[FR Doc. 2024–08713 Filed 4–29–24; 8:45 am]
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Indian Health Service

### 42 CFR Part 136

**RIN 0917–AA24**

### Removal of Outdated Regulations

**AGENCY:** Indian Health Service, Department of Health and Human Services.

**ACTION:** Final rule.

**SUMMARY:** The Indian Health Service (IHS) of the Department of Health and Human Services (HHS or ''the Department'') is issuing this final rule to remove outdated regulations that do not align with the current statutory text.

**DATES:** This final rule is effective May 30, 2024.

**FOR FURTHER INFORMATION CONTACT:** Joshuah Marshall, Senior Advisor to the Director, Indian Health Service, 5600 Fishers Lane, Rockville, MD 20857, email: *joshuah.marshall@ihs.gov,* telephone: 301–443–7252.

**SUPPLEMENTARY INFORMATION:**

## I. Background

On January 27, 1982, the IHS published regulations imposing restrictions on the use of Federal funding for certain abortions, currently codified at 42 CFR 136.51 through 136.57.[1] These regulations implementing IHS program authority pursuant to 25 U.S.C. 13 and 42 U.S.C. 2001 allowed the use of IHS funds for abortions only when a physician certified that ''the life of the mother would be endangered if the fetus were carried to term.'' This restriction was to be consistent with a provision in the annual appropriations legislation for the Departments of Labor, Health and Human Services, and Education, sometimes referred to as the ''Hyde Amendment,'' that restricted the use of Federal funds for certain abortions, which did not automatically apply to IHS funding.[2] The purpose of these IHS regulations was specifically ''to conform IHS practice to that of the rest of the Department [of Health and Human Services] in accordance with the applicable congressional guidelines.'' [3] In 1988, Congress enacted 25 U.S.C. 1676, explicitly extending any limitations on the use of funds included in HHS appropriations laws with respect to the performance of abortions to apply to funds appropriated to IHS. As such, IHS became subject to the Hyde Amendment as included in annual appropriations legislation.

Since the IHS promulgated these regulations in 1982, Congress has repeatedly revised annual restrictions related to the use of Federal funds for certain abortions. In fiscal year 1994, for instance, Congress revised the Hyde Amendment to include additional exceptions to the general prohibition on the use of Federal funds for abortions, including in instances in which a pregnancy is the result of an act of rape or incest.[4] Similarly, in fiscal year 1998, Congress also altered the standards for when the ''life of the mother'' may be considered an exception.[5] As relevant here, the Hyde Amendment currently provides that no covered funds ''shall be expended for any abortion'' or ''for health benefits coverage that includes coverage of abortion,'' except ''if the pregnancy is the result of an act of rape or incest; or . . . in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.'' [6]

The current IHS regulations do not align with the current text of the Hyde Amendment or with 25 U.S.C. 1676. The IHS has complied with, and will continue to comply with, the statutory exceptions; has clarified its compliance with the statutory limitations through policy directives; [7] and now removes these outdated regulations in their entirety.[8] Doing so will eliminate any potential confusion regarding these outdated regulations and will ensure alignment with the applicable congressional restrictions governing HHS given Congress's enactment of 25 U.S.C. 1676, which independently aligns relevant restrictions applicable to the IHS and HHS. Regulations on this subject are not necessary to implement the IHS's authority. Nor are they necessary to comply with statutory directives. Moreover, amending the regulations to reflect the current Hyde Amendment could cause additional confusion in the future if Congress changes the annual appropriations language, as it has in the past.

## II. Development of Rule

The IHS published a notice of proposed rulemaking in the **Federal Register** on January 8, 2024 (89 FR 896), with a sixty-day comment period, which closed on March 8, 2024. Notification regarding a Tribal consultation session was sent via a Dear Tribal Leader Letter on January 17, 2024. The consultation session was conducted virtually on February 27, 2024. The IHS has reviewed public comments it received and addresses them below.

