

I. Consultation With Indian Tribes (E.O. 13175)

The Department of the Interior strives to strengthen its government-to-government relationship with Indian Tribes through a commitment to consultation with Indian Tribes and recognition of their right to self-governance and Tribal sovereignty. We have evaluated this rule under the Department's consultation policy and under the criteria in E.O. 13175 and have determined there are no substantial direct effects on federally recognized Indian Tribes that will result from this rulemaking because the rule is limited to updating outdated terms.

J. Paperwork Reduction Act

This rule does not contain information collection requirements, and a submission to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) is not required. We may not conduct or sponsor and you are not required to respond to a collection of information unless it displays a currently valid OMB control number.

K. National Environmental Policy Act

This rule does not constitute a major Federal action significantly affecting the quality of the human environment. A detailed statement under the National Environmental Policy Act of 1969 (NEPA) is not required because this is an administrative and procedural regulation. (For further information see 43 CFR 46.210(i)). We have also determined that the rule does not involve any of the extraordinary circumstances listed in 43 CFR 46.215 that would require further analysis under NEPA.

L. Effects on the Energy Supply (E.O. 13211)

This rule is not a significant energy action under the definition in E.O. 13211. A Statement of Energy Effects is not required.

M. Determination To Issue Final Rule Without the Opportunity for Public Comment and With Immediate Effective Date

BIA is taking this action under its authority, at 5 U.S.C. 552, to publish regulations in the **Federal Register**. Under the Administrative Procedure Act, statutory procedures for agency rulemaking do not apply "when the agency for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. 553(b)(3)(B). BIA finds that the notice

and comment procedure are impracticable, unnecessary, or contrary to the public interest, because: (1) These amendments are non-substantive; and (2) the public benefits for accurate identification of agency officials, and further delay is unnecessary and contrary to the public interest. Similarly because this final rule makes no substantive changes and merely reflects updates to titles in the existing regulations, this final rule is not subject to the effective date limitation of 5 U.S.C. 553(d).

List of Subjects in 25 CFR Part 248

Fishing, Indians.

For the reasons stated in the preamble, the Department of the Interior, Bureau of Indian Affairs, amends part 248 in title 25 of the Code of Federal Regulations as follows:

PART 248—USE OF COLUMBIA RIVER INDIAN IN-LIEU FISHING SITES

■ 1. The authority for part 248 continues to read as follows:

Authority: 5 U.S.C. 301; 25 U.S.C. 2, 9.

§ 248.1 [Amended]

■ 2. In § 248.1, remove the words "following rules and regulations" and "Portland Area Office" and add, in their place, the words "rules and regulations in this part" and "Northwest Regional Office," respectively.

§ 248.2 [Amended]

■ 3. In § 248.2, remove the words "in accordance" and add, in their place, the words "in accordance."

§ 248.10 [Amended]

■ 4. In § 248.10:

■ a. Remove the reference "this part 248" and add, in its place, the reference "this part."

■ b. Remove the words "to the Commissioner of Indian Affairs" and add, in their place, the words "to the Assistant Secretary—Indian Affairs"; and

■ c. Remove the words "on the Commissioner of Indian Affairs" and add, in their place, "of the Assistant Secretary—Indian Affairs".

§§ 248.1, 248.3, 248.4, 248.6, 248.8, 248.9, and 248.10 [Amended]

■ 5. In 25 CFR part 248, remove the words "Area Director" and add, in their place, the words "Regional Director" wherever they appear in the following places:

- a. Section 248.1;
- b. Section 248.3;
- c. Section 248.4;
- d. Section 248.6;

- e. Section 248.8;
- f. Section 248.9; and
- g. Section 248.10.

Tara Sweeney,

Assistant Secretary—Indian Affairs.

[FR Doc. 2020–24729 Filed 11–16–20; 8:45 am]

BILLING CODE 4337–15–P

DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 199**

[Docket ID: DOD–2017–HA–0058]

RIN 0720–AB71

TRICARE: Referring of Physical Therapy and Occupational Therapy by Doctors of Podiatric Medicine Acting Within the Scope of Their License

AGENCY: Office of the Secretary, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: The DoD is amending its TRICARE regulation. Specifically, this rule allows coverage of otherwise authorized physical therapy (PT) and occupational therapy (OT) for TRICARE beneficiaries when such services are referred by a TRICARE-authorized Doctor of Podiatric Medicine, also known as a Podiatrist, acting within the scope of his/her license.

