in our requirements for formatting. We sought public comments on whether we should require that hospitals use a specific machine-readable format, and if so, which format(s). Specifically, we sought public comment on whether we should require hospitals to make all standard charge data for all items and services available as an .XML file only.

In addition, we considered formats that could allow direct public access to hospital standard charge information and we sought public comment from all stakeholders, particularly hospitals and innovative IT vendors, regarding such technologies or standards that could facilitate public access to real-time updates in a format to make it easier for information to be available when and where consumers want to use it. We specifically sought public comment on adopting a requirement that hospitals make public their standard charges through an open standards-based Application Programming Interface (API) (sometimes referred to as an ''open'' API) through which they would disclose the standard charges and associated data elements discussed in section XVI.E.2 of the CY 2020 OPPS/ASC proposed rule (84 FR 39582 through 39583). We also sought public comment on the additional burden that may be associated with a requirement that hospitals make public their standard charges through a standards-based API.

Comment: Several commenters supported the use of API-based methods to access pricing information, noting that APIs are largely efficient and not burdensome to implement. A few commenters believed this would also encourage the development of an innovative health ecosystem that would facilitate the most user-friendly interface for consuming and presenting the information to patients. A few commenters supported the development of industry-wide API standard or requiring a standards-based API, which would leverage widely-recognized, national standards. One commenter suggested that CMS require all stakeholders in the healthcare industry to adopt standardized data exchange methods for pricing information to allow the primary care or other referring physician to be able to have the price conversation with the patient as decisions are made. Another commenter urged the use of APIs to be able to export a complete health record with both price and clinical information. One commenter recommended that CMS use consensus-based data standards for the posting of machine-readable files, as stated in the June 24, 2019 Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First.

Response: We appreciate comments on this issue. We believe that standardizing exchange of hospital standard charge and other data is an important goal, but we believe that finalizing our requirement that hospitals make their standard charge information available to the public online in a machine-readable format is a good initial step. We continue to work on policies designed to advance the use of APIs to support interoperability in collaboration with other federal partners, such as the Office of the National Coordinator (ONC). As hospital disclosure of standard charges matures, and Fast Healthcare Interoperability Resources (FHIR) or other consensus-based standards for data pricing endpoints develop, we may revisit the issue and consider proposing in future rulemaking approaches using API or other technology.

Final Action: We are finalizing as proposed the requirement that hospitals post their standard charge information in a single digital file in a machine-readable format. We are finalizing our definition of machine-readable format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats. A PDF would not meet this definition because the data contained within the PDF file cannot be easily extracted without further processing or formatting. We are finalizing these format requirements at new 45 CFR 180.50(c) and the definition of machine-readable at new 45 CFR 180.20.

4. Location and Accessibility Requirements for the Comprehensive Machine-Readable File

In the CY 2020 OPPS/ASC proposed rule, we explained that we reviewed how hospitals are currently implementing our updated guidelines, which took effect on January 1, 2019, and we expressed concern that some charge information made public by hospitals may be difficult for the public to locate. For example, information may be difficult to locate if the public is required to click down several levels in order to find the information. We also expressed our concern about barriers that could inhibit the public's ability to access the information once located. For example, we indicated that we were aware that some hospitals require consumers to set up a username and password, or require consumers to submit various types of other information, including, but not limited to, their email address, in order to access the data. We expressed concern that these requirements might deter the public from accessing hospital charge information.

Accordingly, we proposed that a hospital would have discretion to choose the internet location it uses to post its file containing the list of standard charges so long as the comprehensive machine-readable file is displayed on a publicly-available web page, it is displayed prominently and clearly identifies the hospital location with which the standard charges information is associated, and the standard charge data are easily accessible, without barriers, and the data can be digitally searched. For purposes of these proposed requirements: (1) ''displayed prominently'' would mean that the value and purpose of the web page [143] and its content [144] is clearly communicated, there is no reliance on breadcrumbs [145] to help with navigation, and the link to the standard charge file is visually distinguished on the web page; [146] (2) ''easily accessible'' would mean that standard charge data are presented in a single machine-readable file that is searchable and that the standard charges file posted on a website can be accessed with the fewest number of clicks; [147] and (3) ''without barriers'' would mean the data can be accessed free of charge, users would not have to input information (such as their name, email address, or other personally identifying information (PII)) or register to access or use the standard charge data file. We proposed to codify this requirement at proposed new 45 CFR 180.50(d).

We encouraged hospitals to review the HHS Web Standards and Usability Guidelines (available at: *https://webstandards.hhs.gov/*), which are research-based and are intended to provide best practices over a broad range of web design and digital communications issues.

We also requested public comments on an alternative we considered, which would have required hospitals to submit a link to the standard charges file to a CMS-specified central website, or submit a link to the standard charge file to CMS that would be made public on a CMS web page. Such a method could have allowed the public to access standard charge information for their purposes in one centralized location. We stated that we believed this could reduce potential confusion about where to find standard charge information and potentially allow standard charge information to be posted alongside CMS hospital quality information. It could also assist in the assessment of hospital compliance with section 2718(e) of the PHS Act. In spite of these possible benefits, we did not propose to require hospitals to submit or upload a link to their standard charge information to a CMS-specified centralized website because we believed such an effort could be unnecessarily duplicative of ongoing State and private sector efforts to centralize hospital pricing information and potentially confuse consumers who may reasonably look to a hospital website directly for charge information. However, we stated that because we appreciate the advantages of having all data available through a single site, we considered this alternative and sought public comments. We sought comment on this alternative option, specifically, whether the burden outweighs the advantages.

Finally, we sought public comments on potential additional requirements, including easily-searchable file naming

[143] *https://webstandards.hhs.gov/guidelines/49.*

[144] Nielsen J. (2003, November 9). The ten most violated homepage design guidelines. Alertbox. Available at: *http://www.useit.com/alertbox/20031110.html.*

[145] *https://webstandards.hhs.gov/guidelines/78.*

[146] *https://webstandards.hhs.gov/guidelines/88.*

[147] *https://webstandards.hhs.gov/guidelines/181.*

conventions and whether we should specify the website location for posting rather than our proposed requirement that would permit hospitals some flexibility in choosing an appropriate website. Current instances of machine-readable charge files posted on hospital websites contain variable file types, file names, and locations on each website. Standardizing file name or website location information could provide consumers with a standard pathway to find the information and would provide uniformity, making it easier for potential software to review information on each website. Specific requirements for file naming conventions and locations for posting on websites could also facilitate the monitoring and enforcement of the requirement. Therefore, we sought public comments on whether we should propose to adopt these additional requirements or other requirements related to these issues.

Comment: A few commenters supported the development and use centralized price transparency websites. For example, two commenters noted that the use of a centralized posting repository would aid in monitoring to ensure hospital compliance. One commenter agreed that the information should be required to be placed in a standardized location, such as a standardized ''pricing'' uniform resource locator (URL), expressing a belief that it would go a long way toward simplifying the presently time-consuming and confusing process when attempting to comparison shop for healthcare. The commenter indicated that, when combined with the machine-readability requirements, such a standardized location would enable a wide variety of benchmarking and comparison-shopping services that are not possible today. One commenter supported the alternative concept for centralizing the standard charge data from each hospital into a CMS website to which hospitals would link from their respective websites, and quality data would be posted alongside the charge information. Another commenter did not support a central location that would contain all the links, expressing a belief that the requirement to make the charge information ''displayed prominently'' on the hospitals website would be sufficient. A few commenters suggested that CMS host a centralized list of machine-readable pricing websites and recommended that these websites be incorporated into the existing CMS National Plan and Provider Enumeration System (NPPES). Another commenter suggested that CMS launch and maintain a centralized data portal, similar to CMS' Hospital Compare website, with tightly defined file constructs in order to ensure the submission of consistent information by providers so that comparisons could be made. A few commenters suggested that CMS leverage existing price transparency efforts by states, including requirements to report pricing information or publish instructions on hospital websites to facilitate consumer access to pricing information. One commenter noted that states with APCDs and price transparency websites centralize and compare costs/prices and other attributes across providers and payers, providing a platform for disseminating standardized information. The commenter suggested that CMS leverage this experience, invest in interoperability, and advance this work across states to support consumers. Several commenters suggested alternative approaches to enable public access to price transparency information. One commenter recommended the development of a transparency website that incorporates a radius-distance search tool to view and compare hospital charges. The commenters noted that CMS shares the contents of the NPPES database on a regular basis as public use files due to the inevitability of FOIA requests. A few commenters supported the use of an independent third-party online database, with one commenter noting that this approach would not increase burden on hospitals or clinicians, in alignment with CMS' stated policy goals.

Response: We appreciate the many suggestions from stakeholders related to ensuring public access to hospital standard charge information. We agree with stakeholders that centralizing the standard charges information disclosed by hospitals could have many advantages for finding the files and for monitoring to ensure compliance. We decline to finalize such a policy at this time, however, we will continue to consider a requirement for hospitals to submit to CMS their files, or a link to where such files may be located on the internet, for future rulemaking. We agree with commenters that a naming convention could assist in locating hospital charge data files and are therefore finalizing a requirement that hospitals use a CMS-specified naming convention, which, as discussed in the CY 2020 OPPS/ASC proposed rule, we believe will help stakeholders more easily locate the comprehensive machine-readable file that contains all hospital standard charge information. We are finalizing the following naming convention that must be used for the file: <ein>_<hospital-name>_standardcharges.[json|xml|csv] in which the EIN is the Employer Identification Number of the hospital, followed by the hospital name, followed by ''standardcharges'' followed by the hospital's chosen file format.

CMS thanks the commenters for their input on the use of APCDs. We note that this rule does not require hospitals to contribute data to an APCD, but recognize that States with APCDs may seek to integrate the publication of hospital standard charge data and negotiated charges with ongoing price transparency and interoperability efforts. Moreover, we are finalizing our policy to permit hospitals to choose an appropriate public facing website and web page on which to make public its comprehensive machine-readable list of all standard charges for all items and services.

Comment: A few commenters agreed with our proposals for data accessibility, specifically that accessing the hospital charge information would not require consumers to input information (such as their name, email address, or other personal identifying information) or register. One commenter suggested, however, that this requirement does not appear to be in alignment with *Medicare.gov,* which the commenter notes requires visitors to provide personal, identifying information (such as date of birth) when reviewing options for Medicare health plans.

Response: We thank commenters for their support for barrier free access to consumer cost comparison information and are finalizing as proposed the requirement hospitals provide barrier-free access to their machine-readable file of hospital standard charges for all items and services provided by the hospital. The comment about access to *Medicare.gov* is inaccurate; the public may review and compare plans and pricing anonymously—with or without a drug list—without signing into anything or providing personal information. The website requires only a zip code entry in order to narrow down the available plans. Even if the website did require submission of some personal information, we do not believe it is a good analogy for access to a data file. A better analogy might be access to CMS public use file data. Such data is also made public online in a machine-readable format and does not require users to create an account or enter PII to download. In contrast, beneficiary access to a personalized online portal containing or using personalized information (such as would allow a patient to review and select a Medicare

Advantage health plan or to access one's own claims data) would seem to us to be very different. We are therefore finalizing our proposals for barrier-free access as proposed.

Final Action: We are finalizing, with modifications, our proposals related to location and accessibility of the comprehensive machine-readable file of all hospital standard charges for all items and services it provides. Specifically, we are finalizing that a hospital would have discretion to choose the internet location it uses to post its file containing the list of standard charges so long as the comprehensive machine-readable file is displayed on a publicly-available website, it is displayed prominently and clearly identifies the hospital location with which the standard charges information is associated (§ 180.50(d)(1) and (2)). We are finalizing as proposed that the hospital must ensure the standard charge data are easily accessible and without barriers, including but not limited to that the data can be accessed free of charge, without having to establish a user account or password, and without having to submit PII (§ 180.50(d)(3)). We are also finalizing our policy that the data must be able to be digitally searched (§ 180.50(d)(4)). Finally, we are finalizing a modification to also require that the hospital must use a CMS-specified naming convention for the file (§ 180.50(d)(5)). The naming convention for the file must be: <ein>_<hospital-name>_standardcharges.[json|xml|csv].

5. Frequency of Machine-Readable File Updates

The statute requires hospitals to establish, update, and make public their standard charges for each year. Therefore, we proposed to require hospitals to make public and update their file containing the list of all standard charges for all items and services at least once annually (proposed new 45 CFR 180.50(e)). As explained in the CY 2020 OPPS/ASC proposed rule, we recognize that hospital charges may change more frequently and therefore we encouraged, but did not propose to require, that hospitals update this file more often, as appropriate, so that the public could access the most up-to-date charge information. We also recognized that hospitals may update their charges at different times during the year and may also have various State price transparency reporting requirements that require updates. For purposes of these proposed requirements, we explained that updates that would occur at least once in a 12-month period would satisfy our proposed requirement to update at least once annually, and also serve to reduce reporting burden for hospitals. In other words, we indicated that the hospital could make public and update its list of standard charges at any point in time during the year, so long as the update to the charge data would occur no more than 12 months after posting.

We also proposed to require hospitals to clearly indicate the date of the last update they made to the standard charge data, and permitted some discretion as to where the hospital indicated the date of the last update. For example, we stated that if a hospital chose to make public its list of standard charges in .XML format, the first row of the spreadsheet could indicate the date the file was last updated. We also stated that the hospital could alternatively choose to indicate the date the file was last updated in text associated with the file on the web page on which it was posted, or could indicate the date in some other way, as long as that date was clearly indicated and associated with the file or location containing the standard charge information.

Comment: A few commenters expressed concern that requiring updates to the data only once every 12 months may mean the data posted will not be useful to consumers because the information posted may be outdated depending on the frequency and timing of contract renegotiation. A few commenters also noted that updating the database on a continual basis during the year would be a significant burden to hospitals, while another commenter suggested that price information should be updated more frequently, whenever the prices are changed. One commenter specifically supported the requirement to update the standard charge information annually. A few commenters recommended that the web page indicate the date of last update. One commenter asked for clarification regarding the process for price disclosure when new medical information is discovered that ''changes the care plan'' and whether hospitals need to update patients if pricing information has already been provided.

Response: We thank commenters for their support and recommendations. The statute requires hospitals to annually update its list of standard charges, and we believe our proposed requirement for hospitals to update their comprehensive machine-readable list of standard charges at least once in a 12 month period (which we are finalizing) is consistent with its plain language. We recognize the challenges inherent in annual posting of a flat file containing all hospital standard charges for all items in services. Specifically, we recognize that such data may, for various reasons, become outdated over the course of a 12 month period, but we also recognize that it may be burdensome for a hospital to continually update its standard charge information. We believe our final policy strikes a balance between consumer need to plan and compare prices when seeking care with hospital disclosure burden. We note that in the CY 2020 OPPS/ASC proposed rule we sought comment on alternative mechanisms (such as requiring data to be presented in an API format) that could allow for access to continuously updated hospital charge information. As noted in section II.E.3 of this final rule, we will continue to consider this option for future rulemaking. We encourage hospitals to make more frequent updates, at their discretion and commend hospitals that choose to go beyond these requirements to more frequently update the standard charge information they make online, or that provide additional consumer-specific estimates based on consumer care plans.

Final Action: At a new 45 CFR 180.50(e), we are finalizing as proposed the requirement for hospitals to make public and update their file containing the list of all standard charges for all items and services at least once annually. For purposes of assessing compliance, such updates must occur at least once in a 12-month period. We are also finalizing the requirement for hospitals to clearly indicate the date of the last update they have made to the standard charge data, with some discretion as to where the date of the last update is indicated, so long as that date is clearly indicated either within the file or otherwise clearly associated with the file.

6. Requirements for Making Public Separate Machine-Readable Files for Different Hospital Locations

As explained in the CY 2020 OPPS/ASC proposed rule, we indicated our understanding that some hospitals may have different locations operating under a consolidated or single State license, and that different hospital locations may offer different services that have different associated standard charges. To address this circumstance, we proposed at new 45 CFR 180.50(a)(2) that the requirements for making public the machine-readable file containing all standard charges for all items and services would separately apply to each hospital location such that each hospital location would be required to make

public a separate identifiable list of standard charges.

Comment: One commenter supported clearly indicating which hospital location is covered if the hospital is part of a health system. One commenter expressed concern that because academic and teaching institutions have expansive campuses, requiring each health system to fulfill the requirements separately for each hospital location would increase their burden significantly.

Response: We clarify that a hospital need not post separate files for each clinic operating under a consolidated state hospital license; it would be sufficient for a hospital to post a single file of standard charges for a single campus location, if the file includes charges for all items and services offered at the single campus location.

In cases where such off-campus and affiliated sites operate under the same license (or approval) as a main location but have different standard charges or offer different items and services, these locations would separately make public the standard charges for such locations.

Final Action: We are finalizing as proposed at new 45 CFR 180.50(a)(2) (with technical edits for clarity) that the requirements for making public the machine-readable file containing all standard charges for all items and services apply to each hospital location such that a separate identifiable list of all standard charges applicable to each hospital location would also would have to be made public.

F. Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

1. Background and Overview

In the CY 2020 OPPS/ASC proposed rule we indicated our belief that requiring hospitals to post on the internet a machine-readable file containing a list of all standard charges for all items and services would be a good first step for driving transparency in healthcare pricing because the access to such data would allow integration into price transparency tools or into EHR systems for use at the point of care or otherwise where and when the information is necessary to help inform patients. As a result of the January 1, 2019 update to our guidance, we received feedback that long lists of charges in a file posted online in a machine-readable format may not be immediately or directly useful for many healthcare consumers because the amount of data could be overwhelming or not easily understood by consumers. Because of this, we considered ways of requiring or encouraging hospitals to make public standard charges for frequently provided services in a form and manner that would be more directly accessible and consumer friendly. Therefore, in addition to including all their standard charges for all items and services in the machine-readable file, we proposed that hospitals must make public their payer-specific negotiated charges for common services for which consumers may have the opportunity to shop, in a consumer-friendly manner.

First, we proposed requirements for hospitals to display a list of payer-specific negotiated charges for a specified set and number of ''shoppable'' services. We stated that we believed doing so would enable consumers to make comparisons across hospital sites of care. Second, we made proposals intended to ensure the charge information for ''shoppable'' services would be presented in a way that is consumer-friendly, including presenting the information as a service package. Third, we made proposals related to location, accessibility, and timing for updates.

We explained our belief that the proposals related to consumer-friendly display of hospital charge information would align with and enhance many ongoing State and hospital efforts. We sought comment from hospitals regarding the extent to which our proposals are duplicative of such ongoing efforts, and how best to ensure consistency of consumer-friendly data display across hospital settings. We further sought comment from consumers regarding their potential engagement with a list of ''shoppable'' hospital items and services, including whether our proposals would provide for a useful amount of data and data elements that allow for actionable comparisons of ''shoppable'' hospital provided items and services.

2. Definition of ''Shoppable Service''

We proposed that for purposes of this requirement, a ''shoppable service'' would be defined as a service package that can be scheduled by a healthcare consumer in advance. Shoppable services are typically those that are routinely provided in non-urgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule a service at a time that is convenient for them. We proposed this definition because it is consistent with definitions proposed by policy experts or used by researchers who identify a service as ''shoppable'' if a patient is able to determine where and when they will receive services and can compare charges for multiple providers.[148] Since hospitals may not have insight into whether a particular service is available across multiple providers or where a consumer will ultimately determine where to receive a particular service, we focused our proposed definition on the first aspect, that is, whether or not a service offered by the hospital could be scheduled by the consumer in advance.

Additionally, we proposed that the charges for such services be displayed as a grouping of related services, meaning that the charge for the primary shoppable service would be displayed along with charges for ancillary items and services the hospital customarily provides as part of or in addition to the primary shoppable service. We proposed that hospitals would make public the payer-specific negotiated charge for a primary shoppable service that is grouped together with charges for associated ancillary services because we believe charge information displayed in such a way is consumer-friendly and patient-focused. In other words, we believe that consumers want to see and shop for healthcare services in the way they experience the service. We proposed to define an ''ancillary service'' as an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service (proposed new 45 CFR 180.20). Ancillary items and services may include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post-anesthesia and postoperative recovery rooms), therapy services (physical, speech, occupational), hospital fees, room and board charges, and charges for employed professional services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. For example, an outpatient procedure may include many services that are provided by the hospital, for example, local and/or global anesthesia, services of employed professionals, supplies, facility and/or ancillary facility fees, imaging services, lab services and pre- and post-op follow up. To the extent that a hospital customarily provides (and bills for) such ancillary services as a part of or in conjunction with the primary service, we stated the hospital should group the ancillary service

[148] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *National Institute for Health Care Reform* Research Brief Number 18 (2014). Available at: *https://www.mathematica.org/our-publications-and-findings/publications/reference-pricing-a-small-piece-of-the-health-care-price-and-quality-puzzle.*

charges along with the other payer-specific negotiated charges that are displayed for the shoppable service. We indicated that we believed such a practice would be consumer-friendly by presenting standard charge information in a way that reflects how a patient experiences the service.

Examples of primary shoppable services may include certain imaging and laboratory services, medical and surgical procedures, and outpatient clinic visits. The emphasis on shoppable services aligns with various State price transparency efforts and is consistent with stakeholder feedback. Further, this emphasis is consistent with research demonstrating that improving price transparency for shoppable services can have an impact on driving down the cost of healthcare. We proposed to add this definition to our regulations at proposed new 45 CFR 180.20.

Comment: Many commenters generally supported the requirement for hospitals to make public their standard charges for shoppable services, stating that consumers need the ability to shop and compare common hospital services prior to purchase. In particular, one commenter commended CMS for the focus on non-emergency services, for which patients have an opportunity to shop in advance.

Some commenters indicated that the ability to schedule a service in advance alone is not enough to ensure the healthcare service is shoppable. For example, one commenter stated that patients need to have multiple providers available in their insurer's network that provide the service. One commenter argued that there are no healthcare services that could be considered shoppable because beneficiaries are limited to the coverage options in their health plan.

Additionally, commenters suggesting limiting the scope of shoppable services based on individual consumer circumstances, for example, one commenter suggested that the definition of shoppable services be limited to non-covered, non-medically necessary services such as elective cosmetic surgery; otherwise, patients may believe that a shoppable service is not a necessary service. One commenter urged CMS to ensure that the definition of ''shoppable services'' will always clearly exclude emergency department services and that CMS never introduce a definitional change that could in any way be misconstrued to include them so that patients would not be deterred from seeking emergency care. One commenter suggested that CMS focus price transparency efforts on some prescription drugs and diagnostic imaging only. A few commenters argued that certain service such as vaginal delivery and cancer treatments would be excluded from being posted as shoppable services because they believe such services are unpredictable and unable to be scheduled in advance.

Response: Our proposed definition for a shoppable service aligns with scholarly sources indicating that the ability to schedule in advance is a key concept for determining the shoppability of a healthcare service. As we explained in the CY 2020 OPPS/ASC proposed rule, we believe it is reasonable to define a service as ''shoppable'' when a consumer can schedule it in advance and not by additional criteria or concepts that could enhance or reduce the shoppability of a particular service in an individual circumstance. For example, a service may be medically necessary for some patients but not others. A service may be provided in an emergency situation for some patients but not others. A patient may or may not have a plan or insurance network that permits them to receive a service from more than one provider in their region or insurance network. However, such issues are specific to individual circumstances, and are not necessarily the case for all individuals who may have the opportunity to schedule a particular healthcare service from a hospital in advance. We therefore think it is reasonable to use only the first commonly used criterion for the definition of a shoppable service (that the service can be scheduled in advance), as using additional criteria may unduly limit the types of services that may be shoppable for some patients. Moreover, as we noted in the CY 2020 OPPS/ASC proposed rule, we limited the definition of shoppable service to the first commonly used definition (that the service can be scheduled in advance) and did not expand to other commonly used definitions (such as whether or not there is more than one provider in a market) because we are finalizing requirements that apply to hospitals, and hospitals may not be able to determine whether a service is shoppable under other criteria, for example, a hospital may not be aware of whether or not there are other providers of the service available to their patients.

We disagree with stakeholders who asserted that services provided for delivery of babies or that cancer treatments are not able to be scheduled in advance and therefore not shoppable. In most instances, the location for the delivery of a baby is planned well in advance; at least one analysis of a price transparency tool for non-elderly patients found that vaginal deliveries are one of the most commonly shopped healthcare services.[149] Similarly, patients who receive a cancer diagnosis often seek information about providers that are available to treat them before committing to a treatment course by a particular provider. By ensuring the release of hospital standard charge information, we seek to improve consumer knowledge for the cost side of the value proposition. Nothing in this rule would prohibit hospitals from displaying quality information along with standard charge information, and we encourage hospitals to provide consumers with both cost and quality information in a consumer-friendly manner.

Comment: One commenter disagreed with the focus on shoppable services entirely, citing a study that found that no more than 43 percent of hospital spending is attributable to items and services that can reasonably be scheduled in advance, and suggested CMS focus on other hospital services to impact consumer shopping behavior.

Response: Our research has shown that there is great interest among consumers in taking price into consideration when deciding on treatment options and choice of provider. For example, studies have found that more than 40 percent of healthcare services are potentially shoppable by consumers [150] [151] but such services are typically lower cost services such as laboratory tests, imaging, and office visits, along with some higher-cost procedures such as joint replacements. Researchers estimate that approximately $36 billion could be saved when consumers are given the ability to shop and compare prices for common shoppable services.[152] As the

[149] Sinaiko AD, and Rosenthal MB. Examining A Health Care Price Transparency Tool: Who Uses It, And How They Shop For Care. *Health Affairs.* April 2016. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0746.*

[150] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *National Institute for Health Care Reform* Research Brief Number 18 (2014). Available at: *https://www.mathematica.org/our-publications-and-findings/publications/reference-pricing-a-small-piece-of-the-health-care-price-and-quality-puzzle.*

[151] Frost A, and Newman D. Spending on Shoppable Services in Health Care. Health Care Cost Institute Issue Brief No. 11 (2016). Available at *http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf.*

[152] Coluni B. White Paper: Save $36 Billion in U.S. Healthcare Spending Through Price Transparency. Truven Health Analytics, 2012. Available at: *http://www.akleg.gov/basis/get_documents.asp?session=30&docid=14495.*

commenter notes, at least one study indicates that approximately 43 percent of the $524 billion spend on healthcare by individuals with employer-sponsored insurance in 2011 was spent on shoppable services.[153] We believe these studies taken together support our focus on shoppable services; however, we agree that many non-shoppable hospital and emergency services can be very expensive and account for much of the healthcare spending in the United States.

Comment: One commenter agreed with the necessity of displaying ancillary items and services in conjunction with the primary service to give consumers ''true line of sight'' into their potential costs, but suggested that CMS use Medicare claims data to identify the highest volume and highest cost ancillary services associated with the 70 proposed CMS-specified shoppable services, and then provide this mapping of service codes in the final rule. Another commenter similarly suggested a ''numeric standard'' for determining the list of all associated ancillary services by averaging all the required charges associated with the primary services, since in some cases only a small minority of patients who receive the primary service also receive the ancillary services.

Several commenters requested that CMS clarify how hospitals would determine which services they ''customarily'' provide to meet the requirements for displaying ancillary services with the primary shoppable service. A few commenters expressed concern that the definition for ancillary services is not adequately clear, and, as a result, hospitals may not interpret ancillary services consistently and ultimately cause confusion for consumers. One commenter suggested that since complex service packages are difficult to unbundle and shop for in isolation, truly shoppable services should be limited to those that can be grouped into a reliable service package or are typically only administered as an independent service (which the commenter suggests be referred to as discrete services). A few other commenters suggested that in their hospitals, all supplies, drugs, ancillary tests, anesthesia, and recovery are charged separately by contracted clinicians or facilities apart from the primary service and therefore their hospital could not meet the proposed display requirements for standard charges for shoppable services.

Response: We believe that each hospital should be able to query its administrative billing system or EHR system by CPT code to determine what other services or line items from other departments (laboratory, radiology, etc.) are typically billed with the primary shoppable service and present this in a consumer-friendly manner to prospective patients. Although this information may differ across hospitals, we anticipate this effort will be beneficial to consumers who wish to understand their likely cost of care, the items and services that are included, and how each might vary by hospital. We further believe that hospitals should have flexibility to determine how best to display the primary shoppable service as well as the associated ancillary services in a manner that is consumer-friendly. We note that many hospitals and hospital price estimator tools are already making this information available and suggest that hospitals unfamiliar with such efforts look to such tools and displays for suggestions on how to display such information in a consumer-friendly manner. Further, including ancillary services and presenting them together as a shoppable service package conforms with recommended best practice for displaying to consumers prices for shoppable services.[154]

Further, we appreciate the suggestions made by commenters on opportunities for hospitals to report ancillary services by highest volume, frequency, and cost. Since, as the commenter noted, the availability of these services varies by hospital, we decline to impose a standard for the number and types of ancillary services provided.

We appreciate the comment about limiting shoppable services only to those that can be reliably bundled into service package and to include individual services only when they are always offered as an individual service. We recognize that these practices may differ from hospital to hospital. Each hospital, therefore, must determine whether it customarily provides ancillary services in conjunction with the primary shoppable service and if so, how best to communicate and display them. We offer in Table 2 an example template for a display of shoppable service packages which communicates the standard charge for the primary service along with standard charges for ancillary services customarily provided by the hospital. We note that our final rules would require a hospital to display the primary shoppable service charges along with the charges for the ancillary services it provides and hospitals are not required to indicate other ancillary services that are typically furnished by other providers involved in the primary shoppable service. However, for sake of consumer-friendly presentation, we strongly encourage and recommend that the hospital indicate all ancillary services the customer may expect as part of the primary shoppable service, and to indicate they may be billed separately by other entities involved in their care for such services.

Finally, we agree that hospitals may not customarily provide ancillary services with some shoppable services. Such services may be ''simple'' or ''discrete'' as described by commenters, meaning that they are typically experienced by the consumer and billed for by the hospital in the same way—as a single service. In this case, as in the example in Table 2, such services would be listed as a single shoppable service. As a result, we are finalizing a modification to our definition of ''shoppable services'' to remove the reference to a ''service package.'' We believe removing the term ''package'' from the definition is necessary to clarify that not every shoppable service is a service package. In certain instances, a primary ''shoppable service'' may be an individual item or service or a service package. Additionally, not all shoppable services are necessarily associated with additional ancillary services. We believe this will help clarify and simplify the definition. In so doing, however, we do not intend to imply that the display of ancillary services is no longer needed or important; we are still finalizing our policy that hospitals display the ancillary services along with each primary shoppable service, as applicable.