## III. Comments

The IHS received six written comments.[9] Two of the written comments were generally in favor of the removal. These two written comments were submitted by: (1) an individual and (2) a group of 20 individuals and advocacy organizations. Four of the written comments were generally opposed to the removal. These four comments were submitted by advocacy organizations. At the Tribal Consultation session, the IHS received three oral comments from representatives of Indian Tribes. Each of these three oral comments were generally in favor of the removal or non-germane to the removal.

After reviewing both written comments and those comments received orally through the Tribal consultation session, the IHS is finalizing this rule as proposed. Accordingly, this final rule will remove the current IHS Hyde regulations in their entirety, by removing and reserving subpart F, consisting of 42 CFR 136.51 through 136.57. Below, IHS summarizes and

[1] Final Rule, *Provision of Abortion Services by the Indian Health Service,* 47 FR 4016 (Jan. 27, 1982).

[2] Continuing Appropriations for FY 1981, Public Law 96–369 (1980); Continuing Appropriations Act for FY 1982, Public Law 97–92 (1981).

[3] Final Rule, *Provision of Abortion Services by the Indian Health Service,* 47 FR 4016 (Jan. 27, 1982).

[4] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994, Public Law 103–112, 509, 107 Stat. 1082, 1113 (1993).

[5] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1998, Public Law 105–78, 509(b), 111 Stat. 1467, 1516 (1997).

[6] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2024, Public Law 118–47, secs. 506–507, title V of Division D, 138 Stat. 703 (2024).

[7] Indian Health Service Circular No. 22–15, Use of Indian Health Service Funds for Abortions (Jun. 30, 2022), *https://www.ihs.gov/ihm/circulars/2022/use-of-indian-health-service-funds-for-abortions/.*

[8] The regulations also speak to recordkeeping requirements and confidentiality of information. However, these provisions are unnecessary to maintain, because recordkeeping and confidentiality of information are independently required by other laws and regulations that will remain in effect. See, *e.g.,* 45 CFR parts 160, 164 (Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule)).

[9] *See generally,* public comments posted in response to Docket ID # IHS–2024–0001, *https://www.regulations.gov/document/IHS-2024-0001-0001/comment.*

addresses all substantive topics raised in comments.

*A. Comments Supporting the Removal*

One commenter in the consultation session supported removal of the regulations. That commenter additionally suggested as a policy matter that the IHS consider allowing a nurse practitioner or licensed practitioner other than a physician to certify an abortion in cases in which certification is required. Under the current version of the Hyde Amendment, the IHS cannot make the requested change.

The current version of the Hyde Amendment, made applicable to IHS funding by 25 U.S.C. 1676(a), includes an exception in cases ''where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, *as certified by a physician,* place the woman in danger of death unless an abortion is performed.'' Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2024, Public Law 118–47, secs. 506–507, title V of Division D, 138 Stat. 703 (2024) (emphasis added). The IHS' removal of the outdated regulations cannot affect the separate statutory requirement that the certification be made by a physician. Therefore, the IHS has not made changes based on this comment.

Another commenter in the consultation session supported removal of the regulations and asked the IHS whether it intends to replace these regulations at a later time. While the IHS appreciates this question, regulations on this subject are not necessary to implement IHS' authority, nor are they necessary to comply with statutory directives. Moreover, amending the regulations to reflect the current Hyde Amendment could cause additional confusion in the future if Congress changes the annual appropriations language, as it has in the past. Therefore, the IHS has not made changes based on this comment. However, the IHS retains the discretion to promulgate regulations at a later date.

The IHS received an additional comment during the consultation session about what Tribes are permitted to do with their own, non-Federal funds. While the IHS appreciates the comment, it is outside the scope of this action. The regulations at issue apply only to IHS' operations as a healthcare provider and payer. Therefore, the IHS has not made changes based on this comment.