DATES: This rule is effective December 17, 2020.

FOR FURTHER INFORMATION CONTACT: Amber Butterfield, Defense Health Agency, TRICARE Health Plan, Medical Benefits and Reimbursement Section, (303) 676–3565 or amber.l.butterfield.civ@mail.mil.

SUPPLEMENTARY INFORMATION:**I. Executive Summary****A. Purpose of the Rule**

This rule permits coverage of services referred by TRICARE-authorized Podiatrists for PT and OT. Prior to the issuance of this regulatory action, the language of Title 32 Code of Federal Regulations (CFR), § 199.4(c)(3)(x) stated that PT and OT may be cost-shared when services are referred and monitored by a physician, certified physician assistant, or certified nurse practitioner. As a result, otherwise authorized PT and OT services for TRICARE beneficiaries were not covered benefits when Podiatrists (even when acting within their scope of license) referred the services. Podiatrists are included in the provider category of "Other allied health professional" listed

in 32 CFR 199.6(c)(3)(iii) and are recognized by TRICARE statute, 10 U.S.C. 1079(a), as authorized to assess or diagnose illness, injury, or bodily malfunction as a prerequisite for TRICARE coverage of otherwise allowable treatment. According to the American Podiatric Medical Association, all United States jurisdictions recognize podiatrists as independent practitioners and do not limit Podiatrists' authority to refer their patients to PT and OT services. This rule makes it possible for that care to be cost-shared by the TRICARE program.

State governments generally regulate the licensure and practice of health care professionals, and DoD limits TRICARE benefits coverage to services and supplies furnished by otherwise authorized TRICARE individual professional providers performing within the scope of their state license or certification; granted by the applicable state or jurisdiction. State scope of practice laws vary with regard to the range of services, and some include the authority to refer PT and OT. Title 32 CFR 199.6(c)(1) provides that licensing be interpreted as requiring a license to practice in the jurisdiction where services are being furnished; generally a state license in the United States, or for care and treatment provided outside the continental United States, whatever comparable jurisdictional requirements (including licensure or certification) may exist in the host nation. Title 32 CFR 199.1(b) states that the regulation applies in all foreign countries, unless specific exemptions are granted by the Director. After assessing the information available, DoD has determined that it is unnecessarily restrictive not to cover otherwise authorized PT and OT services for TRICARE beneficiaries merely because the services are referred by a Podiatrist. Therefore, the regulation is amended to allow TRICARE coverage of PT and OT services when referred by a Podiatrist who is a TRICARE-authorized provider and acting within the scope of their state licensure or certification.

B. Summary of Major Provisions

This rule allows TRICARE coverage of otherwise authorized PT and OT services when referred by a TRICARE-authorized Podiatrist, acting within the scope of his/her state licensure or certification.

C. Legal Authority for This Program

This rule is issued under 10 U.S.C. 1073 (a)(2) giving authority and responsibility to the Secretary of Defense to administer the TRICARE program. The text of 10 U.S.C. chapter

55 can be found at <https://manuals.health.mil/pages/DisplayManual.aspx?SeriesId=MD>.

II. Regulatory History

The Department of Defense published a proposed rule in the **Federal Register** on April 8, 2019 (84 FR 13855). Comments were accepted for 60 days, and the comment period closed on June 7, 2019. A total of 22 comments were received. Those comments and the resulting changes to the rule text are described in the next section.

III. Discussion of Comments & Changes

The majority of comments received supported the proposed rule as a time and cost-saving measure for TRICARE beneficiaries as well as the TRICARE program. Included were comments received from organizations representing various medical fields regarding specific aspects of the rule. These comments provided feedback that in part, resulted in several changes to the rule text. The changes include: Refocusing to solely address referrals by Podiatrists instead of all "Other allied health professionals" to refer for PT and OT; revising the nomenclature for Podiatrists from Doctors of Podiatry or Surgical Chiropody to Doctors of Podiatric Medicine, or Podiatry; adding Podiatrists to the list of providers who can refer and provide ongoing oversight in order for the services of physical therapists and occupational therapists to be considered for benefits on a fee-for-service basis; and removing the option in the proposed rule for Podiatrists to refer patients to speech therapy (ST) services based on the lack of direct relationship between such a referral and podiatric practice. A discussion of the more significant comments concerning DoD's proposed rule, and our responses to these comments, are set forth below.

A commenter asked why TRICARE doesn't support the use of Physical Therapist Assistants (PTAs) and Certified Occupational Therapy Assistants (COTAs) in the care of its beneficiaries. The commenter also stated that TRICARE was the only payer source to have that restriction. The Department published a final rule on March 17, 2020, (85 FR 15061) which added certified or licensed PTAs and OTAs as TRICARE-authorized providers when supervised by a TRICARE-authorized physical therapist or occupational therapist in accordance with Medicare's rules for supervision and qualification.

Another commenter asserted that athletic trainers, if recognized by TRICARE as paramedical providers, would support the DoD in providing

greater efficiencies through care coordination. The addition of athletic trainers as TRICARE-authorized providers is outside the scope of this rule.

Several commenters requested clarification regarding PTs, OTs, and STs' ability to self-refer where allowed by state law under the proposed rule. The commenters assert that as PTs, OTs and STs are recognized as "Other allied health professionals" under 32 CFR 199.6(c)(3)(iii), the proposed rule includes the ability for PTs, OTs, and STs to self-refer as well as refer beneficiaries to another therapy practitioner where allowed by state law. The commenters reason that when state law is silent, no referral from another health care professional is required, whereas when state law imposes a referral requirement, TRICARE coverage will hinge on the PTs, OTs, and STs securing a referral in accordance with state law. This rule is revised to only allow Podiatrists to refer for PT and OT services, therefore, the commenters' issue is moot. However, to respond to this comment generally, self-referral by TRICARE providers is prohibited under 32 CFR 199.6(a)(13)(xi), which directs providers to "refer CHAMPUS beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in § 199.2." Title 32 CFR 199.2 defines economic interest as "(1) Any right, title, or share in the income, remuneration, payment, or profit of a CHAMPUS-authorized provider, or of an individual or entity eligible to be a CHAMPUS-authorized provider, resulting, directly or indirectly, from a referral relationship; [. . .] (2) A referral relationship exists when a CHAMPUS beneficiary is sent, directed, assigned or influenced to use a specific CHAMPUS-authorized provider, or a specific individual or entity eligible to be a CHAMPUS-authorized provider." Under these provisions, TRICARE-authorized providers are barred from self-referral, even if self-referral is acceptable under the state or jurisdiction's licensure or certification requirements.

A commenter also requested clarification as to whether and how the "ongoing oversight and supervision" of the program of treatment would apply to "Other allied health professionals" who would refer TRICARE beneficiaries for therapy services. As an example, the commenter asked if a social worker [referring] occupational therapy for a TRICARE beneficiary, would have to sign the OT plan of care and would that same social worker have to monitor and sign off on any changes to the plan of care if there is a significant change in

function for the TRICARE beneficiary 6 months after they initiated the plan of care. This rule is revised to only allow Podiatrists to refer PT and OT services; therefore the commenter's issue is moot. However to address the commenter, consider a Podiatrist rather than a social worker referring OT for a TRICARE beneficiary. The Podiatrist will provide ongoing and continual supervision by signing the OT plan of care, monitoring treatment and signing off on any changes to the plan of care if there is a significant change in function for the TRICARE beneficiary six months after they initiated the plan of care. Requirements for referral and supervision are defined at § 199.6(c)(2)(iv).

IV. Summary of Changes From NPRM

We adopt the proposed rule with changes as described in the comment responses.

V. Regulatory Analysis

A. Regulatory Planning and Review

a. Executive Orders

Executive Order 12866, "Regulatory Planning and Review" and Executive Order 13563, "Improving Regulation and Regulatory Review"

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, distribute 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. It has been determined that this rule is not a significant regulatory action. The rule does not: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency; (3) Materially alter the budgetary impact of entitlements, 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 set forth in these Executive Orders.