[150] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *National Institute for Health Care Reform* Research Brief Number 18 (2014). Available at: *https://www.mathematica.org/our-publications-and-findings/publications/reference-pricing-a-small-piece-of-the-health-care-price-and-quality-puzzle.*

[151] Frost A, and Newman D. Spending on Shoppable Services in Health Care. Health Care Cost Institute Issue Brief No. 11 (2016). Available at *http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf.*

[152] Coluni B. White Paper: Save $36 Billion in U.S. Healthcare Spending Through Price Transparency. Truven Health Analytics, 2012. Available at: *http://www.akleg.gov/basis/get_documents.asp?session=30&docid=14495.*

TABLE 2—SAMPLE OF DISPLAY OF SHOPPABLE SERVICES

Hospital XYZ Medical Center			
Prices Posted and Effective [month/day/year]			
Notes: [insert any clarifying notes or disclaimers]			
Shoppable service	Primary service and ancillary services	CPT/HCPCS code	[Standard charge for Plan X]
Colonoscopy	primary diagnostic procedure	45378	$750
	anesthesia (medication only)	[code(s)]	$122
	physician services	Not provided by hospital (may be billed separately)	
	pathology/interpretation of results	Not provided by hospital (may be billed separately)	
	facility fee	[code(s)]	$500
Office Visit	New patient outpatient visit, 30 min	99203	$54
Vaginal Delivery	primary procedure	59400	[$]
	hospital services	[code(s)]	[$]
	physician services	Not provided by hospital (may be billed separately)	
	general anesthesia	Not provided by hospital (may be billed separately)	
	pain control	Not provided by hospital (may be billed separately)	
	two day hospital stay	[code(s)]	[$]
	monitoring after delivery	[code(s)]	[$]

Comment: Several hospital commenters expressed concern that the volume of plans, in some cases more than 100, with which they have contracted rates would present a challenge with respect to collecting and posting ancillary items and services for each primary service.

Response: In the CY 2020 OPPS/ASC proposed rule, we proposed that hospitals make public their payer-specific negotiated charges for at least 300 shoppable services in a consumer-friendly manner. We are finalizing this policy because we believe it is necessary to present hospital standard charge information in a more consumer-friendly manner than simply to make all standard charges for all items and services public in a comprehensive machine-readable file. We did not propose that hospitals display their gross charges in a consumer-friendly format because, as many hospitals commented on the FY 2019 IPPS/LTCH PPS rule in which we updated our guidance to require hospitals to make public their chargemaster rates online in a machine-readable format, such charges are not relevant to most consumers, even to self-pay consumers who are often provided discounted rates by the hospital. As discussed in more detail in section II.D of this final rule, we are also finalizing three additional types of standard charges: (1) The discounted cash price, (2) the de-identified minimum negotiated charge, and (3) the de-identified maximum negotiated charge. We believe these types of standard charges are important and relevant to consumers and therefore will include these types of standard charges in the data elements hospitals must display in a consumer-friendly manner. We discuss this in more detail in section II.F.4 of this final rule.

We recognize that hospitals will be presenting much of their standard charge data in a manner that has historically not been made available to the public. For many hospitals, particularly large hospitals, this may involve display of data for potentially many dozens of payers and plan products. This rule will not require hospitals to change any of their charging or billing practices, but, rather, to provide their standard charge information to the public in a consumer-friendly manner, that is, in a way that more closely approximates hospital provided services as they are experienced by the consumer. A detailed assessment of the estimated burden on hospitals may be found in section V of this final rule.

We note that the final rules, as discussed in more detail in II.F.5 of this final rule, provide hospitals with flexibility to determine the format they wish to use in order to make these data consumer-friendly and readily accessible. For hospitals that lack resources, flat files posted online may be the simplest and least expensive option. In such cases, we believe it would be reasonable and permissible under our final rules related to the consumer-friendly display of shoppable services for a hospital to post one file of shoppable services for each set of standard charges displayed. For example, the hospital could post one consumer-friendly file for each list of the payer-specific negotiated charges the hospital has established with each payer for its list of 300 shoppable services, a stand-alone consumer-friendly file of discounted cash prices for shoppable services, and a stand-alone consumer-friendly file of the de-identified minimum and maximum negotiated charges for each of the shoppable services. In this way, consumers could search for and review only the charges that are standard for their particular insurance plan for 300 shoppable services provided by the hospital in a consumer-friendly format. Self-pay individuals could search for and review a file focused on providing them with discounted cash price information for each of the shoppable services.

Final Action: We are modifying the definition of ''shoppable service'' to remove the phrase ''shoppable service package'' and finalizing a definition of ''shoppable services'' to mean a service that can be scheduled by a healthcare consumer in advance. We are finalizing that when the shoppable service is customarily accompanied by the provision of ancillary services, the hospital must present the shoppable service as a grouping of related services, meaning that the charge for the primary shoppable service (whether an individual item or service or service package) is displayed along with charges for ancillary services. We finalize our definition of ''ancillary service'' for purposes of section 2718(e) of the PHS Act to mean an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service (new 45 CFR 180.20). As explained in the CY 2020 OPPS/ASC proposed rule, ancillary items and services may include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post-anesthesia and postoperative recovery rooms), therapy services (physical, speech, occupational), hospital fees, room and board charges, and charges for employed professional services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine shoppable service charge. For example, an outpatient procedure may include additional services that are provided by the hospital, for example, local and/or global anesthesia, services of employed professionals, supplies, facility and/or ancillary facility fees, imaging services, lab services, and pre- and post-op follow up.

3. Selected Shoppable Services

We proposed to require hospitals to make public a list of their payer-specific negotiated charges for as many of the 70 shoppable services that we identify in Table 3 that are provided by the hospital, and as many additional shoppable services selected by the hospital as are necessary to reach a combined total of at least 300 shoppable services (new 45 CFR 180.60(a)).

In a study of 2011 claims by autoworkers, researchers identified a set of 350 frequently billed healthcare services that consumers could schedule in advance and for which there was variation in charges across providers.[155] Hospitals that are early adopters of price transparency have suggested that it is possible to initially identify and display good-faith individualized price estimates for at least 350 shoppable healthcare services identified by primary billing codes (including prices for ancillary services) with more sophisticated price transparency tool developers creating and being able to display individualized pricing estimates for at least 1000 shoppable services. In contrast, most States that require hospital posting of shoppable services range in requiring 25–50 shoppable services, with California being the only State that requires the corresponding charge information to include ancillary services. In the CY 2020 OPPS/ASC proposed rule, we indicated that since these rules would apply to all hospitals operating in the United States, some of which may not have any experience in displaying charges for shoppable services, we believed it would be reasonable to propose a starting point of at least 300 shoppable services for which hospitals would be required to display payer-specific negotiated charges. We further indicated that we anticipated that we would increase this number over time as hospitals become accustomed to displaying charge information to consumers as a grouping of related charges and as such data is more routinely used by consumers.

We also indicated that we believed it would be reasonable to require a portion of the 300 shoppable services to be CMS-specified in order to ensure standardization that would provide consumers with the ability to compare prices across hospital settings. We stated that we further believed it would be prudent to permit hospitals to select a portion of the shoppable services themselves, recognizing that some hospitals may specialize in certain services (for example, specialized procedures) or may serve populations that utilize other shoppable services with more frequency or are more relevant than the ones we have identified for purposes of the CMS-specified services.

The proposed list of 70 shoppable services were selected based on an analysis of shoppable services that are currently made public under State price transparency requirements, a review of services that frequently appear in web-based price transparency tools, an analysis of high volume services and high cost procedures derived from External Data Gathering Environment (EDGE) server data,[156] and a review by CMS medical officers. In other words, we used a combination of quantitative analysis of the EDGE server claims data, a qualitative review of commonly selected services for State and hospital price transparency initiatives and tools, and clinician review to ensure such services could be scheduled in advance in order to identify our list of 70 CMS-specified shoppable services.

In addition to the proposed 70 CMS-specified shoppable services, we also proposed that each hospital would select, at minimum, 230 additional shoppable services, identified by a primary HCPCS, CPT, DRG (or other widely used industry code, as applicable) and make publicly available a list of its payer-specific negotiated charges for each of those shoppable services, including the payer-specific negotiated charges for the shoppable service in both the inpatient setting and the outpatient setting, if different. We further proposed that hospitals select such services based on the utilization or billing rate of the services in the past year. We stated that we believed that enabling hospitals to select most of the shoppable services for which they make their payer-specific negotiated charges available would permit them to tailor their list of shoppable services to their specific patient populations and area of expertise. For example, a children's hospital could select additional shoppable services that are predominantly provided to children.

Although we indicated that we believed that most hospitals would provide the 70 CMS-specified shoppable services (which are very common and frequently billed by hospitals based on our analysis of claims) it is possible that some hospitals may not offer all of them (for example, specialty hospitals). Therefore, we proposed that hospitals would make public a list of their payer-specific negotiated charges for as many of the 70 shoppable services specified by CMS that are provided by the hospital, plus as many additional shoppable services as would be necessary to reach a total of at least 300 shoppable services.

We articulated an alternative option by which we would specify a larger set of shoppable services and allow

[153] Health Care Cost Institute. Spending on Shoppable Services in Health Care. Issue Brief #11. March 2016. Available at: *https://www.healthcostinstitute.org/images/easyblog_articles/110/Shoppable-Services-IB-3.2.16_0.pdf.*

[156] Consistent with 45 CFR 153.700, in States where HHS is operating the risk adjustment program, issuers must submit enrollment, claims, and encounter data for risk adjustment-covered plans in the individual and small group markets through the External Data Gathering Environment (EDGE) servers. Issuers upload enrollee, pharmaceutical claim, medical claim, and supplemental diagnosis information from their systems to an issuer-owned and controlled EDGE server.

hospitals to select up to 70 CMS-specified shoppable services from the larger list for which it would make its payer-specific negotiated charges publicly available. The hospital would then select an additional 230 shoppable services for a total of 300 shoppable services. But we did not propose this because we believe most hospitals provide the 70 CMS-specified shoppable services and because we were concerned that more discretion would erode our desire to ensure consumers can get hospital charge information for a minimum standardized set of services.

We sought public comments on the 70 CMS-specified shoppable services we proposed. We indicated we were particularly interested in feedback regarding the specific services we identified as shoppable services and whether other services should be included because they are more common, more shoppable, or both. We also indicated we were interested in feedback on whether we should require more or less than a total of 300 shoppable services. Specifically, we sought comment from hospitals and consumers on whether a list of 100 shoppable services (or less) would be a reasonable starting point. We also sought public comment on whether we should identify more specific requirements related to hospital-selected shoppable services; for example, requiring hospitals to select their most frequently billed shoppable services (that are not included in the CMS-specified list).

Comment: Many commenters provided opinions about the number of shoppable services that hospitals would be required to display. Several commenters indicated the total number of shoppable services should be increased to more than 300. For example, one commenter suggested that the list of shoppable services be as robust as necessary, using an example of some price transparency platforms that include up to 8,000–9,000 procedures. One commenter suggested that CMS expand on the required list of 70 and leverage the experience of states to add more services. One commenter suggested that all hospital services should be displayed because any non-emergent service provided by the hospital could be scheduled in advance. In contrast, many commenters supported decreasing the total number of shoppable services, arguing that a lower number would be more manageable and less burdensome for hospitals. For example, one commenter stated that the list of shoppable services should be limited to the 70 that CMS initially provided without expanding. Several commenters argued that requiring a total of 300 shoppable services is excessive, especially for small rural hospitals and CAHs that do not provide surgical, magnetic resonance imaging (MRI), or obstetric care, with one commenter suggesting that 75–100 total items and services would be more reasonable. One commenter suggested reducing the number of shoppable services to reflect the small number of inpatient services provided by LTCHs. One commenter specifically suggested that rather than selecting 230 shoppable services, hospitals should select 100 total services distributed evenly across the 25 highest price inpatient services, the 25 highest dollar value inpatient services (calculated using price per service multiplied by the number of services provided), the 25 highest price outpatient services, and the 25 highest dollar value outpatient services.

Response: As we indicated in the CY 2020 OPPS/ASC proposed rule, we believe that 300 shoppable services is a reasonable number based on research,[157] discussions with hospital executives who are early adopters and indicated it is possible to initially identify and display good-faith individualized price estimates for at least 350 shoppable healthcare services identified by primary billing codes (including prices for ancillary services), and discussions with more sophisticated price transparency tool developers who identify and display more than 1,000 shoppable services. By contrast, we recognized that most States that require hospital posting of shoppable services require 25–50 shoppable services, with California being the only State that requires the corresponding charge information to include ancillary services. Thus, we determined that 300 shoppable services would be a reasonable starting point. While we agree that nearly all hospital items and services could be considered ''shoppable'' because nearly all could be scheduled in advance, we continue to believe that a total of 300 services strikes a balance between the need for consumer-friendly presentation of shoppable services and hospital burden and are therefore finalizing as proposed our requirement that hospitals make public 70 CMS-specified shoppable services along with an additional 230 hospital-selected shoppable services for a total of 300 shoppable services.

Further, as indicated in the CY 2020 OPPS/ASC proposed rule, we recognized that some hospitals may not offer all 70 CMS-specified services. Therefore, we proposed and are finalizing a requirement that hospitals would make public their list of standard charges for as many of the 70 shoppable services specified by CMS that are provided by the hospital, plus as many additional shoppable services as would be necessary to reach a total of at least 300 shoppable services. We agree with commenters that selecting shoppable services based on the highest price and highest dollar value inpatient and outpatient services are good examples of criteria for hospitals to consider as they determine their hospital-selected 230 shoppable services, however, many such services are not as common as other shoppable services provided by the hospital. We believe that hospitals should make final determinations based on how commonly such services are provided to their patient population, and thus we are finalizing as proposed our requirement that hospitals select such services based on the utilization or billing rate of the services in the past year. In other words, the hospital must take into consideration the frequency with which they provide services that meet the definition of 'shoppable' to the patient population they serve when determining the hospital-selected shoppable services. We note that nothing would preclude a hospital from taking additional information (such as the cost of the services) into consideration as they develop their list of 230 shoppable services.

In light of commenters that asserted that some small or specialty hospitals may not offer 300 services that could be scheduled by consumers in advance, we are modifying our requirements to finalize a policy that in cases where a hospital does not provide 300 services that could be scheduled by consumers in advance, the hospital must list as many of the services it provides that could be scheduled by patients in advance (that is, the hospital must list as many shoppable services as it provides).

Comment: Several commenters cited the need for uniformity in hospital selection of shoppable services. A few commenters agreed that shoppable services should be standardized to allow for comparability for consumers. A few commenters argued that patients would not be able to adequately compare pricing information for the items and services in 70 CMS-identified shoppable services that are performed in non-

[157] White C. and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *National Institute for Health Care Reform* Research Brief Number 18 (2014). Available at: *https://www.mathematica.org/our-publications-and-findings/publications/reference-pricing-a-small-piece-of-the-health-care-price-and-quality-puzzle.*

hospital settings. One commenter suggested that CMS define a specific CPT code range to clarify which procedures are required among the list of shoppable services to ensure uniformity and accuracy. One commenter suggested that these requirements be phased in gradually, starting with a requirement to post standard charges for ''simpler'' visits initially, and then include surgeries, DRGs, and services that are more complicated. A few commenters expressed concerns that the variability in how hospitals bundle items and services would not yield accurate consumer comparisons for shoppable services.

Response: To ensure some degree of uniformity in the shoppable services hospitals make public in a consumer-friendly manner, we proposed and are finalizing 70 CMS-specified hospital services identified by CPT and other commonly used billing codes. As we stated in the CY 2020 OPPS/ASC proposed rule, the list of 70 shoppable services were selected based on an analysis of shoppable services that are currently made public under State price transparency requirements, a review of services that frequently appear in web-based price transparency tools, an analysis of high volume services and high cost procedures derived from EDGE server data,[158] and a review by CMS medical officers. In other words, we used a combination of quantitative analysis of the EDGE server claims data, a qualitative review of commonly selected services for State and hospital price transparency initiatives and tools, and clinician review to ensure such services could be scheduled in advance in order to identify our list of 70 CMS-specified shoppable services. Based on this analysis, we believe that these 70 CMS-specified shoppable services are commonly provided by hospitals and we believe hospital display of these services will ensure consumers have access to standard charges for a minimum set of shoppable services.

We recognize that many of the shoppable services included on the list of 70 CMS-specified services are provided by settings other than hospitals; however, our requirements apply only to hospitals (as defined at 45 CFR 180.20), and not when they are provided by non-hospital sites of care. Therefore this information is useful to consumers when they are comparing services across hospital settings. While non-hospital sites of care are not subject to these regulations we are finalizing, we encourage non-hospital sites of care that offer the same shoppable services to standardize their displays of charges so that consumers have more options and information available to them.

We appreciate that beginning with ''simpler'' shoppable services could provide a phased pathway for hospitals to make public their shoppable services; however, we decline to adopt this approach because some of the more ''complex'' shoppable services are those for which consumers routinely shop (for example, colonoscopy or vaginal delivery). We recognize that there may be some variability in the method used by hospitals to establish and display standard charges for shoppable primary services and associated ancillary services, and we encourage hospitals to communicate in consumer-friendly ways what is or is not included in the hospital's prices for a shoppable service and its ancillary services.

Comment: Several commenters offered comments related to the services included on the CMS-specified list of 70 shoppable services. For example, one commenter provided a list of 23 services they suggested removing from the 70 CMS-specific shoppable services due to their variability in cost, charge structure, charge amounts, and associated complexity for providers to develop a sound ''proposed rate.'' The list provided by the commenter included procedures identified by DRG that are typically divided into those with and without major comorbid conditions or complications (MCC).

A few commenters indicated their belief that the services provided by cancer hospitals are not shoppable, and one commenter argued that the list of 70 CMS-specified shoppable services are irrelevant to cancer hospitals because cancer hospitals do not offer standalone services (such as imaging, laboratory or surgical services). Instead, such hospitals provide integrated disease management with disease-specific financial counseling. One commenter indicated that specialty hospitals (such as children's hospitals, orthopedic, or cancer facilities) should have customized lists of shoppable services.

A few commenters requested that Evaluation and Management (E&M) services be removed from the list because E&M services are billed by providers in an office setting and not hospitals. A few commenters requested that laboratory testing be removed from the list with one commenter requesting that CMS remove 14 routine laboratory tests included in the required list of 70 shoppable items and services because they are among the least costly services and are less central to patients' economic and site of care decisions, and suggested that CMS replace them with higher cost procedures more likely to be separately paid when performed in a hospital setting. One commenter stated that the list of shoppable services is too long and includes codes that are not billed by many hospitals and rarely scheduled in advance, for example, laboratory tests and CPT code 93000 for electrocardiogram. By contrast, one commenter encouraged CMS to include clinical laboratory test pricing as part of the standard charge information hospitals are required to post, and requested that CMS ensure the requirements under this rule are consistent with the type of data required to be reported to CMS under section 216(a) of the Protecting Access to Medicare Act (PAMA).

One commenter requested clarification on whether posting an average charge based on historical cases would be sufficient if the hospital does not charge based on the specific CMS-specified CPT or DRG codes. Another commenter pointed out that the standard DRG codes in the list of 70 CMS-specified shoppable services correspond to MS–DRGs and not to DRGs used by third party payers (for example, All Patients Refined (APR)–DRGs). One commenter requested clarification on how the 70 CMS-specified shoppable services would be categorized asking whether it would be DRG for all inpatient services only, and if so, what is the packaging type for ambulatory services.

Response: We appreciate that specialty hospitals offer services that are different from most hospitals, however, we do not believe that should be an impediment to specialty hospitals displaying their charges for shoppable services. Similarly, we believe our requirements have addressed situations in which a hospital does not provide one or more of the 70 CMS-specified shoppable services. Specifically, we proposed and are finalizing a requirement that if a hospital does not provide some of the 70 CMS-specified services, then the hospital would identify enough shoppable services that it commonly provides to its unique patient population so that the total number of shoppable services is at least 300. We believe this policy will ensure that the shoppable services posted are standardized as much as possible across

[158] Consistent with 45 CFR 153.700, in States where HHS is operating the risk adjustment program, issuers must submit enrollment, claims, and encounter data for risk adjustment-covered plans in the individual and small group markets through the External Data Gathering Environment (EDGE) servers. Issuers upload enrollee, pharmaceutical claim, medical claim, and supplemental diagnosis information from their systems to an issuer-owned and controlled EDGE server.

all hospitals while also ensuring specialty hospital have flexibility to make public the most relevant shoppable services for their unique patient populations.

The 70 CMS-specified shoppable services are found in Table 3 and are divided into four broad categories: E&M Services, Laboratory and Pathology Services, Radiology Services, Medicine and Surgery Services. While some such services (for example, E&M or laboratory services) may not be the most expensive hospital services, our analysis indicates they are commonly billed and are healthcare services that are commonly shopped. Such services may be billed by a hospital as part of a hospital inpatient or outpatient visit. As noted above, to the extent such services are not provided by a hospital, the hospital may select additional shoppable services that are relevant to its patient population.

We appreciate commenters who pointed out that the codes numbers listed for DRG procedures are MS–DRG codes and not APR–DRGs or other third party payer service package codes. We recognize this could also be the case for other CMS-specified services that are routinely negotiated by hospitals with third party payers as packaged services. For example, the same or similar shoppable service may be paid as a service package by two different payers that use two different common billing codes (for example, an MS–DRG by Medicare versus an APR–DRG by another third party payer). As such, we will permit hospitals to make appropriate substitutions and cross-walks as necessary to allow them to display their standard charges for the shoppable services across all their third party payers. Average charges based on prior years would not be acceptable as an average charge is not one of the types of standard charges we are finalizing in this rule.

Section 1834A of the SSA, as established by section 216(a) of the PAMA, required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the Clinical Laboratory Fee Schedule. Laboratories, including independent laboratories, physician office laboratories and hospital outreach laboratories, that meet the definition of an applicable laboratory are required to report applicable information, which generally includes each private payor rate for each clinical diagnostic laboratory test for which final payment has been made during the data collection period, the associated volume of tests performed corresponding to each private payor rate, and the specific HCPCS code associated with the test. We do not believe that any of the provisions under this rule conflict with or duplicate the requirements under section 1834A of the SSA. While consumer-friendly display of shoppable laboratory services may include similar data (such as payer-specific negotiated charges), the requirement under this rule is to provide that information in a consumer-friendly format to which consumers have easy access.

We decline to make any changes in our list of CMS-specified shoppable services. As explained in the CY 2020 OPPS/ASC proposed rule, we used a combination of quantitative analysis of the EDGE server claims data, a qualitative review of commonly selected services for State and hospital price transparency initiatives and tools, and clinician review to ensure such services could be scheduled in advance in order to identify our list of 70 CMS-specified shoppable services. We are therefore finalizing the 70 CMS-specified shoppable services as proposed.

Final Action: We are finalizing as proposed our requirement for hospitals to make public their standard charges for as many of the 70 shoppable services that we identify in Table 3 that are provided by the hospital, and as many additional shoppable services selected by the hospital as is necessary for a combined total of at least 300 shoppable services (new § 180.60(a)). In response to comments, we are adding a requirement that if a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide. These requirements will be finalized at 45 CFR 180.60(a). We will also permit hospitals to make appropriate coding substitutions and cross-walks as necessary to be able to display their standard charges for the 70 CMS-specified services across third party payers.

We are further finalizing as proposed that in selecting a shoppable service, a hospital must consider the rate at which it provides and bills for that shoppable service. In other words, the shoppable services selected for display by the hospital should be commonly provided to the hospital's patient population. We note that this proposal, which discussed in the CY 2020 OPPS/ASC proposed rule (84 FR 39589) was inadvertently omitted from the proposed regulation text but we are including it at new 45 CFR 180.60(a).

Finally, we clarify that hospitals should cross-walk and use, as applicable, an appropriate payer-specific billing code (for example, an APR–DRG code) in place of the MS–DRG code indicated for the five procedures in the list of 70 CMS-specified shoppable services that are identified by MS–DRG codes 216, 460, 470, 473, and 743.

TABLE 3—FINAL LIST OF 70 CMS-SPECIFIED SHOPPABLE SERVICES

Evaluation & management services	2020 CPT/HCPCS primary code
Psychotherapy, 30 min	90832
Psychotherapy, 45 min	90834
Psychotherapy, 60 min	90837
Family psychotherapy, not including patient, 50 min	90846
Family psychotherapy, including patient, 50 min	90847
Group psychotherapy	90853
New patient office or other outpatient visit, typically 30 min	99203
New patient office of other outpatient visit, typically 45 min	99204
New patient office of other outpatient visit, typically 60 min	99205
Patient office consultation, typically 40 min	99243
Patient office consultation, typically 60 min	99244
Initial new patient preventive medicine evaluation (18–39 years)	99385
Initial new patient preventive medicine evaluation (40–64 years)	99386

Laboratory & pathology services	2020 CPT/HCPCS primary code
Basic metabolic panel	80048
Blood test, comprehensive group of blood chemicals	80053
Obstetric blood test panel	80055
Blood test, lipids (cholesterol and triglycerides)	80061
Kidney function panel test	80069
Liver function blood test panel	80076
Manual urinalysis test with examination using microscope	81000 or 81001
Automated urinalysis test	81002 or 81003
PSA (prostate specific antigen)	84153–84154
Blood test, thyroid stimulating hormone (TSH)	84443
Complete blood cell count, with differential white blood cells, automated	85025
Complete blood count, automated	85027
Blood test, clotting time	85610
Coagulation assessment blood test	85730

Radiology services	2020 CPT/HCPCS primary code
CT scan, head or brain, without contrast	70450
MRI scan of brain before and after contrast	70553
X-Ray, lower back, minimum four views	72110
MRI scan of lower spinal canal	72148
CT scan, pelvis, with contrast	72193
MRI scan of leg joint	73721
CT scan of abdomen and pelvis with contrast	74177
Ultrasound of abdomen	76700
Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus	76805
Ultrasound pelvis through vagina	76830
Mammography of one breast	77065
Mammography of both breasts	77066
Mammography, screening, bilateral	77067

Medicine and surgery services	2020 CPT/HCPCS primary code
Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	216
Spinal fusion except cervical without major comorbid conditions or complications (MCC)	460
Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC)	470
Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	473
Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	743
Removal of 1 or more breast growth, open procedure	19120
Shaving of shoulder bone using an endoscope	29826
Removal of one knee cartilage using an endoscope	29881
Removal of tonsils and adenoid glands patient younger than age 12	42820
Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope	43235
Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope	43239
Diagnostic examination of large bowel using an endoscope	45378
Biopsy of large bowel using an endoscope	45380
Removal of polyps or growths of large bowel using an endoscope	45385
Ultrasound examination of lower large bowel using an endoscope	45391
Removal of gallbladder using an endoscope	47562
Repair of groin hernia patient age 5 years or older	49505
Biopsy of prostate gland	55700
Surgical removal of prostate and surrounding lymph nodes using an endoscope	55866
Routine obstetric care for vaginal delivery, including pre-and post-delivery care	59400
Routine obstetric care for cesarean delivery, including pre-and post-delivery care	59510
Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care	59610
Injection of substance into spinal canal of lower back or sacrum using imaging guidance	62322–62323
Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	64483
Removal of recurring cataract in lens capsule using laser	66821
Removal of cataract with insertion of lens	66984
Electrocardiogram, routine, with interpretation and report	93000
Insertion of catheter into left heart for diagnosis	93452
Sleep study	95810
Physical therapy, therapeutic exercise	97110

4. Required Corresponding Data Elements

We proposed that the consumer-friendly charge information the hospital makes available to the public online for the CMS and hospital-selected shoppable services must include certain corresponding data elements in order to ensure that consumers understand the hospital's payer-specific negotiated charge for each shoppable service and can use that information to make comparisons across hospitals. Specifically, we proposed that the consumer-friendly display of payer-specific negotiated charge information contain the following corresponding information for each of the 70 CMS-specified and at least 230 hospital-selected shoppable services:

- A plain-language description of each shoppable service. For example, hospitals would not be required, but are invited, to review and use the Federal plain language guidelines.[159]
- The payer-specific negotiated charge that applies to each shoppable service. If the hospital does not provide one or more of the CMS-specified shoppable services, the hospital may indicate ''N/A'' for the corresponding charge or otherwise make it clear that the service is not provided by the hospital. Each payer-specific charge must be clearly associated with the name of the third party payer.
- A list of all the associated ancillary items and services that the hospital provides with the shoppable service, including the payer-specific negotiated charge for each ancillary item or service.
- The location at which each shoppable service is provided by the hospital (for example, Smithville Campus or XYZ Clinic), including whether the payer-specific negotiated charge for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both. If the payer-specific negotiated charge for the shoppable service varies based upon location or whether the hospital provides the shoppable service in the inpatient versus the outpatient setting, the hospital would be required to identify each payer-specific negotiated charge.
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, but not limited to, the CPT code, the HCPCS code, the DRG, or other commonly used service billing code.

[159] See Federal plain language guidelines, available at *https://plainlanguage.gov/guidelines/*.

We proposed that hospitals make public the payer-specific negotiated charge for a shoppable service in a manner that groups the payer-specific negotiated charge for the primary shoppable service along with charges for associated ancillary services because we believe charge information displayed in such a way is consumer-friendly and patient-focused. In other words, we believe that consumers want to see and shop for healthcare services in the way they experience the service. We recognized that not all hospitals will customarily provide exactly the same ancillary items or services with a primary shoppable service and therefore we believe it is important for hospitals to display a list of which ancillary services are included in conjunction with or as part of the primary shoppable service.

We proposed to codify these proposed required data elements at proposed new 45 CFR 180.60(b). We sought public comments on these data elements and whether there are additional data elements that should be displayed to the public in a consumer-friendly manner. We emphasized that nothing in our proposal was meant to inhibit or restrict hospitals from including additional data elements that would improve the ability of healthcare consumers to understand the hospital's charges for shoppable services.

Comment: Some commenters offered suggestions on specific data elements they felt would be necessary to provide consumers with accurate understanding of the shoppable services provided by hospitals. For example, one commenter suggested that CMS specifically require that hospitals list both their technical and professional fees to provide a more accurate picture of potential costs. The commenter argued that including such charges would reduce the likelihood of surprise billing as these additional fees often come in the form of an additional charge or bill to consumers. The commenter cited a new state law in Minnesota requiring that all provider-based clinics that charge a separate facility fee for visits give notice to patients and publicly post a disclosure on their website stating that patients may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense. Another commenter suggested the consumer-friendly display of standard charges should take into account cost-shifting and uncompensated care, federal requirements such as EMTALA, the availability of providers for after-hours care, and whether the provider takes all forms of payment.