One commenter [10] supported removal of the regulations, based on the justifications provided in the notice of proposed rulemaking. The commenter opined that it was common sense to eliminate the regulations, since the IHS is required by 25 U.S.C. 1676 to follow the Hyde Amendment. The commenter also believes that removal would reduce confusion. In addition to agreeing with the justifications provided in the notice of proposed rulemaking, this commenter explained that the outdated regulations could lead to violations of the Equal Protection Clause of the Constitution if enforced. The commenter argued that if the regulation were enforced, American Indian and Alaska Native (AI/AN) people seeking abortions funded by the IHS would be treated differently than other individuals seeking abortions funded by HHS in other circumstances because only the second group would be able to take advantage of all of the exceptions included in the current Hyde Amendment. This comment requires no change to the proposed rule.

One comment,[11] submitted on behalf of a group of individuals, supported the removal but recommended that the IHS address disparate reproductive health outcomes for AI/AN people, including in urban areas, through activities outside of this rulemaking. The comment also recommended that the IHS improve its capacity for abortions consistent with the Hyde Amendment, and provide additional information, education, and engagement with AI/AN people about permitted abortions. This comment also discussed the commenters' opposition to the scope and impact of the Hyde Amendment itself. These comments are outside of the scope of the rulemaking.

*B. Comments Recommending Retaining the Regulations as Written*

Several commenters asked that the IHS retain the regulations as written, specifically 42 CFR 136.53 and 136.54 (the two sections that describe the limitations on the use of IHS funding for abortions). These commenters stated that the Hyde Amendment does not require, only permits, the use of IHS funding for abortion in cases of rape or incest. Therefore, the commenters opined that the IHS regulations are not outdated or in conflict with the current law, and also expressed their belief that abortions should not be provided when a pregnancy is the result of rape or incest. One commenter [12] also expressed concern that, should the Hyde Amendment not be included in the annual appropriations act and these regulations are removed, the IHS would be able to further expand access to abortions.

Congress has intentionally broadened the exceptions to the limitation on the use of Federal funds for abortion to include instances of rape or incest, and has specifically made the current scope of the Hyde Amendment applicable to IHS, via 25 U.S.C. 1676(a). Removing the outdated and unnecessary provisions of 42 CFR 136.53 and 136.54 simply aligns IHS regulations with congressional action. Comments about the substance and application of the Hyde Amendment itself are outside of the scope of this rulemaking.

Should Federal law regarding the use of Federal funds for abortion change in the future, the IHS could consider whether regulatory provisions should be proposed. But this final rule will ensure that the IHS follows applicable statutory provisions at any given time. Therefore, the IHS has not made changes based on these comments.

Two commenters [13] stated that removing the regulations is inconsistent with the IHS mission and authority under the Snyder Act, 25 U.S.C. 13, to provide care and assistance for the ''conservation of health,'' claiming that providing abortions in the case of rape or incest is not healthcare, and that abortion in general does not conserve the health of the fetus. The IHS has determined that removing 42 CFR 136.53 and 136.54 clearly aligns with congressional action, and this regulatory action simply removes outdated and unnecessary regulations. Comments about the substance and application of the Hyde Amendment itself are outside of the scope of this rulemaking. Therefore, the IHS has not made changes based on these comments.

One commenter [14] stated that providing abortions in the cases of rape or incest is not consistent with the trust relationship between the Federal Government and Tribes, and asserted that it infringes on Tribal sovereignty. The IHS has determined that removing 42 CFR 136.53 and 136.54 clearly aligns with congressional action, and this

[10] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0003, *https://www.regulations.gov/comment/IHS-2024-0001-0003.*

[11] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0007, *https://www.regulations.gov/comment/IHS-2024-0001-0007.*

[12] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0005, *https://www.regulations.gov/comment/IHS-2024-0001-0005.*

[13] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0005, *https://www.regulations.gov/comment/IHS-2024-0001-0005,* Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