Executive Order 13771, "Reducing Regulation and Controlling Regulatory Costs"

E.O. 13771 seeks to control costs associated with the government imposition of private expenditures required to comply with Federal regulations and to reduce regulations that impose such costs. Consistent with the analysis of transfer payments under OMB Circular A-4, this rule does not involve regulatory costs subject to E.O. 13771.

b. Summary

This rule allows TRICARE coverage of otherwise authorized PT and OT services when referred by a TRICARE-authorized Podiatrist acting within the scope of his/her license.

c. Affected Population

This rule impacts all TRICARE beneficiaries, TRICARE-authorized providers, the TRICARE program and its Managed Care Support Contractors (MCSC). Beneficiaries will spend less time and expense obtaining referrals from their TRICARE-authorized primary care provider for PT and OT services related to foot and ankle conditions. Beneficiaries' courses of treatment will not be unnecessarily delayed by the need to obtain a referral from their primary care provider. TRICARE-authorized primary care providers and specialists will not need to spend unnecessary time seeing patients requiring PT or OT referrals for foot and ankle conditions, resulting in savings to the TRICARE program. TRICARE-authorized Podiatrists will be able to prescribe and oversee their patients' PT and OT courses of treatment. MCSCs will also be minimally impacted as this rule will require them to update their systems to accommodate the change.

d. Costs

Once beneficiaries initiate an episode of care with a Podiatrist for a covered disease or condition, they need not return to their primary care provider or specialist for an office visit to obtain an examination and a referral for PT and OT services. Assuming two hours by appointment (appointment, travel, waiting room, exam room), beneficiaries will save approximately 20,000 hours each year by not having to visit their referring provider prior to seeking PT or OT services. Referring providers will also save time, approximately 2,200 hours (15 minutes for a podiatrist to consult with a referring provider regarding a PT prescription) each year, as a result of reduced coordination and paperwork.

The amendment covers PT and OT services, when referred by a TRICARE-authorized Podiatrist acting within the scope of their license, and is not expected to increase the amount of otherwise covered PT and OT services. This is because referrals for such services are currently being written by those providers authorized to do so under the TRICARE program or those providers are countersigning prescriptions or referrals from a Podiatrist. The DoD does anticipate, however, that there may be a marginal increase in administrative costs to accommodate changes to our contractors' systems, although the overall result of this change will create an efficiency in the process.

This rule does not create new costs to the government, because it falls under the Transfer Payment clause in accordance with OMB Circular A-4. As this rule states, TRICARE payments for PT and OT services provided to military beneficiaries and prescribed by TRICARE-authorized Podiatrists, represents an "Insurance Payment" as described in OMB Circular A-4.

e. Benefits

The primary impact of this rule will result in less time and expense spent by beneficiaries and referring providers to obtain necessary medical services and supplies. Almost 10,000 beneficiaries visited a primary care provider after seeking care from a Podiatrist, but prior to PT services, in 2017. With an average copay/cost-share of \$24 across networks and TRICARE programs, this rule will conservatively save beneficiaries up to \$230,000 per year in cost-sharing and will conservatively save TRICARE \$1.1 million per year as a result of reduced visits to referring providers.

f. Alternatives

DoD considered several alternatives to this rulemaking. The first alternative involved taking no action. Although this alternative would be the most cost neutral for DoD, it was rejected as not benefitting TRICARE beneficiaries in need of PT and OT services during the regular course of foot and ankle treatment. For example, and according to "American Podiatric Medical Association," plantar fasciitis is treated with conservative efforts such as PT and OT services before turning to surgery. Additionally following foot or ankle surgery PT and OT services are necessary as a part of the post-operative treatment. This alternative also placed TRICARE at odds with common practice by other health care entities.

The second alternative DoD considered, and the regulatory change

offered in the proposed rule, was allowing all TRICARE-authorized “Other allied health professionals” to refer PT, OT and ST services. After the proposed rule was published, the Department received input from internal and external stakeholders and ultimately determined that this alternative was problematic because more than half of the 18 types of TRICARE-authorized “Other allied health professionals” do not have the authority to diagnose and treat a mental or physical illness, injury or bodily malfunction in accordance with 10 U.S.C. 1079(a)(12). Commenters also raised concerns over self-referrals, causing the Department to re-evaluate this alternative. Moreover, in accordance with 32 CFR 199.6(c)(3)(iii), the majority of TRICARE-authorized “Other allied health professionals” require the ongoing monitoring and supervision of a physician for a program or episode of treatment. Those TRICARE-authorized “Other allied health professionals” who may not provide covered care independent of a physician include: Certified Physician Assistant, Anesthesiologist Assistant, Licensed Registered Nurse, Audiologist, Licensed Registered Physical and Occupational Therapists, Licensed Registered Speech Therapist, Nutritionist, Registered Dietician, and TRICARE Certified Mental Health Counselor. While certified physician assistants require supervision of a physician, they were given authority to refer for therapy services under a rule published on August 10, 2018 (75 FR 50882) due to changes in the way billing occurred under the national provider identification system, and to align with Medicare’s allowance for nonphysician providers to provide referrals for therapy services. DoD finds it is appropriate to continue to allow certified physician assistants to refer and oversee therapy services due to the direct relationship physician assistants have with physicians, and because they often serve as a patient’s primary care provider, while not extending this privilege to other providers that may not provide independent care. Therefore DoD reconsidered this alternative and found it to be in conflict with current Program law. DoD considers the approach described in this final rule to be the most beneficial to both TRICARE beneficiaries and the TRICARE program. It offers time and cost savings and optimum continuity of care to beneficiaries, at no additional costs to the TRICARE program and affords the program the opportunity to expand health care delivery options.

B. Public Law 96–354, “Regulatory Flexibility Act” (5 U.S.C. 601)

The Department of Defense certifies that this final rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Therefore, the Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

C. 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).

D. Sec. 202, Public Law 104–4, “Unfunded Mandates Reform Act”

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (2 U.S.C. 1532) requires agencies to 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. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

E. Public Law 96–511, “Paperwork Reduction Act” (44 U.S.C. Chapter 35)

This rulemaking does not contain a “collection of information” requirement, and will not impose additional information collection requirements on the public under Public Law 96–511, “Paperwork Reduction Act” (44 U.S.C. chapter 35).

F. Executive Order 13132, “Federalism”

E.O. 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. This final rule will not have a substantial effect on State and local governments.

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR part 199 is amended as follows:

PART 199—[AMENDED]

■ 1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.4 is amended by revising paragraph (c)(3)(x)(A) to read as follows:

§ 199.4 Basic program benefits.

- * * * * *
- (c) * * *
- (3) * * *
- (x) * * *

(A) The services are prescribed and monitored by a physician, certified physician assistant, certified nurse practitioner or Doctor of Podiatric Medicine (Podiatrist) acting within the scope of their license.

* * * * *

- 3. Section 199.6 is amended by:
 - a. Revising paragraph (c)(3)(iii)(C);
 - b. Revising paragraph (c)(3)(iii)(K)(2) introductory text;
 - c. Removing paragraph (c)(3)(iii)(K)(2)(iii); and
 - d. Adding paragraph (c)(3)(iii)(K)(3).

The revisions and addition read as follows:

§ 199.6 TRICARE-authorized providers.

- * * * * *
- (c) * * *
- (3) * * *
- (iii) * * *

(C) *Doctors of Podiatric Medicine or Podiatrists.*

* * * * *

(K) * * *

(2) The services of the following individual paramedical providers of care to be considered for benefits on a fee-for-service basis may be provided only if: The beneficiary is referred by a physician, certified physician assistant, certified nurse practitioner, or podiatrist; and a physician, certified physician assistant, certified nurse practitioner, or podiatrist must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

* * * * *

(3) Licensed registered speech therapists (speech pathologists). In order to be considered for benefits on a fee-for-service basis, the services of a licensed registered speech therapist as an individual paramedical provider of care may be provided only if: (1) The beneficiary is referred by a physician, a certified physician assistant, or a certified nurse practitioner; and (2) a physician, a certified physician assistant, or a certified nurse practitioner must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

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Dated: November 12, 2020.

Aaron T. Siegel,

*Alternate OSD Federal Register Liaison
Officer, Department of Defense.*

[FR Doc. 2020-25361 Filed 11-16-20; 8:45 am]

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DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Parts 2 and 7

[Docket No. PTO-T-2019-0027]

RIN 0651-AD42

Trademark Fee Adjustment

AGENCY: United States Patent and Trademark Office, Department of Commerce.

ACTION: Final rule.

SUMMARY: The United States Patent and Trademark Office (Office or USPTO) is setting or adjusting certain trademark fees, as authorized by the Leahy-Smith America Invents Act (AIA), as amended by the Study of Underrepresented Classes Chasing Engineering and Science Success Act of 2018 (SUCCESS Act). The changes will allow the USPTO to continue to recover the prospective aggregate costs of strategic and operational trademark and Trademark Trial and Appeal Board (TTAB or Board) goals (based on workload projections included in the USPTO fiscal year (FY) 2021 Congressional Justification), including associated administrative costs. They will also further USPTO strategic objectives by better aligning fees with costs, protecting the integrity of the trademark register, improving the efficiency of agency processes, and ensuring financial sustainability to facilitate effective trademark operations. USPTO has weighed carefully current economic conditions and the potential hardship that the fee increase could create for businesses and individuals. The Office paused development of the fee rule because of uncertainty about the economy earlier this year. The latest economic data point to continued recovery in many sectors of the economy. Because of this and the relatively small annual cost to businesses and individuals from USPTO's trademark applications and maintenance fees, the Office has decided to finalize the fee rule for implementation in January 2021.

DATES: This rule is effective on January 2, 2021.

FOR FURTHER INFORMATION CONTACT: Catherine Cain, Office of the Deputy

Commissioner for Trademark Examination Policy, at 571-272-8946, or by email at TMPolicy@uspto.gov.

SUPPLEMENTARY INFORMATION: The USPTO conducted a fee review in FY 2019 that formed the basis for this regulatory process to adjust and set new trademark user fees. While trademark-related costs of operations have risen, trademark fees have not changed since January 2017. The revenue and workload assumptions in this rule are based on the assumptions found in the FY 2021 Congressional Justification (*i.e.*, the USPTO's FY 2021 budget submission to Congress). However, projections of aggregate revenues and costs are based on point-in-time estimates, and the circumstances surrounding these assumptions can change quickly. Notably, since the FY 2021 Congressional Justification was published, some fee collections have been lower than anticipated, due to lower than expected post-registration and Madrid filings.

Although economic circumstances have changed substantially since the FY 2021 budget was developed, the USPTO determined it remains the most appropriate starting point for developing this Final Rule. First, the USPTO's projections of aggregate revenues and costs are necessarily estimates that can change substantially from one point in time to the next due to numerous factors outside the USPTO's control, including cyclical economic changes or exogenous shocks, such as COVID-19, changes in the laws governing USPTO revenues or expenditures, and other events. Nevertheless, the USPTO has historically used its most recent budget assumptions when setting fees because they are the most recent complete evaluation of the USPTO's budget expectations and requirements, and they provide assumptions for stakeholders to use when formulating their comments. Those projections were developed in late calendar year 2019, prior to the COVID-19 outbreak, and they assumed continuing stable economic growth, not the sharp economic downturn and rebound of 2020.

As part of the multi-year fee-setting process, the Trademark Public Advisory Committee (TPAC) held a public hearing at the USPTO on September 23, 2019. The Office considered and analyzed all comments, advice, and recommendations received from the TPAC in proposing the fees set forth in the notice of proposed rulemaking (NPRM) published in the **Federal Register** on June 19, 2020, at 85 FR 37040. In formulating this rule, the

USPTO considered the state of the U.S. economy, the operational needs of the agency, and public comments submitted pursuant to the NPRM and made adjustments to the substance of this rule based on these considerations.

The USPTO has considered the state of the U.S. economy, the operational needs of the agency, and the comments and advice received from the public during the 45-day comment period. The current economic conditions illustrate the need for the increases set forth in this rule. The majority of USPTO's trademark revenue comes from new applications, but the initial costs to examine applications exceed the revenues from those applications. These examination costs have been increasing over the years while the USPTO has kept filing fees low enough to encourage broad public participation in the trademark system by offsetting examination costs with revenues generated with intent-to-use (ITU) and maintenance filings. Despite this balancing of front- and back-end costs, the USPTO has been observing multi-year consistent trends that have begun to adversely affect this model. The USPTO is receiving record levels of new trademark application filings, carrying with them larger front-end examination costs, while the percentage of ITU and maintenance filings are decreasing, resulting in less back-end revenue. With larger net costs that are not being offset by back-end revenue, the USPTO would be unable to maintain an operating reserve, which puts the Office on an unsustainable funding model.

The USPTO has observed these trends taking place whether the economy is doing well or facing turmoil, but the present situation is particularly challenging in light of the impact of the pandemic and its effect on the economy and filings. In particular, over the last six months, the USPTO has experienced a surge in new applications while maintenance filings continue to be impacted by lower rates of payment from one-time filers and individual applicants. The surge is also undermining the other traditional revenue sources that have historically offset front-end costs, such as ITU, since the USPTO is receiving more use-based applications, especially from foreign filers. While the USPTO is observing a surge in filings at present, given past experience, we expect a future decline to bring filings in line with the underlying economic dynamism. Although the timing and the magnitude of a future correction may be difficult to anticipate with complete accuracy, given past experience, the USPTO anticipates that a correction in filing