A few commenters expressed concern that the proposal does not provide hospitals adequate specificity as to how the data should be formatted to ensure that information is meaningful and presented in a consumer-friendly manner. Many commenters stated that display of standard charges for shoppable services would be incomplete without corresponding data on healthcare quality to allow consumers to understand value. A few commenters recommended requiring hospitals to include quality information alongside price in a meaningful way, with one suggesting that we also draw on the large body of research on healthcare quality measures and presentation format, including volume information. The commenter, however, cautioned that if CMS took this route, procedure complications data would be difficult for consumers to interpret. The commenter recommended that leveraging key measures already being used in various quality efforts, in addition to aligning measures across public and private payers, could help reduce consumer confusion. One commenter urged CMS to establish a Health Quality Roadmap in reference to section 4 of the June 24, 2019 Executive Order on Improving Price and Quality Transparency to establish common quality measurements, align inpatient and outpatient measures, and eliminate low-value or counterproductive measures. The commenter suggested that quality and outcomes data is more valuable to patients than transparency of hospital charges, arguing that they provide information for patients to seek out providers with the best track record. The commenter stated that providing data on readmissions, frequency or revision surgery and mortality, and especially elective procedures such as total joint arthroplasty, would encourage providers to use the best protocols.

Several commenters indicated that information on provider referrals as a required element would be necessary to decrease healthcare costs and to shift consumers to lower cost and higher quality options. One commenter stated that further outreach is necessary to determine what kinds of price information and which methods of display would influence consumer behavior.

As noted in section II.D.4 of this final rule, several commenters supported including a definition of standard charges to reflect the discounted cash price that would be given to a self-pay consumer and the de-identified minimum and maximum negotiated charges because they believe this

information would be beneficial and relevant to consumers. A few commenters believed such standard charges could be confusing to consumers.

Response: We recognize many state legislatures have undertaken efforts to reduce surprise billing and applaud such efforts. We are finalizing as proposed our requirement that hospitals make public and display all ancillary items and services they provide with the primary shoppable service as one of the required data elements. As part of our requirements, hospitals would be required to display facilities fees and fees for services of employed clinicians. However, in accordance with our final policies for defining hospital items and services (section II.C of this final rule) hospitals would not be required to make public the professional fees for all clinicians practicing in hospital-based clinics. We note that nothing in this rule would prevent hospitals from undertaking disclosure charges for all clinicians practicing in a hospital-based clinics, however, and encourage hospitals to do so as a way of improving price transparency for consumers.

We thank commenters for their interest in improving consumer awareness of quality data. We agree that quality is a necessary consideration for consumers deciding on how and where to obtain the highest value medical items and services, however, section 2718(e) of the PHS Act does not require hospitals to disclose quality information. We note that comparative hospital quality information is readily available to the public [160] and that nothing in this final rule would prohibit hospitals from posting quality information along with their standard charge information. We further note that we included an RFI in the CY 2020 OPPS/ASC proposed rule so as to gather feedback that we may consider for our ongoing price transparency and value-based initiatives.

Similarly, although data elements such as referrals, additional places of service, availability of the provider for after-hours care, and what form of payment the provider accepts are all important considerations in driving improvements in value care, we believe requiring hospital disclosure of these data elements is beyond the scope of section 2718(e) of the PHS Act. In addition, we believe our policies represent a balance between data elements that would be useful for the public while being sensitive to hospitals' burden in meeting requirements. We note, however, that nothing in this final rule would prevent a hospital from displaying additional data elements it believes the public would find useful.

Finally, we are making several modifications to the list of data elements that hospitals would be required to make public for its consumer-friendly display of standard charges.

First, we are modifying the list of data elements to align with and include the three new types of standard charges we finalized in section II.D of this final rule. Specifically, we will include the discounted cash price, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge, along with other necessary conforming changes to the list of required data elements throughout. Specifically, we are finalizing the following as data elements:

- The payer-specific negotiated charge that applies to each shoppable service (and corresponding ancillary services, as applicable). We clarify that the hospital must identify and clearly associate each set of payer-specific negotiated charges with the name of the third party payer and plan. For example the hospital's list of payer-specific negotiated charges for Payer X's Silver Plan could be in one tab or column in a spreadsheet titled ''Payer X: Silver Plan'' while the list of payer-specific negotiated charges for Payer Y's Gold Plan could be in another tab or column titled or labeled as ''Payer Y: Gold Plan.''
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its gross charge.
- The de-identified minimum negotiated charge that applies to each shoppable service (and corresponding ancillary services, as applicable).
- The de-identified maximum negotiated charge that applies to each shoppable service (and corresponding ancillary services, as applicable).

Second, in the list of data elements related to the types of standard charges, we are finalizing a few clarifying edits to ensure hospital understanding that the requirement to display the standard charge for a shoppable service applies to each primary shoppable service and to each corresponding ancillary service (as applicable). In other words, the display of standard charges for the shoppable service grouping means display of each charge of the component parts of the shoppable service grouping (for example, the hospital must list the charge associated with the primary shoppable service plus the charge(s) for each ancillary service not already included in the primary shoppable service). In so doing, we are removing the separate requirement to list all the associated ancillary services and instead incorporating the requirement into the list of data elements related to the types of standard charges.

Third, we are clarifying that if the hospital does not offer one or more of the 70 CMS-specified shoppable services, the hospital must clearly indicate that fact with respect to every type of standard charge required for consumer-friendly display. The hospital may use ''N/A'' for the corresponding charge or use another appropriate indicator to communicate to the public that the service is not provided by the hospital. We are finalizing this requirement as a separate data element.

Fourth, we are finalizing the requirement that the hospital include a plain-language description of each shoppable service, as proposed. For example, hospitals would not be required but are invited to review and use, the Federal plain language guidelines.[161] Fifth, we are modifying the data element related to the location of each shoppable service in light of the additional types of standard charges that hospitals must list for the shoppable services to refer more broadly to the ''standard charges'' rather than to ''payer-specific negotiated charges'' in each instance it appears. Specifically, we are finalizing that the location at which each shoppable service is provided by the hospital (for example, Smithville Campus or XYZ Clinic), including whether the *standard charges* for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both. If the *standard charge* for the shoppable service varies based upon location or whether the hospital provides the shoppable service in the inpatient versus the outpatient setting, the hospital would be required to identify each *set of standard charges.*

Finally, we are finalizing without modification the requirement to display any primary code used by the hospital for purposes of accounting or billing for the shoppable service and associated ancillary services, including, but not limited to, the CPT code, the HCPCS code, the DRG, or other commonly used

[160] AHRQ website, Comparative Reports on Hospitals, at *https://www.ahrq.gov/talkingquality/resources/comparative-reports/hospitals.html.*

[161] See Federal plain language guidelines, available at *https://plainlanguage.gov/guidelines/.*

service billing code. We note that, as discussed in section II.F.3 of this final rule, hospitals may use, as applicable, an appropriate payer-specific billing code (for example, an APR–DRG code) in place of the MS–DRG code indicated for the five procedures in the list of 70 CMS-specified shoppable services that are identified by MS–DRG codes 216, 460, 470, 473, and 743.

Comment: Several commenters raised concerns with the time, effort, and technical challenges for hospitals of posting billing and charge codes as part of the consumer-friendly display of standard charge data for shoppable services. One commenter stated that the coding elements and concepts required do not exist or are not maintained in hospital chargemasters, but flow to posted charges through other interfaces. Several commenters indicated they believed that the size and scope of the data that would need to be presented would be quite large, with commenters estimating that the resulting file could be 300 lines long with dozens of columns or could lead to 100,000 rows of data with millions of fields. One commenter indicated that the size and complexity of the data might crash the hospital's website. One commenter stated that in order to compile, display, and maintain service packages for the select shoppable services, a sophisticated relational database analysis with web-based display modules would be necessary unless the hospital has existing software. Similarly, another commenter stated that to comply with the new regulation, it would need to work with its web development team and EHR management system vendor to build a shopper functionality and benefits engine and hire additional vendors to maintain functionality and accuracy. One commenter recommended that CMS take additional time to ensure that posting data for shoppable services is fairly applied across provider types and does not require an abundance of resources. One commenter stated that presenting their standard charge information in a consumer-friendly manner would be difficult for hospitals, for example, rural hospitals and CAHs that rely on cost-based reimbursement, that are unable to afford a vendor for software that would aid in the posting of standard charge data.

Response: We acknowledge that not all data elements required for the display of hospital standard charges in a consumer-friendly manner can be derived solely from a hospital's chargemaster. The set of standard charges found in the hospital chargemaster are only one type of standard charges—the gross charges—which are the undiscounted rates for individual items and services; as pointed out by hospitals that submitted comments in the FY 2019 IPPS/LTCH PPS (83 FR 41686 through 41688), the gross charge does not apply to most consumers of hospital services, for example, consumers with third party payer coverage. In other words, the gross charge is not a standard charge for approximately 90 percent of the hospital's customers who have third party payer coverage. The set of standard charges that applies to consumers with third party payer coverage are the payer-specific negotiated charges the hospital has established with the consumer's third party payer. Such charges are not a part of the hospital's chargemaster. Moreover, many payer-specific standard charges have been negotiated for service packages, as opposed to individual items and services that are listed in the hospital chargemaster. Thus, the data elements required for making public standard charges in a consumer-friendly manner will require hospitals to look beyond their chargemasters and pull the relevant data out of their other accounting and billing systems.

Additionally, we acknowledge that the benefits of compiling these data elements and presenting them in a consumer-friendly manner will likely require more thoughtful effort on the part of hospitals than simply making all their standard charge information public in a comprehensive machine-readable file. For example, identifying and listing the standard charges for ancillary services along with the primary shoppable service may take some thought and clinical input. Translating internal code descriptions into a consumer-friendly plain-language description for items and services provided by the hospital may also require some thought. However, we disagree that consumer-friendly display of hospital standard charge information would overwhelm or ''crash'' a hospital's website, or that the requirements would necessitate the development of an elaborate or expensive tool. As suggested in section II.F.3 of this final rule, we believe there are low-tech and inexpensive ways to compile hospital standard charge information in files posted online that are consumer-friendly, and, in Table 2, we have offered an example of how a hospital might consider making such information public.

Additionally, we note that we are modifying our list of required data elements to align with and reflect the final policies related to the definition of ''standard charge'' as discussed in section II.D of this final rule. As such, the list of data elements would include the discounted cash price, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge for each of the 300 shoppable services and their associated ancillary services. Accordingly, and in light of comments, we have increased our burden estimate (section V of this final rule) to reflect and recognize that hospitals may need to put more time and thought into ensuring that their standard charge information is presented in a consumer-friendly manner than we initially believed and to account for posting additional types of standard charges, specifically, the addition of the discounted cash price and the display of the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge for each shoppable service and corresponding ancillary services.

Final Action: We are specifying the data elements that hospitals must include in their online posting of shoppable services in order to ensure that consumers understand the hospital's standard charges for each shoppable service and can use that information to make comparisons across hospitals.

As noted in responses to comments, we are making several clarifying edits and modifications to align with final policies including: (1) Modifications to align with and include the three new types of standard charges we are finalizing in section II.D of this final rule, (2) we are removing the separate requirement to list all the associated ancillary services and instead incorporating the requirement into the list of data elements related to the types of standard charges, (3) finalizing as a separate data element and clarifying that if a hospital does not offer one or more of the 70 CMS-specified shoppable services, the hospital must clearly indicate that fact with respect to every type of standard charge required for consumer-friendly display, and (4) modifying the data element related to the location of each shoppable service in light of the additional types of standard charges that hospitals must list for the shoppable services to refer more broadly to the three types of standard charges referred to in the section, rather than to ''payer-specific negotiated charges'' in each instance it appears.

In summary, we are specifying in new 45 CFR 180.60(b) that hospitals must include, as applicable, all of the following corresponding data elements when displaying the three types of

standard charges for its list of shoppable services:

- A plain-language description of each shoppable service.
- An indicator when one or more of the CMS-specified shoppable services are not offered by the hospital.
- The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge.
- The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The location at which the shoppable service is provided, including whether the standard charges for the hospital's shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the CPT code, the HCPCS code, the DRG, or other common service billing code.

We note that, as discussed in section II.F.3 of this final rule, hospitals may use, as applicable, an appropriate payer-specific billing code (for example, an APR–DRG code) in place of the MS–DRG code indicated for the five procedures in the list of 70 CMS-specified shoppable services that are identified by MS–DRG codes 216, 460, 470, 473, and 743.

5. Format of Display of Consumer-Friendly Information

In the CY 2020 OPPS/ASC proposed rule, we indicated that we were aware that many hospitals are already communicating charge information to patients in a variety of ways. Some are already making public various types of standard charges for shoppable services available online in various formats. For example, some hospitals offer searchable price transparency tools on their website that offer estimated charges (averages or individualized out-of-pocket costs) or may display charges for shoppable services in brochures (both online and offline) that contain self-pay discounted prices for a service package. In the CY 2020 OPPS/ASC proposed rule, we indicated that we believed many hospitals are already already meeting or exceeding our proposed requirements by offering, for example, patient-friendly price transparency tools that calculate individualized out-of-pocket cost estimates. We sought comment on whether offering such tools could qualify a hospital to be excepted from some of the proposed requirements, for example, the consumer-friendly display requirements (84 FR 39576).

We further noted in the CY 2020 OPPS/ASC proposed rule that because there are a variety of consumer-friendly ways to display charges for hospital services and because we did not want to restrict hospitals from innovating or from having to duplicate efforts, we did not propose to require hospitals to use a specific format for making such data public online in a consumer-friendly manner. Specifically, unlike our proposals for the comprehensive machine-readable list of standard charges for all items and services (discussed in section II.E of this final rule), we did not propose to require that hospitals make payer-specific charge data public in a single digital file posted online. Instead, we proposed that hospitals retain flexibility on how best to display the payer-specific negotiated charge data and proposed associated data elements to the public online, so long as the website is easily accessible to the public. We indicated that we believed this approach would permit some flexibility for hospitals to, for example, post one or more files online with a list of payer-specific charges for the shoppable services and associated data elements, or, for example, to integrate such data into existing price estimate tools.

Additionally, we did not propose, but considered, an option that would require hospitals to make these data available in API format. As explained in more detail in section II.E.3. of this final rule, an API enabled format could allow consumers to access the data by searching for it directly when they do not have a computer by, for example, putting a CPT code in the URL path of the hospital to render in one's mobile phone browser the gross or payer-specific negotiated charge for the service. For example, a consumer searching for the price of a blood test for cholesterol (CPT code 80061) at fictional hospital ABC could look it up by inserting the URL path *https://hospitalABC.com/api/80061.*

We further recognized not all consumers have access to the internet. Therefore, we proposed to require that hospitals make certain data elements available in a consumer-friendly manner offline (84 FR 39589 through 39590). Specifically, we proposed that the hospital would provide a paper copy (for example, a brochure or booklet) of the information to consumers upon request within 72 hours of the request. We proposed to codify this provision at proposed new 45 CFR 180.60(c).

Comment: A few commenters expressed concern that the proposal did not provide hospitals adequate specificity as to how the data should be formatted to ensure that information is meaningful and presented in a consumer-friendly manner.

A few commenters indicated that the requirement to provide to the patient ''a paper copy (for example, a brochure or booklet)'' of the information is available to consumers upon request within 72 hours of the request'' would be challenging to implement because it would be costly and time consuming, and the volume of data would be enormous. Two commenters suggested hospitals should be able to charge a fee to cover the costs of printing a paper copy. One commenter suggested that if individuals do not have access to internet, public libraries provide free internet access to patrons. Two commenters suggested that CMS should permit hospitals to limit the size and contents of the patient-requested paper equivalent (for example, limiting the response to the payer-specific negotiated charges that apply to the individual's circumstances).

Response: In the CY 2020 OPPS/ASC proposed rule we indicated that, because there are a variety of consumer-friendly ways to display charges for hospital services and because we did not want to restrict hospitals from innovating or from having to duplicate efforts, we did not propose to require hospitals to use a specific format for making such data public online in a consumer-friendly manner. We therefore proposed and are finalizing a policy that hospitals retain flexibility on how best to display their standard charge data and proposed associated data elements to the public in a consumer-friendly manner online, so long as the online information is easily accessible to the public. We continue to believe that this approach would permit some flexibility for hospitals to, for example, post one or more files online with a list of payer-specific charges for

the shoppable services and associated data elements, or, for example, to integrate such data into existing price estimate tools. We have included a sample template in Table 2 as an example of the format that would meet our requirements, although hospitals are not required to use this template.

Additionally, in light of our final policy to permit hospitals flexibility to choose an appropriate format, we are not finalizing the proposal that the hospital make available a paper copy. We generally agree with commenters who indicated that a paper format could be burdensome, however, if we determine that lack of a paper copy of hospital standard charges is preventing consumers from accessing hospital charge information, we may revisit this in future rulemaking.

Comment: Commenters stated that they were concerned that consumer-friendly display of standard charges for shoppable services might not provide the consumer with sufficient understanding of their actual costs, with several commenters expressing concern that the payer-specific negotiated charge would differ significantly based on the severity of the patient's condition, leading to variation between the amount displayed in a consumer-friendly format and the amount received by the hospital from the third-party payer. Because of this, commenters suggested that, in order to display standard charges in a ''consumer-friendly'' format, the information must include data on out-of-pocket costs, with several commenters stating that this information should be specific to the individual's health insurance plan.

Response: We recognize the need and desire for consumers to anticipate their out-of-pocket costs. We believe understanding the payer-specific negotiated charge is a necessary first step towards consumers having insight into the cost of their healthcare and being in a better position to choose the healthcare coverage and setting that is most advantageous to them. We expect consumers will use the hospital standard charge information in conjunction and communication with their providers and carriers to understanding their unique cost sharing obligations. Further, we agree that a consumer-friendly online display of shoppable services that would return an immediate out-of-pocket price estimates is preferable to a flat file of standard charges posted online. For this reason we considered and are finalizing as described in more detail below, a policy to deem a hospital price estimator tool as meeting some of the requirements under 45 CFR 180.60. We agree with commenters who indicated that sometimes circumstances during the course of treatment can alter price estimates and because of this we encourage hospitals to continue to engage in patient education, communication, and heightened transparency regarding the cost estimates they provide.

We further emphasize that hospitals are not precluded from providing customized one-on-one financial counseling to consumers, and we applaud hospitals that take the additional step to provide this information to consumers on an individual basis through financial counseling in addition to meeting the posting requirements for the public files.

Comment: Many commenters indicated that many hospitals are already communicating financial obligations to consumers in advance in a variety of consumer-friendly ways. For example, several commenters stated that many hospitals provide good faith estimates, financial counseling services, or have available call centers and/or patient-friendly pricing tools on their websites for use by patients. A few commenters asserted that providing patient-specific estimates, such as a patient's likely out-of-pocket costs based on data provided by the patient's insurer, is more helpful to consumers than sharing charges online as proposed because such information is personalized based on individual circumstances.

Some commenters specifically requested relief from one or more of the requirements under this rule as a result of hospital efforts to communicate personalized out-of-pocket information. Specifically, a few commenters suggested that hospitals that already provide internet-based price estimator tools or good faith estimates to consumers (for brevity, we henceforth refer to such an application as a price estimator tool) be exempt from the requirements of the rule. For example, one commenter suggested that if hospitals offer tools that allow patients to obtain out-of-pocket estimates for 300 shoppable services (including the 70 specified by CMS), they should be considered to have met their obligations under the rule. This commenter further suggested that CMS could set the expectation that hospitals opting for this approach provide estimates for all payers with which they have negotiated rates. A few commenters suggested that this flexibility to provide consumer-friendly charge information in this manner would be beneficial for reasons such as mitigating the risk of disclosure of data that some regard as trade secret or confidential while providing the same baseline information (gross charges) as required under the rule as well as more accurate information about patients' out of cost based on personalized estimates from their plan specific information. Other commenters explained that a price estimator tool that provides meaningful cost information to patients would be more useful to patients than voluminous data sets. One commenter specifically requested that no hospital offering a pricing tool should be exempted from releasing the comprehensive machine-readable data.

A few commenters noted that there are potential limitations associated with the information a patient receives through consumer-friendly pricing tools because providers cannot always estimate what services a patient will need, how they will respond to treatment, and whether complications as a result of co-morbidities or other issues will arise that would require additional services. For example, one commenter noted that accurate price estimation may depend on data elements such as payer coverage/benefit information, hospital/payer contract information, physician order and diagnosis, which may be contained in the hospital's EHR system.

Some commenters that supported an exemption for hospitals that have established a price estimator tool, indicated that if adopted, CMS should specify what qualifies as an acceptable price estimator tool and made specific suggestions for tool functionality, although in some cases these suggestions were made in the context of price estimator tools that could be offered by health insurers rather than hospitals. Suggestions for consumer-friendly tool functionality included:

- Provide users with an estimate of the overall cost and the out-of-pocket costs, including out-of-pocket costs based on an individual's insurance policy.
- Notify user of the availability of financial aid, payment plans, and assistance in enrolling for Medicaid or state program.
- Include a disclaimer about the limitation of the estimation, such as to advise the user to consult with their health insurer to confirm individual payment responsibilities, such as remaining deductible balances.
- Indicate quality of care in the healthcare setting.
- Do not require PII; users would not be required to use any form of account, username, or password to use the price estimator tool.

• Make estimates available in English, Spanish, and other languages as preferred.

• Offer an ad hoc service where a patient can obtain a cost estimate telephonically and/or via email.

• Be prominently featured on the hospital home page, and use plain and obvious language to help ensure that consumers can find it.

• Hospitals should advertise this tool to patients and generate interest.

Several commenters generally encouraged CMS to take steps to facilitate the development and voluntary adoption of price estimator tools by convening stakeholders, including the Departments of Labor and Treasury, to identify best practices, recommending minimum standards for common features, and developing solutions to common technical barriers.

Response: We appreciate commenters' careful consideration of and detailed suggestions for an approach for regarding hospitals as having met the requirement for making public their standard charge information in a consumer-friendly manner. In the CY 2020 OPPS/ASC proposed rule, we noted that as a result of the January 1, 2019 update to our guidance, we received feedback that long lists of charges in a file posted online in a machine-readable format may not be immediately or directly useful for many healthcare consumers because the amount of data could be overwhelming or not easily understood by consumers. We further recognized in the CY 2020 OPPS/ASC proposed rule that hospital standard charges, while necessary for consumers to understand their potential out-of-pocket obligations, are not sufficient in and of themselves. In section II.D of this final rule, we stated that we agree, for example, that the payer-specific negotiated charge does not, in isolation, provide a patient with an individualized out-of-pocket estimate. We referred to the GAO report [162] we described in the CY 2020 OPPS/ASC proposed rule which supports our assertion that payer-specific negotiated charges are a critical piece of information necessary for patients to determine their potential out-of-pocket cost obligations. In other words, in order for an insured individual to determine an out-of-pocket estimate in advance of committing to a healthcare service with a particular provider, the insured individual must have several data points including the total charge (which is the payer-specific negotiated charge) for the item or service and their particular benefits under their insurance plan (for example, their co-pay or deductible) in order to determine their personalize out-of-pocket obligation. More often than not, patients see all this information after the service has been provided in the form of their EOBs. As explained in II.D of this final rule, EOBs are designed to communicate provider charges and resulting patient cost obligations, taking third party payer insurance into account. The payer-specific negotiated charge is a critical data point found on patient's EOB. We further explained that when a consumer has access to payer-specific negotiated charge information prior to receiving a healthcare service (instead of sometimes weeks or months after the fact when the EOB arrives), in combination with additional information from payers, it can help the patient estimate his or her potential out-of-pocket cost.

Because of this, in the CY 2020 OPPS/ASC proposed rule, we considered ways of requiring or encouraging hospitals to make public standard charges for frequently provided services in a form and manner that would be more directly accessible and consumer friendly. Therefore, in addition to including all their standard charges for all items and services in the machine-readable file, we proposed that hospitals must make public their payer-specific negotiated charges for common services for which consumers may have the opportunity to shop, in a consumer-friendly manner. The intent of these provisions was to ensure that the hospital standard charges made public in the comprehensive machine-readable file would be more accessible to the average consumer so that consumers could use the information, combining it with additional necessary benefit information from their insurer, to estimate their individual out-of-pocket cost obligations in advance of receiving a healthcare service from the hospital.

We are persuaded by commenters' suggestions that some hospitals offering online price estimator tools that provide real-time individualized out-of-pocket cost estimates should receive consideration and potential relief from some of the requirements for making public standard charges, particularly as it relates to our intent and goals for requiring that hospitals communicate their standard charges in a consumer-friendly manner. We believe voluntarily offering an online price estimator tool has merit because the hospital standard charges as defined in this final rule are used to develop the individual's out-of-pocket estimate in an even more consumer-friendly way than what we proposed within the limits of our statutory authority. We believe that price estimator tools pick up where our rule ends and take the additional steps that would otherwise be required by the consumer to determine their individualized out-of-pocket by combining hospital standard charge information with the individual's benefit information directly from the insurer. Thus, although some hospital price estimator tools may not display standard charge information in the consumer-friendly manner in the precise ways we proposed and are finalizing under this rule, they do appear to accomplish the goal and intent of ensuring such information is available in a consumer-friendly manner for purposes of individuals to directly determine their specific out-of-pocket costs in advance of committing to a hospital service. Thus, we believe it is possible that hospitals with price estimator tools could be considered as having accomplished the goals we intended to achieve by requiring hospitals to repackage and display their standard charge information for common shoppable services in a consumer-friendly manner. We emphasize, however, that hospitals would still be required to publish all standard charges in a machine-readable file consistent with the requirements we finalize in section II.E of this final rule.

We are finalizing, as modifications to our proposal, in a new 45 CFR 180.60, that a hospital may voluntarily offer an internet-based price estimator tool and thereby be deemed to have met our requirements to make public its standard charges for selected shoppable services in a consumer-friendly manner. We believe this accommodation is responsive to comments indicating that the requirements to make public shoppable services in a consumer-friendly format are duplicative of efforts by hospitals that offer individualized internet-based price estimator tools.

We considered the minimum necessary functionality requirements a price estimator tool must embody to satisfy this new policy. As reflected in the comments we received on this topic, we recognize that different hospitals may maintain different types of internet-based healthcare cost price estimator tools, and that the market for, and technology behind, these applications is growing. Therefore, we believe it is important to ensure there is flexibility for the data elements, format, location and accessibility of a price estimator tool that would be considered to meet the requirements of 45 CFR 180.60. We

[162] GAO. Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care. Publicly released October 24, 2011. Available at: *https://www.gao.gov/products/GAO-11-791.*

believe that the requirements we are establishing in this final rule, for certain minimum data and functionality of a price estimator tool for purposes of meeting the requirements under new 45 CFR 180.60, are a starting point. We appreciate and will consider the commenters' suggestions that we seek stakeholder input for future considerations related to the price estimator tool policies we are finalizing, including to identify best practices, common features, and solutions to overcoming common technical barriers.

Therefore, we are finalizing a modification to our proposed policy to specify in new 45 CFR 180.60(a)(2) that a hospital that maintains an internet-based price estimator that meets certain criteria is deemed to have met our requirements at 45 CFR 180.60. The price estimator tool must:

- Allow healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
- Provide estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Is prominently displayed on the hospital's website and be accessible without charge and without having to register or establish a user account or password.

To be clear, we believe that a price estimator tool would be considered internet-based if it is available on an internet website or through a mobile application. We considered the additional suggestions by commenters related to ensuring that price estimator tools are consumer-friendly. In our review of available online price estimator tools offered by hospitals, we observed that their look and feel are not uniform, so, in this final rule, and so as not to be overly proscriptive or restrict innovation, we are not at this time finalizing a specific definition of a consumer-friendly format for price estimator tools or any additional criteria. However, we encourage hospitals to take note of current estimator tool best practices and seek to ensure the price estimator tools they offer are maximally consumer-friendly. For example, we encourage, but will not require in this final rule, that hospitals provide appropriate disclaimers in their price estimator tools, including acknowledging the limitation of the estimation and advising the user to consult, as applicable, with his or her health insurer to confirm individual payment responsibilities and remaining deductible balances. Similarly, we encourage, but do not require in this final rule, that hospital pricing tools include: (1) Notification of the availability of financial aid, payment plans, and assistance in enrolling for Medicaid or a state program, (2) an indicator for the quality of care in the healthcare setting, (3) and making the estimates available in languages other than English, such as Spanish and other languages that would meet the needs of the communities and populations the hospital serves.

We note that although we decline to be more prescriptive at this time, we may in the future revisit our policy to deem hospital online price estimator tools as having met requirements if we determine such tools are not meeting our goals for making hospital charge information meaningful to consumers. We further note that a hospital that meets the requirements for offering an internet-based price estimator tool would still be required to make public all standard charges for all hospital items and services online in a comprehensive machine-readable format as discussed in section II.E of this final rule and finalized under 45 CFR 180.50.

Comment: A few commenters addressed monitoring and oversight of price transparency tools. For example, one commenter suggested that CMS, or another federal agency, establish standards and require certain disclosures for software application developers of consumer-facing platforms for hospital standard charge data. This commenter expressed concern about consumers losing faith in cost transparency tools as they begin interacting with them, stemming from consumer-facing platforms that are not presenting information accurately or not using information appropriately.

Another commenter suggested that standards must be in place for CMS to monitor and evaluate the impacts of price transparency tools, to help ensure there are not unintended effects, and to identify best practices. The commenter suggested that this includes developing a better understanding of any potential misinterpretations of the data by patients, as well as the extent to which hospitals may misrepresent rates.

Response: For purposes of implementing section 2718(e) of the PHS Act, we will monitor and enforce compliance with the requirements to make public standard charges (as described in section II.G. of this final rule). This will include ensuring that hospitals have made public their standard charges in both ways required under these rules. Specifically, we will monitor to ensure that hospitals have made public all their standard charges for all items and services they provide in a comprehensive online machine-readable file format and have either made public standard charges for shoppable services in a consumer-friendly format (according to the requirements at 45 CFR 180.60), or have voluntarily offered an online price estimator tool. Although comments suggesting that CMS impose monitoring or enforcement efforts on software application developers are beyond the scope of the standard charge disclosure requirements we proposed, and that we are finalizing at new 45 CFR part 180 as discussed in this final rule, we note that HHS has ongoing efforts to improve health information exchange including through the ONC [163] and recently promulgated proposed interoperability rules designed to expand access to health information and improve the seamless exchange of data in healthcare.[164]

Final Action: We are finalizing as proposed to specify in new 45 CFR 180.60(c) that hospitals retain flexibility on how best to display to the public online their standard charges in a consumer-friendly manner, so long as the website is easily accessible to the public.

Based on the comments received, we are not finalizing our proposal to require that hospitals provide a paper copy (for example, a brochure or booklet) of information on consumer-friendly shoppable services to consumers upon request within 72 hours of the request.

We are finalizing a modification to our proposal at new 45 CFR 180.60(a)(2) to specify that a hospital is deemed by CMS to meet the requirements of 45 CFR 180.60 if the hospital maintains an internet-based price estimator tool which meets the following requirements:

- Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Allows health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.