[14] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0005, *https://www.regulations.gov/comment/IHS-2024-0001-0005.*

regulatory action simply removes outdated and unnecessary regulations. Comments about the substance of the Hyde Amendment itself are outside of the scope of this rulemaking. The use of IHS funds for certain abortions does not infringe on Tribal sovereignty. The IHS' clinicians and patients work together to determine the most appropriate treatment in an individual case. Moreover, this action does not affect a Tribe's right to self-determination or self-governance, nor does it impact any Tribe's choice to administer IHS health care programs itself. This action applies only to IHS operations as a healthcare provider and payer. The current regulations also do not reflect a determination that considerations surrounding Tribal sovereignty or the trust relationship forecloses funding for abortions in cases of rape or incest. *See* 46 FR 22617; 47 FR 4017–18. Therefore, the IHS has not made changes based on this comment.

One commenter [15] suggested that an exception to provide abortions in the cases of rape or incest is inappropriate. Removing the outdated regulations, however, would merely align IHS policy, via 25 U.S.C. 1676, with whatever limitations Congress has imposed at any given time, and with that of the rest of HHS. Comments about the substance of the Hyde Amendment itself are outside of the scope of this rulemaking. Therefore, the IHS has not made changes based on this comment.

C. Comments recommending amending the regulations

Several commenters suggested, as an alternative to retaining the regulations as written, that the IHS consider amending 42 CFR 136.54. Two commenters [16] suggested amending 42 CFR 136.54 to align with the Hyde Amendment. One of these commenters [17] recommended options to incorporate a reference to the Hyde Amendment, or to include a qualifier that, if the limitations in the Hyde Amendment change, the regulations will as well, or to cross reference the Hyde Amendment without describing the exceptions currently contained in that language. One of these commenters [18] explained its view that removing the regulations would cause more confusion to providers, and described problematic historical practices as an example of why clear IHS rules are needed. The IHS finds that these recommendations would merely restate Federal law, and are therefore unnecessary. The IHS disagrees that removal will cause more confusion. To the contrary, amending the regulations to reflect the current Hyde Amendment could cause additional confusion in the future if Congress changes the annual appropriations language, as it has in the past. Since 25 U.S.C. 1676 already applies the Hyde Amendment to IHS by law, regulations reflecting the Hyde Amendment are superfluous. The IHS has also clarified its compliance with the statutory limitations through policy directives and will continue to provide clear guidance to its staff. Therefore, the IHS has not made changes based on these comments.

One commenter [19] recommended amending 42 CFR 136.54 to state that Federal funds are available when a physician has found and certified that, on the basis of his or her professional judgment, ''a statutory condition for such funding, referenced in 25 U.S.C. 1676, is satisfied.'' The IHS does not view this change as necessary, since 25 U.S.C. 1676 is applicable to the IHS as a matter of law. In addition, the language recommended by the commenter is unclear, because there are no statutory conditions in 25 U.S.C. 1676 itself. This statute instead applies certain other Federal limitations on the use of funds for the performance of abortions to the IHS. Therefore, the IHS has not made changes based on this comment.

One commenter [20] stated that the IHS must publish a supplemental notice of proposed rulemaking to explain why it is removing and not replacing the regulations. The IHS clearly outlined its reasoning for removing the regulations in the proposed rule.[21] Therefore, the IHS has not made changes based on this comment.

One commenter [22] also offered edits to 42 CFR 136.55 (''Drugs and devices and termination of ectopic pregnancies'') to suggest that Federal funds cannot be used for some treatments for ectopic pregnancy. The IHS does not agree and, consistent with these regulations that are now being withdrawn, reaffirms the policy stated in current 42 CFR 136.55 that Federal funds are available for medical procedures necessary for the termination of an ectopic pregnancy. The IHS has existing broad authority under 25 U.S.C. 13 and 42 U.S.C. 2001 to provide healthcare. Accordingly, a regulation stating that funds are available for medical treatments for ectopic pregnancy is unnecessary and the IHS has not made changes based on this comment.

One commenter [23] stated that the certification requirement in 42 CFR 136.54 should be retained, even if other portions were changed or moved, to ensure compliance with Congress's funding limitations. The IHS believes retaining this section of the regulation is unnecessary. The language in the Hyde Amendment, already made applicable to the IHS via 25 U.S.C. 1676(a), currently contains a physician certification requirement. Retaining that language in the regulation could cause confusion in the future if Congress changes the annual appropriations language, as it has in the past. Therefore, the IHS has not made changes based on this comment.

Some commenters also stated that the remaining sections in subpart F should be retained. These commenters stated that the IHS did not provide justification as to why it was removing the entire section, and not just 42 CFR 136.54. As stated in the notice of proposed rulemaking,[24] the sections on recordkeeping and confidentiality of information (42 CFR 136.56, 136.57) are unnecessary to maintain because these requirements are independently required by other laws and regulations that will remain in effect. See, *e.g.,* 45 CFR parts 160, 164 (Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule)); 44 U.S.C. 31 (The Federal Records Act).

Other commenters similarly requested that the sections on recordkeeping and confidentiality of information be maintained, stating that doing so would ensure accountability, confidentiality, and patient safety. The IHS agrees that recordkeeping and confidentiality requirements serve those important purposes. However, the IHS has sufficient safeguards in place for recordkeeping already required by other

[15] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

[16] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0004, *https://www.regulations.gov/comment/IHS-2024-0001-0004;* Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

[17] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

[18] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0004, *https://www.regulations.gov/comment/IHS-2024-0001-0004.*

[19] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[20] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0004, *https://www.regulations.gov/comment/IHS-2024-0001-0004.*

[21] 89 FR 896 at 897.

[22] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[23] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[24] 89 FR 897.

Federal laws and regulations, and therefore retaining these regulations is unnecessary. The definition of ''physician'' in 42 CFR 136.52 is also unnecessary as the meaning of ''physician'' is well-established in practice and law. See, *e.g.,* 42 U.S.C. 1395x(r).

As acknowledged by a different commenter,[25] certain sections (§§ 136.51 (''Applicability''), 136.53 (''General rule'')) only exist in relation to other sections of subpart F, and thus are superfluous upon the removal of 42 CFR 136.54. Finally, the IHS has existing broad authority under 25 U.S.C. 13 and 42 U.S.C. 2001 to provide healthcare; accordingly, and as described above, 42 CFR 136.55 is unnecessary. Therefore, the IHS has not made changes based on these comments.

*D. Other Comments*

One commenter [26] stated that, as a policy matter, the IHS should not use Federal funds for drugs or devices to prevent implantation of the fertilized ovum. The IHS disagrees with this assertion and the removal of 42 CFR 136.55 makes no changes to IHS' existing authority to use Federal funds for the purposes described in the regulatory language being removed. The IHS' broad authority under 25 U.S.C. 13 and 42 U.S.C. 2001 authorizes the IHS to use Federal funds for necessary medical care such as contraception and therefore the IHS does not accept the commenter's policy suggestion to limit the use of funds for this purpose. Therefore, the IHS has not made changes based on this comment.

One commenter [27] explained its view that abortion harms AI/AN people, and recounted some of the history of maltreatment of AI/ANs. These comments are outside of the scope of this action, which merely aligns IHS regulation with statutory text. Therefore, the IHS has not made changes based on this comment.

One commenter [28] made suggestions for changing IHS policy, including statements in IHS policy about the impact of State law on IHS activities, but recognizes that these policy matters are separate from this rulemaking. The IHS also considers these comments outside of the scope of the rulemaking, and therefore has not made changes based on that discussion.

Another commenter [29] stated that the IHS failed to conduct a federalism analysis pursuant to Executive Order 13132, suggesting that IHS clarify whether ''its regulations can preempt state law and, if so, address the federalism implications of its rule.'' The IHS complied with the requirements of Executive Order 13132.[30] Removing these outdated and unnecessary regulations does not impose a substantial direct requirement or cost on State or local governments, as they apply only to IHS operations as a healthcare provider and payer. This action to remove outdated and unnecessary regulations does not have any preemptive effect. Therefore, the IHS has not made changes based on this comment.