[163] *HealthIT.gov* website, Laws, Regulation, and Policy, at *https://www.healthit.gov/topic/laws-regulation-and-policy.*

[164] *CMS.gov* website, Interoperability, at *https://www.cms.gov/Center/Special-Topic/Interoperability-Center.html.*

• Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

6. Location and Accessibility Requirements

Additionally, we proposed that hospitals make the data elements proposed in section XVI.F.4. of the CY 2020 OPPS/ASC proposed rule (84 FR 39589 through 39590) public online in such a way that the standard charges and associated data elements could be easily located and accessed by consumers.

First, we proposed that a hospital would have discretion to select an appropriate internet location to post the standard charge information required under this section (that is, the payer-specific charges for shoppable services and associated data elements). We further proposed that the website location be publicly available, that the data be displayed prominently and clearly identify the hospital location with which the standard charge information is associated, and that the standard charge data be easily accessible, without barriers, and that the data could be digitally searched. For purposes of the proposed requirements: (1) ''displayed prominently'' meant that the value and purpose of the web page [165] and its content [166] is clearly communicated, there is no reliance on breadcrumbs [167] to help with navigation, and the link to the standard charge information is visually distinguished on the web page; [168] (2) ''easily accessible'' meant that standard charge data are presented in format that is searchable by service description, billing code, and payer, and that the standard charge data posted on the website can be accessed with the fewest number of clicks; [169] and (3) ''without barriers'' meant the data can be accessed free of charge, users would not have to input information (such as their name, email address, or other PII) or register to access or use the standard charge data. We proposed to codify this requirement at proposed new 45 CFR 180.50(d).

We encouraged hospitals to review the HHS Web Standards and Usability Guidelines (available at: *https://webstandards.hhs.gov/*), which are research-based and are intended to provide best practices over a broad range of web design and digital communications issues.

We sought comment on these proposed location and accessibility requirements, including whether there were additional requirements that should be considered to ensure public access to payer-specific negotiated charges for shoppable services.

Comment: Several commenters noted the importance of making the information easily accessible and consumer-friendly. Specifically, a few commenters noted that it is important for hospitals to make this information easy or intuitive for lay-people to find on the websites.

Other commenters made recommendations for requirements related to accessibility of consumer-friendly hospital charge information such as:

• Display on the website home page and clear indicators such as ''Price Check'' or ''Cost Estimator'' in the text for the link, rather than terms like ''Tools and Resources.''

• Conform with American with Disabilities Act (ADA) accessibility standards.

• Make information available in multiple languages based on the hospital's population.

One commenter noted that rural consumers have less access to broadband, making it more difficult for them to access this information online. One commenter recommended that public outreach efforts, content generation, and coordination with existing user channels are needed to educate and engage audiences.

Response: We thank commenters for their suggestions and agree that hospitals should seek to make their standard charge information easy or intuitive for lay-people to find on their websites. We would expect hospitals to post information in a format accessible to people with disabilities or to otherwise ensure that individuals with disabilities can readily access hospital standard charge information, in accordance with applicable federal or state laws.[170] We encourage hospitals to post this information in a language and manner that is consumer-friendly for their specific markets and to use terms to refer to their standard charge information that are clear indicators. While we are not finalizing any specific requirements related to either of these two issues at this time, we will continue to consider these suggestions, and should the information prove to be difficult to find or access, we may revisit these in future rulemaking.

Regarding the concern related to rural consumers being able to access online hospital charge information, we note that in July 2019, the Federal Communications Commission authorized $524 million in funding over the next decade to expand broadband to unserved rural homes and businesses.[171] We agree that the availability of hospital charge information as a result of these final rules should be widely publicized. We plan to engage in communicating and publicizing these final rules and encourage other interested stakeholders to engage in communications strategies to enhance public awareness of the availability of hospital standard charge information.

Comment: One commenter agreed that CMS' proposed location, accessibility, and technical requirements would allow patients to easily access standard charge information for shoppable services. A few other commenters expressed that being able to access standard charge information should be like comparing prices for groceries. One commenter suggested that hospitals clearly link the consumer-friendly list of shoppable services with the comprehensive machine-readable file of all items and services. A few commenters suggested that there be a standardized CMS file and web page format for displaying standard charges for shoppable services, arguing this would more easily enable cost comparisons across different facilities.

Response: We appreciate commenter's support for our location and accessibility requirements and are finalizing them as proposed. We agree with commenters who believe that comparing prices for healthcare services should be as transparent as comparison pricing in other industries. We will continue to consider whether and how best to link the comprehensive machine-readable file and the consumer-friendly display of shoppable services. We agree that an exemplar template (not one that we will presently require) would be beneficial to help standardize format for displaying charges for shoppable services in a consumer-friendly format, and we have included such examples in this final rule. However, as explained in II.F.5 of this final rule, we believe

[165] *https://webstandards.hhs.gov/guidelines/49.*

[166] Nielsen J. (2003, November 9). The ten most violated homepage design guidelines. Alertbox. Available at: *http://www.useit.com/alertbox/20031110.html.*

[167] *https://webstandards.hhs.gov/guidelines/78.*

[168] *https://webstandards.hhs.gov/guidelines/88.*

[169] *https://webstandards.hhs.gov/guidelines/181.*

[170] The Americans with Disabilities Act, the Rehabilitation Act and the ACA (see 45 CFR 92.202) require auxiliary aids and services when needed to communicate effectively with people with disabilities. *https://www.ada.gov/effective-comm.pdf.*

[171] FCC. FCC Authorizes $524 Million for Rural Broadband Expansion in 23 States. News Release, July 15, 2019. Available at: *https://www.fcc.gov/document/fcc-authorizes-524-million-rural-broadband-expansion-23-states.*

hospitals should retain flexibility to determine a format that displays charges for their shoppable services in a consumer-friendly manner.

Comment: A few commenters suggested that patients needed to be able to access standard charge information for shoppable services through a secure portal that is password protected, and that the secure portal be tied to their actual health plan coverage while minimizing the risk that other providers will demand higher rates from payers.

Response: We thank the commenters for their recommendation. However, in the interest of keeping access to the consumer-friendly display of shoppable services barrier-free, we disagree with requiring hospitals to develop a secure portal. As part of the requirements for making standard charges public, hospitals would not post any PII to the internet and consumers would not be asked to provide any in order to view payer-specific negotiated charges.

Final Action: We are finalizing with technical modification our requirements for location and accessibility of information on consumer-friendly shoppable services. Specifically, we are finalizing with modification that a hospital must select an appropriate publicly available internet location for purposes of making public the standard charge information for shoppable services in a consumer-friendly format.

We are also finalizing with technical modification that the information must be displayed in a prominent manner that identifies the hospital location with which the standard charge information is associated.

Finally, we are finalizing with technical modification the shoppable services information must be easily accessible, without barriers, including, but not limited to, ensuring the information is: (i) Free of charge; (ii) accessible without having to register or establish a user account or password; (iii) accessible without having to submit PII; (iv) searchable by service description, billing code, and payer. We note that we would expect hospitals would post information in a format accessible to people with disabilities or to otherwise ensure that individuals with disabilities can readily access hospital standard charge information, in accordance with any applicable federal or state laws.

These final provisions are specified in new 45 CFR 180.60(d).

7. Frequency of Updates

The statute requires hospitals to establish, update, and make public their standard charges for each year. Therefore, we proposed to require hospitals to make public and update the standard charge information proposed in section XVI.F.2 (84 FR 39585 through 39586) at least once annually (proposed new 45 CFR 180.60(e)). We recognized that hospital charges may change more frequently and therefore we encouraged (but are not requiring) hospitals to update this file more often, as appropriate, so that the public may have access to the most up-to-date charge information. We also recognized that hospitals update their charges at different times during the year and may also have various State price transparency reporting requirements that require updates. For purposes of these requirements, we believe that updates that occur at least once in a 12-month period will satisfy our proposed requirement to update at least once annually and reduce reporting burden for hospitals. In other words, the hospital could make public and update its list of standard charges at any point in time during the year, so long as the update to the charge data occurs no more than 12 months after posting.

We also proposed to require hospitals to clearly indicate the date of the last update they have made to the standard charge data, with some discretion as to where the date of late update is indicated.

Comment: A few commenters disagreed that annually updating the display of standard charges in the consumer-friendly format would be sufficient to keep consumers apprised of costs. Commenters recommended more frequent updates, citing frequent changes in commercial payer rates. One commenter recommended requiring hospitals to update this information in real time to avoid the possibility of misleading patients with calendar-related gaming around the disclosure of rate hikes or true prices.

Response: We appreciate the commenters' concerns and we agree that timely updates are an important aspect of keeping information relevant to consumers and avoiding confusion, but we believe the plain language of section 2718(e) of the PHS Act currently limits the requirement to make standard charges public to once annually. We strongly support and encourage hospital efforts to make more frequent updates to the standard charge information they make public online.

Final Action: We are finalizing as proposed a policy to require hospitals to make public and update the standard charge information at least once annually (proposed new 45 CFR 180.60(e)). We are also finalizing as proposed a requirement that the hospital clearly indicate the date that the information was most recently updated. Hospitals would have some discretion as to where the date of late update is indicated.

G. Monitoring and Enforcement of Requirements for Making Standard Charges Public

1. Background

Section 2718(b)(3) of the PHS Act requires the Secretary to promulgate regulations to enforce the provisions of section 2718 of the PHS Act, and, in so doing, the Secretary may provide for appropriate penalties. As such, we proposed that we may impose penalties on hospitals that fail to make their standard charges public in accordance with the requirements we finalize under section 2718(e) of the PHS Act. In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20549), we sought public comments on a variety of issues related to enforcement of the requirement that hospitals make public their standard charges and noted our intent to address enforcement and other actions to ensure compliance in future rulemaking.

We specifically sought comments on the following:

- What is the most appropriate mechanism for CMS to enforce price transparency requirements?
- Should CMS require hospitals to attest to meeting requirements in the provider agreement or elsewhere?
- How should CMS assess hospital compliance?
- Should CMS publicize complaints regarding access to price information or review hospital compliance and post results? What is the most effective way for CMS to publicize information regarding hospitals that fail to comply?
- Should CMS impose CMPs on hospitals that fail to make standard charges publicly available as required by section 2718(e) of the PHS Act?
- Should CMS use a framework similar to the Federal civil penalties under 45 CFR 158.601 through 158.615, that apply to issuers that fail to report information and pay rebates related to medical loss ratios (MLRs), as required by sections 2718(a) and (b) of the PHS Act, or would a different framework be more appropriate?

As described in the CY 2020 OPPS/ASC proposed rule (84 FR 39591), we received a number of comments in response to this RFI. Many commenters agreed that enforcing this requirement under section 2718(e) of the PHS Act would send an important signal that CMS values transparency and ensure that the public has access to hospital charge information. Some commenters

suggested that CMS model enforcement after various quality reporting programs, such as the Hospital Inpatient and Outpatient Quality Reporting Programs or the LTCH Quality Reporting Program. Some commenters recommended publicizing noncompliant hospitals or providing a mechanism for the public to file complaints against noncompliant hospitals. Some commenters suggested that CMS propose to make the publication of standard charges a Medicare condition of participation or provider enrollment. However, one commenter indicated that revoking a provider agreement over lack of a website disclosure would be unnecessarily punitive. Other commenters warned that subjecting hospitals violating pricing transparency provisions to compliance actions could pose a challenge, particularly for smaller hospitals, and recommended limiting or deferring compliance actions to a later date. Some commenters agreed that imposing monetary penalties on noncompliant hospitals was appropriate, while other commenters believed that CMS does not have authority to enforce section 2718(e) of the PHS Act and, for that reason, should not adopt penalties for noncompliance.

We stated in the CY 2020 OPPS/ASC proposed rule that we agree with commenters who noted that an enforcement regime signals the value we place on price transparency and assurance of public access to hospital standard charges. We interpret section 2718(b)(3) of the PHS Act as authorizing us to enforce the provisions of section 2718(e). Therefore, we proposed to adopt mechanisms to monitor and enforce our requirements for making standard charges public.

2. Monitoring Methods

Section 2718(e) of the PHS Act requires hospitals to make public their list of standard charges and authorizes the Secretary to promulgate additional criteria that hospitals must satisfy in order to make such charges public. The statute does not prescribe monitoring procedures or the factors we should consider in imposing penalties on hospitals for noncompliance. Based on our experience with the Medicare program and healthcare marketplace plans, we believe it is important for the public to be informed, and, therefore, for CMS to ensure compliance with this statutory requirement. Therefore, we proposed to employ methods to monitor and assess hospital compliance with section 2718(e) of the PHS Act, and specifically proposed new 45 CFR 180.40, 180.50, and 180.60.

In general, we proposed that CMS may use methods to monitor hospital compliance with the requirements under proposed 45 CFR part 180. As explained in the CY 2020 OPPS/ASC proposed rule, we anticipate relying predominantly on complaints made to CMS by individuals or entities regarding a hospital's potential noncompliance. Therefore, we proposed that our monitoring methods may include, but are not limited to, the following, as appropriate:

- CMS' evaluation of complaints made by individuals or entities to CMS.
- CMS review of individuals' or entities' analysis of noncompliance.

As we gain experience with monitoring compliance with the requirements for proposed 45 CFR part 180, we may consider self-initiating audits of hospitals' websites as a monitoring method. Therefore, we proposed that our monitoring methods may include CMS audit of hospitals' websites.

We proposed to set forth these monitoring methods in the regulations at proposed new 45 CFR 180.70.

Comment: A few commenters suggested that the monitoring and enforcement requirements for making standard charges public should be well defined and robust. A few commenters agreed with CMS' proposal to rely mainly on complaints made to CMS by individuals or entities regarding a hospital's noncompliance, as well as CMS audits of hospitals' websites. One commenter stated that the proposed approach seems reasonable and that the monitoring methods and proposed actions to address noncompliance are appropriately varied and iterative.

A commenter suggested that positive and effective enforcement is needed, such as encouraging community policing efforts that strive for prevention of a problem, and believes this approach could create a more transparent hospital reimbursement system for the public.

A few commenters suggested that the burden of monitoring and enforcement may outweigh its benefits, and one commenter suggested that CMS withdraw altogether its proposed price transparency requirements, including the enforcement processes and CMPs for noncompliance, because of concerns about additional costs of compliance the proposed price transparency policies pose for financially fragile rural safety net providers, in particular Medicare Dependent Hospitals, Rural Referral Centers, and SCHs. One commenter stated that monitoring is a purposeless task.

Response: We appreciate the support of commenters favoring the proposed approach to monitoring for compliance with the requirements for hospitals to make public standard charges. We disagree with the notion, expressed by one commenter, that monitoring hospitals for compliance with these price transparency disclosure requirements is a purposeless task and that its potential burden outweighs its potential benefits. We do, however, appreciate commenters' concerns about the potential additional burden that monitoring activities may pose for hospitals, though we do not believe the monitoring burden will impact hospitals unless they are not in compliance with the requirements.

We decline to altogether forgo enforcement processes and CMPs for noncompliance as suggested by one commenter. We believe that enforcement of the policies is vital to ensuring that hospitals comply with the requirements to make public standard charges. Given the importance of ensuring that patients have access to data they need to make informed healthcare decisions, we believe monitoring hospitals' compliance with the requirements of new 45 CFR part 180 is critical. Therefore, we are finalizing our proposed monitoring methods. Further, we believe it is important to consistently apply the monitoring and enforcement provisions across all entities that meet the definition of ''hospital'' that we are finalizing (as discussed in section II.B.2 of this final rule), regardless of factors such as hospital size, revenue, or location.

In response to the commenter suggesting a community policing approach that strives for prevention of compliance problems, we note that the monitoring methods we are finalizing here include CMS' reliance on receipt of complaints made by individuals or entities to help inform CMS of potential issues so that CMS may initiate its own analyses, or CMS review of individuals' or entities' analysis of noncompliance. Further actions to address hospital noncompliance as described in section II.G.3 of this final rule include CMS' issuance of a written warning notice to a noncompliant hospital and CMS' requests for a CAP from a hospital in the event its noncompliance constitutes a material violation of one or more requirements. This approach contemplates that noncompliant hospitals will be offered opportunities to come into compliance with the requirements prior to the imposition of a CMP. Further, we note that these final policies do not preclude individuals or entities from raising their compliance concerns directly with hospitals, and for

hospitals to voluntarily address disclosure deficiencies.

Comment: A few commenters addressed the scope of CMS' monitoring of hospital compliance to make public standard charges. A few commenters expressed support for meaningful oversight and enforcement by CMS to ensure the quality and accuracy of the standard charge information hospitals are required to disclose pursuant to this rule. One commenter recommended that CMS should have a system in place to ensure that rates are being updated regularly in accordance with the requirements.

Response: We appreciate commenters' support for and interest in CMS' monitoring activities. In response to comments regarding the scope of CMS' proposed monitoring of hospitals with respect to compliance with these requirements to make public standard charges, we believe our authority is broad and includes, for example, our ability to monitor the accuracy of the information made public, and whether the information is made public in the form and manner and with the frequency specified in this final rule.

According to the monitoring methods we are finalizing in this final rule, we anticipate relying on complaints made by individuals or entities, or individuals' or entities' analysis of noncompliance, as the basis for being notified about inaccuracies in the information made public by hospitals. To be clear, such notifications would not directly underlie an enforcement action. Rather, such notifications would merely trigger our independent analysis and conclusions, of which complainant's allegations or analyses may become a part, that would underlie any potential enforcement action. Pursuant to the monitoring methods we finalize here, we may also self-initiate the audit of a hospital's website. We anticipate that our review for inaccuracies in reported information would be for egregious and obvious instances of noncompliance, such as (in the extreme) all items and services made public by a hospital having the same value, or no value at all. Further we decline the commenters' suggestion to establish an additional, or different process, to monitor and take actions to address noncompliance in the form of inaccurate data. We anticipate consistently applying our monitoring and enforcement methods when addressing all types of possible violations. As we describe in section II.G.3 of this final rule, we may provide a written warning notice to a noncompliant hospital, request a CAP from a hospital if the noncompliance constitutes a material violation of one or more requirements, impose a CMP on the hospital if the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP, and publicize the notice of imposition of a CMP on a CMS website.

Comment: A few commenters suggested, as an alternative approach, that hospitals should be required to report to CMS on their compliance with the requirements. For example, commenters' suggestions included that hospitals should be required to notify CMS of their adherence to price transparency requirements at regular intervals, or that hospitals should be required to submit a form to CMS to prove adherence with the requirements. A few commenters suggested that CMS require hospitals to attest that they are in compliance with the rule. One commenter explained that requiring such an attestation would put hospitals at risk of implicating the federal False Claims Act and associated penalties if they were determined to be noncompliant.

One commenter, seeming to misinterpret the President's Executive Order 13877 on ''Improving Price and Quality Transparency in American Healthcare to Put Patients First'' (June 24, 2019), suggested a requirement may exist for hospitals to establish a monitoring mechanism to ensure compliance with the price list posting requirement.

Response: We read the final sentence of section 3(a) of Executive Order 13877 to indicate two separate requirements related to the regulation requiring hospitals to publicly post standard charge information; specifically, that the regulation should: (1) Require hospitals to regularly update the posted information, and (2) establish a monitoring mechanism for the Secretary to ensure compliance with the posting requirement, as needed. We believe that (2) means that HHS should establish a monitoring mechanism to ensure hospitals' compliance with the posting requirements.

At this time, we decline to adopt commenters' suggestions that we require hospitals to report or attest to CMS their compliance with these requirements, but as we gain experience with monitoring hospital compliance with the policies we finalize here, we may revisit these issues in future rulemaking.

Comment: A few commenters stated that it is critical for CMS to implement a process for individuals to report noncompliance. One commenter expressed concern over the potential lack of guidance on how individuals or entities would report to CMS a hospital's noncompliance with the price transparency requirements. In comments on this topic, commenters suggested a variety of methods for how a complaint should be reported to CMS and subsequent actions CMS should take in processing the complaint.

Response: We have established an email address, *PriceTransparencyHospitalCharges@cms.hhs.gov,* through which individuals and entities may report to CMS concerns about hospital compliance with requirements to make public standard charges, including complaints about and analysis of noncompliance.

Comment: Several commenters encouraged CMS to develop robust auditing procedures rather than relying solely on patients to know how to and take steps to report violations.

Response: To clarify, we proposed that monitoring methods include, but are not limited to, CMS' evaluation of complaints made by individuals or entities, CMS review of individuals' or entities' analysis of noncompliance, and CMS audit of hospitals' websites. We agree with the commenters that CMS audit of hospitals may be an important method for monitoring hospitals compliance with the requirements of new 45 CFR part 180.

Comment: Several commenters suggested that CMS work closely with hospitals to ensure they are aware of and understand CMS' monitoring mechanisms. One commenter suggested that CMS ensure both inpatient and outpatient providers have sufficient education and training required for compliance with the proposals. Several commenters suggested that CMS use education and outreach methods that exist within Medicare FFS to promote hospital awareness of and promote compliance with the requirements to make public standard charges.

Response: We thank commenters for their suggestions, and we will consider these suggestions for education and outreach about compliance as we gain experience monitoring hospital compliance with these requirements to make public standard charges. We note that the suggestions of a few commenters focused on methods for education and outreach in relation to the Medicare program, but that the price transparency requirements are not limited to Medicare enrolled hospitals.

Final Action: After considering the comments received on our proposed approach to monitor hospital compliance with the requirements to make public standard charges, we are finalizing our proposal to evaluate whether a hospital has complied with the requirements under §§ 180.40,

180.50, and 180.60. We are also finalizing as proposed that the monitoring methods for determining a hospital's compliance with the requirements for making public standard charges may include, but are not limited to, the following, as appropriate:

- CMS' evaluation of complaints made by individuals or entities to CMS.
- CMS review of individuals' or entities' analysis of noncompliance.
- CMS audit of hospitals' websites.

We are finalizing our proposal to set forth these monitoring methods in the regulations at new 45 CFR 180.70.

3. Actions To Address Hospital Noncompliance With Requirements To Make Public Standard Charges

We proposed that hospitals that CMS identifies as noncompliant would be notified of their deficiencies and given an opportunity to take corrective action to come into compliance. As discussed in section II.G.4. of this final rule, for hospitals determined by CMS to be noncompliant with section 2718(e) of the PHS Act that fail to respond to CMS' requests to submit a CAP or comply with the requirements of a CAP, we proposed that we may impose CMPs and publicize these penalties on a CMS website.

Should we conclude, based upon the proposed monitoring activities previously described, that a hospital is noncompliant with section 2718(e) of the PHS Act and the requirements of proposed 45 CFR part 180, we proposed that CMS may take any of the following actions, which generally, but not necessarily, would occur in this order:

- We may provide a written warning notice to the hospital of the specific violation(s).
- We would request a CAP from the hospital if its noncompliance constitutes a material violation of one or more requirements.
- If the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP, CMS may impose a CMP on the hospital and publicize the penalty on a CMS website.

As discussed in the CY 2020 OPPS/ASC proposed rule (84 FR 39592), prior to requesting a CAP, or in the case of violations that are deemed nonmaterial violations warranting a CAP, CMS anticipates warning, via written notice, a hospital of noncompliance with one or more of the requirements to make public standard charges (according to section 2718(e) of the PHS Act and the requirements of proposed 45 CFR part 180), and of the need for voluntary corrective action. We would then reevaluate the hospital's compliance with the statutory and proposed regulatory requirements. Should we determine the hospital remains noncompliant and that the noncompliance constitutes a material violation of one or more requirements, we anticipate requiring that the hospital submit a CAP, and there would be increasing consequences for failure to remedy noncompliance.

We proposed that a material violation may include, but is not limited to, the following:

- A hospital's failure to make public its standard charges required by proposed new 45 CFR 180.40.
- A hospital's failure to make public its standard charges in the form and manner required under to proposed new 45 CFR 180.50 and 180.60.

We proposed that CMS may request that a hospital submit a CAP, specified in a notice of violation issued by CMS to a hospital. A hospital required to submit a CAP must do so, in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital and must comply with the requirements of the CAP.

We proposed that a hospital's CAP must specify elements including, but not limited to, the deficiency or deficiencies that caused noncompliance to occur, the corrective actions or processes the hospital will take to come into compliance with the requirements of 45 CFR part 180, and the timeframe by which the hospital will complete the corrective action. We proposed that a CAP would be subject to CMS review and approval. We proposed that after CMS' review and approval of a hospital's CAP, CMS may monitor and evaluate the hospital's compliance with the corrective actions.

We proposed that a hospital's failure to respond to CMS' request to submit a CAP includes failure to submit a CAP in the form, manner, or by the deadline, specified in a notice of violation issued by CMS to the hospital. We proposed that a hospital's failure to comply with the requirements of a CAP includes failure to correct violation(s) within the specified timeframes.

We proposed to set forth in the regulations at proposed new 45 CFR 180.70 the actions CMS may take to address a hospital's noncompliance with the requirements to make public standard charges, and to set forth in proposed new 45 CFR 180.80 the requirements for a CAP.

Comment: A few commenters offered suggestions on the process for CMS and hospitals to address potential noncompliance. One commenter expressed concern over the potential lack of guidance regarding the process CMS will use to investigate a complaint about a hospital's noncompliance with the price transparency requirements and request corrective action by a hospital. Another commenter stated that any penalties for noncompliance should not be accrued until the hospital has adequate time to respond to complaints. The commenter suggested, at a minimum, a six-month time frame for responding to and resolving the issues brought forward via a complaint.

Response: The regulations we are finalizing at new 45 CFR 180.70 specify the actions CMS will take to address hospital noncompliance. We anticipate that the specifics of each compliance action may depend on the circumstances of the complaint, CMS' determination of noncompliance, and the severity of the violation(s).

Comment: One commenter expressed support for a policy under which CMS would request a CAP before imposing a CMP.

Response: We appreciate the support of the commenter favoring the proposed approach.

Comment: A few commenters indicated it was unclear what would constitute the basis for a finding of a material violation for CMS to determine it is necessary to request a CAP. One of these commenters recommended that CMS further delineate its expectations and grounds under which a CMP is warranted to avoid a system of arbitrary and capricious actions by CMS to penalize hospitals.

These commenters stated that it is unclear what would constitute a finding of noncompliance with a required public disclosure of standard charges or noncompliance with disclosure in the form and manner required by CMS. One commenter specifically asked whether a hospital would only be cited as noncompliant after repeated violations or egregious violations or whether technical issues with formatting and posting of pricing data, including computer server issues, constitute an actionable violation. Another commenter asked if a hospital would be found noncompliant if a hospital made a good faith effort to publish data as required by CMS, but found some requirements impossible to meet. This commenter asked whether a CMP would be imposed on a hospital for failing to achieve something impractical based merely on web-surfing by federal employees absent consumer complaints.

Response: We believe these comments reflect concerns that hospitals will have limited opportunity to take corrective action prior to the imposition of a CMP.

As described in the CY 2020 OPPS/ASC proposed rule (as discussed above), prior to requesting a CAP for a material violation, CMS may issue a written warning notice so that the hospital may take voluntary corrective action to become compliant. We could then reevaluate the hospital's compliance with the statutory and proposed regulatory requirements. Should we determine the hospital remains noncompliant and that the noncompliance constitutes a material violation of one or more requirements, we anticipate requiring that the hospital submit a CAP. We may impose a CMP on a hospital identified as noncompliant that fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.

We further considered the proposed requirements for a CAP. Upon closer review we believe our proposals to require a hospital to specify in its CAP (i) the deficiency or deficiencies that caused noncompliance to occur, and (ii) the corrective actions or processes the hospital will take to come into compliance with the requirements of this part, among other elements, could raise due process considerations. In particular, the phrasing of these proposed elements suggest that in developing a CAP, the hospital must concur with CMS' finding(s) of noncompliance. This would be potentially problematic for a hospital in the event it seeks to dispute CMS' findings of noncompliance. Therefore, we are finalizing with modification to specify instead that a hospital's CAP must include, among other elements, a description of the corrective actions the hospital will take to address the deficiency or deficiencies identified by CMS. We believe this provision provides hospitals greater flexibility to specify in their CAP considerations about CMS' findings of noncompliance, in addition to actions to address such findings. We anticipate working with hospitals on an individual basis during the corrective action process to address concerns with CMS' findings and concerns about meeting the requirements.

Comment: Many commenters indicated that implementation by January 1, 2020 would not provide enough time to comply with requirements and suggested that CMS consider finalizing an effective date beyond January 1, 2020, or otherwise permit delay or postponement of implementation. Several commenters expressed concern with the complexity of the data extract needed to meet the CY 2020 OPPS/ASC proposed rule's requirements, as well as the availability of that data within existing online systems or the need to divert hospital personnel to create the files manually given a lack of contract management system.

One commenter expressed that, for those hospitals unable to afford a vendor, the staff labor cost will be astronomical and the likelihood of completing this ''herculean'' task prior to January 1, 2020, will be very low. This commenter suggested a postponement of the posting of negotiated rates for small rural and critical access hospitals until affordable software is developed and made available to assist with this task.

Another commenter explained that an effective date of January 1, 2020 would not afford hospitals enough time to evaluate consulting services, contract management systems, or hire additional personnel to fulfill these requirements.

Commenters suggested a variety of alternative effective dates. For example, one commenter suggested an effective date of April 2020 or later, a few commenters suggested requiring implementation by January 1, 2021, and one commenter stated it would take a minimum of 2 years to become compliant.

One commenter expressed concern that CMS proposed ''an invasive and highly punitive'' monitoring and enforcement regime, up to and including CAPs and CMPs, that would take effect January 1, 2020.

Response: We agree with commenters that some hospitals may find it challenging to initially comply with the new requirements of 45 CFR part 180 in a short timeframe, and may need time beyond January 2020 to develop the capacity to meet the new requirements. We also recognize that hospitals vary in the extent to which they already make public standard charge information similar to the data we are requiring hospitals to make public with this final rule. For instance, some hospitals may already comply with similar requirements under state laws, or already voluntarily make such information public and would, therefore, be able to quickly comply with the new requirements.

In light of these considerations, we are finalizing a modification to extend the effective date of policies under new 45 CFR part 180 to January 1, 2021. We believe this duration of delay balances the concerns between providing additional time for hospitals to implement the new requirements while still ensuring that hospitals' standard charges are made public quickly to provide consumers access to this important information. We decline to create a different effective date for a subset of hospitals, such as rural hospitals, to delay price transparency requirements as we believe the hospital price transparency requirements we finalize here are important to informing all consumers' healthcare decision-making.

In the meantime, we note that existing CMS guidance requires that hospitals make public their gross charges for items and services as found in the chargemaster online in a machine-readable format. We note that this guidance remains in effect until the effective date of the regulations we are establishing with this final rule, which is January 1, 2021.