Two commenters [31] stated that the IHS should focus its efforts on services for victims of sexual assault, and improving maternal and infant health, instead of removing the outdated rules. The IHS notes that it has a detailed Sexual Assault policy and a robust Maternal and Child Health Program, which will not be affected by the removal of the outdated regulations. The comment is thus outside of the scope of this action, which merely removes outdated and unnecessary regulations. Therefore, the IHS has not made changes based on these comments.

*E. Required Determinations*

**Executive Orders 12866, 13563, and 14094**

Executive Order 12866, as amended by Executive Order 14094, and Executive Order 13563 direct agencies to assess all costs and benefits of available regulatory alternatives. Section 3(f) of Executive Order 12866, as amended by Executive Order 14094, defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product); or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, 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 legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case. OIRA has determined that this final rule is a significant regulatory action as defined by Executive Order 12866, section 3(f).

**Regulatory Flexibility Act**

This action will not have a significant economic impact on Indian health programs. Therefore, the regulatory flexibility analysis provided for under the Regulatory Flexibility Act is not required.

**Executive Order 13132 (Federalism)**

Executive Order 13132, ''Federalism,'' establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on State and local governments or has federalism implications. HHS has determined that this final rule, which removes outdated regulations, does not impose such costs or have any federalism implications.

**Executive Order 13175**

This rule does not have a substantial direct effect on one or more Indian Tribes under Executive Order 13175, because it only removes outdated regulations that do not align with the current statutory text of the Hyde Amendment, with 25 U.S.C. 1676, or with current IHS practice.

**National Environmental Policy Act**

HHS has determined that this final rule does not have a significant impact on the environment.

**Paperwork Reduction Act**

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) requires the IHS to consider the impact of paperwork and other information collection burdens it imposes on the public. The IHS has determined no new requirement for information collection is associated with this final rule. This action does not affect any information collections.

[25] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[26] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[27] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0005, *https://www.regulations.gov/comment/IHS-2024-0001-0005.*

[28] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002.*

[29] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

[30] See 89 FR 897–98.

[31] Docket ID # IHS–2024–0001, Comment ID # IHS–2024–0001–0002, *https://www.regulations.gov/comment/IHS-2024-0001-0002;* Comment ID # IHS–2024–0001–0006, *https://www.regulations.gov/comment/IHS-2024-0001-0006.*

**Congressional Review Act**

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act, 5 U.S.C 801 *et seq.*), OIRA has determined that this rule does not meet the criteria set forth in 5 U.S.C. 804(2).

**Unfunded Mandates Reform Act of 1995**

We have examined the impacts of this rule as required by section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA; March 22, 1995; Pub. L. 104–4). Section 202 of UMRA requires that a covered agency prepare a budgetary impact statement before promulgating a rule that includes any Federal mandate that may result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year (adjusted for inflation). In 2024, that threshold is approximately $183 million (in 2023 dollars). If a covered agency must prepare a budgetary impact statement, section 205 further requires that it select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with the statutory requirements. In addition, section 203 requires a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule. Based on information currently available, we expect the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of unfunded mandate.

**List of Subjects in 42 CFR Part 136**

Employment, Government procurement, Healthcare, Health facilities, Indians, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 42 CFR part 136 as follows:

## PART 136—INDIAN HEALTH

■ 1. The authority citation for part 136 continues to read as follows:

**Authority:** 25 U.S.C. 13; sec. 3, 68 Stat. 674 (42 U.S.C., 2001, 2003); Sec. 1, 42 Stat. 208 (25 U.S.C. 13); 42 U.S.C. 2001, unless otherwise noted.

### Subpart F—[Removed and Reserved]

■ 2. Remove and reserve subpart F, consisting of §§ 136.51 through 136.57.