Comment: A few commenters suggested that CMS take a phased approach to enforcement of the requirements for hospitals to make public standard charges. A few commenters, concerned about the excessive burden imposed by CMS' proposed requirements and the time it may take hospitals to develop the capacity to become compliant, suggested a grace period prior to the imposition of a CMP for noncompliance. A few commenters suggested that CMS phase-in the proposed monitoring and enforcement actions over several years. One commenter recommended that CMS' enforcement actions should begin by publicizing the names of hospitals determined to be noncompliant (referred to by the commenter as ''name and shame'') prior to giving these hospitals a chance to take corrective action, and then progress to requesting a CAP after several years. According to this commenter, if the implementation of CAPs does not induce full compliance after a few years then CMPs might be prudent.

Response: We believe the monitoring methods we are finalizing as described in Section II.G.2 of this final rule and the actions to address hospital noncompliance described in this section are necessary to ensure compliance. We believe the proposed monitoring methods and enforcement actions give CMS the flexibility to employ a number of methods to be notified of, and investigate, hospital noncompliance, and allow CMS to take enforcement actions that escalate through stages. We believe the proposed approaches to addressing noncompliance, in which CMS (in sequence) issues a written warning notice, requests a CAP if the hospital's noncompliance constitutes a material violation of one or more requirements, and imposes a CMP on the hospital and publicizes the penalty on a CMS website, allows multiple opportunities for hospitals to take

corrective action over a period of time so that they may avoid imposition of a CMP. We decline the commenters' suggestions that we further phase-in the enforcement actions over a number of years, or to establish an approach that routinely provides hospitals a number of years to remedy their noncompliance.

We considered the commenter's suggestion to expand our authority to publicize hospitals determined to be noncompliant with the requirements to make public standard charges. We believe that publicizing a hospital's noncompliance, prior to imposing a CMP (for example), could be an effective tool to raise public awareness of incomplete hospital data (for example), and could encourage hospitals to promptly remedy their violation(s) to avoid being publicly identified as noncompliant. However, at this time, we are finalizing our proposal to publicize on a CMS website the notice of imposition of a CMP. We may revisit through future rulemaking the timing for and approach by which CMS publicizes its determination of a hospital's noncompliance with the requirements to make public standard charges.

Final Action: After considering the comments received, we are finalizing as proposed to set forth in the regulations at new 45 CFR 180.70, actions to address hospital noncompliance with the requirements to make public standard charges. We are finalizing that CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order if CMS determines the hospital is noncompliant with section 2718(e) of the PHS Act and the requirements of 45 CFR part 180:

- Provide a written warning notice to the hospital of the specific violation(s).
- Request a CAP from the hospital if its noncompliance constitutes a material violation of one or more requirements.
- Impose a CMP on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.

We are finalizing with modifications to set forth in new 45 CFR 180.80 the requirements for CAPs. Specifically, we are finalizing as proposed to specify in 45 CFR 180.80(a) that a hospital may be required to submit a CAP if CMS determines a hospital's noncompliance constitutes a material violation of one or more requirements, which may include, but is not limited to, the following:

- A hospital's failure to make public its standard charges required by new 45 CFR 180.40.
- A hospital's failure to make public its standard charges in the form and manner required under new 45 CFR 180.50 and 180.60.

We are finalizing as proposed to specify in 45 CFR 180.80(b), CMS may request that a hospital submit a CAP, specified in a notice of violation issued by CMS to a hospital.

We are finalizing our proposals, except as noted otherwise, to specify in 45 CFR 180.80(c) the following provisions related to CAPs:

- A hospital required to submit a CAP must do so, in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital and must comply with the requirements of the CAP.
- We are finalizing modifications that a hospital's CAP must specify elements including, but not limited to the corrective actions or processes the hospital will take to address the deficiency or deficiencies identified by CMS, and the timeframe by which the hospital will complete the corrective action.
- A CAP is subject to CMS review and approval. After CMS' review and approval of a hospital's CAP, CMS may monitor and evaluate the hospital's compliance with the corrective actions.

We are finalizing as proposed to specify in 45 CFR 180.80(d) provisions for identifying a hospital's noncompliance with CAP requests and requirements:

- A hospital's failure to respond to CMS' request to submit a CAP includes failure to submit a CAP in the form, manner, or by the deadline, specified in a notice of violation issued by CMS to the hospital.
- A hospital's failure to comply with the requirements of a CAP includes failure to correct violation(s) within the specified timeframes.

We are finalizing a modification to extend the effective date of the final policies to January 1, 2021.

4. Civil Monetary Penalties

We proposed that we may impose a CMP on a hospital that we identify as noncompliant with the requirements of proposed 45 CFR part 180, and that fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP as we describe earlier.

We proposed that we may impose a CMP upon a hospital for a violation of each requirement of proposed 45 CFR part 180. The maximum daily dollar amount for a CMP to which a hospital may be subject would be $300. We proposed that even if a hospital is in violation of multiple discrete requirements of proposed 45 CFR part 180, the maximum total sum that a single hospital may be assessed per day is $300.

Further, we proposed to adjust the CMP amount annually by applying the cost-of-living adjustment multiplier determined by the Office of Management and Budget (OMB) for adjusting applicable CMP amounts pursuant to the *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015.* This multiplier, based on the Consumer Price Index for All Urban Consumers (CPI–U), not seasonally adjusted, is applied to the CMPs in 45 CFR 102.3. For instance, the cost-of-living adjustment multiplier for 2018, based on the CPI–U for the month of October 2017, not seasonally adjusted, was 1.02041 (83 FR 51369).

As discussed in the CY 2020 OPPS/ASC proposed rule, given the importance of compliance with the price transparency policies, we believe this proposed CMP amount strikes a balance between penalties that are sufficiently harsh to incentivize compliance but not excessively punitive. We reviewed CMP amounts for other CMS programs that require reporting information and we believe our proposed $300 maximum daily dollar amount for a CMP is commensurate with the level of severity of the potential violation, taking into consideration that nondisclosure of standard charges does not rise to the level of harm to the public as other violations (such as safety and quality issues) for which CMS imposes CMPs and, therefore, should remain at a relatively lower level.

We considered applying lower and higher maximum dollar amounts for a CMP for noncompliance with the requirements of proposed 45 CFR part 180. For example, we considered that CMS has imposed $100 per day penalty amounts with respect to other compliance matters, such as where health insurers fail to comply with premium revenue reporting and rebate requirements found at 45 CFR 158.606. The basis for the CMPs under 45 CFR 158.606 is the number of individuals affected. With respect to the disclosure requirements under proposed 45 CFR part 180, where the lack of information could affect an unknown number of consumers and in myriad ways (for example, not just individuals who paid more for items and services), we noted our belief that it would not be feasible to utilize a ''per person'' type basis. We also considered proposing higher maximum daily dollar amounts, such as $400 per day, $500 per day or more.

Further, we considered establishing a cumulative annual total limit for the

CMP to which a hospital is subject for noncompliance with proposed 45 CFR part 180. For example, we considered applying a cumulative annual total limit of $100,000 per hospital for each calendar year. However, such an approach could, for example, prevent accrual of additional penalties on hospitals that remain noncompliant for multiple years.

If CMS imposes a penalty in accordance with the requirements of proposed 45 CFR part 180, we proposed that CMS provide a written notice of imposition of a CMP to the hospital via certified mail or another form of traceable carrier. This notice may include, but would not be limited to, the following:

- The basis for the hospital's noncompliance, including, but not limited to, the following: CMS' determination as to which requirement(s) the hospital violated; and the hospital's failure to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.
- CMS' determination as to the effective date for the violation(s). This date would be the latest date of the following:

++ The first day the hospital is required to meet the requirements of proposed 45 CFR part 180.

++ If a hospital previously met the requirements of this part but did not update the information annually as required, the date 12 months after the date of the last annual update specified in information posted by the hospital.

++ A date determined by CMS, such as one resulting from monitoring activities specified in proposed new 45 CFR 180.70, or development of a CAP as specified in proposed new 45 CFR 180.80.

- The amount of the penalty as of the date of the notice.
- A statement that a CMP may continue to be imposed for continuing violation(s).
- Payment instructions.
- Intent to publicize the hospital's noncompliance and CMS' determination to impose a CMP on the hospital for noncompliance with the requirements of proposed 45 CFR part 180 by posting the notice of imposition of a CMP on a CMS website.
- A statement of the hospital's right to a hearing (as described in section II.H. of this final rule).
- A statement that the hospital's failure to request a hearing within 30 calendar days of the issuance of the notice permits the imposition of the penalty, and any subsequent penalties pursuant to continuing violations, without right of appeal.

Further, in the event that a hospital elects to appeal the penalty, and if the CMP is upheld only in part by a final and binding decision, we proposed that CMS would issue a modified notice of imposition of a CMP.

We proposed that a hospital must pay a CMP in full within 60 calendar days after the date of the notice of imposition of a CMP from CMS. In the event a hospital requests a hearing (as described in section II.H. of this final rule), we proposed that the hospital must pay the amount in full within 60 calendar days after the date of a final and binding decision to uphold, in whole or in part, the CMP. We also proposed that if the 60th calendar day is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

We also proposed to publicize, by posting on a CMS website, our notice of imposition of a CMP on a hospital for noncompliance with these requirements, and any subsequently issued notice of imposition of a CMP for continuing violations. In the event that a hospital requests a hearing, we proposed that CMS would indicate in its posting that the CMP is under review. If the CMP amount is upheld, in whole, by a final and binding decision, we would maintain the posting of the notice of imposition of a CMP on a CMS website. If the CMP is upheld, in part, by a final and binding decision, we would issue a modified notice of imposition of a CMP, and would make this modified notice public on a CMS website. If the CMP is overturned in full by a final and binding decision, we would remove the notice of imposition of a CMP from a CMS website.

In addition, we proposed that CMS may issue subsequent notice(s) of imposition of a CMP, as described in this section of the CY 2020 OPPS/ASC proposed rule, that result from the same instance(s) of noncompliance.

We proposed to set forth in proposed new 45 CFR 180.90 the proposed CMPs for hospitals determined by CMS to be noncompliant with requirements for making standard charges public.

We sought comment on whether the proposed amount of a CMP, in combination with making public on a CMS website our notice of imposition of a CMP, were reasonable and sufficient to ensure hospitals' compliance with the proposed requirements to make public standard charges. We were interested in public comments on our proposed $300 maximum daily dollar amount for a CMP for noncompliance with section 2718(e) of the PHS Act and proposed 45 CFR part 180. In particular, we sought comment on whether we should impose stronger penalties for noncompliance, or whether we should further limit the maximum amount of penalty we would impose on a hospital for a calendar year and the methodology for creating such a limit (for instance through limiting the maximum daily penalty amount, by establishing a cumulative annual total limit on the penalty amount, or both). We sought comment on unintended consequences of the proposed penalties for noncompliance. We also sought commenters' suggestions on whether other penalties should be applied for noncompliance with section 2718(e) of the PHS Act.

Comment: Several commenters stated that the imposition of CMPs for noncompliance with the requirements to make standard public charges exceeds CMS' authority under section 2718(e) of the PHS Act. These commenters challenged CMS' reliance on section 2718(b)(3) as the basis for enforcing the requirements that hospitals make their standard charges public, and specifically as the basis for imposing a CMP on a hospital for noncompliance with the requirements to make public standard charges. These commenters asserted that section 2718(b)(3) applies only to the MLR and rebate requirements imposed by the ACA on health insurance issuers offering group or individual health insurance coverage under section 2718 of the PHS Act. A few commenters explained that had Congress intended to require the Secretary to enforce the requirement for public availability of hospital standard charge information, it would have constructed the provisions of section 2718 of the PHS Act differently. A few commenters presented a review of the legislative history of section 2718 of the PHS Act, suggesting that the phrasing of section 2718(b)(3), referring to its applicability to ''this section,'' was a drafting error, and suggested that Congress intended to apply this provision only to MLR provisions within the section. A few commenters further asserted that absent an express mandate for the Secretary in section 2718(b)(3) of the PHS Act to enforce the requirements for hospitals to disclose their standard charges under a different provision of law (namely, section 2718(e)), the Secretary may neither imply an intent to do so nor reverse its previous rulemaking policy that limited the use of that enforcement authority to issuers that do not comply with MLR and rebate requirements imposed under section 2718(b). One commenter explained that interpreting section 2718(b)(3) of the PHS Act as CMS does leads to an absurd result.

A few commenters explained that HHS has not previously suggested that it could take enforcement action with respect to section 2718(e) of the PHS Act, which the commenters suggest means the agency lacked such powers. Specifically, one commenter suggested that HHS implicitly recognized that its enforcement authority under section 2718(b)(3) of the PHS Act should be read as confined to enforcing the MLR requirements when it adopted subparts D through F of 45 CFR part 158, stating that these provisions implement enforcement authority in section 2718(b)(3) and provide for enforcement of the reporting obligations set forth in section 2718(a) and rebate requirements in section 2718(b). Another commenter expressed that CMS has not previously asserted its ability to assess CMPs under section 2718(b)(3) of the PHS Act on noncompliant hospitals, or previously claimed any enforcement authority related to section 2718(e) of the PHS Act.

Response: We continue to believe section 2718(b)(3) of the PHS Act, based on its plain meaning, authorizes the Secretary to enforce the provisions of section 2718 of the PHS Act and to provide for appropriate penalties under section 2718 of the PHS Act, including section 2718(e) of the PHS Act. It is not absurd to say that Congress wanted to provide HHS authority more generally to enforce all of the requirements set out in section 2718. Further, HHS has not previously conceded that it lacked authority to issue such rules for enforcing, or penalties pursuant to, section 2718(e) of the PHS Act in promulgating regulations pursuant to sections 2718(a) and (b). In fact, as we explained in earlier rulemaking, we have been considering developing regulations, through notice and comment rulemaking, to establish enforcement mechanisms to address hospital noncompliance with section 2718(e) (83 FR 20548 through 20550; 83 FR 41686 through 41688).

Therefore, consistent with our proposal, we continue to believe we have the legal basis to impose penalties on hospitals that fail to make their standard charges public in accordance with the requirements we finalize under section 2718(e) of the PHS Act. Accordingly, as described in this section and elsewhere in this final rule, we are finalizing our proposals to enforce the requirements under new 45 CFR part 180, and to potentially impose CMPs for noncompliance with the requirements of new 45 CFR part 180.

Comment: A few commenters supported CMS' efforts to take enforcement actions and a few commenters supported the proposal to impose financially significant CMPs on large hospitals for noncompliance with the requirements to make public standard charges. A few commenters suggested that CMS forgo imposition of CMPs altogether while others suggested that CMS limit use of CMPs (particularly to avoid excessive financial penalties) or not impose CMPs on certain types of providers, such as IRFs or rural hospitals.

Several commenters explained that the proposed CMPs were overly punitive, and suggested CMS forgo imposing CMPs. One commenter explained that CMPs are typically reserved for fraud and abuse, and opposed imposition of CMPs for price transparency requirement noncompliance, which is more likely to be based in technical difficulties or IT system limitations. A few commenters cited concerns about imposing CMPs on noncompliant hospitals in light of the complexity of making public standard charge data and the short timeframe by which hospitals would have to come into compliance. One commenter explained that it is not necessary to impose CMPs for noncompliance with price transparency requirements given that hospitals have undertaken numerous initiatives to enhance price transparency in recent years, and that they are making significant progress in this complex area.

Response: We appreciate commenters supporting the importance of enforcement actions and the imposition of CMPs on hospitals as a method for ensuring compliance with the requirements to make public standard charges. We decline the commenters' suggestions that we not finalize the proposed use of CMPs as an enforcement mechanism. Given the importance of the requirements for hospitals to make public standard charges, we believe CMPs serve as an appropriate enforcement action to address noncompliance. As we explained in Section II.G.2. of this final rule, we believe it is important that we apply a consistent approach to imposing CMPs on noncompliant hospitals across all entities, regardless of factors such as hospital size, revenue or location. Therefore, we decline to adopt the commenters' suggestions that we apply alternative policies to a subset of hospitals, such as rural safety net providers. Further, we disagree with the commenter's suggestion that we forgo establishing the authority to impose CMPs for noncompliance in light of the demonstrated commitment to price transparency by some, but not all, institutions.

We respond to comments on the amount of CMPs elsewhere in this section of this final rule. Under the actions to address hospital noncompliance which we are finalizing in this final rule, we anticipate that hospitals would have the opportunity to take corrective action prior to the imposition of a penalty. As we have described elsewhere in Section II.G of this final rule, prior to imposing a CMP on a hospital, we anticipate issuing a written warning notice and requesting a CAP from the hospital as initial steps to promote compliance. We may impose a CMP on a noncompliant hospital if it fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP. By complying with the requirements, a hospital can avoid financial penalties. We also note that hospitals determined to be noncompliant, and subject to a CMP, can avoid accruing larger amounts of CMPs by coming into compliance with the requirements.

Comment: Comments on the amount of the CMP were mostly polarized, with some suggesting lower amounts and other suggesting higher amounts than the proposed $300 maximum daily dollar amount for a CMP. A recurring concern in comments was that the CMP amount could be overly burdensome and potentially detrimental to the continued operation of a small hospital with low margins, particularly CAHs, while posing an inadequate incentive for hospitals (particularly larger hospitals) to comply because the CMP amount does not pose a real financial burden. As one commenter explained, a large hospital could decide that $300 per day ($109,500 per year) is worth paying in order to not disclose information that could lead to payers with higher rates wanting to pay them less in light of discovering other payers have more favorable negotiated rates. A few commenters suggested that the proposed CMP amount is trivial for certain hospitals, compared, for instance, to the salaries of hospital executives, or the hospital's total revenue. One commenter expressed concern that stakeholders will view the noncompliance penalty as a new business expense rather than an incentive to comply with the transparency requirements. Another commenter explained that the proposed CMP amount is too low to compel hospitals to comply if they are adamantly opposed to making public this information.

Another commenter noted that under the PAMA and 42 CFR 414.504(e), applicable laboratories that do not report applicable information as

required may be subject to a CMP in an amount of up to $10,000 per day for each failure to report or each misrepresentation or omission in reporting. The commenter suggested that compliance with these data reporting requirements was below expectations; therefore, the commenter suggested that it would be unlikely that the proposed $300 maximum daily dollar amount for a CMP would be sufficient to encourage prompt reporting of pricing data by hospitals.

One commenter suggested that CMS increase the CMP amount, recommending the penalties be consistent with information blocking penalties (according to section 4004 of the 21st Century Cures Act), which can be up to $1 million per violation (which we note is applicable to health IT developers, health information networks, and health information exchanges),[172] explaining that failure to disclose price information would be information blocking.

A few commenters suggested alternative approaches, such as using factors that allow for scaling of the CMP amount. In particular, a few of these commenters suggested scaling penalties to ensure rural hospitals are not unduly burdened. For example, one commenter suggested that CMPs should be adjusted based on bed size and rural or urban designation. Another commenter suggested that CMS consider scaling the penalty based on the number of patients treated at the facility within a given year. If this information is not available due to lack of data on patients who self-pay or are insured by non-government payers, the commenter suggested that CMS scale the CMP amount according to the number of Medicare beneficiaries served in a given year. The commenter explained this approach could allow CMS to not overly penalize smaller hospitals while also providing a sufficient incentive for hospitals to comply.

Response: We appreciate the comments received on the proposed $300 maximum daily dollar amount for a CMP. Given that commenters tended to be divided between those in favor of lower and higher amounts, we believe the proposed amount strikes an appropriate balance between these concerns, and we are therefore finalizing this amount as proposed.

The $300 maximum daily dollar amount for a CMP for noncompliance with 45 CFR part 180 is lower than CMPs imposed under certain other authorities administered by HHS agencies, where an entity's noncompliance poses immediate jeopardy, results in actual harm, or both. We believe the relatively lower amount for a CMP, for a hospital's noncompliance with requirements to make public standard charges, is reasonable since failure to make this information available is less serious than noncompliance that poses or results in harm to a patient.

At this time, and given the nature of potential noncompliance with the requirements we are finalizing for hospitals to make public standard charges, we decline to impose penalties higher than the proposed amount. We decline to impose the higher penalties that are applicable to health IT developers, health information networks, and health information exchanges for information blocking under the 21st Century Cures Act, for interfering with, preventing, or materially discouraging access, exchange, or use of electronic health information. We also decline to impose a potentially higher CMP amount, such as is applicable to laboratories under PAMA, for noncompliance with reporting information which could affect payment rate setting by CMS.

We also note that the $300 maximum daily dollar amount, when accrued over a year, is higher than our estimate of the cost per hospital to comply with the requirements to make public standard charges in the initial period of implementation (as described in Section V of this final rule). We considered commenters' concerns that a relatively lower CMP amount may be insufficient to encourage compliance if the cost of making public standard charges, or the value to the hospital of not disclosing standard charge data, is higher than the total annual amount of the CMP. For this reason, we believe it is important to maintain a sufficiently sizeable CMP sum and therefore decline commenters' suggestions to finalize a maximum daily dollar amount for a CMP that is less than $300.

We appreciate the commenters' concerns that some hospitals may prefer to forgo meeting the requirements of 45 CFR part 180 (for example, to not expend resources on reporting or to protect pricing information they consider sensitive), and, instead, face compliance actions including a $300 maximum daily dollar amount for a CMP. We decline at this time to increase the amount of the CMP based on this concern alone, but as we gain experience with implementing the policy we intend to monitor for such occurrences, and may revisit the need to adjust the amount of the CMP in future rulemaking.

We would need to further evaluate the feasibility of implementing a sliding scale CMP approach across institutions that meet the definition of hospital according to new 45 CFR 180.20 (as discussed in section II.B of this final rule). We believe it would be especially challenging to find a reliable source of data that provides for a scalable factor across all institutions that meet the definition of hospital. Therefore, we decline the commenters' suggestions to scale the CMP amount based on such factors as hospital bed size, location or patient volume. However, we anticipate that we will continue to consider this issue, and may revisit use of a CMP scaling methodology in future rulemaking. At this time, we are finalizing as proposed a policy that allows for a standardized daily maximum CMP amount.

Comment: One commenter supported the alternative we described in the CY 2020 OPPS/ASC proposed rule, which was to apply a cumulative annual total limit (or cap) on the penalty amount, though the commenter did not specify what this limit should be and suggested only that it be a reasonable amount.

Response: We believe we have struck an appropriate balance in determining the $300 maximum daily dollar amount for a CMP, and we therefore decline at this time to finalize applying a cumulative annual total limit on the CMP amount. We appreciate the commenter's support for this alternative approach.

Comment: One commenter disagreed with the proposal that CMS publicize the notice of imposition of a CMP on a CMS website, explaining that this amounted to public shaming which the commenter believes has no benefit and seems petty.

Response: We continue to believe it is appropriate to publish the notice of imposition of a CMP on a CMS website to identify hospitals determined to be noncompliant with the requirements to make public standard charges. We believe this information will help inform the public of noncompliant hospitals and is an opportunity to demonstrate the outcome of CMS' monitoring and enforcement activities for these important requirements.

Final Action: After considering the comments received, we are finalizing as proposed policies for imposing a CMP on a hospital that we identify as noncompliant with the requirements of 45 CFR part 180, and that fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.

[172] Refer to *HealthIT.gov,* Information Blocking, available at *https://www.healthit.gov/topic/information-blocking.*

We are finalizing as proposed that CMS may impose a CMP upon a hospital for a violation of each requirement of 45 CFR part 180. Further, we are finalizing our proposal that the maximum daily dollar amount for a CMP to which a hospital may be subject is $300, even if the hospital is in violation of multiple discrete requirements of 45 CFR part 180. The amount of the CMP will be adjusted annually using the multiplier determined by OMB for annually adjusting CMP amounts under 45 CFR part 102.

We are finalizing as proposed that CMS provides a written notice of imposition of a CMP to the hospital via certified mail or another form of traceable carrier. We are also finalizing as proposed the elements of this notice to the hospital, as previously described in this section of this final rule, will include but not be limited to the following:

- The basis for the hospital's noncompliance, including, but not limited to, the following: CMS' determination as to which requirement(s) the hospital has violated; and the hospital's failure to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.
- CMS' determination as to the effective date for the violation(s).
- The amount of the penalty as of the date of the notice.
- A statement that a CMP may continue to be imposed for continuing violation(s).
- Payment instructions.
- Intent to publicize the hospital's noncompliance and CMS' determination to impose a CMP on the hospital for noncompliance with the requirements of 45 CFR part 180 by posting the notice of imposition of a CMP on a CMS website.
- A statement of the hospital's right to a hearing according to subpart D of 45 CFR part 180 (as discussed in section II.H of this final rule).
- A statement that the hospital's failure to request a hearing within 30 calendar days of the issuance of the notice permits the imposition of the penalty, and any subsequent penalties pursuant to continuing violations, without right of appeal.

We are finalizing our proposal that CMS may issue subsequent notice(s) of imposition of a CMP, according to the aforementioned requirements (in short, where investigation reveals there is continuing justification), that result from the same instance(s) of noncompliance.

We are finalizing with a clarifying modification that, in the event that a hospital elects to appeal the penalty, and if the CMP is upheld, in part, by a final and binding decision, CMS will issue a modified notice of imposition of a CMP, to conform to the adjudicated finding.

We are also finalizing our proposals on timing of payment of a CMP. Specifically, a hospital must pay the CMP in full within 60 calendar days after the date of the notice of imposition of a CMP from CMS. In the event a hospital requests a hearing, pursuant to subpart D of 45 CFR part 180, the hospital must pay the amount in full within 60 calendar days after the date of a final and binding decision to uphold, in whole or in part, the CMP. If the 60th calendar day is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

We are finalizing as proposed that CMS will post the notice of imposition of a CMP on a CMS website, including the initial notice of imposition of a CMP, and subsequent notice(s) of imposition of a CMP that result from the same instance(s) of noncompliance. Further, in the event that a hospital elects to request a hearing, pursuant to subpart D of 45 CFR part 180, CMS will indicate in its posting that the CMP is under review. We are finalizing the following policies regarding the posting of the notice of imposition of a CMP, pursuant to a final and binding decision from the hearing process specified in subpart D of 45 CFR part 180:

- We are finalizing as proposed, CMS will maintain the posting of the notice of imposition of a CMP on a CMS website if the CMP is upheld, in whole.
- We are finalizing with a clarifying modification, CMS will issue a modified notice of imposition of a CMP, to conform to the adjudicated finding, if the CMP is upheld, in part. CMS will make this modified notice public on a CMS website.
- We are finalizing as proposed, CMS will remove the notice of imposition of a CMP from a CMS website if the CMP is overturned in full.

We are finalizing our proposal to specify these policies on CMPs in new 45 CFR 180.90.

H. Appeals Process

Under section 2718(b)(3) of the PHS Act, we proposed to impose penalties on hospitals that fail to make their standard charges public in accordance with the requirements we finalize under section 2718(e). As we described in the CY 2020 OPPS/ASC proposed rule (84 FR 39593 through 39594), we believe it is important to establish a fair administrative process by which a hospital may appeal CMS' decisions to impose penalties under section 2718(b)(3) regarding the hospital's noncompliance with the requirements of section 2718(e) of the PHS Act and the requirements of proposed 45 CFR part 180. Through various Medicare programs, we have gained experience with administrative hearings and other processes to review CMS' determinations.

We proposed to align the procedures for the appeals process with the procedures established under section 2718(b)(3) of the PHS Act for an issuer to appeal a CMP imposed by HHS for its failure to report information and pay rebates related to MLRs, as required by sections 2718(a) and (b) of the PHS Act, and according to 45 CFR parts 158 and 150. Therefore, we proposed that a hospital upon which CMS has imposed a penalty under proposed 45 CFR part 180 may appeal that penalty in accordance with 45 CFR part 150, subpart D, except as we have otherwise proposed.

Generally, under this proposed approach, a hospital upon which CMS has imposed a penalty may request a hearing before an Administrative Law Judge (ALJ) of that penalty. The Administrator of CMS, at his or her discretion, may review in whole or in part the ALJ's decision. A hospital against which a final order imposing a CMP is entered may obtain judicial review.

For purposes of applying the appeals procedures at 45 CFR part 150 to appeals of CMPs under proposed 45 CFR part 180, we proposed the following exceptions to the provisions of 45 CFR part 150:

- Civil money penalty means a civil monetary penalty according to proposed new 45 CFR 180.90.
- Respondent means a hospital that received a notice of imposition of a CMP according to proposed new 45 CFR 180.90(b).
- References to a notice of assessment or proposed assessment, or notice of proposed determination of CMPs, are considered to be references to the notice of imposition of a CMP specified in proposed new 45 CFR 180.90(b).
- Under 45 CFR 150.417(b), in deciding whether the amount of a civil money penalty is reasonable, the ALJ may only consider evidence of record relating to the following:

++ The hospital's posting(s) of its standard charges, if available.

++ Material the hospital timely previously submitted to CMS (including with respect to corrective actions and CAPs).

++ Material CMS used to monitor and assess the hospital's compliance

according to proposed new 45 CFR 180.70(a)(2).

- The ALJ's consideration of evidence of acts other than those at issue in the instant case under 45 CFR 150.445(g) does not apply.

We proposed to set forth in proposed new 45 CFR 180.100 the proposed procedures for a hospital to appeal the CMP imposed by CMS for its noncompliance with the requirements of proposed 45 CFR part 180.

We also proposed to set forth in proposed new 45 CFR 180.110 the consequences for failure of a hospital to request a hearing. If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a CMP described in proposed new 45 CFR 180.90(b), we proposed that CMS may impose the CMP indicated in such notice and may impose additional penalties pursuant to continuing violations according to proposed new 45 CFR 180.90(f) without right of appeal. We proposed that if the 30th calendar day is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day. We also proposed that the hospital has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with 45 CFR 150.405, unless the hospital can show good cause, as determined at 45 CFR 150.405(b), for failing to timely exercise its right to a hearing.

Alternatively, we considered and sought public comment on following a process for appealing CMPs similar to the approach specified in 42 CFR part 498, subparts D through F. We explained that there are differences between the appeals procedures at 42 CFR part 498 compared to 45 CFR part 150. Under the regulations at 42 CFR part 498, for example, either party dissatisfied with a hearing decision by the ALJ may request Departmental Appeals Board review of the ALJ's decision.

Final Action: We received no comments on our proposed process for a hospital upon which CMS has imposed a penalty under proposed 45 CFR part 180 to appeal that penalty in accordance with 45 CFR part 150, subpart D, except as we otherwise proposed. We are finalizing as proposed to specify in new 45 CFR 180.100 the procedures for a hospital to appeal the CMP imposed by CMS for its noncompliance with the requirements of 45 CFR part 180 to an ALJ, and for the Administrator of CMS, at his or her discretion, to review in whole or in part the ALJ's decision. Specifically, we are finalizing our proposal that a hospital upon which CMS has imposed a penalty under 45 CFR part 180 may appeal that penalty in accordance with 45 CFR part 150, subpart D, with the exceptions (for the propose of applying the provisions of part 150 to CMPs under part 180) as described in this section of this final rule.

We are also finalizing as proposed to set forth in new 45 CFR 180.110 the consequences for failure of a hospital to request a hearing. If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a CMP described in new 45 CFR 180.90(b), CMS may impose the CMP indicated in such notice and may impose additional penalties pursuant to continuing violations according to new 45 CFR 180.90(f) without right of appeal. If the 30th calendar day is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day. The hospital has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with 45 CFR 150.405, unless the hospital can show good cause, as determined at 45 CFR 150.405(b), for failing to timely exercise its right to a hearing.

III. Comments Received in Response To Request for Information: Quality Measurement Relating To Price Transparency for Improving Beneficiary Access to Provider and Supplier Charge Information

In the CY 2020 OPPS/ASC proposed rule (84 FR 39594 through 39595), we included a RFI related to (1) access to quality information for third parties and healthcare entities to use when developing price transparency tools and when communicating charges for healthcare services, and (2) improving incentives and assessing the ability of healthcare providers and suppliers to communicate and share charge information with patients. We received approximately 63 timely pieces of correspondence on this RFI. We appreciate the input provided by commenters.

IV. Collection of Information Requirements

A. Response to Comments

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the OMB for review and approval.

We solicited comments in the CY 2020 OPPS/ASC notice of proposed rulemaking that published in the August 9, 2019 **Federal Register** (84 FR 39398). For the purpose of transparency, we are republishing the discussion of the information collection requirements (ICR) along with a reconciliation of the public comments we received.

B. ICR for Hospital Price Transparency

In this final rule, we seek to promote price transparency in hospital standard charges to implement section 2718(e) of the PHS Act. We believe that in doing so, healthcare costs will decrease, and consumers can be empowered to make more informed decisions about their healthcare. We believe these finalized requirements will represent an important step towards putting consumers at the center of their healthcare and ensuring they have access to needed information.

In the CY 2020 OPPS/ASC proposed rule, we noted that hospitals in the United States maintain chargemasters, a list of their gross charges for all individual items and services as part of their standard billing and business practices.[173] Additionally, we stated that most hospitals maintain electronic data on charges they negotiate with third party payers for hospital items and services as well as service packages. As such, we indicated we believed that the burden for making this information publicly available would be minimal and estimated only a small burden for each hospital to extract, review, and conform the posting of gross charges and third party payer-specific negotiated charges for all hospital items and services in the comprehensive machine-readable format. In addition, we estimated some burden associated with hospitals making public their payer-specific negotiated charges for a set of at least 300 (70 CMS-specified and at least 230 hospital-selected) shoppable services in a consumer-friendly manner, with flexibility for hospitals to determine the most consumer-friendly format. We proposed a policy that hospitals would display the charge for the primary shoppable service along with charges for any ancillary services the hospital customarily provides in conjunction with the primary shoppable service.

We estimated the proposed requirements would apply to 6,002 hospitals operating within the United States under the proposed definition of ''hospital.'' To estimate this number, we subtracted 208 federally-owned or operated hospitals from the total

[173] Batty M. and Ippolito B. Mystery of The Chargemaster: Examining The Role Of Hospital List Prices in What Patients Actually Pay. *Health Affairs.* April 2017; 36(4): 689–696. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0986.*

number of U.S. hospitals, 6,210 hospitals [174] (6,210 total hospitals—208 federally-owned or operated hospitals).

We concluded that the annual burden per hospital should be calculated with all activities performed by four professions combined. The four professions included a lawyer, a general operations manager, a business operations specialist, and a network and computer system administrator. We estimated an annual burden assessment to be 12 hours (2 hours + 8 hours + 2 hours) per hospital with a cost of $1,017.24 ($257.80 + $592.00 + $167.44) per hospital. We also estimated a total national burden of 72,024 hours (12 hours × 6,002 hospitals) and total cost of $6,105,474 ($1,017.24 × 6,002 hospitals).

Comment: Several commenters were concerned that CMS did not take into account the number of hours needed for specific technical activities or consultation with necessary professionals. For example, a few commenters were concerned that CMS underestimated the cost and time involved in consulting legal and compliance experts on implementation of the rule, suggesting that such investment would be necessary to ensure the hospital had satisfactorily met requirements. A few commenters suggested that CMS take into account the time, resources and input of clinical staff necessary for each hospital to identify and compile each shoppable service or service package and corresponding ancillary services to reach a total of 300 shoppable services. One commenter suggested that the burden estimate take into account the time hospitals need to develop policies and business practices to comply with the requirements of the rule. Several commenters were concerned that the burden estimate did not reflect the need to hire multiple additional full time equivalents (FTEs) to staff multiple departments to comply with the rule to keep up with new charges, technology, monitoring and reporting, and contract negotiations.

A few commenters cited a need for increasing consumer-facing clinical staffing as a result of making public hospital standard charge information. Specifically, one commenter expressed concern that the increased complexity of information available to consumers would result in an increased volume of calls from an average of 25 patients per day to 200 patients per day to its hospital customer service center. As a result, the commenter stated that the hospital customer service center would need to add 8–10 additional FTEs, resulting in $500,000 to $1 million in additional costs per year.

Response: We thank commenters for their input and suggestions on the types of professions, and the time and resources needed to comply with these requirements. Our estimate takes into account the time needed to review and comply with these requirements. We acknowledge that some hospitals may require longer time or greater resources than others to identify and compile their standard charges in a manner consistent with our final rules. For example, some hospitals may have many third-payer contracts while others may have relatively few. Similarly, some hospitals may have already compiled and present their services to the public in a manner that is consumer-friendly as a result of state requirements or voluntarily actions. We also believe that the greatest impact will be in the first year related to organizing the display of information in the form and manner required under this final rule after which the hospital would simply have to update the numbers annually. In order to minimize the burden related to the consumer-friendly display of hospital charges for shoppable services, we are finalizing as modifications to new 45 CFR 180.60 that a hospital offering an internet-based price estimator tool, that meets the requirements we set forth in section II.F.5. of the final rule, is an acceptable alternative method for meeting our requirements to make public its standard charges for selected shoppable services in a consumer-friendly manner. We believe that hospitals that have already been offering price estimator tools will incur less costs to comply with the requirements of the final rule given this accommodation.

Even so, we appreciate the suggestion from commenters that we consider time and input from clinical staff. We agree that clinical input would be helpful to ensure the display of shoppable services is presented the way patients experience their care and to translate billing code descriptions into plain language. As a result, we are adding in the wage of Registered Nurses as a proxy for clinical staff and accounting for 30 hours of clinical assistance per hospital. We believe this time would be important in the initial stages of implementation in order to determine what ancillary services are customarily provided with the provision of the primary shoppable service. We do not believe such clinical expertise would be required for annual updates to the disclosed information in subsequent years. Additionally, in response to commenters who indicate more time should be allocated for lawyers and general operations managers, we are increasing the number of hours for those professions to 10 hours per hospital. Since the time allocated for lawyers was for reviewing the final rules, we believe these hours should be included in the initial implementation year estimate only. We are also significantly increasing the number of hours needed in the initial implementation year for business operations specialists to complete necessary processes and procedures to gather and compile required information and post it to the internet in the form and manner specified in the final rule.

Finally, we can find no evidence to support the assertion that public disclosure of hospital standard charges increases the number of consumer calls to hospitals, necessitating hiring of additional staff for a hospital customer service center. To the contrary, price transparency research suggests that disclosure of provider charges can reduce administrative costs for a hospital and improve patient satisfaction.[175] We therefore have not included this in our analysis.

Comment: Several hospitals asserted that CMS had underestimated the total administrative burden and cost of meeting the requirements of the rule and disagreed with the 12-hour estimate. Commenters stated several reasons for this concern including not accounting for the number of payers that could be present in a geographic region, the variety of negotiated payment methodologies between hospitals and payers, and the amount and scope of hospital resources required to gather the relevant data from contracts and accounting systems. Some commenters also indicated that the administrative burden and cost estimate should take into consideration the electronic availability and display of data on a user-friendly platform, and the cost to hospitals to regularly update their standard charge information for monitoring and reporting. Commenters cited the complexity of information to be provided and the burden of gathering the data from disparate accounting and billing systems. In particular, commenters indicated that some hospitals do not already have their standard charge data available in any electronic format, stating that they do not have contract management systems.

[174] American Hospital Association. Fast Facts on U.S. Hospitals, 2019. Available at: *https://www.aha.org/statistics/fast-facts-us-hospitals.*

[175] *https://www.advisory.com/research/market-innovation-center/the-growth-channel/2018/12/price-transparency.*

Several commenters disagreed with the estimate based on their experiences with compliance with the requirements under the FY 2019 IPPS/LTCH PPS final rule (83 FR 41144) and state-based price transparency requirements. For example, one commenter indicated that chargemaster posting took 30 minutes to complete while another commenter said they have already exceeded 12 hours just to comply with posting their chargemaster data alone, while another commenter stated their experience in making standard charges public under the FY 2019 IPPS/LTCH PPS final rule task required 60 to 100 hours. Another commenter stated that their medical center spent 6 months of planning and exceeded 50 hours to meet the requirements for price transparency under the FY 2019 IPPS/LTCH PPS final rule. One commenter stated that one of their hospital members voluntarily produced a website that allows consumers to obtain estimates of their total out-of-pocket costs by plugging in information from their insurers. Their online tool covers 500 of their 6,000 chargemaster services items and the hospital estimates it took them 20 FTE hours to set up the basic framework and an ongoing two to four FTE hours per week to continue the build of all services and test for errors and putting real-time insurance information has taken an estimated 150 FTE hours to date. Similarly, another commenter, a professional organization of individuals involved in various aspects of healthcare financial management, writing on behalf of hospital finance and management professionals based on a survey of those individuals their members estimated that the average time required to comply is 150 hours per hospital, based on a survey of its members. One commenter stated that North Carolina implemented a similar process to the ''service package'' portion of CMS' proposal that included top 100 DRGs, top 20 outpatient surgeries, and top 20 imaging procedures at the State level with the de-identified minimum, average and maximum ''accepted'' (collected) for closed accounts. The commenter estimated that this effort required 500 hours of staff time for the first reporting period. Several commenters provided estimates of their anticipated burden and additional required FTEs to comply with the proposed requirements for hospitals to make public standard charges ranging from $1,000 to over $450,000 per hospital, 12.5 hours to 4,600 hours per hospital, and 3–10 employees per hospital.

Response: We appreciate the input provided by commenters. As indicated in the CY 2020 OPPS/ASC proposed rule at 84 FR 39579 through 39580, based on an internal analysis of plans in the regulated individual and small group insurance markets under the ACA, we determined that per rating area there is an average of 1 to 400 payers in the small group market (averaging nearly 40 products or lines of service in each rating area) and an average of 1 to 200 payers in the individual market (averaging nearly 20 products or lines of service in each rating area). We therefore acknowledge and have taken into account that hospitals may have many payer-specific negotiated charges to compile and make public. We are also aware that hospitals and payers utilize a variety of payment methodologies in their contracts, which is why we have focused on the base payer rates negotiated between the hospital and payer for the services hospitals provide (section II.D.3 of this final rule). We are also aware that the standard charge information may be housed in disparate systems, for example, the gross charges can be found in a hospital chargemaster while the payer-specific negotiated charges can be found in the hospitals' revenue cycle management system or in the rate tables associated with the in-network contract.

Some commenters provided implementation estimates based on a hospital system comprised of more than one hospital, and in such instances, we converted the estimate to a per-hospital basis for our analysis. Others (as in the North Carolina example above) appeared to misunderstand the requirements by referencing a need to calculate and determine paid amounts, in contrast to the policies we are finalizing in this rule. Most of the outlier estimates submitted by commenters were unaccompanied by any details regarding the assumptions that were made to develop the estimate. We also noted that some commenters provided burden estimates in reference to development of a consumer-friendly price estimator tool, however, we are not requiring hospitals to develop or display standard charge data in a tool. Our final policies provide hospitals with flexibility to determine the most appropriate internet-based format for purposes of complying with making standard charges public in a consumer-friendly manner. Further, we believe there are a variety of low cost formats a hospital could choose as suggested in section II.F of this final rule. For example, making public standard charges in a spreadsheet posted to a hospital website would be one way to satisfy the requirements of this final rule. We note that in response to comments on this issue, we have finalized a policy that would reduce hospital reporting burden further, specifically, we are finalizing a policy to specify that a hospital offering an internet-based price estimator tool, that meets the criteria we set forth in new 45 CFR 180.60, would be regarded as having met the requirements to make public their standard charges for selected shoppable services in a consumer-friendly manner. We also believe due to their existing public displays of data, these hospitals already have a framework or business processes that they can leverage that would minimize additional burden.

We also acknowledge that some hospitals may require more time and resources than others to gather the relevant data, prepare for its electronic availability, display it in a consumer-friendly format, and regularly update that information for monitoring and reporting. We believe this to be true because some hospitals are already compiling and reporting similar data to meet State price transparency requirements and some are already making public their charges online in consumer-friendly ways. The wide range of burden hours submitted by commenters appears to support and reflect the notion that hospitals nationwide are at different stages of readiness to offer consumers transparent price information or are at various levels of participation in posting of charge and price information. We also believe that different hospitals may face different constraints when estimating their burden and resources required.

With these considerations in mind, we agree that the burden estimate should be revised to reflect an increased number of hours. Commenters included individuals, hospitals and health systems, hospital associations, and a health finance association. The commenters provided estimates based on both their unique experiences as well as experiences from a wide variety of health financial management experts and members. As noted, estimates submitted by commenters (when calculated on a per hospital basis) ranged from $1,000 to over $450,000 per hospital, 12.5 hours to 4,600 hours per hospital, and 3–10 employees per hospital. Most estimates by commenters fell within a range of 60 to 250 hours per hospital and approximately $4,800 to $20,000 per hospital, which we conclude is reasonable given our assumption that hospitals are in various states of readiness. Specifically, we

determined that a total burden of 150 hours for the first year is reasonable for hospitals nationwide, based on estimates provided by an organization with broad expertise and membership related to healthcare financial management and a large health care system with multiple hospitals. We believe an estimate of 150 hours per hospital for the first year represents a broad industry view that takes into account the range of hospital readiness and ability to comply with these rules.

Comment: Several commenters referenced the cost of ongoing compliance with the rule in subsequent years and recommended an annualized burden estimate that would be reduced from the initial year of implementation of the requirement to publicize standard charges. However, few commenters provided any specific recommendations as to the potential ongoing costs. One commenter, for example, indicated that they believed an estimate of ''several thousand dollars'' would be reasonable to purchase software that would automatically update the charges on an annual basis (thus suggesting that there would be no maintenance costs). Two commenters suggested that maintenance costs would be approximately 25 percent of implementation costs, however, these commenters specifically discussed the costs associated with pricing tool development, and not the burden associated with our final policies. Another commenter estimated their compliance would require $100,000 for the first year working with an outside vendor and close to $50,000 in the out years, however, this commenter assumed that the file would be updated as frequently as weekly. One commenter shared their experience complying with a North Carolina requirement to calculate and report amounts paid and indicated their maintenance burden was approximately 40 percent of their initial effort.

Response: We agree with commenters that there may be a continued cost of compliance with the rule past the initial year for some hospitals and are therefore adding a burden assessment for maintenance costs. We further agree with commenters that the annualized burden should show a reduction compared to the initial year because hospitals will have made the necessary updates to their software and business operations during the first year, and become more acclimated to the rule. Specifically, we believe there will no longer be a need for hospitals to: (1) Consult with a clinical professional to make a selection of shoppable services or to determine associated ancillary services; or (2) consult with a lawyer to review the requirements of this final rule as these are actions that will only need to take place prior to the initial public display of data. We therefore estimate that after eliminating the burden hours for these professionals and reducing the applicable burden hours for business and general operations in subsequent years, the total annual national burden for maintenance costs in subsequent years would be 276,092 hours (46 hours × 6,002 hospitals) and total cost of $21,672,502 ($3,610.88 × 6,002 hospitals). (See Table 6.)

Comment: Several commenters suggested that CMS engage in further research or solicit additional input from stakeholders and focus groups. Commenters recommended CMS work with a focus group of several large health systems and industry consultants to conduct further studies to understand the actual time and effort for implementation of these requirements. A few commenters suggested that CMS should do more research to better inform the COI and burden estimates and suggested CMS seek in-depth input from hospitals on how their contracts are developed and how negotiated rates may be displayed to include such considerations as the full scope of current hospital reporting and unintended consequences.

Response: We appreciate commenters' suggestions. However, we believe that we have sufficient input as a result of our many RFIs and listening sessions conducted over the course of the past 18 months, in addition to the helpful input we received from comments to our CY 2020 OPPS/ASC proposed rule. We note that we are making some accommodations in our final policies to relieve hospital burden and to provide additional time for hospitals to come into compliance with these new rules. Additionally, we are increasing our estimated burden in accordance with the recommendations from commenters, and including ongoing maintenance costs.

Final Estimate: In this final rule, we seek to promote price transparency in hospital standard charges so that consumers can be empowered to make more informed decisions about their healthcare. If finalized, we believe these proposed requirements would represent an important step towards putting consumers at the center of their healthcare and ensuring they have access to needed information. We are making modifications to several of our proposed policies that impact our burden estimate. Specifically, we are adding three additional types of standard charges that the hospital would have to make public: The de-identified minimum negotiated charge, the de-identified maximum negotiated charge and the discounted cash price. We continue to believe that since these data exist in hospital financial and accounting systems (although not always in electronic format), the burden for making this information publicly available would be relatively minimal for posting of gross charges, payer-specific negotiated charges, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and discounted cash prices for all hospital items and services online in a single machine-readable format as specified in the final rule. In addition, we continue to estimate some burden associated with hospitals making public their payer-specific negotiated charges, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and cash discounted price for a set of at least 300 (70 CMS-specified and at least 230 hospital-selected) shoppable services in a consumer-friendly manner, with flexibility for hospitals to determine the most consumer-friendly format.

Although we are increasing the number of the types of standard charges a hospital must make public, we have reduced burden by finalizing a policy to specify that a hospital offering an internet-based price estimator tool, that meets the criteria we set forth in new 45 CFR 180.60, would be deemed as having met the requirements to make public their standard charges for selected shoppable services in a consumer-friendly manner. Because many hospitals already offer such price estimator tools, we believe this policy will serve to minimize the burden while meeting our policy goals of ensuring hospital pricing information can be readily accessible in a consumer-friendly manner.

We estimate that the final rule applies to 6,002 hospitals operating within the United States under the definition of ''hospital'' discussed in section II.B.1. of the final rule. To estimate this number, we subtract 208 federally-owned or operated hospitals from the total number of U.S. hospitals, 6,210 hospitals[176] (6,210 total hospitals − 208 federally-owned or operated hospitals).

We estimate the hourly cost for each labor category used in this analysis by referencing Bureau of Labor Statistics report on Occupational Employment

[176] American Hospital Association. Fast Facts on U.S. Hospitals, 2019. Available at: *https://www.aha.org/statistics/fast-facts-us-hospitals.*

and Wages (May 2018 [177]) in Table 4. There are many professions involved in any business's processes. Therefore, we use the wages of General and Operations Managers as a proxy for management staff, the wages of Lawyers as a proxy for legal staff, the wages of Network and Computer Systems Administrators as a proxy for IT staff, the wage of Registered Nurses as a proxy for clinical staff, and the wage of Business Operations Specialists as a proxy for other business staff throughout this analysis. Obtaining data on overhead costs is challenging. Overhead costs vary greatly across industries and facility sizes. In addition, the precise cost elements assigned as ''indirect'' or ''overhead'' costs, as opposed to direct costs or employee wages, are subject to some interpretation at the facility level. Therefore, we calculate the cost of overhead at 100 percent of the mean hourly wage in line with the Hospital Inpatient Quality Reporting Program and the Hospital Outpatient Quality Reporting Program (81 FR 57260 and 82 FR 59477, respectively).

TABLE 4—OCCUPATION TITLES AND WAGE RATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Lawyers	23–1011	$69.34	$69.34	$138.68
General and Operations Managers	11–1021	59.56	59.56	119.12
Business Operations Specialists	13–1199	37.00	37.00	74.00
Registered Nurses	29–1141	36.30	36.30	72.60
Network and Computer Systems Administrators	15–1142	41.86	41.86	83.72

In order to comply with regulatory updates finalized in the final rule in the initial year of implementation, hospitals would first need to review the rule. We estimate that this task would take a lawyer, on average, 5 hours (at $138.68 per hour, which is based on the Bureau of Labor Statistics (BLS) wage for Lawyers (23–1011) [178]) to perform their review, and a general operations manager, on average, 5 hours (at $119.12 per hour, which is based on the Bureau of Labor Statistics (BLS) wage for General and Operations Managers (11–1021) [179]) to review and determine compliance requirements. Therefore, for reviewing the rule, we estimate 10 burden hours per hospital, with a total of 60,020 burden hours (10 hours × 6,002 hospitals). The cost is $1,289 per hospital (5 hours × $138.68 + 5 hours × $119.12), with a total cost of $7,736,578 ($1,289.00 × 6,002 hospitals).

After reviewing the rule, hospitals would need to review their policies and business practices in the context of the defined terms and requirements for information collection then determine how to comply. We believe this will require minimal changes for affected hospitals because the standard charge information to be collected is already compiled and maintained as part of hospitals' contracting, accounting and billing systems. Some hospitals may have to consult directly with their payer contracts to review and compile payer-specific negotiated charges. We note that we are finalizing requirements for hospitals to make public five types of standard charges including their gross charges (as reflected in the chargemaster), their payer-specific negotiated charges, discounted cash prices, the de-identified minimum negotiated charge, and the de-identified maximum negotiated charge. All five types of standard charges for all items and services, as finalized, must be made public in a comprehensive machine-readable file online. Additionally, all but gross charges would have to be made public for a total of 300 shoppable services (70 CMS-specified and 230 hospital-selected) in a consumer-friendly manner, including listing the charges for associated ancillary services provided by the hospital so that the hospital charge information is more accessible and easier to digest for consumers seeking to obtain pricing information for making decisions about their treatment.

We estimate it would take a business operations specialist, on average, 80 hours (at $74 per hour, which is based on the Bureau of Labor Statistics (BLS) wage for Business Operations Specialists, All Other (13–1199) [180]) to complete necessary processes and procedures to gather and compile required information and post it to the internet in the form and manner specified by the final rule. For this task, we estimate 80 burden hours per hospital. The total burden hours are 480,160 hours (80 hours × 6,002 hospitals). The cost is $5,920 per hospital (80 hours × $74), with a total cost of $35,531,840 ($5,920 × 6,002 hospitals).

We estimate that a network and computer system administrator would spend, on average, 30 hours (at $83.72 per hour, which is based on the Bureau of Labor Statistics (BLS) wage for Network and Computer Systems Administrators (15–1142) [181]) to meet requirements specified by this final rule. The total burden hours are 180,060 hours (30 hours × 6,002 hospitals). The cost is $2,511.60 per hospital (30 hours × $83.72), with a total cost of $15,074,623 (180,060 hours × $83.72).

In addition, in the initial year of implementation, we estimate it would take a registered nurse, on average, 30 hours (at $72.60 per hour, which is based on Bureau of Labor Statistics (BLS) wage for Registered Nurses (29–1141) [182]) to capture necessary clinical input to determine a representative services package for a given service. We estimate 30 burden hours per hospital. The total burden hours for this task are 180,060 hours (30 hours × 6,002 hospitals). The cost is $2,178 per hospital (30 hours × $72.60), with a total cost of $13,072,356 ($2,178 × 6,002 hospitals).

[177] Bureau of Labor Statistics. National Occupational Employment and Wage Estimates, May 2018. Available at: *https://www.bls.gov/oes/2018/may/oes_nat.htm.*

[178] Bureau of Labor Statistics. Occupational Employment and Wage Estimates, May 2018: 23–1011 Lawyers. Available at: *https://www.bls.gov/oes/current/oes231011.htm.*

[179] Bureau of Labor Statistics. Occupational Employment and Wage Estimates, May 2018: 11–1021 General and Operations Managers. Available at: *https://www.bls.gov/oes/current/oes111021.htm.*

[180] Bureau of Labor Statistics. Occupational Employment and Wages, May 2018: 13–1199 Business Operations Specialist, All Other. Available at: *https://www.bls.gov/oes/current/oes131199.htm.*

[181] Bureau of Labor Statistics. Occupational Employment and Wages, May 2018: 15–1142 Network and Computer System Administrators. Available at: *https://www.bls.gov/oes/current/oes151142.htm.*

[182] Bureau of Labor Statistics. Occupational Employment and Wages, May 2018: 29–1141 Registered Nurses. Available at: *https://www.bls.gov/oes/2018/may/oes291141.htm.*

Therefore, we are finalizing the total burden estimate for the first year to be 150 hours (10 hours + 80 hours + 30 hours + 30 hours) per hospital with a cost of $11,898.60 ($1,289 + $5,920 + $2,178 + $2,511.60) per hospital. We also estimate a total national burden of 900,300 hours (150 hours × 6,002 hospitals) and total cost of $71,415,397 ($11,898.60 × 6,002 hospitals). (See Table 5.)

TABLE 5—SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR THE FIRST YEAR

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180	0938–NEW	6,002	6,002	150	900,300	$71,415,397

We anticipate that these costs will decline in subsequent years after the first year of finalization of the rule as hospitals gain additional efficiencies or may utilize the business processes and system infrastructures or software that would be built or purchased during the first year. We expect that the cost associated with maintenance would be significantly less than the cost hospitals would incur in the first year and would remain relatively level for a few years. We further believe that the activities associated with maintenance would only require General and Operations Managers, Business Operations Specialists, and Network and Computer Systems Administrators professions listed in Table 4. Utilizing their corresponding Adjusted Hourly Wage rates from this table, we estimate that it would take a general operations manager, on average, 2 hours to review and determine updates in compliance with requirements. Therefore, we estimate 2 burden hours per hospital, with a total of 12,004 burden hours (2 hours × 6,002 hospitals). The cost is $238.24 per hospital (2 hours × $119.12), with a total cost of $1,429,916 ($238.24 × 6,002 hospitals).

We also estimate it would take a business operations specialist, on average, 32 hours to gather and compile required information and post it to the internet in the form and manner specified by the final rule. For this task, we estimate 32 burden hours per hospital. The total burden hours are 192,064 hours (32 hours × 6,002 hospitals). Using Adjusted Hourly Wage rates from Table 4, the cost is $2,368 per hospital (32 hours × $74.00), with a total cost of $14,212,736 ($2,368 × 6,002 hospitals).

Lastly, we estimate that a network and computer system administrator would spend, on average, 12 hours to maintain requirements specified by this final rule. The total burden hours are 72,024 hours (12 hours × 6,002 hospitals). The cost is $1,004.64 per hospital (12 hours × $83.72), with a total cost of $6,029,849 (72,024 hours × $83.72).

Therefore, we are finalizing the total annual burden estimate for subsequent years to be 46 hours (2 hours + 32 hours + 12 hours) per hospital with a cost of $3,610.88 ($238.24 + $2,368.00 + $1,004.64) per hospital. We also estimate a total annual national burden for subsequent years of 276,092 hours (46 hours × 6,002 hospitals) and total cost of $21,672,502 ($3,610.88 × 6,002 hospitals). (See Table 6.)

TABLE 6—SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR SUBSEQUENT YEARS

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180	0938–NEW	6,002	6,002	46	276,092	$21,672,502

V. Regulatory Impact Analysis

A. Statement of Need

As healthcare costs continue to rise, healthcare affordability has become an area of intense focus. Healthcare spending is projected to consume almost 20 percent of the economy by 2027.[183] We believe that one reason for this upward spending trajectory in spending is the lack of transparency in healthcare pricing. Additionally, numerous studies suggest that consumers want greater healthcare pricing transparency. For example, a study of HDHP enrollees found that respondents wanted additional healthcare price information so that they could make more informed decisions about where to seek care based on price.[184] Health economists and other experts state that significant cost containment cannot occur without widespread and sustained transparency in provider prices. We believe there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs. We believe healthcare markets could work more efficiently and provide consumers with higher-value healthcare if we promote policies that encourage choice and competition. The intent of this rule is to promote price transparency in hospital standard charges to implement section 2718(e) of the PHS Act. We believe that in doing so, healthcare costs will decrease through increased competition and consumers will be empowered to make more informed decisions about their healthcare. We believe these finalized requirements will represent an important step towards putting consumers at the center of their healthcare and ensuring they have access to needed information.

We further identified a need to impose CMPs to ensure compliance with the requirements of this final rule. The amount of the CMP is $300 per day per hospital. We believe this amount to be sufficient to prompt hospitals to

[183] National Health Expenditure Fact Sheet, Centers for Medicare & Medicaid Services, April 26, 2019. Available at: *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.*

[184] Sinaiko AD, et al. Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game. *JAMA Intern Med.* March 2016; 176(3), 395–397. Available at: *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2482348.*

timely and properly display standard charges in both machine-readable and consumer-friendly formats in accordance with the requirements of this final rule.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the SSA, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct 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). 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 1 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.

An RIA must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). In aggregate, we estimate that this rule will cost approximately $71.4 million for hospitals to implement nationwide, in the initial year of implementation. In subsequent years, we anticipate minimal burden on hospitals for remaining compliant with the requirements to make public standard charges by annually updating the data they make public because, as explained in the CY 2020 OPPS/ASC proposed rule, we believe most of the effort will be in reviewing the rule for compliance, selecting the hospital 'shoppable' services, determining the ancillary services and displaying the shoppable services in a consumer-friendly manner. After the first year, hospitals would only need to update the data at least once every 12 months. We estimate that these annual updates and general operations for complying with the final rule will cost hospitals $21,672,502 annually after the initial year.

Almost all hospitals operating within the United States will be affected by the requirement to make standard charges public in both a machine-readable, and consumer-friendly manner. Although the level of disclosure of standard charge data required under this final rule is unprecedented, we do not expect the requirements of the final rule to disrupt normal business operations because hospitals already keep and maintain these data within their billing and accounting systems. However, OMB has determined that the actions are economically significant within the meaning of section 3(f) of the Executive Order. Therefore, OMB has reviewed this regulation, and the Department of Health and Human Services has provided the following assessment of its impact.

C. Anticipated Effects

This final rule would affect each hospital (as defined at 45 CFR 180.20) operating within the United States. We estimate that the final rule applies to 6,002 hospitals operating within the United States under the definition of ''hospital'' discussed in section II.B.1. of this final rule. To estimate this number, we subtracted 208 federally-owned or operated hospitals from the total number of United States hospitals, 6,210 hospitals.[185] In order to comply with regulatory updates finalized in the final rule in the initial year, hospitals would first need to review the rule. We estimate that this task would take a lawyer, on average, 5 hours to perform their review, and a general operations manager, on average, 5 hours to review and determine compliance requirements. We then estimate it would take a business operations specialist, on average, 80 hours to complete necessary processes and procedures to gather and compile required information and post it to the internet in the form and manner specified by the final rule. We also estimate that a network and computer system administrator would spend, on average, 30 hours to meet requirements specified by this final rule. Lastly, we estimate it would take a registered nurse, on average, 30 hours to capture necessary clinical input to determine a representative services package for a given service. Therefore, we are finalizing the total burden estimate to be 150 hours per hospital for the first year immediately following the finalization of this rule.

For the burden hours in subsequent years, we estimate that it would take a general operations manager, on average, 2 hours to review and determine updates in compliance requirements, a business operations specialist, on average, 32 hours to update necessary processes and procedures to gather and compile required information and post it to the internet in the form and manner specified by this final rule, and a network and computer system administrator would spend, on average, 12 hours to maintain requirements specified by this final rule. Therefore, we are finalizing the total burden estimate for the subsequent years to be 46 hours per hospital.

In order to estimate the cost associated with these activities, we use the hourly cost for each labor category used in this analysis by referencing Bureau of Labor Statistics report on Occupational Employment and Wages (May 2018 [186]). There are many professions involved in any business's processes. Therefore, we use the wage rate of a profession as a proxy for professional activities under such category. Also, we calculate the cost of overhead at 100 percent of the mean hourly wage in line with the Hospital Inpatient Quality Reporting Program and the Hospital Outpatient Quality Reporting Program (81 FR 57260 and 82 FR 59477, respectively). As a result, we use adjusted hourly wage rate of $138.68 for lawyers, adjusted hourly wage rate of $119.12 for general and operational managers, adjusted hourly wage rate of $74 for business operations specialists, adjusted hourly wage rate of $83.72 for network and computer systems administrators and hourly wage rate of $72.60 for registered nurses. With these numbers, we estimate a cost of $11,898.60 per hospital with total cost of $71.4 million for affected hospitals nationwide in the initial period for

[185] American Hospital Association. Fast Facts on U.S. Hospitals, 2019. Available at: *https://www.aha.org/statistics/fast-facts-us-hospitals.*

[186] Bureau of Labor Statistics. National Occupational Employment and Wage Estimates, May 2018. Available at: *https://www.bls.gov/oes/2018/may/oes_nat.htm.*

implementing the requirements we are finalizing with this rule.

1. Effects on Private Sector

As discussed in the CY 2020 OPPS/ASC proposed rule (84 FR 39631 through 39632), we considered the estimated effects on the private sector, and welcomed public comments on the impact of the proposed requirements on the private sector. As discussed in the Collection of Information section of this final rule, we continue to believe the burden on hospitals would be minimal. We also indicated that we believe the requirements in the final rule would encourage hospitals to adhere to best practices and industry standards by developing more robust and more efficient revenue integrity processes while working to comply with these requirements. Additionally, we are finalizing policies that could reduce potential compliance burdens, for example, we are finalizing as a modification that a hospital offering an internet-based price estimator tool that meets applicable requirements, is regarded as having met requirements to make public its standard charges for selected shoppable services in a consumer-friendly manner. Some hospitals already offer such tools, so fewer hospitals would need to develop display of consumer-friendly pricing information from scratch. Moreover, such hospitals would spend fewer hours complying because they would only need to review their existing price estimator tool to evaluate whether it meets the criteria specified at 180.60(a)(2).

Therefore, we considered these new variables in estimating burden and cost after the initial period of implementation, and determined their value would largely depend upon the hospitals' initial readiness and compliance status. We believe some variables serve to reduce the hours required for one or more activities associated with complying with the final rule after the first year. For example, to be compliant initially, the hospital must determine its shoppable services and ancillary services for display, must determine the most consumer-friendly format and display site, and must collect payer-specific negotiated charge information from its contracts or existing revenue management cycle process. Such activities are necessary only in the initial period of implementation for hospitals that do not already adhere to industry standards and best practices; once those activities have been completed, a hospital would simply need to update the standard charge data on an annual basis going forward. In addition, these variables may correlate and drive more changes in factors that would affect cost estimating after the initial period of implementation. Due to these considerations, we provided an updated burden estimate that reduces the number of total annual hours in subsequent years and are finalizing with this rule.

Comment: A few commenters stated that CMS has not demonstrated that the benefit of the policies outweigh the costs of implementing the rule.

Response: We appreciate commenters' input. However, we disagree with this comment. This final rule seeks to further advance hospital price transparency efforts that initiated with the FY 2015 IPPS/LTCH PPS and FY 2019 IPPS/LTCH PPS rules seeking to implement section 2718(e) of the PHS Act. At the time these prior rules were published, and as echoed in the comments we are responding to in this final rule, we heard from many stakeholders and public commenters that more guidelines and specificity around the form and manner in which hospitals make standard charges public would be helpful. Such commenters requested that CMS include requirements for more types of standard charges, as gross charges or the chargemaster alone are not sufficient for patients to estimate their financial obligations or to drive improvements in value-based care. This final rule goes a step farther by requiring hospitals to make public payer-specific negotiated charges, the de-identified minimum negotiated charge, the de-identified maximum negotiated charge, and discounted cash prices, in addition to gross charges for all items and services. Throughout section II of this final rule, we discuss the benefits of informing and empowering the public with hospital price information. These requirements would make public data that consumers could use to better understand the cost of care, and inform their healthcare decision-making, before receiving services. Further, technology vendors may innovate and create new products, including internet-based price estimator tools, or upgrade existing technologies to support hospitals in meeting these requirements and aiding consumers and healthcare providers in using data that is made public by hospitals. Other members of the public, such as employers, would be better informed to monitor insurer effectiveness and to help their employees shop for value.

In section V of this final rule, we analyze effects of these requirements on both the private sector and consumers. In section IV of this final rule, we detail how we determined the estimated burden of the requirements we are finalizing, at 150 hours with a cost of $11,898.60 per hospital, and how we arrived at these figures. In the following sub-sections of the RIA, we categorize our analyses within the estimated effects on consumers, small entities, small rural hospitals, and alternatives considered. We provide analyses from these perspectives to demonstrate that these requirements would bring consumers and other stakeholders' insights into healthcare costs, as well as the reasonable burden estimate for hospitals that takes into account commenters' concerns. In summary, we believe the overall benefits to consumers and healthcare markets nationwide will exceed the burden. For the initial year of implementation, we are finalizing an estimate of 150 hours and cost $11,898.60 per hospital for the burden of the requirements we are finalizing in this final rule that takes into account input from public comments.

Comment: We received some comments on the potential impacts of the proposed hospital price transparency requirements on CAHs, rural hospitals, and SCHs, including their suggestion that CMS exempt these entities from part or all requirements to make standard charges public.

Response: We believe that the benefits to consumers, and to the general public as a whole, outweigh the operational challenges faced by these entities. Further, elsewhere in the RIA (see section V.C.5 of this final rule), we analyze effects on small rural hospitals.

Comment: Many commenters cautioned that disclosure of payer-specific negotiated charges would increase, not decrease, healthcare costs in certain markets due to anticompetitive behaviors or increases in prices as a result of hospital knowledge of better rates negotiated by neighboring hospitals.

Response: We continue to believe, as supported by (for instance) academic research, economics research, or both, that the healthcare market could work more efficiently and provide consumers with high-value healthcare through policies that encourage choice and competition. Research suggests that in a normal market, price transparency (more generally) will result in reduced rates, overall.[187] There are models in the

[187] Christensen HB, et al. 2018. ''The Only Prescription Is Transparency: The Effect of Charge-Price-Transparency Regulation on Healthcare Prices.'' SSRN Scholarly Paper ID 2343367. Rochester, NY: Social Science Research Network. Available at: *https://papers.ssrn.com/abstract=2343367.*

States that have shown that release of the information has driven costs down not up.[188] On aggregate, we believe the effects on competition, resulting from hospital price transparency, would drive down healthcare prices. We acknowledge, that knowledge by a hospital of other hospitals' payer-specific negotiated charges could also drive up rates; especially if a hospital discovers it is currently being paid less than other hospitals by a payer and, thereby, negotiates higher rates. On the other hand, payers may negotiate lower rates, if they discover hospitals have negotiated lower rates with competing payers.

Comment: Typically described in the context of commenters' concerns on specific proposals, and as described within section II of this final rule, commenters suggested a number of possible unanticipated consequences for the private sector of the proposed requirements for hospitals to make public standard charges, including the following:

- The disclosure of payer-specific negotiated charges is likely to result in anti-competitive behavior and anti-trust exposure.
- Under the proposed requirements for hospitals to make public standard charges including payer-specific negotiated charges, hospitals would be exposed to litigation risk, due to the belief that these contractual reimbursement rates are proprietary.
- The proposal would contradict the goals of CMS' Patients-over Paperwork initiative.
- The requirement to disclose standard charges for all items and services as defined under the CY 2020 OPPS/ASC proposed rule would result in hospital closures.
- Complying with the requirements, as proposed, would be cost-prohibitive for CAHs, rural hospitals, and small hospitals, among others.
- The CY 2020 OPPS/ASC proposed rule's focus on standard charges would negatively impact hospitals' transition to value-based care.

Response: We appreciate commenters' concerns, and we have addressed these concerns elsewhere in this final rule. We do not believe that these concerns affect our estimate of the impact of the requirements we are finalizing, and accordingly we decline to adjust our economic analyses based on these concerns alone.

As we detailed in Section IV.B, we estimated the total burden to implement the requirements of this rule to be 150 hours at a cost of $11,898.60 per hospital. We noted that hospitals nationwide are at different stages of readiness to offer consumers transparent price information or are at various levels of participation in posting of charge and price information. We also believe that different hospitals may face different constraints when estimating their burden and resources required. We believe that some hospitals will already have a framework or business processes in place that they can leverage that would minimize additional burden. However, there will be other hospitals that will have additional burden, above our projected 150 hours we estimated, to meet the requirements of this rule. Therefore, we are providing alternative estimates on a range of hours in this impact analysis. We note that most commenters stated that a reasonable estimate for burden based for implementing existing requirements to disclose standard charges is within the range of 60–250 hours, therefore we are providing cost estimates ranging from 60 hours to 250 hours.

For a low estimate, we now estimate it would take a take a lawyer 2 hours (at $138.68 per hour); a general operations manager 2 hours (at $119.12 per hour); business operations specialist 32 hours (at $74 per hour), a network and computer system administrator 12 hours (at $83.72 per hour); a registered nurse 12 hours (at $72.60 per hour). Therefore, we are providing a low estimate of the total burden for the first year to be 60 hours (2 hours + 2 hours + 32 hours + 12 hours + 12 hours) per hospital with a cost of $4,759.44 per hospital. Table 7 provides the total cost.

For a high estimate, we now estimate it would take a take a lawyer 8 hours (at $138.68 per hour); a general operations manager 8 hours (at $119.12 per hour); business operations specialist 134 hours (at $74 per hour), a network and computer system administrator 50 hours (at $83.72 per hour); a registered nurse 50 hours (at $72.60 per hour). Therefore, we are providing a high estimate of the total burden for the first year to be 250 hours (8 hours + 8 hours + 134 hours + 50 hours + 50 hours) per hospital with a cost of $19,794.40 per hospital. Table 7 provides the total cost.

TABLE 7—COST RANGE ESTIMATES

Hours per hospitals	Cost per hospital	Total cost
60	4,759.44	28,566,159
250	19,794.40	118,805,989

2. Effects on Consumers

As discussed in the CY 2020 OPPS/ASC proposed rule (84 FR 39632 through 39633), we considered the estimated effects on the consumers, and welcomed public comments on the impact of the proposed requirements on consumers. As indicated in this final rule, we believe the requirements from this final rule will make public data necessary for healthcare consumers to better understand how the level of price dispersion in various healthcare markets and its impacts on healthcare spending and consumer out-of-pocket costs. The information may also benefit other consumers of these data, for example, employers, third party tool developers, clinicians at the point of care, or economics research to drive value-based policy development. We noted in the CY 2020 OPPS/ASC proposed rule that the negotiated charges for various procedures vary widely within and across geographic regions in the United States.[189] Some factors associated with the level of hospital price dispersion in a geographic area are the hospital's size, healthcare demand, labor costs, and technology, although it was the hospital's market power (level of competition) that was most positively associated with high price dispersion.[190] [191] One major barrier to fully understanding healthcare price variation (and understanding the impact of transparency of healthcare pricing in general) is the lack of availability of negotiated charges to researchers and the public.[192] We continue to believe that requirements from this final rule will make hospital charge information available, which will generate a better understanding of (1) hospital price dispersion, and (2) the relationship between hospital price dispersion and healthcare spending. Additionally, we believe understanding this relationship through the disclosure of pricing data could lead to downward price pressure and reductions in overall spending system-wide.

[188] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics*. Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf*.

[189] Kennedy K, et al. Health Care Cost Institute. Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area. Healthy Marketplace Index. April 30, 2019. Available at: *https://www.healthcostinstitute.org/blog/entry/hmi-2019-service-prices*.

[190] Cooper Z, et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics*. December 2015. Available at: *https://pdfs.semanticscholar.org/cb9c/f90786cc39ddac6d88f3ba1074a7c2d5f0a5.pdf*.

[191] Bai G and Anderson GF. Market Power: Price Variation Among Commercial Insurers For Hospital Services. *Health Affairs*. Oct 2018; 37(10): 1615–1622. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0567*.

[192] Ibid.

Consumers may feel more satisfied with their care when they are empowered to make decisions about their treatment. A recent survey [193] indicated a strong desire for price transparency and openness. Eighty-eight percent of the population polled, demanded improved transparency with their total financial responsibility, including co-pays and deductibles. Other studies such suggest that improving a patient's financial experience served as the biggest area to improve overall customer satisfaction.[194] Literature regarding consumer engagement with existing price transparency interventions demonstrates that disclosing price information positively impacts consumers by allowing them to compare prices for common procedures and shift their demand towards lower-priced options. One study examined consumer use of an employer-sponsored, private price transparency tool and its impact on claims payments for three common medical services: Laboratory tests; advanced imaging services; and clinician office visits.[195] That study found that those who used the tool had lower claims payments by approximately 14 percent for laboratory tests; 13 percent for advanced imaging services; and approximately one percent for office visits compared to those who did not use the tool. Those using the tool mainly searched for information on shoppable services and also tended to have more limited insurance coverage.

Price transparency initiatives have more impact when they are combined with other cost control tools like reference-based pricing. For example, for a plan with reference-based pricing, price transparency tools were associated with a reduction of 32 percent in lab test prices over three years.[196]

Employers have also been encouraging consumers to share in the savings realized from engaging in comparative shopping. The state of Kentucky's public employee benefit program's price transparency shared savings initiative has saved state taxpayers $13 million dollars since its inception in 2015, and almost $2 million in cash benefits have been shared with the state's public employees.[197] Another study of a group of 35 self-funded employers who deployed a shared savings program in 2017 demonstrated an overall 2.1 percent cost reduction of the cost of medical care and total savings of $23 million a year, with 23 percent of the employees receiving shared savings rewards.[198]

Finally, studies indicate that the existence of comparative price shopping information has the effect of reducing healthcare costs for everyone, regardless of whether they engage in shopping behavior. A national study of state price transparency efforts found an overall reduction of hospital pricing by 5 percent and a state of New Hampshire effort reduced consumer costs by 5 percent.[199] [200]

Comment: Typically described in the context of commenters' concerns on specific proposals, and as described within section II of this final rule, commenters suggested a number of possible unanticipated consequences for consumers of the proposed requirements for hospitals to make public standard charges, including the following:

- The volume of data required for the display of standard charges under the rule would confuse consumers and potentially cause them to seek out the cheapest care, rather than the most effective or best quality care.
- The burden of understanding costs of care would shift from hospitals and/or payers to consumers.
- The information on standard charges would still not be sufficient to inform consumers of their plan-specific, out-of-pocket costs. The concerns included that the required information would be insufficient for consumers to rely on, as well as concerns that too much information is being required, will be overwhelming and potentially confusing to consumers.

Response: We appreciate commenters' concerns, and we have addressed these concerns elsewhere in this final rule. We believe the requirements we are finalizing for hospitals to make public standard charges will provide information to consumers that helps inform their healthcare decision-making, and therefore ultimately benefit consumers. Informed decision-making, in turn, may have other positive effects; for example, as research suggests, informed healthcare consumers, that have a price estimate before getting care are more likely to pay their bills in a timely manner.[201] [202]

We do not believe that these concerns about unintended consequences on consumers affect our estimate of the impact of the requirements we are finalizing, and accordingly we decline to adjust our economic analyses based on these concerns alone.

3. Effects on Small Entities

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. More than half of 6,002 hospitals are small entities, either by nonprofit status or by having revenues of less than $41.5 million in any 1 year.[203] We analyzed these hospitals and found that the estimated burden from this final rule never exceeded 1 percent of reported revenue for any hospital in this category, including the

[193] See Gruessner V. Consumer Satisfaction Dips When Payers Lack Price Transparency. *Private Payers News* (October 3, 2016). Available at: *https://healthpayerintelligence.com/news/consumer-satisfaction-dips-when-payers-lack-price-transparency*.

[194] See for example, Government Accountability Office. September 2011. Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care. Available at: *https://www.gao.gov/assets/590/585400.pdf*. Experian Health, Improve the healthcare financial journey. *Patient Engagement* (June 21, 2018). Available at: *https://www.experian.com/blogs/healthcare/2018/06/healthcare-financial-journey/*.

[195] Whaley C, et al. ''Association Between Availability of Health Service Prices and Payments for These Services.'' *JAMA*. 2014; 312(16):1670–1676. Available at *https://jamanetwork.com/journals/jama/fullarticle/1917438*.

[196] Robinson JC, Whaley BA, Brown TT. Association of Reference Pricing for Diagnostic Laboratory Testing With Changes in Patient (2016) JAMA Int Med. 2016; 176(9); 1353–1359. Available at: *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2536187*.

[197] Rhoads J. Right to Shop for Public Employees: How Health Care Incentives are Saving Money in Kentucky. Foundation for Government Accountability. March 8, 2019. Available at: *https://thefga.org/wp-content/uploads/2019/03/RTS-Kentucky-HealthCareIncentivesSavingMoney-DRAFT8.pdf*.

[198] Whaley CM, et al. Paying Patients To Switch: Impact Of A Rewards Program On Choice Of Providers, Prices, And Utilization. *Health Affairs*. March 2019. Available at: *https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05068*.

[199] Christensen HB, et al. 2018. ''The Only Prescription Is Transparency: The Effect of Charge-Price-Transparency Regulation on Healthcare Prices.'' SSRN Scholarly Paper ID 2343367. Rochester, NY: Social Science Research Network. Available at: *https://papers.ssrn.com/abstract=2343367*.

[200] Brown ZY. Equilibrium Effects of Health Care Price Information. *The Review of Economics and Statistics*. Published October 2019; 101:4, 699–712. Available at: *http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf*.

[201] Kutscher, B. ''Report: Consumers demand price transparency, but at what cost?'' *Modern Healthcare*. June 2015. Available at: *https://www.modernhealthcare.com/article/20150623/NEWS/150629957/consumers-demand-price-transparency-but-at-what-cost*.

[202] HFMA Executive Roundtable: Reimagining Patient Access. December 2015. Available at: *https://api.hfma.org/Content.aspx?id=43731*.

[203] U. S. Small Business Administration, Table of Small Business Size Standards, Matched to North American Industry Classification System Codes (size standards effective August 19, 2019). Available at: *https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf*.

hospital with the lowest revenue.[204] For the over 3,000 hospitals that meet the standards for small entities defined by the SBA, we estimate the burden from this final rule to be, on average, 0.007 percent of hospital total annual revenue. It is reasonable to assume that the inclusion or exclusion of hospitals with nonprofit status would not drive the percentages to go over the threshold because even the historically lowest revenue hospitals indicate the burden would not exceed at most about 1 percent of total hospital revenue in the most extreme case. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this final rule. As a result, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small entities.

4. Effects on Small Rural Hospitals

Section 1102(b) of the SSA requires us to prepare an RIA if a rule may have a significant 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. For purposes of section 1102(b) of the SSA, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We identified almost 1,900 hospitals as having rural status and fewer than 100 beds. We note that commenters submitted various concerns related to burden for smaller or less resourced hospitals. We have responded to these concerns throughout this final rule. As noted previously, we are aware that hospitals are in varying stages of readiness for implementation of this final rule. While smaller or rural hospitals may not have the staff or automation that larger hospital systems may have (which may increase burden relative to a better resourced hospital or hospital system), they are likely to have far fewer contracts with payers and provide fewer items and services overall, which would reduce rural hospital burden compared to larger hospitals in regions with many payers. For this reason it is difficult to determine a unique impact on small rural hospitals. For these small, rural hospitals, we estimate the burden from this final rule to be, on average, 0.037 percent of hospital total annual revenue.[205] Therefore, we conclude that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

5. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2019, that threshold is approximately $154 million. This final rule contains no such unfunded mandates.

6. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

D. Alternatives Considered

The final rule promulgates rules for hospital compliance with section 2718(e) of the PHS Act and aims to make price information more readily available to the public. As described in the CY 2020 OPPS/ASC proposed rule (84 FR 39633), we considered a number of alternative approaches to maximize the value and accessibility of these data to the public generally and directly to consumers. For example, proposals to require release of hospital standard charge data in an API format. We also considered other types of ''standard charges'' that could be useful to consumers. For example, in addition to or instead of the requirement to disclose gross charges and payer-specific charges, we sought comment on whether we should consider a definition of 'standard charge' to be a volume-driven negotiated charge, the minimum/median/maximum negotiated charge, or all allowed charges. Such charges could be relevant to specific groups of individuals, particularly those with health insurance coverage. We also sought comment on a definition of 'standard charge' that might be relevant to subgroups of individuals who are self-pay, specifically, types of standard charges representing the discounted cash price for a service package, or the median cash price.

We finalized the definition of standard charges to include gross charge (as discussed in section II.D.2 of this final rule), and payer-specific negotiated charge (as discussed in section II.D.3), as proposed. We finalized modifications to include within the definition of standard charges the discounted cash price (as described in section II.D.4.c of this final rule), as well as the de-identified minimum negotiated charge, and de-identified maximum negotiated charge (as discussed in section II.D.4.d of this final rule). Of the other alternatives considered, we determined that allowed amounts of plans that are not negotiated are already publicly disclosed (as discussed in section II.D.4.b of this final rule), and that the median negotiated charge would have limited usefulness for consumers (as discussed in section II.D.4.d of this final rule). We also decided not to require standardization in the release of hospital standard charges, such as by requiring data be presented in an API format, noting that the requirements we are finalizing in this final rule, for hospitals to make public their standard charges, are a good initial step.

As a result of comments, we considered an alternative in which CMS would specify all 300 shoppable services and specify the corresponding ancillary services. We estimate that this could reduce burden for hospitals by removing the clinical input necessary to develop such service groupings which would result in a first year burden of $9,721 per hospital, or $58.3 million for all hospitals.

Finally, we also considered an alternative approach that would require hospitals to make public a comprehensive machine-readable file of all standard charges for all hospital items and services, but not require hospitals to display charges for shoppable services in a consumer-friendly manner. We estimate that this could reduce burden for hospitals by removing the clinical input necessary and decrease the number of hours for the other professions which would result in a first year burden of $4,860 per hospital, or $29.2 million for all hospitals.

E. Accounting Statement and Table

In accordance with OMB Circular A–4, Table 8 depicts an accounting statement summarizing the assessment of the benefits and costs associated with this regulatory action.

[204] CMS Office of the Actuary analysis of 2016 Medicare Cost Report data.

[205] Hospital Cost Report PUF is used for calculating these statistics. The latest PUF file publicly available is a 2014 dataset as of July 15, 2018, available at this link: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Cost-Report/HospitalCostPUF.html.*

TABLE 8—ACCOUNTING STATEMENT ESTIMATED IMPACTS

[CYs 2020–2022]

Category	Primary estimate (million)	Units		
		Year dollars	Discount rate (%)	Period covered
Benefits				
Qualitative	The rule is anticipated to have the potential to reduce the range of prices charged by hospitals such that a net savings would result for payers and consumers from a corresponding reduction in income to hospitals. Price transparency would help to create a healthcare information ecosystem that allows and encourages the healthcare market to tailor products and services to compete for patients, thereby increasing quality, decreasing costs, and helping them live better, healthier lives.			
Costs				
Annualized monetized $ millions/year	$39.4	2019	7	2020–2022
	38.7	2019	3	2020–2022

F. Regulatory Reform Analysis Under E.O. 13771

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 considered an Executive Order 13771 regulatory action. We estimate the rule generates $23.0 million in annualized costs in 2016 dollars, discounted at 7 percent relative to year 2016 over a perpetual time horizon. Details on the estimated costs of this rule can be found in the preceding and subsequent analyses.

G. Conclusion

The analysis in this section, together with the remainder of this preamble, provides an RIA. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

List of Subjects in 45 CFR Part 180

Definitions, Hospitals, Reporting and recordkeeping requirements.

■ For reasons stated in the preamble of this document, the Department of Health and Human Services amends 45 CFR subtitle A by adding subchapter E to read as follows:

Subchapter E—Price Transparency

PART 180—HOSPITAL PRICE TRANSPARENCY

PARTS 181–199 [RESERVED]

PART 180—HOSPITAL PRICE TRANSPARENCY

Sec.

Subpart A—General Provisions

180.10 Basis and scope.
180.20 Definitions.
180.30 Applicability.

Subpart B—Public Disclosure Requirements

180.40 General requirements.
180.50 Requirements for making public hospital standard charges for all items and services.
180.60 Requirements for displaying shoppable services in a consumer-friendly manner.

Subpart C—Monitoring and Penalties for Noncompliance

180.70 Monitoring and enforcement.
180.80 Corrective action plans.
180.90 Civil monetary penalties.

Subpart D—Appeals of Civil Monetary Penalties

180.100 Appeal of penalty.
180.110 Failure to request a hearing.

Authority: 42 U.S.C. 300gg–18, 42 U.S.C. 1302.

Subpart A—General Provisions

§ 180.10 Basis and scope.

This part implements section 2718(e) of the Public Health Service (PHS) Act, which requires each hospital operating within the United States, for each year, to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups (DRGs) established under section 1886(d)(4) of the Social Security Act. This part also implements section 2718(b)(3) of the PHS Act, to the extent that section authorizes CMS to promulgate regulations for enforcing section 2718(e). This part also implements section 1102(a) of the Social Security Act, which authorizes the Secretary to make and publish rules and regulations, not inconsistent with that Act, as may be necessary to the efficient administration of the functions for which the Secretary is charged under that Act.

§ 180.20 Definitions.

The following definitions apply to this part, unless specified otherwise:

Ancillary service means an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service.

Chargemaster (Charge Description Master or CDM) means the list of all individual items and services maintained by a hospital for which the hospital has established a charge.

De-identified maximum negotiated charge means the highest charge that a hospital has negotiated with all third party payers for an item or service.

De-identified minimum negotiated charge means the lowest charge that a hospital has negotiated with all third party payers for an item or service.

Discounted cash price means the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

Gross charge means the charge for an individual item or service that is

reflected on a hospital's chargemaster, absent any discounts.

Hospital means an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Items and services means all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples include, but are not limited to, the following:

(1) Supplies and procedures.

(2) Room and board.

(3) Use of the facility and other items (generally described as facility fees).

(4) Services of employed physicians and non-physician practitioners (generally reflected as professional charges).

(5) Any other items or services for which a hospital has established a standard charge.

Machine-readable format means a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats.

Payer-specific negotiated charge means the charge that a hospital has negotiated with a third party payer for an item or service.

Service package means an aggregation of individual items and services into a single service with a single charge.

Shoppable service means a service that can be scheduled by a healthcare consumer in advance.

Standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. This includes all of the following as defined under this section:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

Third party payer means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.

§ 180.30 Applicability.

(a) *General applicability.* Except as provided in paragraph (b) of this section, the requirements of this part apply to hospitals as defined at § 180.20.

(b) *Exception.* Federally owned or operated hospitals are deemed by CMS to be in compliance with the requirements of this part including but not limited to:

(1) Federally owned hospital facilities, including facilities operated by the U.S. Department of Veterans Affairs and Military Treatment Facilities operated by the U.S. Department of Defense.

(2) Hospitals operated by an Indian Health Program as defined in section 4(12) of the Indian Health Care Improvement Act.

(c) *Online availability.* Unless otherwise stated, hospital charge information must be made public electronically via the internet.

Subpart B—Public Disclosure Requirements

§ 180.40 General requirements.

A hospital must make public the following:

(a) A machine-readable file containing a list of all standard charges for all items and services as provided in § 180.50.

(b) A consumer-friendly list of standard charges for a limited set of shoppable services as provided in § 180.60.

§ 180.50 Requirements for making public hospital standard charges for all items and services.

(a) *General rules.* (1) A hospital must establish, update, and make public a list of all standard charges for all items and services online in the form and manner specified in this section.

(2) Each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location.

(b) *Required data elements.* A hospital must include all of the following corresponding data elements in its list of standard charges, as applicable:

(1) Description of each item or service provided by the hospital.

(2) Gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(3) Payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.

(4) De-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(5) De-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(6) Discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(7) Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier.

(c) *Format.* The information described in paragraph (b) of this section must be published in a single digital file that is in a machine-readable format.

(d) *Location and accessibility.* (1) A hospital must select a publicly available website for purposes of making public the standard charge information required under paragraph (b) of this section.

(2) The standard charge information must be displayed in a prominent manner and clearly identified with the hospital location with which the standard charge information is associated.

(3) The hospital must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is accessible:

(i) Free of charge;

(ii) Without having to establish a user account or password; and

(iii) Without having to submit personal identifying information (PII).

(4) The digital file and standard charge information contained in that file must be digitally searchable.

(5) The file must use the following naming convention specified by CMS, specifically: <ein>_<hospital-name>_standardcharges.[json|xml|csv].

(e) *Frequency of updates.* The hospital must update the standard charge information described in paragraph (b)

of this section at least once annually. The hospital must clearly indicate the date that the standard charge data was most recently updated, either within the file itself or otherwise clearly associated with the file.

§ 180.60 Requirements for displaying shoppable services in a consumer-friendly manner.

(a) *General rules.* (1) A hospital must make public the standard charges identified in paragraphs (b)(3) through (6) of this section, for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(i) In selecting a shoppable service for purposes of this section, a hospital must consider the rate at which it provides and bills for that shoppable service.

(ii) If a hospital does not provide 300 shoppable services, the hospital must make public the information specified in paragraph (b) of this section for as many shoppable services as it provides.

(2) A hospital is deemed by CMS to meet the requirements of this section if the hospital maintains an internet-based price estimator tool which meets the following requirements.

(i) Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(ii) Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.

(iii) Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

(b) *Required data elements.* A hospital must include, as applicable, all of the following corresponding data elements when displaying its standard charges (identified in paragraphs (b)(3) through (6) of this section) for its list of shoppable services selected under paragraph (a)(1) of this section:

(1) A plain-language description of each shoppable service.

(2) An indicator when one or more of the CMS-specified shoppable services are not offered by the hospital.

(3) The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.

(4) The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).

(5) The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(6) The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(7) The location at which the shoppable service is provided, including whether the standard charges identified in paragraphs (b)(3) through (6) of this section for the shoppable service apply at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.

(8) Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), or other common service billing code.

(c) *Format.* A hospital has discretion to choose a format for making public the information described in paragraph (b) of this section online.

(d) *Location and accessibility of online data.* (1) A hospital must select an appropriate publicly available internet location for purposes of making public the information described in paragraph (b) of this section.

(2) The information must be displayed in a prominent manner that identifies the hospital location with which the information is associated.

(3) The shoppable services information must be easily accessible, without barriers, including but not limited to ensuring the information is:

(i) Free of charge.

(ii) Accessible without having to register or establish a user account or password.

(iii) Accessible without having to submit personal identifying information (PII).

(iv) Searchable by service description, billing code, and payer.

(e) *Frequency.* The hospital must update the standard charge information described in paragraph (b) of this section at least once annually. The hospital must clearly indicate the date that the information was most recently updated.

Subpart C—Monitoring and Penalties for Noncompliance

§ 180.70 Monitoring and enforcement.

(a) *Monitoring.* (1) CMS evaluates whether a hospital has complied with the requirements under §§ 180.40, 180.50, and 180.60.

(2) CMS may use methods to monitor and assess hospital compliance with the requirements under this part, including, but not limited to, the following, as appropriate:

(i) CMS' evaluation of complaints made by individuals or entities to CMS.

(ii) CMS review of individuals' or entities' analysis of noncompliance.

(iii) CMS audit of hospitals' websites.

(b) *Actions to address hospital noncompliance.* If CMS concludes that the hospital is noncompliant with one or more of the requirements of § 180.40, § 180.50, or § 180.60, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

(1) Provide a written warning notice to the hospital of the specific violation(s).

(2) Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements, according to § 180.80.

(3) Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website according to § 180.90 if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan.

§ 180.80 Corrective action plans.

(a) *Material violations requiring a corrective action plan.* CMS determines if a hospital's noncompliance with the requirements of this part constitutes material violation(s) requiring a corrective action plan. A material violation may include, but is not limited to, the following:

(1) A hospital's failure to make public its standard charges required by § 180.40.

(2) A hospital's failure to make public its standard charges in the form and manner required under §§ 180.50 and 180.60.

(b) *Notice of violation.* CMS may request that a hospital submit a corrective action plan, specified in a notice of violation issued by CMS to a hospital.

(c) *Compliance with corrective action plan requests and corrective actions.* (1) A hospital required to submit a corrective action plan must do so, in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital and must comply with the requirements of the corrective action plan.

(2) A hospital's corrective action plan must specify elements including, but not limited to:

(i) The corrective actions or processes the hospital will take to address the deficiency or deficiencies identified by CMS.

(ii) The timeframe by which the hospital will complete the corrective action.

(3) A corrective action plan is subject to CMS review and approval.

(4) After CMS' review and approval of a hospital's corrective action plan, CMS may monitor and evaluate the hospital's compliance with the corrective actions.

(d) *Noncompliance with corrective action plan requests and requirements.* (1) A hospital's failure to respond to CMS' request to submit a corrective action plan includes failure to submit a corrective action plan in the form, manner, or by the deadline, specified in a notice of violation issued by CMS to the hospital.

(2) A hospital's failure to comply with the requirements of a corrective action plan includes failure to correct violation(s) within the specified timeframes.

§ 180.90 Civil monetary penalties.

(a) *Basis for imposing civil monetary penalties.* CMS may impose a civil monetary penalty on a hospital identified as noncompliant according to § 180.70, and that fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan as described in § 180.80(d).

(b) *Notice of imposition of a civil monetary penalty.* (1) If CMS imposes a penalty in accordance with this part, CMS provides a written notice of imposition of a civil monetary penalty to the hospital via certified mail or another form of traceable carrier.

(2) This notice to the hospital may include, but is not limited to, the following:

(i) The basis for the hospital's noncompliance, including, but not limited to, the following:

(A) CMS' determination as to which requirement(s) the hospital has violated.

(B) The hospital's failure to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, as described in § 180.80(d).

(ii) CMS' determination as to the effective date for the violation(s). This date is the latest date of the following:

(A) The first day the hospital is required to meet the requirements of this part.

(B) If a hospital previously met the requirements of this part but did not update the information annually as required, the date 12 months after the date of the last annual update specified in information posted by the hospital.

(C) A date determined by CMS, such as one resulting from monitoring activities specified in § 180.70, or development of a corrective action plan as specified in § 180.80.

(iii) The amount of the penalty as of the date of the notice.

(iv) A statement that a civil monetary penalty may continue to be imposed for continuing violation(s).

(v) Payment instructions.

(vi) Intent to publicize the hospital's noncompliance and CMS' determination to impose a civil monetary penalty on the hospital for noncompliance with the requirements of this part by posting the notice of imposition of a civil monetary penalty on a CMS website.

(vii) A statement of the hospital's right to a hearing according to subpart D of this part.

(viii) A statement that the hospital's failure to request a hearing within 30 calendar days of the issuance of the notice permits the imposition of the penalty, and any subsequent penalties pursuant to continuing violations, without right of appeal in accordance with § 180.110.

(3) If the civil monetary penalty is upheld, in part, by a final and binding decision according to subpart D of this part, CMS will issue a modified notice of imposition of a civil monetary penalty, to conform to the adjudicated finding.

(c) *Amount of the civil monetary penalty.* (1) CMS may impose a civil monetary penalty upon a hospital for a violation of each requirement of this part.

(2) The maximum daily dollar amount for a civil monetary penalty to which a hospital may be subject is $300. Even if the hospital is in violation of multiple discrete requirements of this part, the maximum total sum that a single hospital may be assessed per day is $300.

(3) The amount of the civil monetary penalty will be adjusted annually using the multiplier determined by OMB for annually adjusting civil monetary penalty amounts under part 102 of this title.

(d) *Timing of payment of civil monetary penalty.* (1) A hospital must pay the civil monetary penalty in full within 60 calendar days after the date of the notice of imposition of a civil monetary penalty from CMS under paragraph (b) of this section.

(2) In the event a hospital requests a hearing, pursuant to subpart D of this part, the hospital must pay the amount in full within 60 calendar days after the date of a final and binding decision, according to subpart D of this part, to uphold, in whole or in part, the civil monetary penalty.

(3) If the 60th calendar day described in paragraphs (d)(1) and (2) of this section is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

(e) *Posting of notice.* (1) CMS will post the notice of imposition of a civil monetary penalty described in paragraphs (b) and (f) of this section on a CMS website.

(2) In the event that a hospital elects to request a hearing, pursuant to subpart D of this part:

(i) CMS will indicate in its posting, under paragraph (e)(1) of this section, that the civil monetary penalty is under review.

(ii) If the civil monetary penalty is upheld, in whole, by a final and binding decision according to subpart D of this part, CMS will maintain the posting of the notice of imposition of a civil monetary penalty on a CMS website.

(iii) If the civil monetary penalty is upheld, in part, by a final and binding decision according to subpart D of this part, CMS will issue a modified notice of imposition of a civil monetary penalty according to paragraph (b)(3) of this section, to conform to the adjudicated finding. CMS will make this modified notice public on a CMS website.

(iv) If the civil monetary penalty is overturned in full by a final and binding decision according to subpart D of this part, CMS will remove the notice of imposition of a civil monetary penalty from a CMS website.

(f) *Continuing violations.* CMS may issue subsequent notice(s) of imposition of a civil monetary penalty, according to paragraph (b) of this section, that result from the same instance(s) of noncompliance.

Subpart D—Appeals of Civil Monetary Penalties

§ 180.100 Appeal of penalty.

(a) A hospital upon which CMS has imposed a penalty under this part may appeal that penalty in accordance with subpart D of part 150 of this title, except as specified in paragraph (b) of this section.

(b) For purposes of applying subpart D of part 150 of this title to appeals of civil monetary penalties under this part:

(1) Civil money penalty means a civil monetary penalty according to § 180.90.

(2) Respondent means a hospital that received a notice of imposition of a civil monetary penalty according to § 180.90(b).

(3) References to a notice of assessment or proposed assessment, or notice of proposed determination of civil monetary penalties, are considered to be references to the notice of imposition of a civil monetary penalty specified in § 180.90(b).

(4) Under § 150.417(b) of this title, in deciding whether the amount of a civil money penalty is reasonable, the ALJ may only consider evidence of record relating to the following:

(i) The hospital's posting(s) of its standard charges, if available.

(ii) Material the hospital timely previously submitted to CMS (including with respect to corrective actions and corrective action plans).

(iii) Material CMS used to monitor and assess the hospital's compliance according to § 180.70(a)(2).

(5) The ALJ's consideration of evidence of acts other than those at issue in the instant case under § 150.445(g) of this title does not apply.

§ 180.110 Failure to request a hearing.

(a) If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a civil monetary penalty described in § 180.90(b), CMS may impose the civil monetary penalty indicated in such notice and may impose additional penalties pursuant to continuing violations according to § 180.90(f) without right of appeal in accordance with this part.

(1) If the 30th calendar day described in this paragraph (a) is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

(2) [Reserved]

(b) The hospital has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with § 150.405 of this title, unless the hospital can show good cause, as determined at § 150.405(b) of this title, for failing to timely exercise its right to a hearing.

PARTS 181–199—[RESERVED]

Dated: November 5, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 7, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2019–24931 Filed 11–15–19; 4:15 pm]

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Part III

Department of State

Bureau of Political-Military Affairs, Directorate of Defense Trade Controls: Notifications to the Congress of Proposed Commercial Export Licenses; Notice

DEPARTMENT OF STATE

[Public Notice: 10945]

Bureau of Political-Military Affairs, Directorate of Defense Trade Controls: Notifications to the Congress of Proposed Commercial Export Licenses

AGENCY: Department of State.

ACTION: Notice.

SUMMARY: Notice is hereby given that the Department of State has forwarded the attached Notifications of Proposed Export Licenses to the Congress on the dates indicated on the attachments pursuant to sections 36(c) and 36(d), and in compliance with section 36(f), of the Arms Export Control Act.

DATES: As shown on each of the 91 letters.

FOR FURTHER INFORMATION CONTACT: Ms. Paula C. Harrison, Directorate of Defense Trade Controls, Department of State, telephone (202) 663–3310; email *DDTCResponseTeam@state.gov.* ATTN: Congressional Notification of Licenses.

SUPPLEMENTARY INFORMATION: Section 36(f) of the Arms Export Control Act (22 U.S.C. 2778) mandates that notifications to the Congress pursuant to sections 36(c) and 36(d) must be published in the **Federal Register** when they are transmitted to Congress or as soon thereafter as practicable.

Following are such notifications to the Congress:

Nov 30, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for export for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the United Kingdom to support the design, manufacture, integration, installation, operation, training, testing, maintenance, repair, marketing, and sale of the Brimstone Weapon System.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 16–087.

Nov 30, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the Philippines to support the manufacture, integration, installation, operation, testing, maintenance, and report of 22 TCM and 22 TCM 9R ammunition cartridges.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 17–096.

Nov 30, 2018

Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services, to support the design, development, production, manufacture, assembly, operation, repair, testing, inspection, maintenance, modification and upgrades of the Evolved Sea Sparrow Missile (ESSM) Block 1.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 17–135.

Oct 15, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Mexico to support the assembly and testing of certain F107–WR–105 engine assemblies.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–002.

Dec 03, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of

State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data, and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, technical data, and defense services to Saudi Arabia for the support of integration, installation, operation, training, testing, maintenance, and repair of the Patriot Air Defense System (Configuration 3), including upgrade to the Patriot Guidance Enhanced Missile-Tactical (GEM–T).

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–014.

Nov 02, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Kuwait, Germany, Italy, Spain and the UK to support the integration of the SNIPER Advanced Targeting Pod (ATP) on the Eurofighter Typhoon aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–018.

Oct 16, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export to Israel of 5.56mm automatic rifles and major components to the Israeli MOD. The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–023.

Nov 6, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Israel to support the manufacture of Joint Strike Fighter Outer Wing Box assemblies.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–025.

Oct 15, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Canada, the UK, and France for the manufacture of F/A–18A–F and derivative aircraft landing gear assemblies, sub-assemblies, parts, and components.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–026.

Oct 16, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to the Republic of Korea to support the manufacture, assembly, test, integration, operation, maintenance, and repair of the AN/ARC–223A and AN/ARC–164A Radio Systems and associated equipment.

The U.S. government is prepared to license the export of these items having taken into account political, military,

economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–027.

Nov 06, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data, defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services to Israel to support the performance of maintenance, repair and overhaul services of J52 and F100 engines to maintain readiness of the Israeli Air Force's fleet of A–4, F–15 and F–16 aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–032.

Oct 9, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for export of defense articles, including technical data, defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles and technical data to Sweden and the Netherlands to support the installation, testing, maintenance, and repair of 35/50mm automatic chain guns for end use by the Netherlands Ministry of Defense.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–033.

Nov 02, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of firearms abroad controlled under Category I of the United States Munitions List in amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 7.62mm fully automatic machine guns and spare barrels to Brazil for end use by the Brazilian Army.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–034.

Nov 02, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 5.56mm automatic rifles to Israel for government end-use.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–040.

Nov 30, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of semi-automatic rifles, pistols and bolt-action rifles to Peru for commercial resale.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–041.

Nov 06, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the

United States Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of rifles and pistols to Peru for commercial resale.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–042.

Oct 5, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Malaysia to support the transfer of six MD530G Scout/Attack helicopters, one MD530G Flight Training device, and MD530G training to Malaysian Army.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–044.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Taiwan to support the manufacture of the AR–1500 International 1-Channel Airborne Radio.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–046.

Oct 15, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Japan to manufacture AN/ARC–182(V) VHF/UHF AM/FM radio sets.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–047.

Oct 16, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, to include technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the transfer of defense articles, to include technical data, and defense services to support the Proton integration and launch of the Eutelsat 5 West B (E5WB) Commercial Communication Satellite and the Mission Extension Vehicle–1 (MEV–1) from the Baikonur Cosmodrome in Kazakhstan.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Charles S. Faulkner, *Acting Assistant Secretary Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–048.

Nov 02, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, we are transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Japan to support the upgrades of the Japan E–767 Airborne Warning and Control System fleet.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause

competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–049.

Nov 30, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department if State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data, defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the Netherlands, Italy, Japan, and the UK to support the delivery, manufacture, and testing of conventional edge control surfaces for the F–35 Joint Strike Fighter program.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–052.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Belgium support the design, development, integration and installation for the North Atlantic Treaty Organization (NATO) Alliance Ground Surveillance (AGS) program.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–055.

Nov 13, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Japan to support the development, integration, and support for Assault Amphibious Vehicles Reliability, Availability, Maintenance/Rebuild to Standard (AAV7A1 RAM/RS) vehicles.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–058.

Nov 6, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms parts and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 120mm main gun sub-caliber devices to Oman for the Omani Ministry of Defense.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–059.

Nov 30, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export to New Zealand of bolt-action rifles, components, and sound suppressors for use by the New Zealand Defence Force.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–060.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of fully automatic 5.56mm rifles to Qatar for use by their Internal Security Force.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–061.

Dec 20, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Japan to support the integration, installation, operation, training, testing, maintenance, and repair of the IBIS III System.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–063.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Switzerland and the UK to support the integration, installation, upgrade, operation, training, testing, maintenance, and repair of the F/A 18 Tactical Operational Flight Trainer (TOFT).

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–064.

Nov 30, 2019

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of rifles, flash hiders and rifle major component parts to Canada for commercial resale.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–071.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the manufacture of significant military equipment abroad and the export of firearm parts and components, including technical data and defense services, abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Italy and Qatar to support the manufacture, integration, assembly, operation, training, testing, and maintenance, of 5.56mm upper receivers.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–073.

Nov 30, 2019

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 9mm semi-automatic pistols to Denmark for the Ministry of Defense.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant,

publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–076.

Dec 21, 2018

The Honorable Paul D. Ryan, *Speaker of the House of Representatives.*

Dear Mr. Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $25,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK to support integration of the MK 41 vertical launch system (VLS) on three Type 26 Global Combat Ships for use by the UK's Ministry of Defence.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–079.

Feb 12, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Sections 36(c) and 36(d) of the Arms Export Control Act, the Department of State is transmitting certification of a license for the manufacture of significant military equipment abroad and export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Italy, Turkey, and the Netherlands for the manufacture of the F–35 Lightning II's Center Fuselage and related assemblies, subassemblies and components associated with all variants of the F–35 aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 17–076.

Mar 7, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for export for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Turkey to support the manufacture, sales, and maintenance training of all variants of Armored Combat Vehicle (ACV) Family of Vehicles, Sharpshooter and 40/50 Turrets, the remotely fired .50 caliber Cupola, and modernization kits and materials.

The U.S. Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 17–141.

Mar 7, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of state is transmitting certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the United States Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of automatic rifles to Oman.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–006.

Feb 12, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services related of firearms parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Brazil to support the manufacture of components for sporting handguns and rifles.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–017.

Mar 15, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed the Department of State's certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of .50 caliber machine guns to the Royal Oman Police.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–053.

Mar 15, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed the Department of State's certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK and Israel to support the development, integration, and support for F–135 propulsion system Organizational Level (O-Level) maintenance, field training, and services for the operation and sustainment of the F–35 Lightening II air systems operated by the Ministry of Defense in Israel.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–057.

Feb 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Norway, Italy, Japan and Denmark to support the manufacture, integration, installation, operation, training, testing, maintenance, and repair of auxiliary aerostructures and wing conventional control surfaces for the F–35 aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–068.

Feb 6, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the manufacture of significant military equipment and the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Canada to support the manufacture, integration, installation, operation, training, and testing of small caliber weapons parts.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–078.

Mar 15, 2019

The Honorable Nancy Pelosi, *Speaker of the House Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed the Department of State's certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 5.56mm semi-automatic assault rifles to Oman for the Omani Ministry of Defense.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–087.

Mar 7, 2019

The Honorable Nancy Pelosi, *Speaker of House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to

support the manufacture, development, integration and support for Air-to-Air Pylons for the F–35 Lightning II Aircraft for end-use by the United States.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–088.

Mar 7, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, the Department of State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Japan to support the manufacture, integration, assembly, operation, training, testing, and maintenance of AN/ARC–164 (RT–1145 and RT–1504) UHF Receiver/Transmitters and related radio equipment.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–094.

Mar 15, 2019

The Honorable Nancy Pelosi, *Speaker of House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed the Department of State's certification of a proposed license for the manufacture of significant military equipment abroad and the export of technical data and defense services in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of technical data and defense services to Israel and Germany to support the manufacture of firearm components, parts, accessories, barrels, blank receivers, and breech mechanisms.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–101.

Apr 3, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting certification of a proposed license for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Australia, Italy, Japan, and the Netherlands to support the manufacture of composite components and subassemblies of the F–35 Lightning II Aircraft.

The United States government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 17–078.

Apr 3, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a proposed license for the export of defense articles, including technical data, and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data defense services, to Denmark, Italy, Japan, and the Netherlands, to support the design, development and manufacture of composite components and subassemblies for the F–35 Aircraft Center Fuselage.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–001.

Apr 16, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Australia, the UK, and India to support

the manufacture, integration, installation, operation, training, testing, maintenance, and repair of Unmanned Aerial Systems in India.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Acting Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–009.

Apr 08, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a proposed license for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Turkey, Poland, and the UK for the manufacture, inspection, test, delivery, and repair of machined parts, machined assemblies, and components for the H–60/S–70, H–53, and H–92 model helicopters.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–021.

Apr 16, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the manufacture of significant military equipment in the form of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Belgium, Canada, and Japan to support the manufacture, integration, installation, operation, training, testing, maintenance, and repair of sporting and recreational rifles.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–045.

Apr 17, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for export for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the Republic of Korea and Thailand to support the manufacture, integration, installation, operation, training, testing, maintenance, and repair of the T–50TH aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–066.

Apr 08, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Qatar to support manufacture of the fusion rifle system/target illuminator system.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–067.

Apr 29, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Italy to support manufacture of Chemical Agent Resistant Coatings (CARC).

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor,
Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–069.

Apr 11, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of rifles and rifle conversion kits to Denmark and Sweden for commercial resale.

The U.S government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–075.

Apr 01, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, The Department of the State is transmitting certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK and Spain to support the production of the U.S. Army's Guided Multiple Launch Rocket System (GMLRS) weapon systems for use by the U.S. Army.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–081

Apr 16, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Taiwan to support the manufacture, development, integration, and support for F100 engine parts and components for end-use by the United States.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–082

Apr 25, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of rifles and submachine guns to Thailand for end use by the Royal Thai Police.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–085.

Apr 16, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Denmark to support the manufacture, development, integration, and support for Air-to-Ground Pylons for the F–35 Lightning II Aircraft for end-use by the United States.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–089.

Apr 08, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms and components abroad controlled under Category I of

the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 7.62mm rifles and suppressors to the Philippines for end use by the Department of National Defense.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–092.

Jun 10, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the Republic of Korea and Singapore to support the manufacture, integration, installation, operation, training, testing, maintenance, and repair of the F–15 Wide Field of View (WFOV) Heads-up Display (HUD).

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–100.

Jun 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Italy to support the installation, integration, modification, maintenance, and repair for F–35 Advanced Rail Launchers.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–104.

Jun 14, 2019.

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to France, Germany, Switzerland, and the UK to support the testing, installation, interfacing, and training in operation and intermediate level of maintenance of the Ammunition Handling System for the UK's Specialist Vehicle Program.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, Assistant Secretary Bureau of Legislative Affairs.
Enclosure: Transmittal No. DDTC 18–105.

Apr 16, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export to Jamaica of 5.56mm automatic rifles, barrels and upper receivers for use by the Jamaican Defense Forces.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–106.

Jun 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to the UK to support the design, development, engineering, production, assembly, testing, repair, rework, maintenance, modification, operation, and processing of components and parts for integration into the TOW Missile System.

The U.S. government is prepared to license the export of these items having

taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–107.

Jun 24, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK to support the maintenance, repair, and overhaul of the F135 propulsion system powering the F35 Lightning II aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–108.

Jun 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more. The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Israel to support the qualification, modification, test, repair, assembly, manufacture, and production of components and parts for integration into the Tamir Interceptor (a missile) used in the Iron Dome program.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 18–113.

Apr 25, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK to support manufacture of Harpoon missile canisters, capsules, certification and training vehicles, inert test vehicles, and discharge verification rounds for the Harpoon Weapon System.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–003.

Jun 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Germany and the UK to support the design, development, production, manufacture, assembly, operation, repair, testing, maintenance, and modification to develop P200–P400 series gas turbine engines.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–006.

Jun 10, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK to support the manufacture, design, assembly, qualification, test, repair, and maintenance of the F–35 electrical power management system.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–007.

May 02, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export to Australia of M134D 7.62mm machineguns.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–009.

Jun 27, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Sections 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export for the manufacture of significant military equipment abroad and the export of defense articles, including technical data and defense services, abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Israel to support the development and manufacture of component parts of pistols and rifles.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–011.

Jun 11, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Japan to support the operation, installation, provisioning of organizational and intermediate level maintenance, and repairs of the MK15 Phalanx Close-In Weapon System Block 0–1B Baseline 2 and SeaRAM Weapon System Defense Articles.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–014.

Jun 13, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Japan to support the transfer, modification, maintenance, and repair for F135 propulsion system for the F–35 Lightning II for use by the Government of Japan.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–015.

Jun 27, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms, parts, and components abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of 7.62mm automatic rifles and parts to India for the Indian Armed Forces.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–016.

Jun 14, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $25,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Denmark to support the integration, installation, operation, training, testing,

maintenance, and repair of the Joint Direct Attack Munition (JDAM), Small Diameter Bomb, and Laser Small Diameter Bomb onto the F–16 and F–35 aircraft.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 19–017.

Jun 12, 2019

The Honorable Nancy Pelosi, *Speaker of the House of Representatives.*

Dear Madam Speaker:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export to the Netherlands of 7.62mm machine guns and associated barrel assemblies. The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Mary Elizabeth Taylor, *Assistant Secretary Bureau of Legislative Affairs.*
Enclosed: Transmittal No. DDTC 19020.

UNCLASSIFIED

May 24, 2019

DETERMINATION UNDER THE ARMS EXPORT CONTROL ACT

SUBJECT: Emergency Arms Sales to Saudi Arabia, the United Arab Emirates, and Jordan

Pursuant to sections 36(b)(1), 36(c)(2), and 36(d)(2) of the Arms Export Control Act, 22 U.S.C. 2776, I hereby state that an emergency exists which requires the immediate sale of the following foreign military sales and direct commercial sales cases, including any further amendments specific to the cost, quantity, or requirements of these cases, in the national security interest of the United States:

For the Kingdom of Saudi Arabia:

- F–15 Support
- Sale and Co-production of Paveway Precision Guided Munitions
- Aircraft Maintenance Support
- Aurora Bomb Fuzing System
- 120mm M933 A1 Mortar Bombs
- F110 Engines for F–15s
- F/A–18 Panel Manufacture in Saudi Arabia for other end-users
- Advising and support of Ministry of Defense reform
- Continuation of follow-on logistics support and services for Royal Saudi Air Force, including Tactical Air Surveillance System support

For the United Arab Emirates:

- AH–64 Equipment
- APKWS Laser-guided Rockets
- Javelin Anti-Tank Missiles
- Paveway Precision Guided Munitions and Maverick Missile Support
- RQ–21 Blackjack UAS
- M107A1 .50 caliber rifles
- FMU–152A/B Programmable Bomb Fuse
- Patriot Guidance Enhanced Missile—Tactical Ballistic Missile
- U.S. Marine Corps training of UAE Presidential Guard
- F–16 engine parts
- Amendment to previously Congressionally notified case for ScanEagle and Integrator Unmanned Aerial Systems

For Jordan:

- Transfer of Paveway II Precision Guided Munitions from the United Arab Emirates

This determination shall be published in the **Federal Register** and along with the accompanying Memorandum of Justification shall be transmitted to Congress.

May 24, 2019

The Honorable Michael R. Pence, *President of the Senate.*

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data, and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and this, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to the UAE, France and the UK to support the integration, installation, operation, training, testing, maintenance, and repair of the Maverick AGM–65 Weapons System and the Paveway II, Paveway III, Enhanced Paveway II and Enhanced Paveway III Weapons Systems.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,
Michael R. Pompeo, *Bureau of Legislative Affairs.*
Enclosure: Transmittal No. DDTC 17–079 Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence, *President of the Senate.*

Dear Mr. President:

Pursuant to Section 36(c) and (d) of the Arms Export Control Act, please find enclosed a certification of a proposed amendment for the manufacture of significant military equipment abroad and the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more. Furthermore, I have determined that an emergency exists which requires the proposed sale in the national in the national security interest of the United States, and thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to Saudi Arabia, UK, Spain, and Italy to support the coproduction, manufacture, assembly, development, integration, installation, operation, testing, maintenance, repair, and demilitarization of the Paveway and Enhanced Paveway Weapon System for the Royal Saudi Air Force F–15,

Tornado, and Eurofighter Typhoon aircraft.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 17–094
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data, and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UK for the manufacture of the Aurora Fuzing System for the Paveway IV Precision Guided Bomb Program for end use by the UK Ministry of Defense and the Royal Saudi Air Force.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 17–112
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(d) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the retransfer of defense articles in the amount of $50,000,000 or more. Furthermore, pursuant to section 3(d)(2), I have determined that an emergency exists which requires that proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the retransfer of Paveway II laser guided bombs to Jordan.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 17–126
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of technical data and defense services in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and this, waives the congressional review requirement. As required by law, a justification for me determination is attached.

The transaction contained in the attached certification involves the export of technical data, and defense services to Saudi Arabia to provide technically qualified personnel to advise and assist the Royal Saudi Air Force (RSAF) in maintenance and training for the RSAF F–15 fleet of aircraft.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 17–128
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services, to the UAE to support the integration of the FMU–152A/B Joint Programmable Bomb Fuze system into the UAE Armed Forces General Headquarters' fleet of aircraft and associated weapons.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–013
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data, defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I will have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, defense services, and technical data to Saudi Arabia to support the performance of maintenance and repair services of F110 engines for the Kingdom of Saudi Arabia Ministry of Defense.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–029
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of firearms abroad controlled under Category I of the U.S. Munitions List in amount of $1,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of M107A1, .50 caliber semi-automatic rifles and sound suppressors to the UAE for end use by the General Headquarters, UAE Armed Forces.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–030
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President to the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of 120mm mortar bombs to the Saudi Arabian Royal Land Forces.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–050
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to Australia, the UK, and the UAE to support the marketing, sale, and on-going support of Unmanned Aerial Systems and support for future Intelligence, Surveillance and Reconnaissance (ISR) requirements for the UAE Armed Forces.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–080
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license amendment for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to support the installation, integration, modification, maintenance, and repair

for F110–GE–132 gas turbine engines for use in F–16 Aircraft by the UAE.

The U.S. government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–103
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to India, Saudi Arabia, Israel and the Republic of Korea to support the manufacture, production, test, inspection, modification, enhancement, rework, and repair of F/A18E/F and derivative series aircraft panels.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–109
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of technical data and defense services in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United States, and thus, waives the congressional review requirements. As required by law, a justification for determination is attached.

The transaction contained in the attached certification involves the export of technical data and defense services to Saudi Arabia and the UAE to support the Kingdom of Saudi Arabia Ministry of Defense Transformation Project.

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 18–110.
Memorandum of Justification.

May 24, 2019

The Honorable Michael R. Pence,
President of the Senate.

Dear Mr. President:

Pursuant to Section 36(c) of the Arms Export Control Act, please find enclosed a certification of a proposed license for the export of defense articles, including technical data and defense services, in the amount of $50,000,000 or more. Furthermore, pursuant to section 36(c)(2), I have determined that an emergency exists which requires the proposed sale in the national security interest of the United Sates, and, thus, waives the congressional review requirements. As required by law, a justification for my determination is attached.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services, to the UAE and the UK to support the preparation, shipment, delivery, and acceptance of the Guidance Enhanced Missiles (GEM–T).

The U.S. government is licensing the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification, which though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the U.S. firm concerned.

Sincerely,
Michael R. Pompeo
Enclosure: Transmittal No. DDTC 19–001
Memorandum of Justification.

Paula C. Harrison,

Senior Management Analyst, Directorate of Defense Trade Controls, U.S. Department of State.

[FR Doc. 2019–25491 Filed 11–26–19; 8:45 am]

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