Dated: April 24, 2024.

**Xavier Becerra,**

*Secretary, Department of Health and Human Services.*

[FR Doc. 2024–09152 Filed 4–29–24; 8:45 am]

**BILLING CODE 4166–14–P**

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Parts 1, 2, 9, and 25

**[GN Docket No. 23–65, IB Docket No. 22–271; FCC 24–28; FR ID 210313]**

## Single Network Future: Supplemental Coverage From Space; Space Innovation

**AGENCY:** Federal Communications Commission.

**ACTION:** Final rule.

**SUMMARY:** In this document, the Federal Communications Commission (FCC or Commission) adopts rules to facilitate the deployment of supplemental coverage from space (SCS) in an effort to serve several important public interest goals for the Nation and expand the reach of communications services, particularly emergency services, so that connectivity and assistance is available in more remote places. In this document, to allow satellite communications on spectrum previously allocated only to terrestrial services, the Commission modifies the United States Table of Frequency Allocations to authorize bi-directional, secondary mobile-satellite service operations in certain spectrum bands that have no primary, non-flexible-use legacy incumbents, Federal or non-Federal. For these bands, we authorize SCS only where one or more terrestrial licensees—together holding all licenses on the relevant channel throughout a defined geographically independent area—lease access to their spectrum rights to a participating satellite operator, whose license reflects these frequencies and the geographically independent area in which they will offer SCS. In recognition that this new offering has the potential to bring life-saving connectivity to remote areas, the Commission also applies interim 911 call and text routing requirements to ensure that help is available to those who need it today while we work toward enabling automatic location-based routing of all emergency communications whether or not there is a terrestrial connection available.

**DATES:** The rules are effective May 30, 2024, except for the amendments to §§ 1.9047(d)(2) (amendatory instruction 3), 9.10(t)(3) through (5) (amendatory instruction 8), and 25.125(b)(1) and (2) and (c) (amendatory instruction 16), which are indefinitely delayed. The Federal Communications Commission will publish a document in the **Federal Register** announcing the effective date of these rule sections.

**FOR FURTHER INFORMATION CONTACT:** For additional information on this proceeding, contact Jon Markman of the Mobility Division, Wireless Telecommunications Bureau, at *Jonathan.Markman@fcc.gov* or (202) 418–7090, or Merissa Velez of the Space Bureau Satellite Programs and Policy Division, at *Merissa.Velez@fcc.gov* or (202) 418–0751. For information regarding the Paperwork Reduction Act of 1995 (PRA) information collection requirements contained in this document, contact Cathy Williams, Office of Managing Director, at (202) 418–2918 or *Cathy.Williams@fcc.gov.*

**SUPPLEMENTARY INFORMATION:** This is a summary of Commission's *Report and Order*, in GN Docket No. 23–65 and IB Docket No. 22–271; FCC 24–28, adopted and released on March 15, 2024. The full text of this document is available for public inspection online at *https://docs.fcc.gov/public/attachments/FCC-24-28A1.pdf.* The *Report and Order* was corrected by an erratum released on April 18, 2024. The changes made by the erratum are included in this document.

**Synopsis**

1. In the *Report and Order*, the Commission adopts a regulatory framework—the first of its kind in the world—to enable collaborations between satellite operators and terrestrial service providers to offer ubiquitous connectivity directly to consumer handsets using spectrum previously allocated only to terrestrial service. We anticipate that supplemental coverage from space, or SCS, will enable consumers in areas not covered by terrestrial networks to be connected using their existing devices via satellite-based communications.

2. In the *Report and Order*, to allow satellite communications on spectrum previously allocated only to terrestrial services, the Commission modifies the United States Table of Frequency Allocations to authorize bi-directional, secondary mobile-satellite service (MSS) operations in certain spectrum bands that have no primary, non-flexible-use legacy incumbents, Federal or non-Federal. Accordingly, the list of bands that will be available for the provision of SCS (the SCS Bands) is as follows: