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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 120

[Docket No.: FAA–2012–0688; Amdt. No. 120–1]

RIN 2120–AK01

Combined Drug and Alcohol Testing Programs

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This rulemaking allows air carrier operators and commuter or on-demand operators that also conduct commercial air tour operations to combine the drug and alcohol testing required for each operation into one testing program. The current rule requires those operators to conduct separate testing programs for their commercial air tour operations. This results in an unnecessary duplication of effort. The intended effect of this rulemaking is to decrease operating costs by eliminating the requirement for duplicate programs while maintaining the level of safety intended by existing rules. This final rule also clarifies existing instructions within the rule, corrects a typographical error, and removes language describing a practice that has been discontinued.

DATES: Effective September 13, 2013. Any currently held exemptions allowing part 121 or part 135 operators to combine their drug and alcohol testing programs with the testing programs for their commercial air tour operations will expire on the effective date of this rule.

ADDRESSES: For information on where to obtain copies of rulemaking documents and other information related to this final rule, see ''How To Obtain Additional Information'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: For technical questions concerning this action, contact Rafael Ramos, Office of Aerospace Medicine, Drug Abatement Division, AAM–800, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone (202) 267–8442; facsimile (202) 267–5200; email: *drugabatement@faa.gov.*

For legal questions concerning this action, contact Neal O'Hara, Attorney, Office of the Chief Counsel—International Law, Legislation, and Regulations Division, AGC–200, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone (202) 267–5348; email: *neal.o'hara@faa.gov.*

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

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

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Chapter 451, Section 45102—Alcohol and Controlled Substances Testing. Under that section, the FAA is charged with prescribing regulations for operators to establish and to conduct pre-employment, reasonable suspicion, random, and post-accident drug and alcohol testing. Parts of this rule, for example those sections dealing with contract air traffic controllers, were promulgated under the FAA's general rulemaking authority in 49 U.S.C. 44701(a)(5). This regulation is within the scope of that authority.

I. Overview of Final Rule

Some part 121 air carriers and part 135 commuter and on-demand operators also conduct commercial air tours. Part 121 and part 135 each contain requirements for drug and alcohol testing. Until 2007, an operator's drug and alcohol testing program covered its commercial air tour operations.

In 2007, the National Air Tour Safety Standards rule (72 FR 6884, February 13, 2007) established a separate subpart in part 91 to govern commercial air tour operators. That rule required drug and alcohol testing for commercial air tour operations that was separate from, and in addition to, the testing required by part 121 and part 135. This final rule gives part 121 and part 135 operators with commercial air tour operations the option of administering one drug and alcohol testing program that will cover both operations. The intent of this action is to lessen the administrative burden on such operators.

This rule also includes four other actions—

1. It makes clear that operators obtaining a Letter of Authorization from the local Flight Standards District Office (FSDO) to conduct commercial air tour operations are considered to have registered their drug and alcohol testing program by submitting certain information to the FSDO.
2. It corrects the omission of a reference reiterating that on-duty use of alcohol is grounds for permanent disqualification from service. That reference was inadvertently left out of the May 14, 2009, final rule titled ''Drug and Alcohol Testing Program'' (74 FR 22653).
3. It reorganizes existing rule text to alleviate any confusion about the requirement that training of supervisors, as well as training of employees, must be documented as part of each employer's employee assistance program.
4. It makes clear that the Agency's practice of approving the employer's drug and alcohol testing program has been discontinued.

II. Background

As noted above, in May 2009, the FAA published the Drug and Alcohol Testing Program rule. That rule moved the drug and alcohol testing regulations into a new part 120.

Part 120 of Title 14 of the Code of Federal Regulations (CFR) requires the establishment of a drug and alcohol testing program designed to prevent accidents and injuries that result from the use of prohibited drugs and the misuse of alcohol. Specifically, the rule requires three groups of operators to implement a drug and alcohol testing program:

- Part 119 certificate holders authorized to conduct part 121 operations.
- Part 119 certificate holders authorized to conduct part 135 operations.

• Commercial air tour operators as defined in § 91.147.

These requirements are meant to ensure that any person who performs safety-sensitive functions for these operators, either directly or by contract (including subcontractor at any tier), is subject to drug and alcohol testing.

Under the current rules, operators who are conducting a part 121 or part 135 operation and commercial air tour operations must administer separate drug and alcohol testing programs. Numerous operators have petitioned the FAA for an exemption from the requirement to maintain two separate drug and alcohol testing programs because having two programs often requires testing the same employees twice. This duplication adds administrative and financial burdens for the operator but it does not increase safety.

Since 2008, the FAA has granted approximately 135 exemptions allowing operators to implement a single testing program. Given the large number of exemptions that the Agency has granted, and the need to renew them every two years, the FAA believes it is appropriate to simply amend the existing rule. This approach relieves operators from seeking an operator-specific exemption. In granting these exemptions, the FAA has recognized that, in most cases, the same employees and equipment are used interchangeably between the part 121 or part 135 operation and its commercial air tour operation. Therefore, the FAA has found that when a part 119 certificate holder operates both a part 121 or a part 135 operation and a § 91.147 commercial air tour operation, combining the two testing programs maintains a level of safety equivalent to that provided by the current regulations. Under one testing program, employees are still subject to drug and alcohol testing in accordance with part 120. Any existing exemptions for combined testing programs held by part 121 or part 135 operators that also conduct § 91.147 operations will expire on the effective date of this rule. Those certificate holders with current exemptions need not take any action to comply with the requirements outlined in this rule.

III. Discussion of Public Comments

On July 2, 2012, the FAA published a Notice of Proposed Rulemaking (NPRM) (77 FR 39194), entitled ''Combined Drug and Alcohol Testing Programs.'' The comment period for the NPRM closed on August 31, 2012. The FAA received four comments to the NPRM. The National Air Transportation Association expressed its support for the proposed rule, noting that the rule would reduce costs and ease administrative burdens without compromising safety.

One individual suggested that combining the two testing programs should be a requirement rather than an option. The FAA believes that most operators will take advantage of the option to reduce the amount of work and cost involved in administering duplicate testing. Regardless of how many operators take advantage of this option, however, it would not be appropriate to require it. While combining programs may have financial and administrative benefits, it has no safety benefit.

The Drug and Alcohol Testing Industry Association (DATIA) commented in support of this rule and requested that the FAA address how operators can make the transition from two programs to one and how Management Information System (MIS) information should be reported after combining the programs. The FAA will post instructional information in a separate document on its Drug Abatement Web site (*http://www.faa.gov/go/drugabatement*) for part 119 certificate holders operating part 121 or part 135 operations and § 91.147 operations to describe what must be done when first seeking to combine programs. The first step is for the part 121 or part 135 operator to advise the Principal Operations Inspector (POI) that one program will be implemented for both the part 121 or part 135 operation and the § 91.147 operation. The POI will annotate the § 91.147 operator's records (Letter of Authorization (LOA)) with an ''A3'' and the part 121 or part 135 certificate number to indicate that the programs are combined. The operator must then give the same notification to the FAA's Drug Abatement Division. Once a single testing program is established, the part 121 or part 135 operation must submit a single MIS report. The FAA wishes to emphasize that an operator currently holding an exemption to conduct one combined drug and alcohol testing program is not required to take any action to continue administering its combined testing program.

Another comment was received from the Aircraft Owners and Pilots Association (AOPA) regarding the proposal that, under a combined testing program, the FAA would take enforcement action for noncompliance against the part 121 or part 135 operation, even if the pilot whose testing is in question is only used for § 91.147 commercial air tour operations. The AOPA maintains that the FAA should be able to discern which operation was responsible for the infraction and adjust the enforcement action accordingly. The FAA, however, assesses penalties against the employer, not the type of operation. Under this rule, once the two programs have been combined, they become one program. So, for example, when a part 121 operator fails to give a pre-employment drug test to a pilot who conducts part 121 and air tour flights, the part 121 operator has responsibility for the error. Therefore, any civil penalties for regulatory violations are assessed at the part 121 or part 135 operator level. This is consistent with existing exemptions allowing part 119 certificate holders to combine their part 121 or part 135 operation's testing program with their § 91.147 commercial air tour operation's testing program.

Additionally, AOPA commented that the proposed language for clarifying the consequence of on-duty alcohol use was still not completely clear and suggested alternate language. The FAA agrees with AOPA's comment and has adopted its suggested language for § 120.221(b).

IV. Discussion of Other Provisions in the Final Rule

The NPRM proposed provisions identical to those codified here with the exception that the wording of a few sections have been revised to make their meaning clearer. The headings of §§ 120.117(e) and 120.225(e) have been changed along with the regulatory language to clarify that the procedure for registering a drug and alcohol testing program for a § 91.147 commercial air tour operator is similar to the procedure used to obtain a drug and alcohol testing program operations specification for a part 121 or part 135 operator. Specifically, the revised rule requires the commercial air tour operator to submit certain information to the local FSDO instead of the Drug Abatement Division. In addition, paragraph (f) of both §§ 120.117 and 120.225 have been changed slightly to clarify that the paragraphs apply to employers who are not certificated air carriers or commercial air tour operators. Also, the wording of § 120.221 has been revised. The meaning and intent of § 120.221 have not changed from what was originally proposed.

This rule amends §§ 120.117 and 120.225 to give a part 121 or part 135 operator the option of including its commercial air tour operation employees under § 91.147 in a combined drug and alcohol testing program.

This rule also clarifies the requirement for registering a drug and

alcohol program for a § 91.147 commercial air tour operator by aligning that requirement with the requirements for obtaining a drug and alcohol program operations specification for a part 121 or part 135 operator. Currently, § 91.147 specifies that operators intending to begin commercial air tour operations must obtain a Letter of Authorization which includes an ''Antidrug and Alcohol Misuse Prevention Program registration.'' The current §§ 120.117 and 120.225, which contain the drug and alcohol testing requirements that apply to commercial air tour operations, refer to a need for operators intending to begin commercial air tours to ''register with the FAA.'' This rule changes §§ 120.117(e) and 120.225(e) to clarify that operators obtaining a Letter of Authorization from their local FSDO are considered to have registered their drug and alcohol testing program by submitting certain information to the local FSDO. In addition, the language of §§ 120.117(f) and 120.225(f) was changed slightly to indicate that it applies to contractors and repair stations, but not to certificated air carriers or commercial air tour operators. Also, the FAA has removed language in § 120.117(e) and (f) and § 120.225(e) and (f) that referred to submitting information to the FSDO in duplicate. The FAA does not need the information to be submitted in duplicate.

Other errors in the Agency's 2009 Drug and Alcohol Testing Program final rule were also brought to the FAA's attention. In § 120.221(b), references to §§ 120.19(c) and 120.37(c) were inadvertently omitted. The omitted references point the reader to existing §§ 120.19(c) and 120.37(c), which indicate that one occurrence of on-duty alcohol use carries the consequence of permanent disqualification from service. The FAA has corrected that error and has reorganized that paragraph for clarity.

Additionally, when the FAA combined part 121 appendices I and J to form part 120, the FAA renumbered the requirements. This reorganization created some confusion in § 120.115, which contains the requirement that employers must include documentation of the training given to both supervisors and employees in their employee assistance programs. When moving these requirements from appendix I to the subpart in part 120, not only did the FAA need to assign new section numbers to the requirements but the FAA also needed to list the details of those requirements under separate line numbers. Requirements that had been previously stated in one paragraph were now broken into separate lines. For § 120.115, the requirements were ultimately numbered in such a way that it appeared that employers needed only to retain employee training records. The FAA is reordering the wording to make it clear that supervisory training must be documented as well. It was never the FAA's intention to change this requirement.

Finally, in 2004, the FAA discontinued the practice of approving drug and alcohol testing programs. That language was never removed from the Code of Federal Regulations. This rule amends § 120.115 to remove ''submitted to the FAA for approval.''

V. Regulatory Notices and Analyses

Changes to Federal regulations must undergo several economic analyses. First, Executive Order 12866 and Executive Order 13563 direct that each Federal agency shall propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs. Second, the Regulatory Flexibility Act of 1980 (Pub. L. 96–354) requires agencies to analyze the economic impact of regulatory changes on small entities. Third, the Trade Agreements Act (Pub. L. 96–39) prohibits agencies from setting standards that create unnecessary obstacles to the foreign commerce of the United States. In developing U.S. standards, this Trade Act requires agencies to consider international standards and, where appropriate, that they be the basis of U.S. standards. Fourth, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires agencies to prepare a written assessment of the costs, benefits, and other effects of proposed or final rules that include a Federal mandate likely to result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more annually (adjusted for inflation with base year of 1995). This portion of the preamble summarizes the FAA's analysis of the economic impacts of this final rule.

Department of Transportation Order DOT 2100.5 prescribes policies and procedures for simplification, analysis, and review of regulations. If the expected cost impact is so minimal that a proposed or final rule does not warrant a full evaluation, this order permits that a statement to that effect and the basis for it be included in the preamble if a full regulatory evaluation of the cost and benefits is not prepared. Such a determination has been made for this final rule. The reasoning for this determination follows:

(1) The final rule is voluntary. The final rule does not impose new regulatory requirements or additional costs.

(2) The final rule is not a ''significant regulatory action'' as defined in section 3(f) of Executive Order 12866;

(3) The final rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act;

(4) The final rule will not have a significant effect on international trade; and

(5) The final rule will not impose an unfunded mandate on State, local, or tribal governments, or on the private sector, by exceeding the monetary threshold identified.

(6) No comments were received on the economic portions of the NPRM during the public comment period.

These analyses are summarized below.

Currently, part 121 operators or part 135 operators who also conduct air tour operations must have separate drug and alcohol testing programs for the air tour operations and their other (part 121 or part 135) operations. The intended effect of this rulemaking is to decrease this duplicative drug and alcohol testing by eliminating the requirement for two testing programs while maintaining the level of safety required by the current drug and alcohol testing regulations. This may reduce operators' costs by allowing them to eliminate one testing program and its associated costs. This final rule will also reduce the FAA's costs by reducing the number of drug and alcohol testing programs that the FAA will have to inspect.

In addition, this rulemaking allows the agency to clarify that air tour operators obtaining a Letter of Authorization from the local FSDO to conduct air tour operations are considered to have registered their drug and alcohol testing program by submitting certain information to the FSDO. This may reduce costs to the operators and the FAA by reducing the amount of time spent attempting to clarify requirements.

Based on the above analyses, this final rule is considered to be a cost-relieving rule. For this reason, and because the FAA made a similar determination for the proposed rule and received no comment on this point, the FAA believes that the final rule will reduce costs with no loss of benefits. Thus this final rule is cost beneficial.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) establishes ''as a principle of regulatory issuance that agencies shall endeavor, consistent with the objective

of the rule and of applicable statutes, to fit regulatory and informational requirements to the scale of the businesses, organizations, and governmental jurisdictions subject to regulation.'' To achieve that principle, the RFA requires agencies to solicit and consider flexible regulatory proposals and to explain the rationale for their actions. The RFA covers a wide range of small entities, including small businesses, not-for-profit organizations and small governmental jurisdictions.

Agencies must perform a review to determine whether a proposed or final rule will have a significant economic impact on a substantial number of small entities. If the agency determines that it will, the agency must prepare a regulatory flexibility analysis as described in the Act.

However, if an agency determines that a proposed or final rule is not expected to have a significant economic impact on a substantial number of small entities, section 605(b) of the 1980 RFA provides that the head of the agency may so certify and a regulatory flexibility analysis is not required. The certification must include a statement providing the factual basis for this determination, and the reasoning should be clear.

Size Standards

Size standards for small entities are published by the Small Business Administration (SBA) on their Web site at *http://www.sba.gov/size.* The size standards used herein are from ''SBA U.S. Small Business Administration, Table of Small Business Size Standards, Matched to North American Industry Classification System Codes.'' The Table is effective November 5, 2010, and uses the 2007 NAICS codes. Scheduled Passenger Air Transportation is listed in Sector 48–49–Transportation and Warehousing; Subsector 481–Air Transportation; NAICS Code 48111. Non-Scheduled Chartered Passenger Air Transportation is listed under the same Sector and Subsector with NAICS code 481211. In both cases the small entity size standard is 1,500 employees.

It is estimated that most of the air carriers involved in this type of activity are small entities. Therefore, the final rule affects a large number of small entities.

However, the final rule imposes no costs and may result in a cost reduction for an entity that should choose to use the final rule. No comments were received on the Regulatory Flexibility Section of the NPRM. Therefore, the FAA Administrator certifies that this final rule will not have a significant economic impact on a substantial number of small part 119 certificate holders that conduct part 121 operations or part 135 operations and commercial air tour operations under § 91.147.

International Trade Impact Assessment

The Trade Agreements Act of 1979 (Pub. L. 96–39), as amended by the Uruguay Round Agreements Act (Pub. L. 103–465), prohibits Federal agencies from establishing standards or engaging in related activities that create unnecessary obstacles to the foreign commerce of the United States. Pursuant to these Acts, the establishment of standards is not considered an unnecessary obstacle to the foreign commerce of the United States, so long as the standard has a legitimate domestic objective, such as the protection of safety, and does not operate in a manner that excludes imports that meet this objective. The statute also requires consideration of international standards and, where appropriate, that they be the basis for U.S. standards. No comments were received on this section in the NPRM during the public comment period. The FAA has assessed the potential effect of this final rule and has determined that it will have little or no effect on international trade.

Unfunded Mandates Assessment

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires each Federal agency to prepare a written statement assessing the effects of any Federal mandate in a proposed or final agency rule that may result in an expenditure of $100 million or more (adjusted annually for inflation) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector; such a mandate is deemed to be a ''significant regulatory action.'' The FAA currently uses an inflation-adjusted value of $143.1 million in lieu of $100 million. No comments on this section in the NPRM were received during the public comment period. This final rule does not contain such a mandate; therefore, the requirements of Title II do not apply.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) requires that the FAA consider the impact of paperwork and other information collection burdens imposed on the public. The FAA has determined that there is no new information collection associated with allowing operators to combine drug and alcohol testing programs.

International Compatibility and Cooperation

In keeping with U.S. obligations under the Convention on International Civil Aviation, it is FAA policy to conform to International Civil Aviation Organization (ICAO) Standards and Recommended Practices to the maximum extent practicable. The FAA has reviewed the corresponding ICAO Standards and Recommended Practices and has identified no differences with these regulations.

Executive Order 13609, Promoting International Regulatory Cooperation

Executive Order 13609, Promoting International Regulatory Cooperation, (77 FR 26413, May 4, 2012) promotes international regulatory cooperation to meet shared challenges involving health, safety, labor, security, environmental, and other issues and to reduce, eliminate, or prevent unnecessary differences in regulatory requirements. The FAA has analyzed this action under the policies and agency responsibilities of Executive Order 13609, and has determined that this action would have no effect on international regulatory cooperation.

Environmental Analysis

FAA Order 1050.1E identifies FAA actions that are categorically excluded from preparation of an environmental assessment or environmental impact statement under the National Environmental Policy Act in the absence of extraordinary circumstances. The FAA has determined this rulemaking action qualifies for the categorical exclusion identified in paragraph 312d and involves no extraordinary circumstances.

VI. Executive Order Determinations

A. Executive Order 13132, Federalism

The FAA has analyzed this final rule under the principles and criteria of Executive Order 13132, Federalism. The agency determined that this action will not have a substantial direct effect on the States, or the relationship between the Federal Government and the States, or on the distribution of power and responsibilities among the various levels of government, and, therefore, does not have Federalism implications.

B. Executive Order 13211, Regulations That Significantly Affect Energy Supply, Distribution, or Use

The FAA analyzed this final rule under Executive Order 13211, Actions Concerning Regulations that Significantly Affect Energy Supply, Distribution, or Use (May 18, 2001). The

agency has determined that it is not a ''significant energy action'' under the executive order and it is not likely to have a significant adverse effect on the supply, distribution, or use of energy.

VII. How To Obtain Additional Information

A. Rulemaking Documents

An electronic copy of a rulemaking document may be obtained by using the Internet—

1. Search the Federal eRulemaking Portal at *http://www.regulations.gov;*
2. Visit the FAA's Regulations and Policies Web page at *http://www.faa.gov/regulations_policies/* or
3. Access the Government Printing Office's Federal Digital System Web page at *http://www.gpo.gov/fdsys/.*

Copies may also be obtained by sending a request (identified by notice, amendment, or docket number of this rulemaking) to the Federal Aviation Administration, Office of Rulemaking, ARM–1, 800 Independence Avenue SW., Washington, DC 20591, or by calling (202) 267–9680.

B. Comments Submitted to the Docket

Comments received may be viewed by going to *http://www.regulations.gov* and following the online instructions to search the docket number for this action. Anyone is able to search the electronic form of all comments received into any of the FAA's dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.).

C. Small Business Regulatory Enforcement Fairness Act

The Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 requires FAA to comply with small entity requests for information or advice about compliance with statutes and regulations within its jurisdiction. A small entity with questions regarding this document may contact its local FAA official, or the person listed under the **FOR FURTHER INFORMATION CONTACT** heading at the beginning of the preamble. To find out more about SBREFA on the Internet, visit *http://www.faa.gov/regulations_policies/rulemaking/sbre_act/.*

List of Subjects in 14 CFR Part 120

Alcoholism, Air carriers, Air traffic control, Airmen, Alcohol abuse, Alcohol testing, Aviation safety, Charter flights, Commercial air tour operators, Contract air traffic controllers, Drug abuse, Drug testing, Operators, Reporting and recordkeeping requirements, Safety, Safety-sensitive, Transportation.

The Amendment

In consideration of the foregoing, the Federal Aviation Administration amends chapter I of title 14, Code of Federal Regulations as follows:

PART 120—DRUG AND ALCOHOL TESTING PROGRAM

■ 1. The authority citation for part 120 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40101–40103, 40113, 40120, 41706, 41721, 44106, 44701, 44702, 44703, 44709, 44710, 44711, 45101–45105, 46105, 46306.

■ 2. Amend § 120.115 as follows:

■ a. Redesignate paragraphs (c)(1)(iii) and (c)(5) as paragraphs (c)(5) and (c)(6) respectively.

■ b. Revise newly redesignated paragraphs (c)(5) and (c)(6).

The revisions read as follows:

§ 120.115 Employee Assistance Program (EAP).

* * * * *

(c) * * *

(5) Documentation of all training given to employees and supervisory personnel must be included in the training program.

(6) The employer shall identify the employee and supervisor EAP training in the employer's drug testing program.

■ 3. Amend § 120.117 as follows:

■ a. Revise paragraphs (a) and (b);

■ b. Redesignate paragraph (e) as paragraph (f);

■ c. Add new paragraph (e);

■ d. Revise newly redesignated paragraph (f).

The additions and revisions read as follows:

§ 120.117 Implementing a drug testing program.

(a) Each company must meet the requirements of this subpart. Use the following chart to determine whether your company must obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification, Letter of Authorization, or Drug and Alcohol Testing Program Registration from the FAA:

If you are . . .	You must . . .
(1) A part 119 certificate holder with authority to operate under parts 121 or 135.	Obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification by contacting your FAA Principal Operations Inspector.
(2) An operator as defined in § 91.147 of this chapter	Obtain a Letter of Authorization by contacting the Flight Standards District Office nearest to your principal place of business.
(3) A part 119 certificate holder with authority to operate under parts 121 or 135 and an operator as defined in § 91.147 of this chapter.	Complete the requirements in paragraphs 1 and 2 of this chart and advise the Flight Standards District Office and the Drug Abatement Division that the § 91.147 operation will be included under the part 119 testing program. Contact the Drug Abatement Division at FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.
(4) An air traffic control facility not operated by the FAA or by or under contract to the U.S. Military.	Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.
(5) A part 145 certificate holder who has your own drug testing program.	Obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification by contacting your Principal Maintenance Inspector or register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, if you opt to conduct your own drug testing program.
(6) A contractor who has your own drug testing program	Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, if you opt to conduct your own drug testing program.

(b) Use the following chart for implementing a drug testing program if you are applying for a part 119 certificate with authority to operate under parts 121 or 135 of this chapter, if you intend to begin operations as defined in § 91.147 of this chapter, or if you intend to begin air traffic control operations (not operated by the FAA or by or under contract to the U.S. Military). Use it to determine whether you need to have an Antidrug and Alcohol Misuse Prevention Program Operations Specification, Letter of Authorization, or Drug and Alcohol Testing Program Registration from the FAA. Your employees who perform safety-sensitive functions must be tested in accordance with this subpart. The chart follows:

If you . . .	You must . . .
(1) Apply for a part 119 certificate with authority to operate under parts 121 or 135.	(i) Have an Antidrug and Alcohol Misuse Prevention Program Operations Specification, (ii) Implement an FAA drug testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(2) Intend to begin operations as defined in § 91.147 of this chapter	(i) Have a Letter of Authorization, (ii) Implement an FAA drug testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(3) Apply for a part 119 certificate with authority to operate under parts 121 or 135 and intend to begin operations as defined in § 91.147 of this chapter.	(i) Have an Antidrug and Alcohol Misuse Prevention Program Operations Specification and a Letter of Authorization, (ii) Implement your combined FAA drug testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(4) Intend to begin air traffic control operations (at an air traffic control facility not operated by the FAA or by or under contract to the U.S. military).	(i) Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, prior to starting operations, (ii) Implement an FAA drug testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.

* * * * *

(e) *Register your Drug and Alcohol Testing Program by obtaining a Letter of Authorization from the FAA in accordance with § 91.147.* (1) A drug and alcohol testing program is considered registered when the following information is submitted to the Flight Standards District Office nearest your principal place of business:

(i) Company name.

(ii) Telephone number.

(iii) Address where your drug and alcohol testing program records are kept.

(iv) Type of safety-sensitive functions you or your employees perform (such as flight instruction duties, aircraft dispatcher duties, maintenance or preventive maintenance duties, ground security coordinator duties, aviation screening duties, air traffic control duties).

(v) Whether you have 50 or more covered employees, or 49 or fewer covered employees.

(vi) A signed statement indicating that your company will comply with this part and 49 CFR part 40.

(2) This Letter of Authorization will satisfy the requirements for both your drug testing program under this subpart and your alcohol testing program under subpart F of this part.

(3) Update the Letter of Authorization information as changes occur. Send the updates to the Flight Standards District Office nearest your principal place of business.

(4) If you are a part 119 certificate holder with authority to operate under parts 121 or 135 and intend to begin operations as defined in § 91.147 of this chapter, you must also advise the Federal Aviation Administration, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.

(f) *Obtaining a Drug and Alcohol Testing Program Registration from the FAA.* (1) Except as provided in paragraphs (d) and (e) of this section, to obtain a Drug and Alcohol Testing Program Registration from the FAA, you must submit the following information to the Office of Aerospace Medicine, Drug Abatement Division:

(i) Company name.

(ii) Telephone number.

(iii) Address where your drug and alcohol testing program records are kept.

(iv) Type of safety-sensitive functions you or your employees perform (such as flight instruction duties, aircraft dispatcher duties, maintenance or preventive maintenance duties, ground security coordinator duties, aviation screening duties, air traffic control duties).

(v) Whether you have 50 or more covered employees, or 49 or fewer covered employees.

(vi) A signed statement indicating that: your company will comply with this part and 49 CFR part 40; and you intend to provide safety-sensitive functions by contract (including subcontract at any tier) to a part 119 certificate holder with authority to operate under part 121 or part 135 of this chapter, an operator as defined in § 91.147 of this chapter, or an air traffic control facility not operated by the FAA or by or under contract to the U.S. military.

(2) Send this information to the Federal Aviation Administration, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.

(3) This Drug and Alcohol Testing Program Registration will satisfy the registration requirements for both your drug testing program under this subpart and your alcohol testing program under subpart F of this part.

(4) Update the registration information as changes occur. Send the updates to the address specified in paragraph (f)(2) of this section.

■ 4. Amend § 120.221 by revising paragraph (b) to read as follows:

§ 120.221 Consequences for employees engaging in alcohol-related conduct.

* * * * *

(b) *Permanent disqualification from service.* (1) An employee who violates §§ 120.19(c) or 120.37(c) is permanently precluded from performing for an employer the safety-sensitive duties the

employee performed before such violation.

(2) An employee who engages in alcohol use that violates another alcohol misuse provision of §§ 120.19 or 120.37, and who had previously engaged in alcohol use that violated the provisions of §§ 120.19 or 120.37 after becoming subject to such prohibitions, is permanently precluded from performing for an employer the safety-sensitive duties the employee performed before such violation.

* * * * *

■ 5. Amend § 120.225 as follows:
■ a. Revise paragraphs (a) and (b);
■ b. Redesignate paragraph (e) as paragraph (f);
■ c. Add new paragraph (e);
■ d. Revise newly redesignated paragraph (f).

The additions and revisions read as follows:

§ 120.225 Implementing an alcohol testing program.

(a) Each company must meet the requirements of this subpart. Use the following chart to determine whether your company must obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification, Letter of Authorization, or Drug and Alcohol Testing Program Registration from the FAA:

If you are . . .	You must . . .
(1) A part 119 certificate holder with authority to operate under part 121 or 135.	Obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification by contacting your FAA Principal Operations Inspector.
(2) An operator as defined in § 91.147 of this chapter	Obtain a Letter of Authorization by contacting the Flight Standards District Office nearest to your principal place of business.
(3) A part 119 certificate holder with authority to operate under part 121 or part 135 and an operator as defined in § 91.147 of this chapter.	Complete the requirements in paragraphs 1 and 2 of this chart and advise the Flight Standards District Office and Drug Abatement Division that the § 91.147 operation will be included under the part 119 testing program. Contact Drug Abatement Division at FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.
(4) An air traffic control facility not operated by the FAA or by or under contract to the U.S. Military.	Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.
(5) A part 145 certificate holder who has your own alcohol testing program.	Obtain an Antidrug and Alcohol Misuse Prevention Program Operations Specification by contacting your Principal Maintenance Inspector or register with the FAA Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, if you opt to conduct your own alcohol testing program.
(6) A contractor who has your own alcohol testing program	Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, if you opt to conduct your own alcohol testing program.

(b) Use the following chart for implementing an alcohol testing program if you are applying for a part 119 certificate with authority to operate under part 121 or part 135 of this chapter, if you intend to begin operations as defined in § 91.147 of this chapter, or if you intend to begin air traffic control operations (not operated by the FAA or by or under contract to the U.S. Military). Use it to determine whether you need to have an Antidrug and Alcohol Misuse Prevention Program Operations Specification, Letter of Authorization, or Drug and Alcohol Testing Program Registration from the FAA. Your employees who perform safety-sensitive duties must be tested in accordance with this subpart. The chart follows:

If you . . .	You must . . .
(1) Apply for a part 119 certificate with authority to operate under parts 121 or 135.	(i) Have an Antidrug and Alcohol Misuse Prevention Program Operations Specification, (ii) Implement an FAA alcohol testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(2) Intend to begin operations as defined in § 91.147 of this chapter	(i) Have a Letter of Authorization, (ii) Implement an FAA alcohol testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(3) Apply for a part 119 certificate with authority to operate under parts 121 or 135 and intend to begin operations as defined in § 91.147 of this chapter.	(i) Have an Antidrug and Alcohol Misuse Prevention Program Operations Specification and a Letter of Authorization, (ii) Implement your combined FAA alcohol testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.
(4) Intend to begin air traffic control operations (at an air traffic control facility not operated by the FAA or by or under contract to the U.S. military).	(i) Register with the FAA, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591, prior to starting operations, (ii) Implement an FAA alcohol testing program no later than the date you start operations, and (iii) Meet the requirements of this subpart.

* * * * *

(e) *Register your Drug and Alcohol Testing Program by obtaining a Letter of Authorization from the FAA in accordance with § 91.147.* (1) A drug

and alcohol testing program is considered registered when the following information is submitted to the Flight Standards District Office nearest your principal place of business:

(i) Company name.

(ii) Telephone number.

(iii) Address where your drug and alcohol testing program records are kept.

(iv) Type of safety-sensitive functions you or your employees perform (such as flight instruction duties, aircraft dispatcher duties, maintenance or preventive maintenance duties, ground security coordinator duties, aviation screening duties, air traffic control duties).

(v) Whether you have 50 or more covered employees, or 49 or fewer covered employees.

(vi) A signed statement indicating that your company will comply with this part and 49 CFR part 40.

(2) This Letter of Authorization will satisfy the requirements for both your drug testing program under subpart E of this part and your alcohol testing program under this subpart.

(3) Update the Letter of Authorization information as changes occur. Send the updates to the Flight Standards District Office nearest your principal place of business.

(4) If you are a part 119 certificate holder with authority to operate under part 121 or part 135 and intend to begin operations as defined in § 91.147 of this chapter, you must also advise the Federal Aviation Administration, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.

(f) *Obtaining a Drug and Alcohol Testing Program Registration from the FAA.* (1) Except as provided in paragraphs (d) and (e) of this section, to obtain a Drug and Alcohol Testing Program Registration from the FAA you must submit the following information to the Office of Aerospace Medicine, Drug Abatement Division:

(i) Company name.

(ii) Telephone number.

(iii) Address where your drug and alcohol testing program records are kept.

(iv) Type of safety-sensitive functions you or your employees perform (such as flight instruction duties, aircraft dispatcher duties, maintenance or preventive maintenance duties, ground security coordinator duties, aviation screening duties, air traffic control duties).

(v) Whether you have 50 or more covered employees, or 49 or fewer covered employees.

(vi) A signed statement indicating that: your company will comply with this part and 49 CFR part 40; and you intend to provide safety-sensitive functions by contract (including subcontract at any tier) to a part 119 certificate holder with authority to operate under part 121 or part 135 of this chapter, an operator as defined in § 91.147 of this chapter, or an air traffic control facility not operated by the FAA or by or under contract to the U.S. military.

(2) Send this information to the Federal Aviation Administration, Office of Aerospace Medicine, Drug Abatement Division (AAM–800), 800 Independence Avenue SW., Washington, DC 20591.

(3) This Drug and Alcohol Testing Program Registration will satisfy the registration requirements for both your drug testing program under subpart E of this part and your alcohol testing program under this subpart.

(4) Update the registration information as changes occur. Send the updates to the address specified in paragraph (f)(2) of this section.

Issued under authority provided by 49 U.S.C. 106(f) and 45102 in Washington, DC, on July 1, 2013.

Michael P. Huerta,

Administrator.

[FR Doc. 2013–16852 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 520 and 558

[Docket No. FDA–2013–N–0002]

Oral Dosage Form New Animal Drugs; Nicarbazin; Oclacitinib; Zilpaterol

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval actions for new animal drug applications (NADAs) and abbreviated new animal drug applications (ANADAs) during May 2013. FDA is also informing the public of the availability of summaries the basis of approval and of environmental review documents, where applicable.

DATES: This rule is effective July 15, 2013.

FOR FURTHER INFORMATION CONTACT: George K. Haibel, Center for Veterinary Medicine (HFV–6), Food and Drug Administration, 7519 Standish Pl., Rockville, MD 20855, 240–276–9019, *ghaibel@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: FDA is amending the animal drug regulations to reflect approval actions for NADAs and ANADAs during May 2013, as listed in table 1. In addition, FDA is informing the public of the availability, where applicable, of documentation of environmental review required under the National Environmental Policy Act (NEPA) and, for actions requiring review of safety or effectiveness data, summaries of the basis of approval (FOI Summaries) under the Freedom of Information Act (FOIA). These public documents may be seen in the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, between 9 a.m. and 4 p.m., Monday through Friday. Persons with access to the Internet may obtain these documents at the CVM FOIA Electronic Reading Room: *http://www.fda.gov/AboutFDA/CentersOffices/OfficeofFoods/CVM/CVMFOIAElectronicReadingRoom/default.htm.*

This rule does not meet the definition of ''rule'' in 5 U.S.C. 804(3)(A) because it is a rule of ''particular applicability.'' Therefore, it is not subject to the congressional review requirements in 5 U.S.C. 801–808.

TABLE 1—ORIGINAL AND SUPPLEMENTAL NADAS AND ANADAS APPROVED DURING MAY 2013

NADA/ ANADA	Sponsor	New animal drug product name	Action	21 CFR section	FOIA summary	NEPA review
141–279	Zoetis Inc., 333 Portage St., Kalamazoo, MI 49007.	NICARB 25% (nicarbazin) and BMD (bacitracin methylene disalicylate) Type A medicated articles.	Supplement revising nicarbazin dosage to a range consistent with dosage approved for use in combination feeds.	558.366	No	CE [1]

TABLE 1—ORIGINAL AND SUPPLEMENTAL NADAS AND ANADAS APPROVED DURING MAY 2013—Continued

NADA/ ANADA	Sponsor	New animal drug product name	Action	21 CFR section	FOIA summary	NEPA review
141–345	Zoetis Inc., 333 Portage St., Kalamazoo, MI 49007.	APOQUEL (oclacitinib tablet)	Original approval for control of pruritus associated with allergic dermatitis and control of atopic dermatitis in dogs at least 12 months of age.	520.1604	Yes	CE [1]
200–544	Huvepharma AD, 5th Floor, 3A Nikolay Haytov Str., 1113 Sophia, Bulgaria.	ZILMAX (zilpaterol hydrochloride) plus RUMENSIN (monensin) plus TYLOVET 100 (tylosin phosphate) plus MGA (melengestrol acetate) Type A medicated articles.	Original aapproval as a generic copy of NADA 141–280).	528.665	Yes	CE [1]

[1] The Agency has determined under 21 CFR 25.33 that this action is categorically excluded (CE) from the requirement to submit an environmental assessment or an environmental impact statement because it is of a type that does not individually or cumulatively have a significant effect on the human environment.

List of Subjects

21 CFR Part 520

Animal drugs.

21 CFR Part 558

Animal drugs, Animal feeds.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, 21 CFR parts 520 and 558 are amended as follows:

PART 520—ORAL DOSAGE FORM NEW ANIMAL DRUGS

■ 1. The authority citation for 21 CFR part 520 continues to read as follows:

Authority: 21 U.S.C. 360b.

■ 2. Add § 520.1604 to read as follows:

§ 520.1604 Oclacitinib.

(a) *Specifications.* Each tablet contains 3.6, 5.4, or 16 milligrams (mg) of oclacitinib as oclacitinib maleate.

(b) *Sponsor.* See No. 054771 in § 510.600(c) of this chapter.

(c) *Conditions of use*—(1) *Amount.* Administer orally 0.18 to 0.27 mg/per pound of body weight (0.4 to 0.6 mg/kg body weight) twice daily for up to 14 days; then administered once daily for maintenance therapy.

(2) *Indications for use.* For control of pruritus associated with allergic dermatitis and control of atopic dermatitis in dogs at least 12 months of age.

(3) *Limitations.* Federal law restricts this drug to use by or on the order of a licensed veterinarian.

PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

■ 3. The authority citation for 21 CFR part 558 continues to read as follows:

Authority: 21 U.S.C. 360b, 371.

■ 4. In § 558.366, in paragraph (d), amend the table by:

■ a. Revising the entry for ''90.8 to 181.6 (0.01 to 0.02 pct)'', and

■ b. Removing the entry for ''Bacitracin methylene disalicylate 4 to 50'' under the heading ''113.5 (0.0125 pct)''; and

■ c. Removing the entry for ''Bacitracin methylene disalicylate 50'' under the heading ''113.5 (0.0125 pct)''.

The additions and revisions read as follows:

§ 558.366 Nicarbazin.

* * * * *

(d) * * *

Nicarbazin in grams per ton	Combination in grams per ton	Indications for use	Limitations	Sponsor
*	*	* *	* *	*
90.8 to 181.6 (0.01 to 0.02 pct).	.....	Broiler chickens: As an aid in preventing outbreaks of cecal (*Eimeria tenella*) and intestinal (*E. acervulina, E. maxima, E. necatrix,* and *E. brunetti*) coccidiosis.	Feed continuously as sole ration from time chicks are placed on litter until past the time when coccidiosis is ordinarily a hazard. Do not use as a treatment for coccidiosis. Do not feed to laying hens. Withdraw 4 days before slaughter for use levels at or below 113.5 g/ton. Withdraw 5 days before slaughter for use levels above 113.5 g/ton.	066104
	Bacitracin methylene disalicylate 4 to 50.	Broiler chickens: As an aid in preventing outbreaks of cecal (*Eimeria tenella*) and intestinal (*E. acervulina, E. maxima, E. necatrix,* and *E. brunetti*) coccidiosis; for increased rate of weight gain and improved feed efficiency.	Feed continuously as sole ration from time chicks are placed on litter until past the time when coccidiosis is ordinarily a hazard. Do not use as a treatment for coccidiosis. Do not feed to laying hens. Withdraw 4 days before slaughter for use levels at or below 113.5 g/ton. Withdraw 5 days before slaughter for use levels above 113.5 g/ton. Bacitracin methylene disalicylate as provided by No. 054771 in § 510.600(c) of this chapter.	054771

Nicarbazin in grams per ton	Combination in grams per ton	Indications for use	Limitations	Sponsor
	Bacitracin methylene disalicylate 4 to 50 and roxarsone 22.7 to 45.4.	Broiler chickens: As an aid in preventing outbreaks of cecal (*Eimeria tenella*) and intestinal (*E. acervulina, E. maxima, E. necatrix,* and *E. brunetti*) coccidiosis; for increased rate of weight gain and improved feed efficiency.	Feed continuously as sole ration from time chicks are placed on litter until past the time when coccidiosis is ordinarily a hazard. Do not use as a treatment for coccidiosis. Discontinue medication 5 days before marketing birds for human consumption. Do not feed to laying hens. Nicarbazin as provided by No. 066104; bacitracin methylene disalicylate and roxarsone as provided by No. 054771 in § 510.600(c) of this chapter.	066104
	Bacitracin methylene disalicylate 30.	Broiler chickens: As an aid in preventing outbreaks of cecal (*Eimeria tenella*) and intestinal (*E. acervulina, E. maxima, E. necatrix,* and *E. brunetti*) coccidiosis; for increased rate of weight gain and improved feed efficiency.	Feed continuously as sole ration from time chicks are placed on litter until past the time when coccidiosis is ordinarily a hazard. Do not use as a treatment for coccidiosis. Do not feed to laying hens. Withdraw 4 days before slaughter for use levels at or below 113.5 g/ton. Withdraw 5 days before slaughter for use levels above 113.5 g/ton. Bacitracin methylene disalicylate as provided by No. 054771 in § 510.600(c) of this chapter.	066104
	Bacitracin methylene disalicylate 50.	Broiler chickens: As an aid in preventing outbreaks of cecal (*Eimeria tenella*) and intestinal (*E. acervulina, E. maxima, E. necatrix,* and *E. brunetti*) coccidiosis; as an aid in the prevention of necrotic enteritis caused or complicated by *Clostridium* spp. or other organisms susceptible to bacitracin.	Feed continuously as sole ration from time chicks are placed on litter until past the time when coccidiosis is ordinarily a hazard. Do not use as a treatment for coccidiosis. Do not feed to laying hens. Withdraw 4 days before slaughter for use levels at or below 113.5 g/ton. Withdraw 5 days before slaughter for use levels above 113.5 g/ton. Bacitracin methylene disalicylate as provided by No. 054771 in § 510.600(c) of this chapter.	054771
*	*	* *	* *	*

* * * * *

■ 5. In § 558.665, in the table, in paragraphs (e)(2), (e)(4), and (e)(6), revise the last sentence in the ''Limitations'' column and revise the ''Sponsor'' column to read as follows:

§ 558.665 Zilpaterol.

* * * * *

(e) * * *

Zilpaterol in grams/ton	Combination in grams/ton	Indications for use	Limitations	Sponsor
*	*	* *	* *	*
(2)	.....	.....	* * * Melengestrol acetate as provided by Nos. 000986 or 054771 in § 510.600(c) of this chapter.	000061 000986
*	*	* *	* *	*
(4)	.....	.....	* * * Monensin as provided by No. 000986; and melengestrol acetate as provided by Nos. 000986 or 054771 in § 510.600(c) of this chapter.	000061 000986
*	*	* *	* *	*
(6)	.....	.....	* * * Monensin as provided by No. 000986; tylosin as provided by Nos. 000986 or 016592; and melengestrol acetate as provided by Nos. 000986 or 054771 in § 510.600(c) of this chapter.	000061 000986 016592

Dated: July 1, 2013.

Bernadette Dunham,

Director, Center for Veterinary Medicine.

[FR Doc. 2013–16258 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Part 4022

Benefits Payable in Terminated Single-Employer Plans; Interest Assumptions for Paying Benefits

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: This final rule amends the Pension Benefit Guaranty Corporation's regulation on Benefits Payable in Terminated Single-Employer Plans to prescribe interest assumptions under the regulation for valuation dates in August 2013. The interest assumptions are used for paying benefits under terminating single-employer plans covered by the pension insurance system administered by PBGC.

DATES: Effective August 1, 2013.

FOR FURTHER INFORMATION CONTACT: Catherine B. Klion (*Klion.Catherine@pbgc.gov*), Assistant General Counsel for Regulatory Affairs, Pension Benefit Guaranty Corporation, 1200 K Street NW., Washington, DC 20005, 202–326–4024. (TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION: PBGC's regulation on Benefits Payable in Terminated Single-Employer Plans (29 CFR Part 4022) prescribes actuarial assumptions—including interest assumptions—for paying plan benefits under terminating single-employer plans covered by title IV of the Employee Retirement Income Security Act of 1974. The interest assumptions in the regulation are also published on PBGC's Web site (*http://www.pbgc.gov*).

PBGC uses the interest assumptions in Appendix B to Part 4022 to determine whether a benefit is payable as a lump sum and to determine the amount to pay. Appendix C to Part 4022 contains interest assumptions for private-sector pension practitioners to refer to if they wish to use lump-sum interest rates determined using PBGC's historical methodology. Currently, the rates in Appendices B and C of the benefit payment regulation are the same.

The interest assumptions are intended to reflect current conditions in the financial and annuity markets. Assumptions under the benefit payments regulation are updated monthly. This final rule updates the benefit payments interest assumptions for August 2013.[1]

The August 2013 interest assumptions under the benefit payments regulation will be 1.75 percent for the period during which a benefit is in pay status and 4.00 percent during any years preceding the benefit's placement in pay status. In comparison with the interest assumptions in effect for July 2013, these interest assumptions represent an increase of 0.50 percent in the immediate annuity rate and are otherwise unchanged.

PBGC has determined that notice and public comment on this amendment are impracticable and contrary to the public interest. This finding is based on the need to determine and issue new interest assumptions promptly so that the assumptions can reflect current market conditions as accurately as possible.

Because of the need to provide immediate guidance for the payment of benefits under plans with valuation dates during August 2013, PBGC finds that good cause exists for making the assumptions set forth in this amendment effective less than 30 days after publication.

PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this amendment, the Regulatory Flexibility Act of 1980 does not apply. See 5 U.S.C. 601(2).

List of Subjects in 29 CFR Part 4022

Employee benefit plans, Pension insurance, Pensions, Reporting and recordkeeping requirements.

In consideration of the foregoing, 29 CFR part 4022 is amended as follows:

PART 4022—BENEFITS PAYABLE IN TERMINATED SINGLE-EMPLOYER PLANS

■ 1. The authority citation for part 4022 continues to read as follows:

Authority: 29 U.S.C. 1302, 1322, 1322b, 1341(c)(3)(D), and 1344.

■ 2. In appendix B to part 4022, Rate Set 238, as set forth below, is added to the table.

Appendix B to Part 4022—Lump Sum Interest Rates for PBGC Payments

* * * * *

Rate set	For plans with a valuation date		Immediate annuity rate (percent)	Deferred annuities (percent)				
	On or after	Before		i_1	i_2	i_3	n_1	n_2
*	*		*	*	*	*	*	
238	8–1–13	9–1–13	1.75	4.00	4.00	4.00	7	8

■ 3. In appendix C to part 4022, Rate Set 238, as set forth below, is added to the table.

Appendix C to Part 4022—Lump Sum Interest Rates for Private-Sector Payments

* * * * *

Rate set	For plans with a valuation date		Immediate annuity rate (percent)	Deferred annuities (percent)				
	On or after	Before		i_1	i_2	i_3	n_1	n_2

[1] Appendix B to PBGC's regulation on Allocation of Assets in Single-Employer Plans (29 CFR Part 4044) prescribes interest assumptions for valuing benefits under terminating covered single-employer plans for purposes of allocation of assets under ERISA section 4044. Those assumptions are updated quarterly.

Rate set	For plans with a valuation date		Immediate annuity rate (percent)	Deferred annuities (percent)				
	On or after	Before		i_1	i_2	i_3	n_1	n_2
*	*		*	*	*	*	*	
238	8–1–13	9–1–13	1.75	4.00	4.00	4.00	7	8

Issued in Washington, DC, on this 10th day of July 2013.

Leslie Kramerich,

Acting Chief Policy Officer, Pension Benefit Guaranty Corporation.

[FR Doc. 2013–16853 Filed 7–12–13; 8:45 am]

BILLING CODE 7709–02–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0469]

Drawbridge Operation Regulation; Isle of Wight (Sinepuxent) Bay, Ocean City, MD

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from regulation.

SUMMARY: The Commander Fifth Coast Guard District has issued a temporary deviation from the regulations governing the operation of the US 50 Bridge, over Isle of Wight (Sinepuxent) Bay, mile 0.5, at Ocean City, MD. The deviation is necessary to accommodate the 10th annual ''Island 2 Island'' Half Marathon. This deviation allows the drawbridge to remain in the closed position to vessels during the race.

DATES: This deviation is effective from 8 a.m. until 10:30 a.m. April 26, 2014.

ADDRESSES: The docket for this deviation [USCG–2013–0469] is available at *http://www.regulations.gov.* Type the docket number in the ''Search'' box and click ''Search.'' Click on the Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140, on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Kashanda Booker, Bridge Management Specialist, Fifth Coast Guard District, telephone 757–398–6227, email *Kashanda.l.booker@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: OC Tri Running Sports, on behalf of Maryland Transportation Authority, has requested a temporary deviation from the current operating regulations of the US 50 Bridge across Isle Wight (Sinepuxent) Bay mile 0.5, at Ocean City, MD.

The closure has been requested to ensure the safety of the increased volume of runners and spectators that will be participating in the 10th annual ''Island 2 Island'' Half Marathon on April 26, 2014. The event is expected to bring in over 4,000 runners and 6,000 spectators. The OC Tri Sports is extending the course to 13.1 miles to accommodate the request of the community. Under this temporary deviation, the Route 50 Bridge will remain in the closed position to vessels, from 8 a.m. through 10:30 a.m. Information provided by our Coast Guard Station Ocean City reveals that, in the past, vessel traffic for that time of year is very limited with most vessels being small enough to pass without a bridge lift. The US 50 Bridge, over Isle of Wight (Sinepuxent) Bay, mile 0.5, at Ocean City, MD has a vertical clearance in the closed position to vessels of 13 feet above mean high water. Vessels that can pass under the bridge without a bridge opening may do so at any time and are advised to proceed with caution. The Atlantic Ocean is the alternate route for vessels with mast heights greater than 13 feet transiting this section of Isle of Wight (Sinepuxent) Bay. At all other times during the effected period, the bridge will operate as outlined at 33 CFR 117.559.

The Coast Guard will inform waterway users through our Local and Broadcast Notices to Mariners of the closure periods for the bridge so that vessels can arrange their transits to minimize any impacts caused by the temporary deviation.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: July 3, 2013.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2013–16811 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0607]

Drawbridge Operation Regulation; Delaware River, NJ

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the bascule span of the Tacony-Palmyra Bridge (Route 73), across the Delaware River, mile 107.2, between the townships of Tacony, PA and Palmyra, NJ. The deviation is necessary to facilitate the replacement of the bridge deck. This deviation allows the bridge to remain in the closed to navigation position during the rehabilitation project.

DATES: This deviation is effective from 9 p.m. on Friday, August 16, 2013 until 9 p.m. on Friday, August 30, 2013.

ADDRESSES: The docket for this deviation [USCG–2013–0607] is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH''. Click on Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Terrance Knowles, Environmental Protection Specialist, Coast Guard; telephone 757–398–6587, email *Terrance.A.Knowles@uscg.mil.* If you

have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, at 202–366–9826.

SUPPLEMENTARY INFORMATION: The Burlington County Bridge Commission, who owns and operates this bascule drawbridge, has requested a temporary deviation from the current operating regulations to facilitate the resurfacing of the bridge roadway.

The Tacony-Palmyra Bridge (Route 73) at mile 107.2, across the Delaware River, between PA and NJ, has a vertical clearance in the closed position of 53 feet above mean high water (MHW). This clearance will be reduced during the resurfacing by approximately three feet, to 50 feet above MHW.

Under the current operating schedule set out in 33 CFR 117.5 and 117.716(b): The regulation requires that the drawbridge must open promptly and fully for the passage of vessels when a request or signal to open is given, and that the opening not be delayed more than five minutes.

Under this temporary deviation, the bridge will be closed-to-navigation for resurfacing repairs, which will restrict the operation of the draw span from 9 p.m. on August 16, 2013 until 9 p.m. August 30, 2013.

Vessels that can pass under the bridge in the closed position may do so at all times and are advised to proceed with caution. Emergency openings cannot be provided. There are no alternate routes for vessels transiting this section of the Delaware River.

The Coast Guard has coordinated this with the Delaware Pilots, and will inform the users of the waterways through our Local and Broadcast Notices to Mariners of the closure period for the bridge so that vessels can arrange their transits to minimize any impact caused by the temporary deviation. Waterway traffic consists of freighters, recreational boats, tugs, and barges.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: July 3, 2013.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2013–16810 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0601]

Drawbridge Operation Regulation; The Straights, Harkers Island, NC

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the swing of the Route 70/Harkers Island Bridge, across The Straights, mile 0.6, Harkers Island, NC. This deviation is necessary to facilitate coupling repair on the Route 70/Harkers Island Bridge. This temporary deviation allows the swing bridge to remain in the closed to navigation position.

DATES: This deviation is effective from noon until 11:59 p.m. on August 5, 2013.

ADDRESSES: The docket for this deviation, [USCG–2013–0601] is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Mr. Jim Rousseau, Bridge Administration Branch Fifth District, Coast Guard; telephone 757–398–6557, email *James.L.Rousseau2@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, 202–366–9826.

SUPPLEMENTARY INFORMATION: The North Carolina Department of Transportation, who owns and operates this swing-type bridge, has requested a temporary deviation from the current operating regulations set out in 33 CFR 117.5 to facilitate coupling repair.

Under the regular operating schedule for the Route 70/Harkers Island Bridge, across The Straights, mile 0.6, in Harkers Island, NC, the draw must open promptly and fully for the passage of vessels when a request or signal to open is given. The drawbridge has a vertical clearance in the closed position to vessels of 14.2 feet, above mean high water.

Under this temporary deviation, the drawbridge will be maintained in the closed to navigation position from noon to 11:59 p.m. on August 5, 2013; the bridge will operate under normal operating schedule at all other times. The drawbridge normally opens on demand with several small commercial and recreational vessels transiting a week. Emergency openings cannot be provided. There are no alternate routes for vessels transiting this section of The Straights, but vessels that require an opening may proceed before noon and after midnight. Mariners able to pass under the bridge in the closed position may do so at any time and are advised to proceed with caution.

The Straights is used by a variety of vessels including small commercial and recreational vessels. The Coast Guard has carefully coordinated the restrictions with these waterway users. The Coast Guard will also inform additional waterway users through our Local and Broadcast Notices to Mariners of the closure periods for the bridge so that vessels can arrange their transits to minimize any impacts caused by the temporary deviation.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: July 2, 2013.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2013–16809 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0599]

Drawbridge Operation Regulations; The Gut, South Bristol, ME

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, First Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the SR129 Bridge across The Gut, mile 0.2, between Rutherford Island and South Bristol, Maine. The bridge owner, Maine Department of

Transportation will be performing test borings at the bridge. This deviation allows the bridge to delay bridge openings by ten minutes for a four hour period to facilitate scheduled test borings at the bridge.

DATES: This deviation is effective from 10 a.m. through 2 p.m. on July 15, 2013.

ADDRESSES: Documents mentioned in this preamble as being available in the docket are part of docket USCG–2013–0599 and are available online at *www.regulations.gov,* inserting USCG–2013–0599 in the ''Keyword'' and then clicking ''Search''. They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Mr. John McDonald, Project Officer, First Coast Guard District, telephone (617) 223–8364, *john.w.mcdonald@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The SR129 Bridge, across The Gut, mile 0.2, between Rutherford Island and South Bristol, Maine, has a vertical clearance in the closed position of 3 feet above mean high water and 12 feet above mean low water. The bridge operating regulations are listed at 33 CFR 117.5.

The waterway is transited by recreational and commercial fishing boats. There is an alternate route for navigation around Rutherford Island and the bridge can be opened as soon as possible for an emergency situation.

The bridge owner, Maine Department of Transportation, requested a temporary deviation from the normal operating schedule to facilitate test boring operations.

Under this temporary deviation the SR129 Bridge may delay bridge openings by up to ten minutes between 10 a.m. and 2 p.m. on July 15, 2013 to facilitate moving a test boring rig out of the channel.

In accordance with 33 CFR 117.35(e), the bridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: July 1, 2013.

Gary Kassof,

Bridge Program Manager, First Coast Guard District.

[FR Doc. 2013–16808 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2011–1108]

RIN 1625–AA11, 1625–AA00

Safety Zone and Regulated Navigation Area; Chicago Sanitary and Ship Canal, Romeoville, IL

AGENCY: Coast Guard, DHS.

ACTION: Interim rule with request for comments.

SUMMARY: The Coast Guard is issuing this Interim Rule to address two omissions from the regulatory text of the Safety zone and Regulated Navigation Area in the Chicago Sanitary and Ship Canal, Romeoville, IL. These omissions include requirements for the regulated navigation area that vessels must be greater than twenty feet in length and must not be a personal or human powered watercraft of any kind (*e.g.* jet skis, wave runners, kayaks, row boats, etc.). This revision is intended to make the regulatory text consistent with the discussion of the rule as originally published in the **Federal Register** on December 12, 2011.

DATES: This rule will be enforced with actual notice from June 19, 2013, until July 15, 2013. This rule is effective in the Code of Federal Regulations on July 15, 2013. Comments and related material must be received by the Coast Guard on or before August 14, 2013.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2011–1108 and are available online by going to *www.regulations.gov,* inserting USCG–2011–1108 in the ''SEARCH'' box, and then clicking ''Search.'' They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call CDR Scott Anderson, U.S. Coast Guard, Ninth District Prevention Department, Cleveland, OH, at (216) 902–6049 or email him at *scott.e.anderson@uscg.mil.* If you have questions on viewing or submitting material to the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

ACOE U.S. Army Corps of Engineers
CSSC Chicago Sanitary and Ship Canal
CFR Code of Federal Regulations
DHS Department of Homeland Security
IR Interim Rule
NPRM Notice of Proposed Rulemaking
RNA Regulated Navigation Area

A. Public Participation and Request for Comments

We encourage you to participate in this rulemaking 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.

1. Submitting Comments

If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. You may submit your comments and material online (via *http://www.regulations.gov*) or by fax, mail, or hand delivery, but please use only one of these means. If you submit a comment online via *www.regulations.gov,* it will be considered received by the Coast Guard when the comment is successfully transmitted; a comment submitted via fax, hand delivery, or mail, will be considered as having been received by the Coast Guard when the comment is received at the Docket Management Facility. 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.

To submit your comment online, go to *http://www.regulations.gov,* type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on ''Submit a Comment'' on the line associated with this rulemaking.

If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to

know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period and may change the rule based on your comments.

2. Viewing Comments and Documents

To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on ''OPEN DOCKET FOLDER'' on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

3. Privacy Act

Anyone can search the electronic form of comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act notice regarding our public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

4. Public Meeting

We do not now plan to hold a public meeting. You may submit a request for one using one of the four methods specified under **ADDRESSES**. Please explain why you believe a public meeting would be beneficial. If we determine that one would aid this rulemaking, we will hold one at a time and place announced by a later notice in the FR.

B. Regulatory History and Information

Since 2005, the Coast Guard has established and enforced a series of safety zones and RNAs on the CSSC to address safety risks associated with the operation of the ACOE's electric dispersal fields. A summary of this regulatory history can be found in the background section of the final rule establishing the current version of 33 CFR 165.923 (76 FR 77121). Notably, the Coast Guard published a temporary final rule with request for comments in the **Federal Register** on December 2, 2010 (75 FR 75145). This rule established RNA restrictions for the CSSC, which included requirements that (1) vessels must be greater than twenty feet in length and (2) must not be personal or human powered watercraft of any kind. Although these requirements were adopted and discussed in 76 FR 77121 (see *Discussion of Rule*), they were omitted from the regulatory text of 33 CFR 165.923. To correct this discrepancy and conform the regulation to established enforcement practice of the RNA, the Coast Guard is issuing this IR.

The Coast Guard is issuing this IR without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because doing so would be impracticable and is unnecessary. The fish barrier remains active and publishing an NPRM and accepting comments prior to the issuance of an effective rule is impracticable because it inhibits the Coast Guard's ability to protect vessels less than 20 feet in length and personal watercrafts from harm. The electrified barriers pose a significant threat of harm to vessels less than 20 feet in length and personal watercrafts.

Additionally, the RNA restrictions that (1) vessels must be greater than twenty feet in length and (2) must not be personal or human powered watercraft of any kind were subject to a 30 day comment period in a temporary interim rule establishing the RNA for the CSSC (75 FR 75145), which published on December 2, 2010. The Coast Guard received no comments on portions relating to vessels less than 20 feet or personal watercrafts. Moreover, based on the Coast Guard's interpretation of that temporary interim rule, as discussed in its preamble, vessels less than 20 feet and personal watercraft are not allowed to travel through the barrier. Because the restriction on vessels less than 20 feet and personal watercraft has already been the subject public comment and the Coast Guard has interpreted the temporary interim rule published at 75 FR 75145 to exclude these vessels, prior notice and comment for this interim rule is unnecessary.

Although the Coast Guard finds that good cause exists not to publish an NPRM, comments from the public as to the addition of this provision to the regulation text are welcomed. The Coast Guard will consider comments prior to the finalization of this rule. Such comments may be submitted by following the instruction in the *Public Participation and Request for Comments* section.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register.** For the same reasons discussed above about not publishing an NPRM, the Coast Guard finds that waiting for a 30 day notice period to run would be unnecessary, impracticable, and contrary to the public interest.

C. Basis and Purpose

In response to the threat of Asian carp reaching the Great Lakes and devastating the Great Lakes commercial and sport fishing industries, the ACOE began in 2002 the operation of a series of electrical barriers in the CSSC. These barriers are located approximately 30 miles from Lake Michigan and create an electric field in the water by pulsing low voltage DC current through steel cables secured to the bottom of the canal. Currently, three electrical barriers are in operation. These barriers are meant to prevent and reduce the dispersal of Asian carp in the CSSC.

The Coast Guard's Ninth District Commander has determined that the electric current radiated from the electric barriers poses certain safety risks to commercial vessels, recreational boaters, and people on or in portions of the CSSC in the vicinity of the barriers. Consequently, the Coast Guard's Ninth District Commander has concluded that an RNA is necessary to mitigate such risks.

In addition to safety concerns about electric current in the water, concerns have also been raised about the potential transport of carp eggs, gametes, and juvenile fish in bilge, ballast, or other non-potable water from south of the barriers to waters north of the barriers. To address these concerns, the Coast Guard's Ninth District Commander has determined that a safety zone is necessary to mitigate the threat of such transportation.

For a fuller discussion on the history of the electrical dispersal barriers and the potential transportation of eggs, gametes, and juvenile fish across the barriers see 70 FR 76694, 75 FR 754, and 75 FR 75145, which were published on December 28, 2005, January 6, 2010, and December 2, 2010 respectively.

To address the aforesaid safety risks, the Coast Guard's Ninth District Commander, as discussed in the *Regulatory History and Information* section, established a series of safety

zones and RNAs from 2005 to 2010. Most recently, on December 1, 2011, the Coast Guard's Ninth District Commander established a permanent RNA on all waters located adjacent to, and over, the electrical dispersal barriers on the CSSC between mile marker 295.5 and mile marker 297.2 (76 FR 77121). In the same rule-making, the Coast Guard's Ninth District Commander also established a permanent safety zone over a smaller portion of the same waterway between mile marker 296.1 and mile marker 296.7. This rule-making represents the current version of 33 CFR 165.923.

D. Discussion of Rule

This IR only addresses two requirements in the RNA of 33 CFR 165.923, which although included in the *Discussion of Rule* of 76 FR 77121 were omitted from the regulatory text of 33 CFR 165.923. As previously noted, these requirements are that (1) vessels must be greater than twenty feet in length and (2) must not be a personal or human powered watercraft of any kind (*i.e.* jet skis, wave runners, kayaks, row boats, *etc.*). These requirements, as with all others included in the 33 CFR 165.923, are necessary for safe navigation of the RNA and to ensure the safety of vessels and their personnel as well as the public in general. The requirements are also necessary to protect against the harms presented by a potential invasion of Asian carp in Lake Michigan.

Deviation from this final rule is prohibited unless specifically authorized by the Coast Guard's Ninth District Commander or his or her designated representatives. For the life of this RNA, the Coast Guard's Ninth District Commander designates as his or her representatives the Captain of the Port, Sector Lake Michigan, and the Commanding Officer, Marine Safety Unit Chicago.

The safety zone and RNA will be enforced at all times. If, however, enforcement of the safety zone or RNA is at any time suspended, the Coast Guard's Ninth District Commander or his or her designated representatives will cause notice of the suspension to be made by all appropriate means to effect the widest publicity among the affected segments of the public.

E. Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on these statutes or executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We conclude that this rule is not a significant regulatory action because we anticipate that it will have minimal impact on the economy, will not interfere with other agencies, will not adversely alter the budget of any grant or loan recipients, and will not raise any novel legal or policy issues. The two RNA restrictions are limited in scope to vessels under twenty feet in length and personal watercraft of any kind.

2. Impact on Small Entities

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

This rule will affect the following entities, some of which might be small entities: The owners or operators of vessels under 20 feet and personal or human powered watercraft intending to transit the RNA during enforcement. This RNA will not have a significant economic impact on a substantial number of small entities for the following reasons: The RNA restrictions in this rule are limited in scope of vessels under 20 feet and personal or human powered watercraft.

3. Assistance for Small Entities

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 so that they can better evaluate its effects on them and participate in the rulemaking process.

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.

4. 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).

5. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

6. 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 would not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble.

7. Taking of Private Property

This rule will not affect the taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

8. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to

minimize litigation, eliminate ambiguity, and reduce burden.

9. Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

10. Indian Tribal Governments

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.

11. Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a ''significant energy action'' under that order because it is not a ''significant regulatory action'' under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

12. Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

13. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves the establishment of a regulated navigation area, and, therefore it is categorically excluded from further review under paragraph 34(g) of Figure 2–1 of the Commandant Instruction. An environmental analysis checklist supporting this determination and a Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this rule.

List of Subjects in 33 CFR Part 165

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

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

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Revise § 165.923(b) to read as follows:

§ 165.923 Safety Zone and Regulated Navigation Area, Chicago Sanitary and Ship Canal, Romeoville, IL.

* * * * *

(b) *Regulated Navigation Area.* (1) The following is a regulated navigation area (RNA): all waters of the Chicago Sanitary and Ship Canal, Romeoville, IL located between mile marker 295.5 and mile marker 297.2.

(2) *Regulations.* (i) The general regulations contained in 33 CFR 165.13 apply.

(ii) Vessels that comply with the following restrictions are permitted to transit the RNA:

(A) Vessels must be greater than 20 feet in length.

(B) Vessels must not be a personal or human powered watercraft (*i.e.* jet skis, wave runners, kayaks, row boats, etc.).

(C) All up-bound and down-bound barge tows that consist of barges carrying flammable liquid cargos (Grade A through C, flashpoint below 140 degrees Fahrenheit, or heated to within 15 degrees Fahrenheit of flash point) must engage the services of a bow boat at all times until the entire tow is clear of the RNA.

(D) Vessels engaged in commercial service, as defined in 46 U.S.C. 2101(5), may not pass (meet or overtake) in the RNA and must make a SECURITE call when approaching the RNA to announce intentions and work out passing arrangements.

(E) Commercial tows transiting the RNA must be made up with only wire rope to ensure electrical connectivity between all segments of the tow.

(F) All vessels are prohibited from loitering in the RNA.

(G) Vessels may enter the RNA for the sole purpose of transiting to the other side and must maintain headway throughout the transit. All vessels and persons are prohibited from dredging, laying cable, dragging, fishing, conducting salvage operations, or any other activity, which could disturb the bottom of the RNA.

(H) Except for law enforcement and emergency response personnel, all personnel on vessels transiting the RNA should remain inside the cabin, or as inboard as practicable. If personnel must be on open decks, they must wear a Coast Guard approved personal flotation device.

(I) Vessels may not moor or lay up on the right or left descending banks of the RNA.

(J) Towboats may not make or break tows if any portion of the towboat or tow is located in the RNA.

(K) Persons on board any vessel transiting this RNA in accordance with this rule or otherwise are advised they do so at their own risk.

* * * * *

Dated: June 19, 2013.

M.N. Parks,

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

[FR Doc. 2013–16803 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0326]

RIN 1625–AA00

Safety Zone; Discovery World Fireworks, Milwaukee Harbor, Milwaukee, WI

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone within Milwaukee Harbor, Milwaukee, Wisconsin. This zone is intended to restrict vessels from a portion of Milwaukee Harbor due to 4 fireworks displays at Discovery World Pier. This safety zone is necessary to protect the surrounding public and vessels from the hazards associated with these fireworks displays.

DATES: This rule will be enforced with actual notice from July 10, 2013, until July 15, 2013. This rule is effective in the Code of Federal Regulations from July 15, 2013 until October 5, 2013. This rule will be enforced at the dates and times listed in the ''Discussion of Comments, Changes, and the Final Rule'' section that follows.

ADDRESSES: Documents mentioned in this preamble are part of docket USCG–2013–0326. To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary rule, contact or email MST1 Joseph McCollum, U.S. Coast Guard Sector Lake Michigan, at 414–747–7148 or *Joseph.P.McCollum@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone (202) 366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

DHS Department of Homeland Security
FR Federal Register
NPRM Notice of Proposed Rulemaking
TFR Temporary Final Rule

A. Regulatory History and Information

On May 17, 2013, the Coast Guard published a notice of proposed rulemaking entitled, ''Safety Zone; Discovery World Fireworks, Milwaukee Harbor, Milwaukee, Wisconsin'' in the **Federal Register** (78 FR 29086). We received 0 comments on the proposed rule. No public meeting was requested, and none was held.

The Coast Guard finds that good cause exists under 5 U.S.C. 553(d)(3), for making this rule effective less than 30 days after publication in the **Federal Register**. Waiting for a 30 day notice period to run would be impracticable and contrary to the public interest because the Coast Guard did not receive the necessary information in time for this regulation to undertake both an NPRM and a 30 day delayed effective date. The Coast Guard chose to seek public comment in the time that remained. Additionally, undergoing a 30 day delayed effective date would inhibit the Coast Guard's ability to protect spectators and vessels from the hazards associated with a maritime fireworks display, which are discussed further below.

B. Basis and Purpose

The legal basis for the rule is the Coast Guard's authority to establish regulated navigation areas and limited access areas: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, 160.5; Public Law 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

Bartolotta Catering Company has informed the Coast Guard of 4 fireworks displays planned for 2013. These displays are scheduled for July 10; August 3 and 22; and October 5. Each display is expected to involve fireworks no larger than 4″ in size and will be fired from the same location on Discovery World Pier. The Captain of the Port, Lake Michigan, has determined that the likelihood of transiting watercraft during the fireworks displays presents a significant risk of serious injuries or fatalities. The safety risks associated with these displays include falling debris, accidental detonations, and the spread of fire among spectator vessels.

C. Discussion of Comments, Changes, and the Final Rule

No comments were received and no changes were made. The Captain of the Port, Lake Michigan, has determined that a safety zone is necessary to mitigate the aforementioned safety risks. Thus, this rule establishes a safety zone that encompasses all waters of Milwaukee Harbor, including Lakeshore inlet and Discovery World Marina, within the arc of a circle with a 300-foot radius from the fireworks launch site located in approximate position 43°02′10.7″ N, 087°53′37.5″ W (NAD 83).

This safety zone is effective from July 10, 2013, until October 5, 2013. This safety zone will be enforced from 9 p.m. until 11 p.m. on July 10; August 3 and 22; and October 5, 2013.

Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port, Lake Michigan, or his designated on-scene representative. The Captain of the Port or his designated on-scene representative may be contacted via VHF Channel 16.

D. Regulatory Analyses

We developed this temporary rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on these statutes and executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We conclude that this rule is not a significant regulatory action because we anticipate that it will have minimal impact on the economy, will not interfere with other agencies, will not adversely alter the budget of any grant or loan recipients, and will not raise any novel legal or policy issues. The safety zone created by this rule will be small and enforced for only two hours on a given day. Under certain conditions, moreover, vessels may still transit through the safety zone when permitted by the Captain of the Port.

2. Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered the impact of this rule on small entities. 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. 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. This rule will affect the following entities, some of which might be small entities: The owners or operators of vessels intending to transit or anchor in a portion of Lake Michigan in Milwaukee Harbor during the times when this rule is enforced.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities. This rule will affect the following entities, some of which might be small entities: The owners or operators of vessels intending to transit or anchor within the vicinity of the Discovery World Marina or Lakeshore inlet during the times that this zone is enforced.

This safety zone will not have a significant economic impact on a substantial number of small entities for the following reasons: This rule will be enforced for a limited time on 4 days. This safety zone has been designed to allow traffic to pass safely around the zone whenever possible and vessels will be allowed to pass through the zone with the permission of the Captain of the Port. If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this rule would have a significant economic impact on it, please submit a comment (see **ADDRESSES**) explaining why you think it qualifies and how and to what degree this rule would economically affect it.

3. Assistance for Small Entities

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

4. Collection of Information

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

5. Federalism

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 determined that this rule does not have implications for federalism.

6. 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.

7. 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.

8. Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children From Environmental Health Risks

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

11. Indian Tribal Governments

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.

12. Energy Effects

This action is not a ''significant energy action'' under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves the establishment of a safety zone and, therefore it is categorically excluded from further review under paragraph 34(g) of Figure 2–1 of the Commandant Instruction. An environmental analysis checklist supporting this determination and a Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 165

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

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

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T09–0326 to read as follows:

§ 165.T09–0326 Safety Zone; Discovery World Fireworks, Milwaukee Harbor, Milwaukee, Wisconsin.

(a) *Location.* All waters of Milwaukee Harbor, including Lakeshore inlet and Discovery World Marina, within the arc of a circle with a 300-foot radius from the fireworks launch site located in approximate position 43°02′10.7″ N, 087°53′37.5″ W (NAD 83).

(b) *Effective Period.* This safety zone will be effective from July 10, 2013, until October 5, 2013. This safety zone will be enforced from 9 p.m. until 11 p.m. on July 10; August 3 and 22; and October 5, 2013.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry into, transiting, or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port, Lake Michigan or his designated on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port, Lake Michigan or his designated on-scene representative.

(3) The ''on-scene representative'' of the Captain of the Port, Lake Michigan is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port, Lake Michigan to act on his behalf.

(4) Vessel operators desiring to enter or operate within the safety zone shall contact the Captain of the Port, Lake Michigan or his on-scene representative to obtain permission to do so. The Captain of the Port, Lake Michigan or his on-scene representative may be contacted via VHF Channel 16. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port, Lake Michigan, or his on-scene representative.

Dated: July 1, 2013.

M.W. Sibley,

Captain, U.S. Coast Guard, Captain of the Port, Lake Michigan.

[FR Doc. 2013–16807 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2012–0799; FRL–9833–2]

Determination of Attainment for the Sacramento Nonattainment Area for the 2006 Fine Particle Standard; California; Determination Regarding Applicability of Clean Air Act Requirements

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking final action to determine that the Sacramento nonattainment area in California has attained the 2006 24-hour fine particle ($PM_{2.5}$) National Ambient Air Quality Standard (NAAQS or standard). This determination is based upon complete, quality-assured, and certified ambient air monitoring data showing that this area has monitored attainment of the 2006 24-hour $PM_{2.5}$ NAAQS based on the 2010–2012 monitoring period. Based on the above determination, the requirements for this area to submit an attainment demonstration, together with reasonably available control measures, a reasonable further progress (RFP) plan, and contingency measures for failure to meet RFP and attainment deadlines are suspended for so long as the area continues to attain the 2006 24-hour $PM_{2.5}$ NAAQS.

DATES: *Effective Date:* This rule is effective on August 14, 2013.

ADDRESSES: EPA has established docket number EPA–R09–OAR–2012–0799 for this action. Generally, documents in the docket for this action are available electronically at *www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed at *www.regulations.gov,* some information may be publicly available only at the hard copy location (e.g., copyrighted material, large maps, multi-volume reports), and some may not be publicly available in either location (e.g., Confidential Business Information). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: John Ungvarsky, (415) 972–3963, or by email at *ungvarsky.john@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document, wherever ''we'', ''us'' or ''our'' are used, we mean EPA.

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I. Summary of EPA's Proposed Action

On October 26, 2012 (77 FR 65346), EPA proposed to determine that the Sacramento nonattainment area in California has attained the 2006 24-hour NAAQS for fine particles (generally referring to particles less than or equal to 2.5 micrometers in diameter, $PM_{2.5}$). The 2006 24-hour $PM_{2.5}$ NAAQS is 35 micrograms per cubic meter ($\mu g/m^3$), based on a 3-year average of the 98th percentile of 24-hour concentrations. The Sacramento $PM_{2.5}$ nonattainment area includes Sacramento County, the western portions of El Dorado and Placer counties, and the eastern portions of Solano and Yolo counties. Other than the El Dorado County portion of the nonattainment area, the Sacramento $PM_{2.5}$ nonattainment area lies within the Sacramento Valley Air Basin.

In our proposed rule, we explained how EPA makes an attainment determination for the 2006 24-hour $PM_{2.5}$ NAAQS by reference to complete, quality-assured data gathered at a State and Local Air Monitoring Station(s) (SLAMS) and entered into EPA's Air Quality System (AQS) database and by reference to 40 CFR 50.13 (''National primary and secondary ambient air quality standards for $PM_{2.5}$'') and appendix N to [40 CFR] part 50 (''Interpretation of the National Ambient Air Quality Standards for $PM_{2.5}$''). EPA proposed the determination of attainment for the Sacramento nonattainment area based upon a review of the monitoring network and the ambient air quality data collected at the monitoring sites during the 2009–2011 period. The monitoring network in the area is operated by the California Air Resources Board (CARB) and three local air pollution control agencies in the area: Sacramento Metropolitan Air Quality Management District, Placer County Air Pollution Control District, and Yolo-Solano Air Quality Management District. Based on these reviews, EPA found that complete, quality-assured and certified data for the

Sacramento nonattainment area showed that the 24-hour design value for the 2009–2011 period was equal to or less than 35 μ/m³ at all five SLAMs monitor sites.

Since publication of our October 26, 2012 proposal, CARB and the air districts within the Sacramento nonattainment area have entered data into AQS for the final two quarters of 2012 and the first quarter of 2013, and have certified the data for 2012.[1] Thus, we now have complete, quality-assured for 2010–2012.

Because we make determinations of attainment based on the most recent 3 years of complete, quality-assured and certified data, we have updated the proposed determination of attainment (which had been based on 2009–2011 data) to reflect the 2010–2012 period. Specifically, we have updated table 1 (shown below) from the proposed rule to reflect the data for 2012, including data from the newly established Auburn monitoring site. As shown in table 1, the design value (31 μg/m³) in the Sacramento nonattainment area for the 2010–2012 period is less than 35 μg/m³ and thus shows that the area has attained the 2006 24-hour $PM_{2.5}$ standard. Therefore, we are taking final action today to determine that the Sacramento nonattainment area has attained the 2006 24-hour $PM_{2.5}$ standard based on complete, quality-assured and certified data for 2010–2012. Preliminary data for 2013 (not shown in table 1 but included in the docket for this action) show that the area continues to attain the standard.

TABLE 1—2009–2012 24-HOUR $PM_{2.5}$ MONITORING SITES AND DESIGN VALUES FOR THE SACRAMENTO NONATTAINMENT AREA [c]

Monitoring site	AQS Site identification no.	98th percentile (μg/m³)				Design values (μg/m³)	
		2009	2010	2011	2012	2009–2011	2010–2012
Auburn[a]	06–061–0003	n/a	n/a	n/a	15.7	n/a	n/a
Roseville	06–061–0006	21.3	20.3	23.0	14.9	22	19
Sacramento—Del Paso Manor	06–067–0006	38.7	27.0	39.8	27.1	[b]35	31
Sacramento—1309 T Street	06–067–0010	27.2	27.3	45.1	20.5	33	31
Sacramento Health Dept—Stockton Blvd	06–067–4001	34.9	26.5	44.8	20.5	[a]35	31
Woodland	06–113–1003	27.4	18.6	25.8	14.2	24	20

[a] The Auburn site (AQS ID 06–061–0003) started operating in January, 2012 and, therefore, does not have a valid design value.

[b] The average of the 98th percentile values for 2009–2011 equals 35.2 and 35.4 at the Del Paso Manor and Stockton Blvd. sites, respectively, but consistent with applicable rounding conventions in 40 CFR part 50, Appendix N, section 4.3, 24-hour standard design values are rounded to the nearest 1 μg/m³ (decimals 0.5 and greater are rounded up to the nearest whole number, and any decimal lower than 0.5 is rounded down to the nearest whole number).

[c] **Source:** Design Value Report, May 30, 2013 (in the docket to this final action).

In our proposed rule, based on the proposed determination of attainment, we also proposed to apply EPA's Clean Data Policy to the 2006 24-hour $PM_{2.5}$ NAAQS and thereby suspend the requirements for this area to submit an attainment demonstration and associated reasonably available control measures (RACM), a reasonable further progress (RFP) plan, and contingency measures for so long as the area continues to attain the 2006 24-hour $PM_{2.5}$ NAAQS. See pages 65348–65350 of our October 26, 2012 proposed rule. In proposing to apply the Clean Data Policy to the 2006 24-hour $PM_{2.5}$ NAAQS, we explained how we are applying the same statutory interpretation with respect to the implications of clean data determinations that the Agency has long applied in regulations for the 1997 8-hour ozone and $PM_{2.5}$ NAAQS and in individual rulemakings for the 1-hour ozone, PM_{10} and lead NAAQS. *See* 77 FR 65346, at 65349 (October 26, 2012).

EPA notes that on January 4, 2013, in *Natural Resources Defense Council* v. *EPA,* the DC Circuit remanded to EPA the ''Final Clean Air Fine Particle Implementation Rule'' (72 FR 20586, April 25, 2007) and the ''Implementation of the New Source Review (NSR) Program for Particulate Matter Less than 2.5 Micrometers ($PM_{2.5}$)'' final rule (73 FR 28321, May 16, 2008) (collectively, ''1997 $PM_{2.5}$ Implementation Rule'' or ''Implementation Rule''). 706 F.3d 428 (DC Cir. 2013). While the DC Circuit, in its January 4, 2013 decision, remanded the 1997 $PM_{2.5}$ Implementation Rule to EPA to re-promulgate the Implementation Rule pursuant to subpart 4,[2] the court did not address the merits of that regulation, nor cast doubt on EPA's interpretation of the statutory provisions under its Clean Data Policy.

EPA has taken the Court's decision into consideration in evaluating the effects of a determination of attainment for the Sacramento nonattainment area under subpart 4, in addition to subpart 1.[3] Pursuant to EPA's Clean Data Policy interpretation, a determination that the area has attained the standard suspends the State's obligation to submit attainment-related planning requirements of subpart 4 (as well as the applicable provisions of subpart 1) for so long as the area continues to attain the standard. These include requirements to submit an attainment demonstration, RFP, RACM, and contingency measures, because the purpose of these provisions is to help

[1] See letter from Sylvia Vanderspek, Chief, Air Quality Data Branch, Planning and Technical Support Division, CARB, to Jared Blumenfeld, Regional Administrator, U.S. EPA Region IX, certifying calendar year 2012 ambient air quality data and quality assurance data, May 16, 2013.

[2] EPA established the Implementation Rule pursuant to subpart 1 (''Nonattainment Areas in General'') of part D (''Plan Requirements for Nonattainment Areas'') of title I of the CAA. Subpart 4 (''Additional Provisions for Particulate Matter Nonattainment Areas'') includes more prescriptive SIP nonattainment area requirements than those set forth in subpart 1.

[3] For the purposes of evaluating the effects of this determination of attainment under subpart 4, we are considering Sacramento to be a ''moderate'' $PM_{2.5}$ nonattainment area. Under section 188 of the CAA, all areas designated nonattainment areas under subpart 4 would initially be classified by operation of law as ''moderate'' nonattainment areas, and would remain moderate nonattainment areas unless and until EPA reclassifies the area as a ''serious'' nonattainment area. Accordingly, the evaluation of the potential impact of subpart 4 requirements is limited to those applicable to moderate nonattainment areas. Sections 189(a) and (c) of subpart 4 apply to moderate nonattainment areas and include: An attainment demonstration (section 189(a)(1)(B)); provisions for RACM (section 189(a)(1)(C)); and quantitative milestones demonstrating RFP toward attainment by the applicable attainment date (section 189(c)). In addition, EPA also evaluates the applicable requirements of subpart 1.

reach attainment, a goal that has already been achieved. Thus, under both subpart 1 and subpart 4, a determination of attainment suspends a state's obligations to submit attainment-linked planning requirements for so long as the area continues in attainment.

EPA has long applied its Clean Data interpretation under subpart 4 in implementing the PM_{10} standard.[4] In EPA's proposed and final rulemakings determining that the San Joaquin Valley nonattainment area attained the PM_{10} standard, EPA set forth at length its rationale for applying the Clean Data Policy to subpart 4. The Ninth Circuit upheld EPA's final rulemaking, and specifically EPA's Clean Data Policy, in the context of subpart 4. *Latino Issues Forum* v. *EPA,* supra. Nos. 06–75831 and 08–71238 (9th Cir.), Memorandum Opinion, March 2, 2009. In rejecting petitioner's challenge to the Clean Data Policy under subpart 4 for PM_{10}, the Ninth Circuit stated, ''As the EPA explained, if an area is in compliance with PM_{10} standards, then further progress for the purpose of ensuring attainment is not necessary.''

EPA is determining, based on the most recent three years of complete, quality-assured data meeting the requirements of 40 CFR part 50, appendix N, that the Sacramento nonattainment area is currently attaining the 2006 24-hour $PM_{2.5}$ NAAQS. In conjunction with and based upon our determination that Sacramento nonattainment area has attained and is currently attaining the standard, EPA is also determining that the obligation to submit the following attainment-related planning requirements is not applicable for so long as the area continues to attain the $PM_{2.5}$ standard: The part D, subpart 4 obligations to provide an attainment demonstration pursuant to section 189(a)(1)(B); the RACM provisions of section 189(a)(1)(C); the RFP provisions of section 189(c); and the related attainment demonstration, RACM, RFP and contingency measure provisions requirements of subpart 1, section 172. This determination does not constitute a redesignation to attainment under CAA section 107(d)(3).

Please see the October 26, 2012 proposed rule for more detailed information concerning the $PM_{2.5}$ NAAQS, designations of $PM_{2.5}$ nonattainment areas, the regulatory basis for determining attainment of the NAAQS, the Sacramento nonattainment area's $PM_{2.5}$ monitoring network, and EPA's review and evaluation of the data.

II. Public Comments

EPA's proposed rule provided a 30-day public comment period. We received no comments.

III. EPA's Final Action

For the reasons provided in the proposed rule and summarized herein, EPA is taking final action to determine that the Sacramento nonattainment area in California has attained the 2006 24-hour $PM_{2.5}$ NAAQS based on three years of complete, quality-assured, and certified data in AQS for 2010–2012. Preliminary data for 2013 show that this area continues to attain the NAAQS.

EPA is also taking final action, based on the above determination of attainment, to suspend the requirements for the Sacramento nonattainment area to submit an attainment demonstration and associated RACM, a RFP plan, contingency measures, and any other planning SIPs related to attainment of the 2006 24-hour $PM_{2.5}$ NAAQS for so long as the area continues to attain the 2006 24-hour $PM_{2.5}$ NAAQS. EPA's final action is consistent and in keeping with its long-held interpretation of CAA requirements, as well as with EPA's regulations for similar determinations for ozone (*see* 40 CFR 51.918) for the 1997 8-hour ozone and in individual rulemakings for the 1-hour ozone, PM_{10} and lead NAAQS.

Today's final action does not constitute a redesignation of the Sacramento nonattainment area to attainment for the 2006 24-hour $PM_{2.5}$ NAAQS under CAA section 107(d)(3) because we have not yet approved a maintenance plan for the Sacramento nonattainment area as meeting the requirements of section 175A of the CAA or determined that the area has met the other CAA requirements for redesignation. The classification and designation status in 40 CFR part 81 remain nonattainment for this area until such time as EPA determines that California has met the CAA requirements for redesignating the Sacramento nonattainment area to attainment.

If the Sacramento nonattainment area continues to monitor attainment of the 2006 24-hour $PM_{2.5}$ NAAQS, the requirements for the area to submit an attainment demonstration and associated RACM, a RFP plan, contingency measures, and any other planning requirements related to attainment of the 2006 24-hour $PM_{2.5}$ NAAQS will remain suspended. If after today's action EPA subsequently determines, after notice-and-comment rulemaking in the **Federal Register**, that the area has violated the 2006 24-hour $PM_{2.5}$ NAAQS, the basis for the suspension of the attainment planning requirements for the area would no longer exist, and the area would thereafter have to address such requirements.

IV. Statutory and Executive Order Reviews

This final action makes a determination of attainment based on air quality and suspends certain federal requirements, and thus, this action would not impose additional requirements beyond those imposed by state law. For this reason, the final action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- Does not provide EPA with the discretionary authority to address disproportionate human health or environmental effects with practical, appropriate, and legally permissible

[4] See, e.g., 75 FR 6571 (February 10, 2010) (Baton Rouge, Louisiana area); 71 FR 6352 (February 8, 2006) (Ajo, Arizona area); 71 FR 13021 (March 14, 2006) (Yuma, Arizona area); 71 FR 40023 (July 14, 2006) (Weirton, West Virginia area); 71 FR 44920 (August 8, 2006) (Rillito, Arizona area); 71 FR 63642 (October 30, 2006) (San Joaquin Valley, California area); 72 FR 14422 (March 28, 2007) (Miami, Arizona area); and 75 FR 27944 (May 19, 2010) (Coso Junction, California area). Thus EPA has established that, under subpart 4, an attainment determination suspends the obligations to submit an attainment demonstration, RACM, RFP, contingency measures, and other measures related to attainment.

methods under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this final action does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP obligations discussed herein do not apply to Indian Tribes, and thus this action will not impose substantial direct costs on tribal governments or preempt tribal law.

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

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by September 13, 2013. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Nitrogen oxides, Particulate Matter, Sulfur oxides, Reporting and recordkeeping requirements.

Dated: June 28, 2013.

Alexis Strauss,

Acting Regional Administrator, Region IX.

Part 52, Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

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

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

Subpart F—California

■ 2. Section 52.247 is amended by adding paragraph (c) to read as follows:

§ 52.247 Control Strategy and Regulations: Fine Particle Matter.

* * * * *

(c) *Determination of Attainment:* Effective August 14, 2013, EPA has determined that, based on 2010 to 2012 ambient air quality data, the Sacramento $PM_{2.5}$ nonattainment area has attained the 2006 24-hour $PM_{2.5}$ NAAQS. This determination suspends the requirements for this area to submit an attainment demonstration, associated reasonably available control measures, a reasonable further progress plan, contingency measures, and other planning SIPs related to attainment for as long as this area continues to attain the 2006 24-hour $PM_{2.5}$ NAAQS. If EPA determines, after notice-and-comment rulemaking, that this area no longer meets the 2006 24-hour $PM_{2.5}$ NAAQS, the corresponding determination of attainment for that area shall be withdrawn.

[FR Doc. 2013–16785 Filed 7–12–13; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[Docket No. 120706221–2705–02]

RIN 0648–XC748

Atlantic Highly Migratory Species; Commercial Gulf of Mexico Aggregated Large Coastal Shark and Gulf of Mexico Hammerhead Shark Management Groups

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; closure.

SUMMARY: NMFS is closing the commercial management groups for aggregated large coastal sharks (LCS) and hammerhead sharks in the Gulf of Mexico region. This action is necessary because the commercial landings of Gulf of Mexico aggregated LCS for the 2012 fishing season has exceeded 80 percent of the available commercial quota as of July 5, 2013.

DATES: The commercial Gulf of Mexico aggregated LCS and Gulf of Mexico hammerhead shark management groups are closed effective 11:30 p.m. local time, July 17, 2013, until the end of the 2013 fishing season on December 31, 2013 or if NMFS announces, via a notice in the **Federal Register**, that additional quota is available and the season is reopened.

FOR FURTHER INFORMATION CONTACT: Karyl Brewster-Geisz or Peter Cooper 301–427–8503; fax 301–713–1917.

SUPPLEMENTARY INFORMATION: The Atlantic shark fisheries are managed under the 2006 Consolidated Atlantic Highly Migratory Species (HMS) Fishery Management Plan (FMP), its amendments, and its implementing regulations (50 CFR part 635) issued under authority of the Magnuson-Stevens Fishery Conservation and Management Act (16 U.S.C. 1801 *et seq.*).

Under § 635.5(b)(1), sharks that are first received by dealers from a vessel must be submitted electronically on a weekly basis through a NMFS-approved electronic reporting system by the dealer and received by NMFS no later than midnight, local time, of the first Tuesday following the end of the reporting week unless the dealer is otherwise notified by NMFS. Under § 635.28(b)(2), when NMFS calculates that the landings for any species and/or management group of a linked group has reached or is projected to reach 80 percent of the available quota, NMFS will file for publication with the Office of the Federal Register a notice of closure for all of the species and/or management groups in a linked group that will be effective no fewer than 5 days from date of filing. From the effective date and time of the closure until NMFS announces, via a notice in the **Federal Register**, that additional quota is available and the season is reopened, the fishery for all linked species and/or management groups is closed, even across fishing years.

On July 3, 2013 (78 FR 40318), NMFS announced the final rule for Amendment 5a to the Consolidated Atlantic Highly Migratory Species (HMS) Fishery Management Plan (FMP), which, among other things, established new, final adjusted 2013 quotas for aggregated LCS and hammerhead sharks in the Gulf of Mexico region. The Gulf of Mexico aggregated LCS management group quota is 157.5 metric tons (mt) dressed weight (dw) (347,317 lb dw), and the Gulf of Mexico hammerhead shark management group quota is 25.3 metric tons (mt) dressed weight (dw) (55,722 lb dw). Dealer reports recently received through July 5, 2013, indicate that 128.7 mt dw or 82 percent of the available Gulf of Mexico aggregated LCS quota has been landed, and that 9.2 mt

dw or 37 percent of the available Gulf of Mexico hammerhead shark quota has been landed. Based on these dealer reports, NMFS estimates that the 80-percent limit specified for a closure notice in the regulations has been reached or exceeded. Accordingly, NMFS is closing both the commercial aggregated LCS and hammerhead management groups in the Gulf of Mexico region as of 11:30 p.m. local time, July 17, 2013. All other shark management groups remain open, except for the commercial porbeagle shark management group, which did not open in 2013 (78 FR 75896), and the commercial Gulf of Mexico blacktip shark management group, which closed on July 7, 2013 (78 FR 40318).

At § 635.27(b)(1), the boundary between the Gulf of Mexico region and the Atlantic region is defined as a line beginning on the East Coast of Florida at the mainland at 25°20.4′ N. lat, proceeding due east. Any water and land to the south and west of that boundary is considered, for the purposes of quota monitoring and setting of quotas, to be within the Gulf of Mexico region.

During the closure, retention of aggregated LCS and hammerhead sharks in the Gulf of Mexico region is prohibited for persons fishing aboard vessels issued a commercial shark limited access permit under § 635.4—unless, that is, the vessel is properly permitted to operate as a charter vessel or headboat for HMS and is engaged in a for-hire trip, in which case the recreational retention limits for sharks and ''no sale'' provisions apply (§ 635.22(a) and (c)), or if the vessel possesses a valid shark research permit under § 635.32 and a NMFS-approved observer is onboard. A shark dealer issued a permit pursuant to § 635.4 may not purchase or receive aggregated LCS and/or hammerhead sharks in the Gulf of Mexico region from a vessel issued an Atlantic Shark Limited Access Permit (LAP), except that a permitted shark dealer or processor may possess aggregated LCS and/or hammerhead sharks in the Gulf of Mexico region that were harvested, off-loaded, and sold, traded, or bartered, prior to the effective date of the closure and were held in storage consistent with § 635.28(b)(5).

However, a permitted shark dealer or processor may possess aggregated LCS and/or hammerhead sharks in the Gulf of Mexico region that were harvested by a vessel issued a valid shark research fishery permit per § 635.32 with a NMFS-approved observer onboard during the trip the sharks were taken on as long as the non-sandbar shark research fishery remains open. Under this closure, a shark dealer issued a permit pursuant to § 635.4 may, in accordance with state regulations, purchase or receive aggregated LCS and/or hammerhead sharks in the Gulf of Mexico region if the sharks were harvested, off-loaded, and sold, traded, or bartered from a vessel that fishes only in state waters and that has not been issued an Atlantic Shark LAP, HMS Angling permit, or HMS Charter/Headboat permit pursuant to § 635.4.

Classification

Pursuant to 5 U.S.C. 553(b)(B), the Assistant Administrator for Fisheries, NOAA (AA), finds that providing prior notice and public comment for this action is impracticable and contrary to the public interest because the fishery is currently underway and any delay in this action would result in overharvest of the quota and be inconsistent with management requirements and objectives. Similarly, affording prior notice and opportunity for public comment on this action is contrary to the public interest because if the quota is exceeded, the stock may be negatively affected and fishermen ultimately could experience reductions in the available quota and a lack of fishing opportunities in future seasons. For these reasons, the AA also finds good cause to waive the 30-day delay in effective date pursuant to 5 U.S.C. 553(d)(3). This action is required under § 635.28(b)(2) and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 10, 2013.

Galen Tromble,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2013–16882 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 120918468–3111–02]

RIN 0648–XC753

Fisheries of the Exclusive Economic Zone Off Alaska; ''Other Rockfish'' in the Western Regulatory Area of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; closure.

SUMMARY: NMFS is prohibiting retention of ''other rockfish'' in the Western Regulatory Area of the Gulf of Alaska (GOA). This action is necessary because the 2013 total allowable catch of ''other rockfish'' in the Western Regulatory Area of the GOA has been reached.

DATES: Effective 1200 hours, Alaska local time (A.l.t.), July 9, 2013, through 2400 hours, A.l.t., December 31, 2013.

FOR FURTHER INFORMATION CONTACT: Steve Whitney, 907–586–7269.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the GOA exclusive economic zone according to the Fishery Management Plan for Groundfish of the Gulf of Alaska (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 2013 total allowable catch (TAC) of ''other rockfish'' in the Western Regulatory Area of the GOA is 44 metric tons as established by the final 2013 and 2014 harvest specifications for groundfish of the GOA (78 FR 13162, February 26, 2013).

In accordance with § 679.20(d)(2), the Administrator, Alaska Region, NMFS (Regional Administrator), has determined that the 2013 TAC of ''other rockfish'' in the Western Regulatory Area of the GOA has been reached. Therefore, NMFS is requiring that ''other rockfish'' caught in the Western Regulatory Area of the GOA be treated as prohibited species in accordance with § 679.21(b).

Classification

This action responds to the best available information recently obtained from the fishery. The Acting 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) as such 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 prohibiting the retention of ''other rockfish'' in the Western Regulatory Area of the GOA. NMFS was unable to publish a notice providing time for public comment because the most recent, relevant data only became available as of July 8, 2013.

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.

This action is required by §§ 679.20 and 679.21 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 9, 2013.

Kelly Denit,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2013–16771 Filed 7–9–13; 4:15 pm]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 121018563–3148–02]

RIN 0648–XC752

Fisheries of the Exclusive Economic Zone Off Alaska; Atka Mackerel 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; modification of closure.

SUMMARY: NMFS is opening directed fishing for Atka mackerel in the Central Aleutian district (CAI) of the Bering Sea and Aleutian Islands Management Area (BSAI) by vessels participating in the BSAI trawl limited access fishery. This action is necessary to fully use the 2013 total allowable catch (TAC) of Atka mackerel in the CAI by vessels participating in the BSAI trawl limited access fishery.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), July 9, 2013, through 2400 hrs, A.l.t., December 31, 2013. Comments must be received on or before July 24, 2013.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2012–0210, by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2012-0210,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Mail comments to P.O. Box 21668, Juneau, AK 99802–1668.
- *Hand delivery to the Federal Building:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Deliver comments to 709 West 9th Street, Room 420A, Juneau, AK.

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) 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). Attachments to electronic comments will be accepted in Microsoft Word or Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Steve Whitney, 907–586–7269.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the BSAI 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.

NMFS closed directed fishing for Atka mackerel in the CAI by vessels participating in the BSAI trawl limited access fishery under § 679.2(d)(1)(iii) on June 11, 2013 (78 FR 35771, June 14, 2013).

As of July 8, 2013, NMFS has determined that TAC of Atka mackerel in the CAI for vessels participating in the BSAI trawl limited access fishery remains to support directed fishing. Therefore, in accordance with § 679.25(a)(1)(i), (a)(2)(i)(C) and (a)(2)(iii)(D), and to fully utilize the 2013 TAC of Atka mackerel in the BSAI, NMFS is terminating the previous closure and is opening directed fishing for Atka mackerel in the CAI for vessels participating in the BSAI trawl limited access fishery. This will enhance the socioeconomic well-being of harvesters in this area. The Administrator, Alaska Region (Regional Administrator) considered the following factors in reaching this decision: (1) The current catch of Atka mackerel in the CAI for vessels participating in the BSAI trawl limited access fishery and, (2) the harvest capacity and stated intent on future harvesting patterns of vessels in participating in this fishery.

Classification

This action responds to the best available information recently obtained from the fishery. The Acting 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 § 679.25(c)(1)(ii) as such 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 opening directed fishing for Atka mackerel in the CAI by vessels participating in the BSAI trawl limited access fishery. NMFS was unable to publish a notice providing time for public comment because the most recent, relevant data only became available as of July 8, 2013.

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.

Without this inseason adjustment, NMFS could not allow the fishery for Atka mackerel in the CAI by vessels participating in the BSAI trawl limited access fishery to be harvested in an expedient manner and in accordance with the regulatory schedule. Under § 679.25(c)(2), interested persons are invited to submit written comments on this action to the above address until July 24, 2013.

This action is required by §§ 679.20 and 679.25 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 9, 2013.

Kelly Denit,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2013–16764 Filed 7–9–13; 4:15 pm]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 120918468–3111–02]

RIN 0648–XC756

Fisheries of the Exclusive Economic Zone Off Alaska; Northern Rockfish and Dusky Rockfish in the Western Regulatory Area of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; modification of closure.

SUMMARY: NMFS is opening directed fishing for northern rockfish and dusky rockfish for 48 hours in the Western Regulatory Area of the Gulf of Alaska (GOA). This action is necessary to fully use the total allowable catch (TAC) of northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), July 10, 2013, through 1200 hrs, A.l.t., July 12, 2013. Comments must be received on or before July 25, 2013.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2012–0180, by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA–NMFS–2012–0180,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Mail comments to P.O. Box 21668, Juneau, AK 99802–1668.
- *Hand delivery to the Federal Building:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Deliver comments to 709 West 9th Street, Room 420A, Juneau, AK.

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) 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). Attachments to electronic comments will be accepted in Microsoft Word or Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Steve Whitney, 907–586–7269.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the GOA exclusive economic zone according to the Fishery Management Plan for Groundfish of the Gulf of Alaska (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.

NMFS closed directed fishing for northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA under § 679.20(d)(1)(iii) on July 3, 2013 (78 FR 40638 July 8, 2013).

As of July 8, 2013, NMFS has determined that approximately 1,000 metric tons of northern rockfish and 260 metric tons of dusky rockfish TAC remain in the Western Regulatory Area of the GOA. Therefore, in accordance with § 679.25(a)(1)(i), (a)(2)(i)(C), and (a)(2)(iii)(D), and to fully utilize the TAC of northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA, NMFS is terminating the previous closure and is reopening directed fishing for northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA, effective 1200 hrs, A.l.t., July 10, 2013.

In accordance with § 679.20(d)(1)(iii), the Regional Administrator finds that this directed fishing allowance will be reached after 48 hours. Consequently, NMFS is prohibiting directed fishing for northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA, effective 1200 hrs, A.l.t., July 12, 2013. The Administrator, Alaska Region (Regional Administrator) considered the following factors in reaching this decision: (1) the current catch of northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA and, (2) the harvest capacity and stated intent on future harvesting patterns of vessels in participating in this fishery.

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) as such 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 opening of directed fishing for northern rockfish and dusky rockfish in the Western Regulatory Area of the GOA. Immediate notification is necessary to allow for the orderly conduct and efficient operation of these fisheries, 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 July 8, 2013.

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.

Without this inseason adjustment, NMFS could not allow pollock fishery in Statistical Area 630 of the GOA to be harvested in an expedient manner and in accordance with the regulatory schedule. Under § 679.25(c)(2), interested persons are invited to submit written comments on this action to the above address until July 25, 2013.

This action is required by § 679.25 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 10, 2013.

James P. Burgess,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2013–16876 Filed 7–10–13; 4:15 pm]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 78, No. 135
Monday, July 15, 2013

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.

CONSUMER PRODUCT SAFETY COMMISSION

16 CFR Chapter II

[Docket No. CPSC–2013–0028]

Petition for Rulemaking To Eliminate Accessible Cords on Window Covering Products

AGENCY: Consumer Product Safety Commission.

ACTION: Notice of petition for rulemaking.

SUMMARY: The Consumer Product Safety Commission (CPSC or Commission) received a petition requesting the Commission to: promulgate a mandatory standard that prohibits any window covering cords, when a feasible cordless alternative exists; and require that all window covering cords be made inaccessible through the use of a passive guardian device when a feasible cordless alternative does not exist. The Commission invites written comments concerning the petition.

DATES: The Office of the Secretary must receive comments on the petition by September 13, 2013.

ADDRESSES: You may submit comments, identified by Docket No. CPSC–2013–0028, by any of the following methods:

Electronic Submissions: Submit electronic comments to the Federal eRulemaking Portal at: *http://www.regulations.gov.* Follow the instructions for submitting comments. The Commission does not accept comments submitted by electronic mail (email), except through www.regulations.gov. The Commission encourages you to submit electronic comments by using the Federal eRulemaking Portal, as described above.

Written Submissions: Submit written submissions in the following way: Mail/Hand delivery/Courier (for paper, disk, or CD–ROM submissions), preferably in five copies, to: Office of the Secretary, Consumer Product Safety Commission, Room 820, 4330 East West Highway, Bethesda, MD 20814; telephone (301) 504–7923.

Instructions: All submissions received must include the agency name and docket number for this notice. All comments received may be posted without change, including any personal identifiers, contact information, or other personal information provided, to: http://www.regulations.gov. Do not submit confidential business information, trade secret information, or other sensitive or protected information that you do not want to be available to the public. If furnished at all, such information should be submitted in writing.

Docket: For access to the docket to read background documents or comments received, go to: *http://www.regulations.gov,* and insert the docket number, CPSC–2013–0028, into the ''Search'' box, and follow the prompts. A copy of the petition is available at *http://www.regulations.gov* under Docket No. CPSC–2013–0028, Supporting and Related Materials.

FOR FURTHER INFORMATION CONTACT: Rockelle Hammond, Office of the Secretary, U.S. Consumer Product Safety Commission, Room 820, 4330 East West Highway, Bethesda, MD 20814; telephone (301) 504–6833.

SUPPLEMENTARY INFORMATION: The Consumer Product Safety Commission (CPSC or Commission) received a petition requesting initiation of a rulemaking to promulgate a mandatory standard to eliminate accessible cords on window covering products. The petition was filed by nine organizations representing consumer groups, safety consultants, and legal counsel: Parents for Window Blind Safety; Consumer Federation of America; Consumers Union; Kids in Danger; Public Citizen; U.S. PIRG; Independent Safety Consulting; Safety Behavior Analysis, Inc.; and Onder, Shelton, O'Leary & Peterson (collectively petitioners). CPSC has docketed the petition (CP13–2).

The petition asserts that a mandatory rule is necessary because attempts to develop a voluntary standard that adequately mitigates the risk of injury associated with window covering cords have failed. Petitioners state that, based on CPSC's data, between 1985 and 2012, 324 children have been killed, and 122 have been injured by window covering cords.

To support their request for rulemaking, petitioners detail the history of the voluntary standards process for window coverings since 1985. Petitioners argue that although the first voluntary standard, ANSI/WCMA A100.1–1996, issued in 1996, addressed some hazards associated with outer cord loops, the manner in which this hazard was addressed did not fully resolve the strangulation and asphyxiation risk. The voluntary standard was subsequently updated in 2002, 2007, 2009, and 2010, following CPSC recalls for unaddressed hazards related to rear inner cord fatalities on roman shades and lifting loops on roll-up shades. Petitioners argue that these efforts also had limited success, detailing additional fatalities and injuries. Petitioners assert that the most recent version of the ANSI standard, approved on November 28, 2012, still fails to adequately address the strangulation hazard posed by accessible cords on window coverings, despite increased international governmental and retailer pressure to address the hazard.

Petitioners assert that the voluntary standard is inadequate. They analyzed the incidents associated with window covering cords between 1996 and 2012 to determine what characteristic of the cord was involved in each incident. Of the 293 incidents that occurred during that period, enough data to determine the cord characteristic involved was available in 250 of the incidents. Petitioners conclude that 102 of these 250 incidents, or 40%, would not have been prevented by adherence to the current 2012 voluntary standard. Petitioners also detail characteristics of newer window covering designs that meet the voluntary standard but that Petitioners argue are more dangerous than traditional corded blinds.

Petitioners assert that substantial noncompliance with the voluntary standard is demonstrated by CPSC's 16 recalls involving blinds that purportedly complied with the voluntary standard since 2007. Petitioners state that CPSC found numerous other violations of the voluntary standard when evaluating roman shades and roll-up shades, including looped pull cords, no inner cord stops, no tension devices, and failure to attach tension devices to a continuous loop cord. Petitioners assert that many of these products had been on

the market for years before the defects were detected and recalled.

Petitioners ask the Commission to issue a mandatory standard to eliminate the hazard posed by accessible cords in window coverings. The petition specifically requests that the Commission: (1) Promulgate a mandatory standard that prohibits any window covering cords when a feasible cordless alternative exists; and (2) require that all cords be made inaccessible through the use of a passive guardian device when a feasible cordless alternative does not exist.

By this notice, the Commission seeks comments concerning this petition. Interested parties may obtain a copy of the petition by writing or calling the Office of the Secretary, U.S. Consumer Product Safety Commission, Room 820, 4330 East West Highway, Bethesda, MD 20814; telephone (301) 504–7923. A copy of the petition also will be made available for viewing under ''Supporting and Related Materials'' in *www.regulations.gov* under this docket number.

Dated: July 3, 2013.

Todd A. Stevenson,

Secretary, U.S. Consumer Product Safety Commission.

[FR Doc. 2013–16403 Filed 7–12–13; 8:45 am]

BILLING CODE 6355–01–P

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2520

RIN 1210–AB20

Proposed Amendment To Advance Notice of Proposed Rulemaking for Pension Benefit Statements

AGENCY: Employee Benefits Security Administration, U.S. Department of Labor.

ACTION: Notice of Extension of Comment Period for Advance Notice of Proposed Rulemaking.

SUMMARY: The Department of Labor is extending until August 7, 2013, the comment period for an advance notice of proposed rulemaking focusing on lifetime income illustrations given to participants in defined contribution pension plans, such as 401(k) and 403(b) plans. The ANPRM serves as a request for comments on specific language and concepts in advance of a proposed regulation.

DATES: The Department of Labor is extending the comment period of an advance proposed rule published May 8, 2013, 78 FR 26727. Written comments must be received by the Department on or before August 7, 2013.

ADDRESSES: You may submit comments, identified by RIN 1210–AB20, by one of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Email: e-ORI@dol.gov. Include RIN 1210–AB20 in the subject line of the message.

Mail: Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N–5655, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, Attention: Pension Benefit Statements Project.

Comments received will be available for public inspection in the Public Disclosure Room of the Employee Benefits Security Administration, U.S. Department of Labor, Room N–1513, 200 Constitution Avenue NW., Washington, DC 20210. They also will be available online at *www.regulations.gov* and *www.dol.gov/ebsa,* at no charge. 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 may be posted on the Internet and can be retrieved by most Internet search engines.

FOR FURTHER INFORMATION CONTACT: Suzanne Adelman or Tom Hindmarch at (202) 693–8500. This is not a toll free number.

SUPPLEMENTARY INFORMATION: On May 8, 2013, the Department of Labor (Department) published at 78 FR 26727 an advance notice of proposed rulemaking (ANPRM) regarding the pension benefit statement requirements under section 105 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The ANPRM requested comments on specific language and concepts the Department is considering as part of proposed regulations currently under development.

The ANPRM provides that the Department is considering a rule that would require a participant's ''total benefits accrued'' to be expressed on his pension benefit statement as an estimated lifetime stream of payments, in addition to being presented as an account balance. The ANPRM also states that the Department is considering a rule that would require a participant's account balance to be projected to his retirement date and then converted to and expressed as an estimated lifetime stream of payments.

The comment period for the ANPRM is scheduled to close on July 8, 2013. A substantial number of stakeholders are concerned that the original 60-day comment period is not sufficient to provide well thought out and useful feedback to the Department on the complex matters raised in the ANPRM. Accordingly, to ensure that all interested persons have the opportunity to prepare and submit comments, EBSA extends the comment period from July 8 to August 7, 2013.

Signed at Washington, DC, this 8th day of July, 2013.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

[FR Doc. 2013–16739 Filed 7–12–13; 8:45 am]

BILLING CODE 4510–29–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0476]

RIN 1625–AA00

Safety Zone; San Diego Bayfair; Mission Bay, San Diego, CA

AGENCY: Coast Guard, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard is proposing a temporary safety zone on the navigable waters of Mission Bay in San Diego, CA for the San Diego Bayfair power boat races from September 13, 2013, until September 15, 2013. The safety zone as proposed would be in effect from 7 a.m. to 5:30 p.m. daily during this timeframe. This temporary safety zone is necessary to provide for the safety of the participants, crew, spectators, participating vessels, and other vessels and users of the waterway. Persons and vessels would be prohibited from entering into, transiting through or anchoring within this safety zone unless authorized by the Captain of the Port or his designated representative.

DATES: Comments and related material must be received by the Coast Guard on or before August 14, 2013.

Requests for public meetings must be received by the Coast Guard on or before July 29, 2013.

ADDRESSES: You may submit comments identified by docket number using any one of the following methods:

(1) *Federal eRulemaking Portal: http://www.regulations.gov.*

(2) *Fax:* 202–493–2251.

(3) *Mail or Delivery:* Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001. Deliveries accepted between 9 a.m. and 5 p.m., Monday through Friday, except federal holidays. The telephone number is 202–366–9329.

See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** section below for further instructions on submitting comments. To avoid duplication, please use only one of these three methods.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant John Bannon, Waterways Management, U.S. Coast Guard Sector San Diego; telephone (619) 278–7261, email *John.E.Bannon@uscg.mil.* If you have questions on viewing or submitting material to the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone (202) 366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

DHS Department of Homeland Security
FR Federal Register
NPRM Notice of Proposed Rulemaking

A. Public Participation and Request for Comments

We encourage you to participate in this rulemaking 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.

1. Submitting comments

If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. You may submit your comments and material online at *http://www.regulations.gov*, or by fax, mail, or hand delivery, but please use only one of these means. If you submit a comment online, it will be considered received by the Coast Guard when you successfully transmit the comment. If you fax, hand deliver, or mail your comment, it will be considered as having been received by the Coast Guard when it is received at the Docket Management Facility. 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.

To submit your comment online, go to *http://www.regulations.gov*, type the docket number [USCG–2013–0476] in the ''SEARCH'' box and click ''SEARCH.'' Click on ''Submit a Comment'' on the line associated with this rulemaking.

If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period and may change the rule based on your comments.

2. Viewing comments and documents

To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov*, type the docket number (USCG–2013–0476) in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

3. Privacy Act

Anyone can search the electronic form of comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act notice regarding our public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

4. Public meeting

We do not now plan to hold a public meeting. But you may submit a request for one, using one of the methods specified under **ADDRESSES**. Please explain why you believe a public meeting would be beneficial. If we determine that one would aid this rulemaking, we will hold one at a time and place announced by a later notice in the **Federal Register**.

B. Basis and Purpose

The San Diego Bayfair power boat races occur annually over a weekend in September after the Labor Day weekend. This temporary safety zone encompassing a portion of Mission Bay is necessary to provide for the safety of the participants, crew, spectators, participating vessels, and other vessels and users of the waterway. Persons and vessels would be prohibited from entering into, transiting through or anchoring within this safety zone unless authorized by the Captain of the Port or his designated representative. As an annual event, permitted by the City of San Diego, it is well advertised, supported by the community, and includes numerous safety support boats.

The Ports and Waterways Safety Act (33 U.S.C. sections 1221 et seq.) authorizes the Coast Guard to establish safety zones. Thunderboats Unlimited Inc. is sponsoring San Diego Bayfair, which is held on the navigable waters of Mission Bay in San Diego, CA. The proposed temporary safety zone is necessary to provide for the safety of the participants, crew, spectators, sponsor vessels, and other vessels and users of the waterway. This event involves approximately 200 various power boats racing on a predetermined course. The sponsor will provide thirty seven patrol and rescue vessels to help facilitate the event and ensure public safety.

C. Discussion of Proposed Rule

The Coast Guard is proposing a temporary safety zone that would be enforced from 7 a.m. to 5:30 p.m. from September 13, 2013, through September 15, 2013. This safety zone is necessary to provide for the safety of the crews, spectators, participants, and other vessels and users of the waterway. Persons and vessels would be prohibited from entering into, transiting through, or anchoring within this safety zone unless authorized by the Captain of the Port, or his designated representative. The limits of the safety zone will be the navigable waters of Mission Bay bound by the following coordinates; 32°47′32″ N, 117°13′25″ W to 32°47′32″ N, 117°13′00″ W to 32°47′20″ N, 117°13′00″ W then west to 32°46′45″ N, 117°14′09″ W to 32°46′11″ N, 117°14′01″ W. Before the effective period, the Coast Guard will publish a Local Notice to Mariners (LNM).

D. Regulatory Analyses

We developed this proposed rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses

based on a number of these statutes or executive orders.

1. Regulatory Planning and Review

This proposed rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders. This determination is based on the size and location of the safety zone. Commercial vessels will not be hindered by the safety zone. Recreational vessels will be allowed to transit through the designated safety zone during specified times, but can transit safely around the safety zone. Additionally, before the effective period, the Coast Guard will publish a Local Notice to Mariners (LNM).

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this proposed rule will not have a significant economic impact on a substantial number of small entities. This rule will affect the following entities, some of which may be small entities: Owners or operators of vessels intending to transit or anchor in this portion of Mission Bay from September 13–15, 2013, from 7 a.m. to 5:30 p.m.

This safety zone will not have a significant economic impact on a substantial number of small entities for the following reasons. Vessel traffic can pass safely around the zone, and may transit through the safety zone if they obtain permission from the Captain of the Port or his designated representative. Before the effective period, the Coast Guard will issue broadcast notice to mariners alerts via marine channel 16 VHF.

If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this rule would have a significant economic impact on it, please submit a comment (see **ADDRESSES**) explaining why you think it qualifies and how and to what degree this rule would economically affect it.

3. Assistance for Small Entities

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 proposed 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. The Coast Guard will not retaliate against small entities that question or complain about this proposed rule or any policy or action of the Coast Guard.

4. Collection of Information

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

5. Federalism

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 proposed rule under that Order and determined that this rule does not have implications for federalism.

6. 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.

7. 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 proposed rule would not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

8. Taking of Private Property

This proposed rule would not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This proposed rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children From Environmental Health Risks

We have analyzed this proposed rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and would not create an environmental risk to health or risk to safety that might disproportionately affect children.

11. Indian Tribal Governments

This proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

This proposed rule is not a ''significant energy action'' under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This proposed rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this proposed rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have made a preliminary 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 proposed rule involves establishing a temporary safety zone. This rule is categorically excluded from further review under paragraph 34(g) of Figure 2–1 of the Commandant Instruction. A preliminary environmental analysis checklist supporting this determination and a Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

List of Subjects in 33 CFR Part 165

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

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

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T11–578 to read as follows:

§ 165.T11–578 Safety zone; San Diego Bayfair; Mission Bay, San Diego, CA.

(a) *Location.* The limits of the safety zone will be the navigable waters of Mission Bay bound by the following coordinates; 32°47′32″ N, 117°13′25″ W to 32°47′32″ N, 117°13′00″ W to 32°47′20″ N, 117°13′00″ W then west to 32°46′45″ N, 117°14′09″ W to 32°46′11″ N, 117°14′01″ W.

(b) *Enforcement Period.* This section will be enforced from 7 a.m. to 5:30 p.m. on September 13, 14, and 15, 2013. Before the effective period, the Coast Guard will publish a Local Notice to Mariners (LNM). If the event concludes prior to the scheduled termination time, the Captain of the Port will cease enforcement of this safety zone and will announce that fact via Broadcast Notice to Mariners.

(c) *Definitions.* The following definition applies to this section: *Designated representative,* means any commissioned, warrant, or petty officer of the Coast Guard on board Coast Guard, Coast Guard Auxiliary, and local, state, and federal law enforcement vessels who have been authorized to act on the behalf of the Captain of the Port.

(d) *Regulations.*

(1) Entry into, transit through or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port of San Diego or his designated representative.

(2) Mariners can request permission to transit through the safety zone from the Patrol Commander. The Patrol Commander can be contacted on VHF–FM channels 16 and 23.

(3) All persons and vessels shall comply with the instructions of the Coast Guard Captain of the Port or his designated representative.

(4) Upon being hailed by U.S. Coast Guard patrol personnel by siren, radio, flashing light, or other means, the operator of a vessel shall proceed as directed.

(5) The Coast Guard may be assisted by other federal, state, or local agencies.

Dated: June 27, 2013.

S.M. Mahoney,

Captain, U.S. Coast Guard, Captain of the Port San Diego.

[FR Doc. 2013–16806 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF DEFENSE

Department of the Army, Corps of Engineers

33 CFR Part 207

Reservoirs at Headwaters of the Mississippi River; Use and Administration

AGENCY: U.S. Army Corps of Engineers, DoD.

ACTION: Notice of proposed rulemaking and request for comments.

SUMMARY: The U.S. Army Corps of Engineers is proposing to amend the rules regarding use and administration of the reservoirs at the headwaters of the Mississippi River by deleting from the Code of Federal Regulations all references to minimum discharges and to operating limits for the reservoirs. Following extensive public input and environmental review, the St. Paul District of the Corps of Engineers recently adopted an updated operating plan for the Mississippi River Headwaters reservoirs containing minimum flow values that differ from those currently codified in the Code of Federal Regulations. Deleting all references to minimum flows in the regulations will eliminate the current discrepancy between the regulations and the approved operating plan for the reservoirs. The operating limits are also contained in the operating plan for the reservoirs, and eliminating both the minimum flow values and the operating limits from the rule will make it unnecessary to amend the regulations each time the values are modified in the operating plan in the future.

DATES: Submit comments on or before September 13, 2013.

ADDRESSES: You may submit comments, identified by docket number COE–2013–0008, by any of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Email: Jerry.W.Webb@usace.army.mil and *Chandra.S.Pathak@usace.army.mil.* Include the docket number, COE–2013–0008 in the subject line of the message.

Mail: U.S. Army Corps of Engineers, Attn: CECW–CE (Chandra S. Pathak), 441 G Street NW., Washington, DC 20314–1000.

Hand Delivery/Courier: Due to security requirements, we cannot receive comments by hand delivery or courier.

Instructions: Direct your comments to docket number COE–2013–0008. All comments received will be included in the public docket without change and may be made available on-line at *http://www.regulations.gov,* including any personal information provided, unless the commenter indicates that the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI, or otherwise protected, through regulations.gov or email. The regulations.gov Web site is an anonymous access system, which means we will not know your identity or contact information unless you provide it in the body of your comment. If you send an email directly to the Corps without going through regulations.gov, your email address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, we recommend that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If we cannot read your comment because of technical difficulties and cannot contact you for clarification, we may not be able to consider your comment. Electronic comments should avoid the use of any special characters, any form of encryption, and be free of any defects or viruses.

Docket: For access to the docket to read background documents or

comments received, go to regulations.gov. All documents in the docket are listed. Although listed in the index, some information is not publicly available, such as CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form.

FOR FURTHER INFORMATION CONTACT: Mr. Jerry W. Webb, Headquarters, U.S. Army Corps of Engineers, Engineering and Construction Community of Practice, Washington, DC at 202–761–0673; Mr. Chandra S. Pathak, Headquarters, U.S. Army Corps of Engineers, Engineering and Construction Community of Practice, Washington, DC at 202–761–4668; or Mr. Kenton Spading, U.S. Army Corps of Engineers, St. Paul District, at 651–290–5623.

SUPPLEMENTARY INFORMATION:

Executive Summary

The purpose of this action is to amend the current rule regarding minimum discharges and minimum operating limits of the reservoirs at the headwaters of the Mississippi River to ensure that the regulations do not conflict with the current operating plan for those reservoirs.

The Corps' authority to amend the minimum flow values and minimum operating limits for the reservoirs of the headwaters of the Mississippi River is Section 7 of the Rivers and Harbors Act of 1917 (40 Stat. 266; 33 U.S.C. 1) and Section 216 of the Flood Control Act of 1970 (84 Stat. 1830; 33 U.S.C. 549a).

Background

The Rivers and Harbors Acts of June 14, 1880, and August 2, 1882, authorized the construction of dams at each of the six Mississippi River Headwaters lakes for the purpose of augmenting Mississippi River flow for navigation. The lakes affected by these acts are Winnibigoshish, Leech, Pokegama, Sandy, Cross (Pine River), and Gull. Following authorization of the reservoirs, the Secretary of War prescribed regulations governing operation of the reservoirs on February 11, 1931, which were codified at 33 CFR 207.340. The current regulations list minimum discharges for each reservoir at 33 CFR 207.340(d)(2). The current regulations also list minimum operating limits, or the lowest level at which the Corps may operate each reservoir, at 33 CFR 207.340(d)(7).

The Corps' procedure adopting and publishing regulations related to reservoirs has changed since the aforementioned regulations were originally codified in 1931. The present-day practice is to include minimum flow values, operating limits and other related information in Water Control Manuals that are adopted following an extensive public and environmental review process, as outlined in Engineer Regulation (ER) 1110–2–240. Moreover, the operating limits in the Water Control Manuals prescribe not only the minimum level at which a reservoir may operate but also the absolute upper limit on reservoir operations, effectively providing a band within which the Corps may operate a reservoir.

As a precursor to updating the Water Control Manuals for the Mississippi River Headwaters reservoirs in 2009, we completed a study known as the Mississippi River Headwaters Reservoir Operating Plan Evaluation (ROPE). The primary purpose of the ROPE was to evaluate alternative operating plans for the Headwaters reservoirs in an attempt to improve the operation of the system while balancing tribal trust obligations, flood risk reduction, environmental concerns, water quality, water supply, recreation, navigation, hydropower, and other public interests.

On January 19, 2010, after thoroughly assessing potential environmental impacts and involving the public in the process, the District Engineer for the St. Paul District signed a Record of Decision approving the ROPE's recommended operating plan for the Headwaters reservoirs. The ROPE's recommended plan adopts minimum discharges that were scientifically developed using a habitat in-stream flow analysis (Tenant 1976), as described in the ROPE. The minimum discharges in the ROPE's recommended plan differ from the minimum discharges listed in 33 CFR 207.340 as it is currently written. We are in the process of updating the Water Control Manuals for the Headwaters reservoirs to implement the recommendations from the 2009 ROPE. Once the Water Control Manuals are revised, the minimum discharge values in the revised Water Control Manuals will also be in conflict with 33 CFR 207.340 if the regulation is not amended.

Table No. 1 illustrates the differences between the current regulations and the 2009 ROPE study minimum flows.

TABLE 1—MISSISSIPPI RIVER HEADWATER RESERVOIR SYSTEM OPERATING LIMITS AND CFR VERSUS ROPE MINIMUM DISCHARGES

	Winni-bigoshish	Leech	Pokegama	Sandy	Cross L. Pine R.	Gull
Total Operating Limit	1294.94–1303.14.	1292.70–1297.94.	1270.42–1278.42.	1214.31–1221.31.	1225.32–1235.30.	1192.75–1194.75
Minimum Flow: 33 CFR 207.340	150 cfs	70 cfs	200 cfs	80 cfs	90 cfs	30 cfs
Minimum Flow: 2009 ROPE	≥1294.94	≥1292.70	≥1273.17	≥1214.31	≥1225.32	≥1192.75
	100 cfs	120 cfs	200 cfs	20 cfs	30 cfs	20 cfs
	<1294.94	<1292.70	<1273.17	<1214.31	<1225.32	<1192.75
	50 cfs	60 cfs	Sum of Flow From Winni-bigoshish plus Leech.	10 cfs	15 cfs	10 cfs

We are proposing to amend the regulations to delete all references to minimum flows to eliminate any conflict between the regulations and the Water Control Manuals that guide operations at the Mississippi River Headwaters reservoirs. We further propose to remove the minimum operating limits from the regulations. Any future changes to the minimum flows or the operating limits of the Headwaters reservoirs will be handled through revisions to the Water Control Manuals, which will be accomplished in accordance with the guidance provided in ER 1110–2–240 after public input and any necessary environmental reviews. The proposed change to the rule will eliminate the necessity of amending the Code of Federal

Regulations each time a Water Control Manual is updated.

Administrative Requirements

Plain Language

In compliance with the principles in the President's Memorandum of June 1, 1998, (63 FR 31855) regarding plain language, this preamble is written using plain language. The use of ''we'' in this notice refers to the Corps. We have also used the active voice, short sentences, and common everyday terms except for necessary technical terms.

Paperwork Reduction Act

This proposed action will not impose any new information collection burden under the provisions of the Paperwork Production Act (44 U.S.C. 3501 et seq.). The proposed modification would eliminate minimum flow values and operating limits from the rule. Since the proposed rule does not involve any additional collection of information from the public, this action is not subject to the Paperwork Reduction Act.

Executive Order 12866

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Corps must determine whether the regulatory action is ''significant'' and therefore subject to review by OMB and the requirements of the Executive Order. The Executive Order defines ''significant regulatory action'' as one that is likely to result in a rule that may:

(1) Have an annual effect on the economy of $100 million or more 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, 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 the Executive Order.

Pursuant to the terms of Executive Order 12866, we have determined that the proposed rule is not a ''significant regulatory action'' because it does not meet any of these four criteria. The proposed rule modifies the regulations to be consistent with an approved, updated operating plan for the Mississippi River Headwaters reservoirs.

Executive Order 13132

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), requires the Corps to develop an accountable process to ensure ''meaningful and timely input by State and local officials in the development of regulatory policies that have Federalism implications.'' The phrase ''policies that have Federalism implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects 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.''

The proposed rule does not have Federalism implications. We do not believe that amending the regulation to eliminate references to minimum flow values and operating limits for the Mississippi River Headwaters reservoirs will have substantial direct effects on the 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. The proposed rule does not impose new substantive requirements. In addition, the proposed changes will not impose any additional substantive obligations on State or local governments. Therefore, Executive Order 13132 does not apply to this proposed rule.

Regulatory Flexibility Act, as Amended by the Small Business Regulatory Enforcement Fairness Act of 1996, 5 U.S.C. 601 et seq.

The Regulatory Flexibility Act generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice-and-comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations and small governmental jurisdictions.

For purposes of assessing the impacts of this proposed rule on small entities, a small entity is defined as: (1) A small business based on Small Business Administration size standards; (2) a small governmental jurisdiction that is a government of a city, county, town, school district, or special district with a population of less than 50,000; or (3) a small organization that is any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.

After considering the economic impacts of the proposed rule on small entities, we believe that this action will not have a significant economic impact on a substantial number of small entities. The proposed rule is consistent with current agency practice, does not impose new substantive requirements, and therefore would not have a significant economic impact on a substantial number of small entities.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and Tribal governments and the private sector. Under Section 202 of the UMRA, the agencies generally must prepare a written statement, including a cost-benefit analysis, for proposed and final rules with ''Federal mandates'' that may result in expenditures to State, local, and Tribal governments, in the aggregate, or to the private sector, of $100 million or more in any one year. Before promulgating a rule for which a written statement is needed, Section 205 of the UMRA generally requires the agencies to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective, or least burdensome alternative that achieves the objectives of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. Moreover, section 205 allows an agency to adopt an alternative other than the least costly, most cost-effective, or least burdensome alternative if the agency publishes with the final rule an explanation why that alternative was not adopted. Before an agency establishes any regulatory requirements that may significantly or uniquely affect small governments, including Tribal governments, it must have developed, under Section 203 of the UMRA, a small government agency plan. The plan must provide for notifying potentially affected small governments, enabling officials of affected small governments to have meaningful and timely input in the development of regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements.

We have determined that the proposed rule does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and Tribal governments, in the aggregate, or the private sector in any one year. The proposed rule is

consistent with current agency practice, does not impose new substantive requirements and therefore does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and Tribal governments, in the aggregate, or the private sector in any one year. Therefore, the proposed rule is not subject to the requirements of Sections 202 and 205 of the UMRA. For the same reasons, we have determined that the proposed rule contains no regulatory requirements that might significantly or uniquely affect small governments. Therefore, the proposed rule is not subject to the requirements of Section 203 of UMRA.

Executive Order 13045

Executive Order 13045, ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), applies to any rule that: (1) is determined to be ''economically significant'' as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that we have reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, we must evaluate the environmental health or safety effects of the proposed rule on children, and explain why the regulation is preferable to other potentially effective and reasonably feasible alternatives.

The proposed rule is not subject to this Executive Order because it is not economically significant as defined in Executive Order 12866. In addition, it does not concern an environmental or safety risk that we have reason to believe may have a disproportionate effect on children.

Executive Order 13175

Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 6, 2000), requires agencies to develop an accountable process to ensure ''meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications.'' The phrase ''policies that have tribal implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and the Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.''

The proposed rule does not have tribal implications. It will not have substantial direct effects on tribal governments, on the relationship between the Federal government and the Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes. It is generally consistent with current agency practice and does not impose new substantive requirements. Therefore, Executive Order 13175 does not apply to this proposed rule.

Environmental Documentation

The purpose of this proposed rulemaking is to make the Code of Federal Regulations consistent with the current operating plan for the Mississippi River Headwaters Reservoirs. This action is solely administrative in nature. There is no intended change in the use or operation of the reservoirs as a result of this action. The substantive change in reservoir operations has already occurred as a consequence of the adoption of an updated operating plan, as approved in the Record of Decision for Mississippi River Headwaters Reservoir Operating Plan Evaluation dated January 19, 2010. The potential environmental impacts of the updated operating plan were thoroughly assessed in the Final Integrated Reservoir Operating Plan Evaluation and Environmental Impact Statement dated September 2009. Because the present action is merely administrative and an environmental analysis was completed at the time the substantive changes to the operating plan were adopted, no additional environmental documentation will be required at this time.

Congressional Review Act

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

Executive Order 12898

Executive Order 12898 requires that, to the greatest extent practicable and permitted by law, each Federal agency must make achieving environmental justice part of its mission. Executive Order 12898 provides that each Federal agency conduct its programs, policies, and activities that substantially affect human health or the environment in a manner that ensures that such programs, policies, and activities do not have the effect of excluding persons (including populations) from participation in, denying persons (including populations) the benefits of, or subjecting persons (including populations) to discrimination under such programs, policies, and activities because of their race, color, or national origin.

The proposed rule is not expected to negatively impact any community, and therefore is not expected to cause any disproportionately high and adverse impacts to minority or low-income communities.

Executive Order 13211

The proposed rule is not a ''significant energy action'' as defined in Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The proposed rule is consistent with current agency practice, does not impose new substantive requirements and therefore will not have a significant adverse effect on the supply, distribution, or use of energy.

List of Subjects in 33 CFR Part 207

Navigation (water), Penalties, Reporting and recordkeeping requirements, Waterways.

Dated: July 3, 2013.

Approved By:

James R. Hannon,

Chief of Operations.

For the reasons stated in the preamble, the Corps proposes to amend 33 CFR part 207 as follows:

PART 207—NAVIGATION REGULATIONS

■ 1. The authority citation for part 207 continues to read as follows:

Authority: 40 Stat. 266 (33 U.S.C. 1).

■ 2. Revise § 207.340 to read as follows:

§ 207.340 Reservoirs at headwaters of the Mississippi River; use and administration.

(a) *Description.* These reservoirs include Winnibigoshish, Leech Lake, Pokegama, Sandy Lake, Pine River and Gull Lake.

(b) *Penalties.* The River and Harbor Act approved August 11, 1888 (25 Stat.

419, 33 U.S.C. 601) includes the following provisions as to the administration of the headwater reservoirs:

And it shall be the duty of the Secretary of War to prescribe such rules and regulations in respect to the use and administration of said reservoirs as, in his judgment, the public interest and necessity may require; which rules and regulations shall be posted in some conspicuous place or places for the information of the public. And any person knowingly and willfully violating such rules and regulations shall be liable to a fine not exceeding five hundred dollars, or imprisonment not exceeding six months, the same to be enforced by prosecution in any district court of the United States within whose territorial jurisdiction such offense may have been committed.

(c) *Previous regulations now revoked.* In accordance with the above act, the Secretary of War prescribed regulations for the use and administration of the reservoirs at the headwaters of the Mississippi River under date of February 11, 1931, which together with all subsequent amendments are hereby revoked and the following substituted therefor.

(d) *Authority of officer in charge of the reservoirs.* The accumulation of water in, and discharge of water from the reservoirs, including that from one reservoir to another, shall be under the direction of the U.S. District Engineer, St. Paul, Minnesota, and of his authorized agents subject to the following restrictions and considerations:

(1) Notwithstanding any other provision of this section, the discharge from any reservoir may be varied at any time as required to permit inspection of, or repairs to, the dams, dikes or their appurtenances, or to prevent damage to lands or structures above or below the dams.

(2) During the season of navigation on the upper Mississippi River, the volume of water discharged from the reservoirs shall be so regulated by the officer in charge as to maintain as nearly as practicable, until navigation closes, a sufficient stage of water in the navigable reaches of the upper Mississippi and in those of any tributary thereto that may be navigated and on which a reservoir is located.

(e) *Passage of logs and other floating bodies.* Logs and other floating bodies may be sluiced or locked through the dams, but prior authority for the sluicing of logs must be obtained from the District Engineer when this operation necessitates a material change in discharge.

(f) *Obstructions to flow of water.* No person shall place floating bodies in a stream or pond above or below a reservoir dam when, in the opinion of the officer in charge, such act would prevent the necessary flow of water to or from such dam, or in any way injure the dam and its appurtenances, its dikes and embankments; and should floating bodies lying above or below a dam constitute at any time an obstruction or menace as beforesaid, the owners of said floating bodies will be required to remove them immediately.

(g) *Trespass.* No one shall trespass on any reservoir dam, dike, embankment or upon any property pertaining thereto.

[FR Doc. 2013–16877 Filed 7–12–13; 8:45 am]

BILLING CODE 3720–58–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[WC Docket No. 12–375; DA 13–1445]

More Data Sought on Extra Fees Levied on Inmate Calling Services

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Wireline Competition Bureau (Bureau) seeks additional comment on certain fees related to inmate calling services (ICS). The record to date indicates that ICS providers may charge ICS account holders fees that appear ancillary to making calls, such as account setup fees, account replenishment fees, account refund fees, and account inactivity fees.

DATES: Comments due on or before July 17, 2013; reply comments due on or before July 24, 2013.

ADDRESSES: You may submit comments, identified by WC Docket No. 12–375, by any of the following methods:

- *Federal Communications Commission's Web site: http://fjallfoss.fcc.gov/ecfs2/.* Follow the instructions for submitting comments.
- *Mail:* Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street SW., Washington DC 20554.
- *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by email: *FCC504@fcc.gov* or phone: 202–418–0530 or TTY: 202–418–0432.

For detailed instructions for submitting comments and additional information on the rulemaking process, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Gregory Haledjian, Wireline Competition Bureau, Pricing Policy Division, (202) 418–1520 or *gregory.haledjian@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Public Notice, WC Docket No. 12–375; DA 13–1445, released June 26, 2013. The complete text of this document is available for inspection and copying during normal business hours in the FCC Reference Information Center, Portals II, 445 12th Street SW., Room CY–A257, Washington DC 20554. The document may also be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street SW., Room CY–B402, Washington, DC 20554, telephone (800) 378–3160 or (202) 863–2893, facsimile (202) 863–2898, or via Internet at *http://www.bcpiweb.com.*

The Bureau requests that parties provide data and information about such fees. Specifically, we request that parties identify any ancillary ICS fees that ICS providers charge in connection with the provision of interstate ICS, the level of each fee, the total amount of revenue received from each fee, and the cost of providing the service for which the fee recovers. We also request that parties identify any portion of ancillary service costs that are shared or common to the provision of other services, and explain how these costs, and recovery of them, are apportioned among the services to which they are shared or common. To evaluate how costs associated with providing ancillary services relate to ICS providers' overall costs, we request that costs that are shared or common to the provision of ancillary ICS services be identified, and that parties explain how such costs are apportioned to and recovered by ICS rates. Providers submitting joint and common costs are requested to provide both per-minute rates and fixed charges associated with interstate ICS and intrastate ICS and information on the costs of providing ICS, including but not limited to Customer Premise Equipment or CPE, installation, specific security enhancements (such as monitoring and call blocking), labor, maintenance, interconnection fees, and any other cost recovered by ICS rates. In addition to per-minute or incremental costs, we

seek information on fixed costs, including recovered and unrecovered costs, historic and projected demand, and information on how such costs are recovered.

Procedural Matters

Initial Regulatory Flexibility Act Analysis

As discussed above, the Public Notice seeks comment on certain issues raised in the Rates for Interstate Inmate Calling Services NPRM that is intended to refresh the record regarding rates for interstate ICS calling. The Initial Regulatory Flexibility Analysis (IRFA) for that proceeding is found at Appendix C of the *Rates for Interstate Inmate Calling Services NPRM, 78 FR 4369–01* (January 22, 2013). In addition, we invite comment on the IRFA in light of developments since the issuance of the original IRFA.

Paperwork Reduction Act

As discussed above, this Public Notice seeks comment on certain issues raised in the Rates for Interstate Inmate Calling Services NPRM that is intended to refresh the record regarding rates for interstate ICS calling. The Initial Regulatory Flexibility Analysis (IRFA) for that proceeding is found at Appendix C of the Rates for Interstate Inmate Calling Services NPRM, 78 FR 4369–01 (January 22, 2013). In addition, we invite comment on the IRFA in light of developments since the issuance of the original IRFA.

Ex Parte Requirements

This proceeding shall be treated as a ''permit-but-disclose'' proceeding in accordance with the Commission's ex parte rules. Persons making ex parte presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral ex parte presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the ex parte presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during ex parte meetings are deemed to be written ex parte presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written ex parte presentations and memoranda summarizing oral ex parte presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's ex parte rules.

Filing Requirements

Pursuant to §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on or before the date indicated on the first page of this document. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS). See *Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (1998).*

- *Electronic Filers:* Comments may be filed electronically using the Internet by accessing the ECFS: *http://fjallfoss.fcc.gov/ecfs2/.*
- *Paper Filers:* Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.

Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th Street SW., Room TW–A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes and boxes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street SW., Washington DC 20554.

People with Disabilities: To request materials in accessible formats for people with disabilities (Braille, large print, electronic files, audio format), send an email to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at (202) 418–0530 (voice) or (202) 418–0432 (tty).

The proceeding the Public Notice refers to shall be treated as a ''permit-but-disclose'' proceeding in accordance with the Commission's ex parte rules. Persons making ex parte presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral ex parte presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the ex parte presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during ex parte meetings are deemed to be written ex parte presentations and must be filed consistent with rule § 1.1206(b). In proceedings governed by rule § 1.49(f) or for which the Commission has made available a method of electronic filing, written ex parte presentations and memoranda summarizing oral ex parte presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's ex parte rules.

Federal Communications Commission.

Kalpak Gude,

Division Chief, Pricing Policy Division, Wireline Competition Bureau.

[FR Doc. 2013–16776 Filed 7–12–13; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MB Docket No. 13–156; DA 13–1377]

Radio Broadcasting Services; Port Lions, AK, De Beque, CO, Benjamin, Cisco, Rule, and Shamrock, TX

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Audio Division, on its own motion, proposes the deletion of six vacant allotments in various communities in Alaska, Colorado, and Texas. We tentatively conclude that it is in the public interest to delete six FCC-held permits that have been offered in two FM auctions. No bids were entered for these allotments in the recently completed FM Auction 94 and these allotments are now considered unsold permits. Deletion of these allotments may create other opportunities in nearby communities for new FM allotments or upgrades of existing stations. Therefore, we believe that the proposed deletion of these vacant allotments may promote a more effective and efficient use of the FM broadcast spectrum. Interested parties must file comments expressing an interest in the vacant allotments to prevent their removal. Moreover, interested parties must provide an explanation as to why they did not participate in prior auction events for any permit in which an interest is expressed.

DATES: Comments must be filed on or before August 5, 2013, and reply comments on or before August 20, 2013.

ADDRESSES: Secretary, Federal Communications Commission, 445 Twelfth Street SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Rolanda F. Smith, Media Bureau, (202) 418–2700.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rule Making, MB Docket No. 13–156, adopted June 13, 2013, and released June 14, 2013. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC's Reference Information Center at Portals II, CY–A257, 445 Twelfth Street SW., Washington, DC 20554. This document may also be purchased from the Commission's duplicating contractors, Best Copy and Printing, Inc., 445 12th Street SW., Room CY–B402, Washington, DC 20554, telephone 1–800–378–3160 or via email *www.BCPIWEB.com*. This document does not contain proposed information collection requirements subject to the Paperwork Reduction Act of 1995, Public Law 104–13. In addition, therefore, it does not contain any proposed information collection burden ''for small business concerns with fewer than 25 employees,'' pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4).

Provisions of the Regulatory Flexibility Act of l980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, see 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio, Radio broadcasting.

Federal Communications Commission.

Nazifa Sawez,

Assistant Chief, Audio Division, Media Bureau.

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR Part 73 as follows:

PART 73—RADIO BROADCAST SERVICES

■ 1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, 336, and 339.

§ 73.202 [Amended]

■ 2. Amend § 73.202(b) Table of FM Allotments as follows:

■ a. Remove Port Lions, under Alaska, Channel 221C0

■ b. Remove De Beque, under Colorado, Channel 247C3.

■ c. Remove Benjamin, under Texas, Channel 237C3; Cisco, Channel 261C3; Rule, Channel 288C2; and Shamrock, Channel 225C2.

[FR Doc. 2013–16888 Filed 7–12–13; 8:45 am]

BILLING CODE 6712–01–P

Notices

Federal Register
Vol. 78, No. 135
Monday, July 15, 2013

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF COMMERCE

Submission for OMB Review; Comment Request

The Department of Commerce 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 (44 U.S.C. chapter 35).

Agency: U.S. Census Bureau.

Title: 2013 Census Test.

OMB Control Number: None.

Form Number(s): The automated survey instrument will have no form number.

Type of Request: New collection.

Burden Hours: 334.

Number of Respondents: 2,000.

Average Hours per Response: 10 minutes.

Needs and Uses: The U.S. Constitution gives the Census Bureau the authority to enumerate the U.S. population every ten years. In 2010, the Census Bureau encouraged housing units in areas that received a mailed 2010 Census form to fill out and mail back this Census questionnaire. In total, 47,197,405 housing units did not mail back their form and were included in Nonresponse Followup (NRFU), which employed enumerators to obtain information from each occupied housing unit included in the NRFU workload. This activity cost $1,589,397,886.

In preparation for the 2020 Census, the Census Bureau is testing self-response strategies to decrease the NRFU workload and contact strategies to decrease the cost of NRFU. This pre-test will examine the use of administrative records and an adaptive contact strategy tailored to each household to reduce the NRFU workload and to increase NRFU production rates, while attempting to maintain or to increase the level of data quality. Specifically, this pre-test will use current Census infrastructure to research (1) removing households from the NRFU interviewer workload using administrative records and (2) employing an adaptive contact strategy tailored to each household. This pre-test will inform the use of administrative records and future NRFU contact strategies tested during the 2020 Research and Testing Program. The results from this pre-test are necessary to reduce the risks associated with a larger scale implementation of an adaptive contact strategy component, which is planned for the 2014 Census Test.

The Census Bureau will conduct the 2013 Census Test on 2,000 housing units in the Philadelphia metropolitan area. To simulate a NRFU data collection environment, the sample will consist of housing units that did not mail back a self-response form in the 2010 decennial census based on the 2010 Census NRFU universe. Data collection will begin in October 2013 and end in November 2013.

The sampled housing units will be divided across four treatments:

- (Treatment 1) use of administrative records to reduce workload and a fixed contact strategy, in which all cases have the same contact strategy until enumerated,
- (Treatment 2) no use of administrative records to reduce workload and a fixed contact strategy,
- (Treatment 3) use of administrative records to reduce workload and an adaptive contact strategy, in which cases are assigned unique contact strategies determined by response likelihood and cost models, and
- (Treatment 4) no use of administrative records to reduce workload (records used only to prioritize cases) and an adaptive contact strategy.

After mailing a pre-notice asking for participation in this study, the Census Bureau will employ administrative records in Treatments 1 and 3 to remove occupied housing units from the NRFU workload, if there are records for these units containing sufficient information to enumerate them. The suitability of records for enumerating these housing units is determined through the Census Bureau's research on matching administrative records information to 2010 Census NRFU housing units.

The Census Bureau will mail all housing units a prenotice letter two weeks before the start of data collection, alerting residents about the upcoming study. For the treatments in which administrative records are employed to reduce the NRFU workload (Treatments 1 and 3), the Census Bureau will remove housing units from this data collection whose prenotice letters are not returned with ''undeliverable as addressed'' United States Postal Service information and that have record evidence of occupancy. These housing units will be classified as ''occupied'' for purposes of the study. In these treatments, the Census Bureau also will remove housing units from this data collection whose prenotice letters are returned with ''undeliverable as addressed'' United States Postal Service information and that have no other record evidence of occupancy. These housing units will be classified as ''vacant'' for purposes of the study.

The Census Bureau will not employ administrative records to reduce workload in Treatments 2 and 4. Instead, administrative records will prioritize cases for contact in the adaptive design condition (Treatment 4).

The Census Bureau will match NRFU housing units to cell and landline telephone numbers. In the fixed contact strategy treatments (Treatments 1 and 2), the Census Bureau will instruct computer-assisted personal interviewing (CAPI) interviewers to telephone housing units before performing personal visits. Interviewers will attempt to contact housing units without telephone numbers via personal visits. If an interviewer cannot complete an interview, they will be instructed to obtain a proxy interview.

In the adaptive contact strategy treatments (Treatments 3 and 4), the Census Bureau will send telephone numbers to a computer-assisted telephone interviewing (CATI) operation where interviewers will attempt to contact and to interview housing units for two weeks. At the end of these two weeks, nonresponding CATI cases will be moved to CAPI interviewers who will attempt personal visits (Housing units without telephone numbers will be sent straight to CAPI interviewers during these two weeks). CAPI interviewers in the adaptive contact strategy treatments will be told on a daily basis which cases are priority for contact and when to perform proxy

interviews, as determined by response likelihood and cost models.

The Census Bureau will use existing staff and office infrastructure for this pre-test. Where necessary, the Census Bureau will modify existing systems and field procedures.

The Census Bureau will use the 2013 Census Test to test operational procedures that might increase NRFU efficiency. Secondary goals of the research include gaining an initial measurement of the cost savings associated with using administrative records and an adaptive design contact strategy to enumerate simulated non-responding housing units and measuring the quality of data produced by these approaches.

The primary goal of the test will be to assess whether the Census Bureau can implement a simulated NRFU data collection using adaptive design and administrative records during production. Secondary goals will measure the cost and data quality between two sets of groups. One analysis will compare operational efficiency, cost, and data quality between treatments that use and that do not use administrative records to reduce the NRFU workload. Another analysis will compare operational efficiency, cost, and data quality between treatments that use an adaptive design contact strategy versus a fixed contact strategy. The Census Bureau will also examine the interaction of adaptive design and the use of administrative records on operational efficiency, cost, and data quality.

The 2013 Census Test will inform future 2020 Census NRFU tests, which includes a test of administrative records and self-response and NRFU contact strategies in 2014. Data will not be released as Census Bureau data products or be used for official estimates. Rather, results will aid in determining how to test the use of administrative records and an adaptive contact strategy in future, larger tests. Results will also inform the infrastructure required to support using administrative records and a centralized CATI system to enumerate a NRFU population, as well as an operational control system (OCS) that enables real-time case prioritization and mode switching.

The Census Bureau plans to make the aggregated results of this study available to the public. Information quality is an integral part of the pre-dissemination review of the information disseminated by the Census Bureau (fully described in the Census Bureau's Information Quality Guidelines). Information quality is also integral to the information collections conducted by the Census Bureau and is incorporated into the clearance process required by the Paperwork Reduction Act.

Data from the test will be included in reports with clear statements about the test's methodology and limitations. Reports will state that the data were produced for decision-making and exploratory research, not for official estimates. Research results may be prepared for presentations at professional meetings or in publications in professional journals to promote discussion within the larger survey and statistical community and to encourage further research and refinement. All presentations or publications will provide clear descriptions of the test's methodology and its limitations.

The Census Bureau published a notice in the **Federal Register** on September 6, 2012 (Vol. 77, No. 173, pp. 54887–54889) announcing its intention to conduct a test of alternative contact strategies in a census environment. The 2013 Census Test is being submitted as a component of and a precursor to that larger test to be conducted in 2014 (the 2014 Census Test). In the notice, we requested 36,167 burden hours. The 2013 Census Test will use 334 of that total. The 2014 Census Test will use the remainder of this amount.

Affected Public: Individuals or households.

Frequency: One Time.

Respondent's Obligation: Mandatory.

Legal Authority: Title 13 U.S.C., Sections 141 and 193.

OMB Desk Officer: Brian Harris-Kojetin, (202) 395–7314.

Copies of the above information collection proposal can be obtained by calling or writing Jennifer Jessup, Departmental Paperwork Clearance Officer, (202) 482–0336, Department of Commerce, Room 6616, 14th and Constitution Avenue NW., Washington, DC 20230 (or via the Internet at *jjessup@doc.gov).*

Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to Brian Harris-Kojetin, OMB Desk Officer either by fax (202–395–7245) or email *(bharrisk@omb.eop.gov).*

Dated: July 9, 2013.

Gwellnar Banks,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 2013–16822 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

[Docket No.: 130520483–3598–02]

Privacy Act New System of Records

AGENCY: Department of Commerce.

ACTION: Notice; COMMERCE/DEPT–23, Information Collected Electronically in Connection with Department of Commerce Activities, Events, and Programs.

SUMMARY: The Department of Commerce (Commerce) publishes this notice to announce the effective date of a Privacy Act system of records entitled COMMERCE/DEPT–23, Information Collected Electronically in Connection with Department of Commerce Activities, Events, and Programs.

DATES: The system of records becomes effective on July 15, 2013.

ADDRESSES: For a copy of the system of records please mail requests to Brenda Dolan, U.S. Department of Commerce, Suite A300, Room A326, 1401 Constitution Avenue NW., Washington, DC 20230, 202–482–3258.

FOR FURTHER INFORMATION CONTACT: Brenda Dolan, U.S. Department of Commerce, Suite A300, Room A326, 1401 Constitution Ave. NW., Washington, DC 20230, 202–482–3258.

SUPPLEMENTARY INFORMATION: On June 5, 2013, Commerce published and requested comments on a proposed Privacy Act system of records entitled COMMERCE/DEPT–23, Information Collected Electronically in Connection with Department of Commerce Activities, Events, and Programs. No comments were received in response to the request for comments.

By this notice, the Department is adopting the proposed system as final without changes effective July 15, 2013.

Dated: July 9, 2013.

Brenda Dolan,

U.S. Department of Commerce, Departmental Freedom of Information and Privacy Act Officer.

[FR Doc. 2013–16813 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–25–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–865]

Certain Hot-Rolled Carbon Steel Flat Products From the People's Republic of China: Preliminary Results of 2011–2012 Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce (''Department'') is conducting an administrative review of the antidumping duty order on certain hot-rolled carbon steel flat products (''hot-rolled steel'') from the People's Republic of China (''PRC''),[1] covering the period of review (''POR'') November 1, 2011 through October 31, 2012. The Department preliminarily determines that Baosteel Group Corporation, Shanghai Baosteel International Economic & Trading Co., Ltd., and Baoshan Iron and Steel Co., Ltd. (collectively, ''Baosteel'') had no shipments of subject merchandise to the United States during the POR.

DATES: *Effective Date:* July 15, 2013.

FOR FURTHER INFORMATION CONTACT: Steven Hampton, AD/CVD Operations, Office 9, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230; telephone (202) 482–0116.

SUPPLEMENTARY INFORMATION:

Background

The Department is conducting an administrative review of the antidumping duty order on hot-rolled steel from the PRC. On November 29, 2001, the Department published in the **Federal Register** an antidumping duty order on hot-rolled steel from the PRC. On December 31, 2012, the Department published a notice of initiation of an administrative review of the antidumping duty order on hot-rolled steel from the PRC covering the period November 1, 2011, to October 31, 2012, for one company, Baosteel.[2] On January 28, 2013, in response to the Department's *Initiation Notice,* Baosteel certified that it had no sales of subject merchandise during the POR.[3]

Scope of the Order

The products covered by the order are certain hot-rolled carbon steel flat products of a rectangular shape, of a width of 0.5 inch or greater, neither clad, plated, nor coated with metal and whether or not painted, varnished, or coated with plastics or other non-metallic substances, in coils (whether or not in successively superimposed layers), regardless of thickness, and in straight lengths of a thickness of less than 4.75 mm and of a width measuring at least 10 times the thickness. Universal mill plate (*i.e.,* flat-rolled products rolled on four faces or in a closed box pass, of a width exceeding 150 mm, but not exceeding 1,250 mm, and of a thickness of not less than 4.0 mm, not in coils and without patterns in relief) of a thickness not less than 4.0 mm is not included within the scope of the order. Specifically included within the scope of the order are vacuum degassed, fully stabilized (commonly referred to as interstitial-free (''IF'')) steels, high strength low alloy (''HSLA'') steels, and the substrate for motor lamination steels. IF steels are recognized as low carbon steels with micro-alloying levels of elements such as titanium or niobium (also commonly referred to as columbium), or both, added to stabilize carbon and nitrogen elements. HSLA steels are recognized as steels with micro-alloying levels of elements such as chromium, copper, niobium, vanadium, and molybdenum. The substrate for motor lamination steels contains micro-alloying levels of elements such as silicon and aluminum. Steel products included in the scope of the order, regardless of definitions in the Harmonized Tariff Schedule of the United States (''HTSUS''), are products in which: (i) Iron predominates, by weight, over each of the other contained elements; (ii) the carbon content is two percent or less, by weight; and, (iii) none of the elements listed below exceeds the quantity, by weight, respectively indicated:

1.80 percent of manganese, or
2.25 percent of silicon, or
1.00 percent of copper, or
0.50 percent of aluminum, or
1.25 percent of chromium, or
0.30 percent of cobalt, or
0.40 percent of lead, or
1.25 percent of nickel, or
0.30 percent of tungsten, or
0.10 percent of molybdenum, or
0.10 percent of niobium, or
0.15 percent of vanadium, or
0.15 percent of zirconium.

All products that meet the physical and chemical description provided above are within the scope of the order unless otherwise excluded. The following products, for example, are outside or specifically excluded from the scope of the order:

- Alloy hot-rolled steel products in which at least one of the chemical elements exceeds those listed above (including, *e.g.,* American Society for Testing and Materials (''ASTM'') specifications A543, A387, A514, A517, A506).
- Society of Automotive Engineers (''SAE'')/American Iron & Steel Institute (''AISI'') grades of series 2300 and higher.
- Ball bearing steels, as defined in the HTSUS.
- Tool steels, as defined in the HTSUS.
- Silico-manganese (as defined in the HTSUS) or silicon electrical steel with a silicon level exceeding 2.25 percent.
- ASTM specifications A710 and A736.
- USS abrasion-resistant steels (USS AR 400, USS AR 500).
- All products (proprietary or otherwise) based on an alloy ASTM specification (sample specifications: ASTM A506, A507).
- Non-rectangular shapes, not in coils, which are the result of having been processed by cutting or stamping and which have assumed the character of articles or products classified outside chapter 72 of the HTSUS.

The merchandise subject to the order is classified in the HTSUS at subheadings: 7208.10.15.00, 7208.10.30.00, 7208.10.60.00, 7208.25.30.00, 7208.25.60.00, 7208.26.00.30, 7208.26.00.60, 7208.27.00.30, 7208.27.00.60, 7208.36.00.30, 7208.36.00.60, 7208.37.00.30, 7208.37.00.60, 7208.38.00.15, 7208.38.00.30, 7208.38.00.90, 7208.39.00.15, 7208.39.00.30, 7208.39.00.90, 7208.40.60.30, 7208.40.60.60, 7208.53.00.00, 7208.54.00.00, 7208.90.00.00, 7211.14.00.90, 7211.19.15.00, 7211.19.20.00, 7211.19.30.00, 7211.19.45.00, 7211.19.60.00, 7211.19.75.30, 7211.19.75.60, and 7211.19.75.90. Certain hot-rolled carbon steel flat products covered by the order, including: Vacuum degassed fully stabilized; high strength low alloy; and the substrate for motor lamination steel may also enter under the following tariff numbers: 7225.11.00.00, 7225.19.00.00,

[1] *See Notice of Antidumping Duty Order: Certain Hot-Rolled Carbon Steel Flat Products from the People's Republic of China,* 66 FR 59561 (November 29, 2001).

[2] *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part,* 77 FR 77017 (December 31, 2012) (''*Initiation Notice*'').

[3] *See* Letter from Baosteel regarding Certain Hot-Rolled Carbon Steel Flat Products from the People's Republic of China/No Sales Certification, dated January 28, 2013 (''Baosteel No Sales Certification'').

7225.30.30.50, 7225.30.70.00, 7225.40.70.00, 7225.99.00.90, 7226.11.10.00, 7226.11.90.30, 7226.11.90.60, 7226.19.10.00, 7226.19.90.00, 7226.91.50.00, 7226.91.70.00, 7226.91.80.00, and 7226.99.00.00. Subject merchandise may also enter under 7210.70.30.00, 7210.90.90.00, 7211.14.00.30, 7212.40.10.00, 7212.40.50.00, and 7212.50.00.00. Although the HTSUS subheadings are provided for convenience and customs purposes, the written description of the merchandise subject to the order is dispositive.

Preliminary Determination of No Shipments

As noted in the ''Background'' section above, Baosteel has submitted a timely-filed certification indicating that it had no sales of subject merchandise to the United States during the POR.[4] In addition, in response to our request for information on entries of subject merchandise during the POR, U.S. Customs and Border Protection (''CBP'') did not provide any evidence contradicting Baosteel's claim of no sales. Further on June 5, 2013, the Department released to interested parties the results of the CBP used to corroborate Baosteel's no sales claim which indicated that there were no entries of subject merchandise during the POR from any exporter, including Baosteel.[5] The Department received no comments from any interested parties concerning the results of the CBP query.

Based on the certification of Baosteel and our analysis of CBP information, the Department preliminarily determines that Baosteel did not have any reviewable transactions during the POR. In addition, consistent with the Department's refinement to its assessment practice in non-market economy (''NME'') cases, the Department finds that it is appropriate not to rescind the review in these circumstances but rather, to complete the review with respect to Baosteel and issue appropriate instructions to CBP based on the final results of the review.[6]

Disclosure and Public Comment

Pursuant to 19 CFR 351.309(c), interested parties may submit cases briefs no later than 30 days after the date of publication of this notice. Rebuttal briefs, limited to issues raised in the case briefs, may be filed not later than five days after the date for filing case briefs.[7] Parties who submit case briefs or rebuttal briefs in this proceeding are encouraged to submit with each argument: (1) A statement of the issue; (2) a brief summary of the argument; and (3) a table of authorities.[8] Case and rebuttal briefs should be filed electronically via the Import Administration's Antidumping and Countervailing Duty Centralized Electronic Service System (''IA ACCESS'').[9]

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing, or to participate if one is requested, must submit a written request to the Assistant Secretary for Import Administration, filed electronically via IA ACCESS. An electronically filed document must be received successfully in its entirety by the Department's electronic records system, IA ACCESS, by 5 p.m. Eastern Standard Time within 30 days after the date of publication of this notice.[10] Requests should contain: (1) The party's name, address and telephone number; (2) the number of participants; and (3) a list of issues to be discussed. Issues raised in the hearing will be limited to those raised in the respective case briefs.

The Department will issue the final results of this administrative review, including the results of its analysis of the issues raised in any written briefs, not later than 120 days after the date of publication of this notice, pursuant to section 751(a)(3)(A) of the Tariff Act of 1930, as amended (''Act'').

Assessment Rates

Upon issuance of the final results, the Department will determine, and CBP shall assess, antidumping duties on all appropriate entries. The Department intends to issue assessment instructions to CBP 15 days after the date of publication of the final results of review. Pursuant to the refinement to its assessment practice in NME cases, if the Department continues to determine that an exporter under review had no shipments of subject merchandise, any suspended entries that entered under that exporter's case number (*i.e.,* at that exporter's rate) will be liquidated at the PRC-wide rate.[11]

Cash Deposit Requirements

The following cash deposit requirements will be effective upon publication of the final results of this administrative review for all shipments of the subject merchandise from the PRC entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided by section 751(a)(2)(C) of the Act: (1) For Baosteel, which claimed no shipments, the cash deposit rate will remain unchanged from the rate assigned to the company in the most recently completed review of the company; (2) for previously investigated or reviewed PRC and non-PRC exporters not listed above that have separate rates, the cash deposit rate will continue to be the exporter-specific rate published for the most recent period; (3) for all PRC exporters of subject merchandise which have not been found to be entitled to a separate rate, the cash deposit rate will be the PRC-wide rate of 90.83 percent; and (4) for all non-PRC exporters of subject merchandise which have not received their own rate, the cash deposit rate will be the rate applicable to the PRC exporter(s) that supplied that non-PRC exporter. These deposit requirements, when imposed, shall remain in effect until further notice.

Notification to Importers

This notice also serves as a preliminary 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 Department's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

The Department is issuing and publishing these results in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 8, 2013.

Paul Piquado,

Assistant Secretary for Import Administration.

[FR Doc. 2013–16896 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–DS–P

[4] *See* Baosteel No Sales Certification.

[5] *See* Memorandum to the File from Steven Hampton, International Trade Analyst, Office 9, Import Administration regarding 2011–2012 Administrative Review of Certain Hot-Rolled Carbon Steel Flat Products from the People's Republic of China: CBP confirmation of No Sales with respect to Baosteel, dated June 5, 2013.

[6] *See Non-Market Economy Antidumping Proceedings: Assessment of Antidumping Duties,* 76 FR 65694, 65694–95 (October 24, 2011) and the ''Assessment Rates'' section, below (''*Assessment Practice Refinement*'').

[7] *See* 19 CFR 351.309(d).

[8] *See* 19 CFR 351.309(c)(2) and (d)(2).

[9] *See* 19 CFR 351.303.

[10] *See* 19 CFR 351.310(c).

[11] For a full discussion of this practice, *see Assessment Practice Refinement,* 76 FR at 65694–95.

DEPARTMENT OF COMMERCE

International Trade Administration

Travel and Tourism Trade Mission to Taiwan, Japan, and Korea

AGENCY: International Trade Administration, Department of Commerce.

ACTION: Notice.

SUMMARY: The United States Department of Commerce, International Trade Administration, U.S. and Foreign Commercial Service is amending notice for the Travel and Tourism Trade Mission to Taiwan, Japan and Korea scheduled for March 10–14, 2014, published at 78 FR 34344, June 7, 2013, to identify the mission as an Executive-led Trade Mission.

FOR FURTHER INFORMATION CONTACT: Frank Spector, Office of Domestic Operations, Trade Promotion Programs, Phone: 202–482–2054; Fax: 202–482–9000, email: *Frank.Spector@trade.gov.*

SUPPLEMENTARY INFORMATION: The International Trade Administration will have a senior executive lead the Travel and Tourism Trade Mission to Taiwan, Japan and Korea, March 10–14, 2014, published at 78 FR 34344, June 7, 2013. As previously published, the notice did not specify that a senior executive will be leading the mission.

Amendments

For these reasons, the Mission Description of the Notice of the Travel and Tourism Trade Mission to Taiwan, Japan, and Korea is amended to read as follows:

The United States Department of Commerce, International Trade Administration, U.S. & Foreign Commercial Service, is organizing an Executive-led Trade Mission to Taiwan, Japan, and Korea March 10–14, 2014. The purpose of the mission is to help U.S. firms in the travel and tourism industry find business partners and sell services in Taipei, Taiwan; Seoul, Korea; and Tokyo, Japan. The targeted sector for participation in this mission is travel and tourism, including U.S.-based travel and tourism suppliers, destination marketing organizations (i.e., convention and visitors bureaus), travel promotion organizations and other travel and tourism entities promoting and selling travel to the United States including trade associations.

Frank Spector,

Senior International Trade Specialist.

[FR Doc. 2013–16815 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–FP–P

DEPARTMENT OF COMMERCE

International Trade Administration

U.S. Healthcare Trade Mission to Russia, October 21–25, 2013; Correction

AGENCY: International Trade Administration, Department of Commerce.

ACTION: Notice; Cancellation.

SUMMARY: The United States Department of Commerce, International Trade Administration, U.S. and Foreign Commercial Service published a document in the **Federal Register** of May 30, 2013 regarding the U.S. Healthcare Trade Mission to Russia, October 21–25, 2013. This mission has been cancelled. Please update the existing notice with a note that this mission is cancelled as of July 8, 2013.

Cancellation Notice

In the **Federal Register** of December 4, 2012, in 78 FR 32369 on page 32369, title, note a top of page, correct the subject heading of the notice to read: U.S. Healthcare Trade Mission to Russia has been Cancelled, Oct 21–25, 2013.

FOR FURTHER INFORMATION CONTACT: Jessica Dulkadir, Commercial Service Trade Missions Program, Tel: 202–482–2026, Fax: 202–482–9000, email: *jessica.dulkadir@trade.gov*

Dated: May 30, 2013.

Elnora Moye,

Trade Program Assistant.

[FR Doc. 2013–16814 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–FP–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XC100

Marine Mammals; File No. 17115

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; receipt of application for permit amendment.

SUMMARY: Notice is hereby given that James Lloyd-Smith, Department of Ecology and Evolutionary Biology, University of California, Los Angeles, 610 Charles E. Young Dr. South, Box 723905, Los Angeles, CA 90095–7239, has applied for an amendment to Scientific Research Permit No. 17115–00.

DATES: Written, telefaxed, or email comments must be received on or before August 14, 2013.

ADDRESSES: The application and related documents are available for review by selecting ''Records Open for Public Comment'' from the *Features* box on the Applications and Permits for Protected Species home page, *https://apps.nmfs.noaa.gov,* and then selecting File No. 17115 from the list of available applications.

These documents are also available upon written request or by appointment in the following offices:

Permits and Conservation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301) 427–8401; fax (301) 713–0376; and

Southwest Region, NMFS, 501 West Ocean Blvd., Suite 4200, Long Beach, CA 90802–4213; phone (562) 980–4001; fax (562) 980–4018.

Written comments on this application should be submitted to the Chief, Permits and Conservation Division, at the address listed above. Comments may also be submitted by facsimile to (301) 713–0376, or by email to *NMFS.Pr1Comments@noaa.gov.* Please include File No. 17115 in the subject line of the email comment.

Those individuals requesting a public hearing should submit a written request to the Chief, Permits and Conservation Division at the address listed above. The request should set forth the specific reasons why a hearing on this application would be appropriate.

FOR FURTHER INFORMATION CONTACT: Amy Sloan, (301) 427–8401.

SUPPLEMENTARY INFORMATION: The subject amendment to Permit No. 17115–00 is requested under the authority of the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 *et seq.*), and the regulations governing the taking and importing of marine mammals (50 CFR part 216).

Permit No. 17115–00, issued on September 24, 2012 (77 FR 63296), authorizes the permit holder to study the prevalence of leptospirosis in wild California sea lions (*Zalophus californianus*) in California. Up to 80 California sea lions may be taken annually on Año Nuevo Island by capture (including restraint and anesthesia); marking and measuring; sampling (blood, urine, vibrissae); and release. A limited number of non-target sea lions may be captured and released without sampling. Up to 5,000 sea lions, 3,000 northern elephant seals (*Mirounga angustirostris*), and 60 harbor seals (*Phoca vitulina*) may be taken by incidental disturbance annually. Four

unintentional mortalities of California sea lions are authorized. The permit expires September 30, 2017.

The permit holder is requesting the permit be amended to expand the scope of the study and include authorization for capture, sampling, and release of California sea lions as described above at two additional sampling sites in California (160 animals at San Nicolas Island and 80 animals at Monterey Bay). A limited number of non-target sea lions may be captured and released without sampling. The permit holder also requests incidental disturbance at each of the new sites for the following species: California sea lions (6,000 on San Nicolas Island; and 3,000 in Monterey Bay); Northern elephant seals (2,000 on San Nicolas; and 100 in Monterey Bay); and Pacific harbor seals (100 on San Nicolas, and 50 in Monterey Bay). The permit holder proposes to disentangle and mark/sample a limited number of California sea lions encountered during the research activities. Permission to increase the number of mortalities of California sea lions from four to eight over the duration of the permit is requested. The applicant also requests to extend the maximum number of sampling years from four to five over the duration of the permit.

In compliance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), an initial determination has been made that the activity proposed is categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Concurrent with the publication of this notice in the **Federal Register**, NMFS is forwarding copies of this application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Dated: July 9, 2013.

P. Michael Payne,

Chief, Permits and Conservation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2013–16766 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XC486

Taking of Marine Mammals Incidental to Specified Activities; U.S. Marine Corps Training Exercises at Air Station Cherry Point

AGENCY: National Marine Fisheries Service, National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; issuance of incidental harassment authorization.

SUMMARY: In accordance with the Marine Mammal Protection Act (MMPA) regulation, we hereby give notification that we have issued an Incidental Harassment Authorization (Authorization) to take marine mammals incidental to various training exercises at Marine Corps Air Station (MCAS) Cherry Point Range Complex, North Carolina for a period of one year. The U.S. Marine Corps' activities are military readiness activities pursuant to the Marine Mammal Protection Act (MMPA), as amended by the National Defense Authorization Act (NDAA) for Fiscal Year 2004.

DATES: Effective June 17, 2013 through June 14, 2014.

ADDRESSES: To obtain an electronic copy of the Authorization, write to P. Michael Payne, Chief, Permits and Conservation Division, Office of Protected Resources, National Marine Fisheries Service, 1315 East-West Highway, Silver Spring, MD 20910–3225 or download an electronic copy at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications.*

The following associated document is also available at the same internet address: The Marine Corps' Environmental Assessment (EA) titled, ''Environmental Assessment MCAS Cherry Point Range Operations,'' for their federal action of supporting and conducting current and emerging training operations. Their EA evaluates the effects of the proposed training operations on the human environment including impacts to marine mammals and their 2009 Finding of No Significant Impact (FONSI) for the activities.

FOR FURTHER INFORMATION CONTACT: Jeannine Cody, National Marine Fisheries Service, Office of Protected Resources, (301) 427–8401.

SUPPLEMENTARY INFORMATION:

Background

Section 101(a)(5)(D) of the Marine Mammal Protection Act of 1972, as amended (MMPA; 16 U.S.C. 1361 *et seq.*) directs the Secretary of Commerce to authorize, upon request, the incidental, but not intentional, taking of small numbers of marine mammals of a species or population stock, by United States citizens who engage in a specified activity (other than commercial fishing) within a specified geographical region if, after notice of a proposed authorization to the public for review and public comment: (1) We make certain findings; and (2) the taking is limited to harassment.

We shall grant authorization for the incidental taking of small numbers of marine mammals if we find 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 subsistence uses (where relevant). The authorization must set forth the permissible methods of taking; other means of effecting the least practicable adverse impact on the species or stock and its habitat; and requirements pertaining to the mitigation, monitoring and reporting of such taking. We have defined ''negligible impact'' in 50 CFR 216.103 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.''

Section 101(a)(5)(D) of the MMPA established an expedited process by which citizens of the United States can apply for an authorization to incidentally take small numbers of marine mammals by harassment. Section 101(a)(5)(D) of the MMPA establishes a 45-day time limit for our review of an application followed by a 30-day public notice and comment period on any proposed authorizations for the incidental harassment of small numbers of marine mammals. Within 45 days of the close of the public comment period, we must either issue or deny the authorization and must publish a notice in the **Federal Register** within 30 days of our determination to issue or deny the authorization.

The National Defense Authorization Act of 2004 (NDAA; (Pub. L. 108–136)) amended section 101(a)(5)(A) of the MMPA by removing the small numbers and specified geographic region provisions; revising the definition of harassment as it applies to a military readiness activity; and explicitly requiring that our determination of ''least practicable adverse impact'' include consideration of: (1) Personnel safety; (2) the practicality of implementation; and (3) impact on the

effectiveness of the military readiness activity.

The NDAA's definition of harassment as it applies to a military readiness activity is: (i) Any act that injures or has the significant potential to injure a marine mammal or marine mammal stock in the wild [Level A Harassment]; or (ii) any act that disturbs or is likely to disturb a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns, including, but not limited to, migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered [Level B Harassment].

Summary of Request

We received a request from the Marine Corps on January 28, 2013, requesting that we issue an Incidental Harassment Authorization (Authorization) for the take, by Level B harassment only, of small numbers of Atlantic bottlenose dolphins (*Tursiops truncatus*) incidental to air-to-surface and surface-to-surface training exercises conducted around two bombing targets within southern Pamlico Sound, North Carolina, at Marine Corps Air Station Cherry Point. We received a complete and adequate application on March 19, 2013 and released the application for public comment (see **ADDRESSES**) for consideration of issuing an Authorization to the USMC. To date, we have issued two, 1-year Authorizations to the Marine Corps for the conduct of the same activities from 2010 to 2012 (75 FR 72807, November 26, 2010; 77 FR January 3, 2012).

Description of the Specified Activity

The Marine Corps plan to conduct weapon delivery training at two bombing targets: Brant Island Target (BT–9) and Piney Island Bombing Range (BT–11) within MCAS Cherry Point Range Complex, located within Pamlico Sound, North Carolina. The two targets are located at the convergence of the Neuse River and Pamlico Sound.

Training at BT–9 would involve air-to-surface (from aircraft to in-water targets) and surface-to-surface (from vessels to in-water targets) warfare training, including bombing, strafing, special (laser systems) weapons; surface fires using non-explosive and explosive ordnance; and mine laying exercises (inert). Training at BT–11 would involve air- to-surface exercises to provide training in the delivery of conventional (non-explosive) and special (laser systems) weapons. Surface-to-surface training by small military watercraft would also be executed here. The types of ordnances proposed for use at BT–9 and BT–11 include small arms, large arms, bombs, rockets, missiles, and pyrotechnics. All munitions used at BT–11 are inert, practice rounds and no live firing would occur at BT–11. Training for any activity may occur year-round.

The Marine Corps requested authorization to harass bottlenose dolphins from firing exercises conducted at two bombing targets within MCAS Cherry Point Range Complex, located within Pamlico Sound, North Carolina at the convergence of the Neuse River and Pamlico Sound. These activities include gunnery; mine laying; bombing; or rocket exercises and are classified into two categories here based on delivery method: (1) Surface-to-surface gunnery and (2) air-to-surface bombing. Active sonar is not a component of these specified training exercises.

Exercises may occur year round, day or night (approximately 15 percent of training occurs at night). The Marine Corps would conduct all inert and live-fire exercises so that all ammunition and other ordnances strike and/or fall on the land or water based target or within the existing danger zones or water restricted areas.

Acoustic stimuli (i.e., increased underwater sound) generated during the training exercises, may have the potential to cause behavioral disturbance for marine mammals in BT–9 and BT–11. This is the principal means of marine mammal taking associated with these activities. We expect these disturbances to be temporary and result in a temporary modification in behavior and/or low-level physiological effects (Level B harassment only) of small numbers of certain species of marine mammals.

We have outlined the purpose of the program in a previous notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013). Refer to the notice of the proposed Authorization (78 FR 19224, Friday, March 29, 2013), the application, and the Marine Corps' EA for a more detailed description of the authorized action.

The amounts of all ordnance to be expended at BT–9 and BT–11 (both surface-to-surface and air-to-surface) are 1,225,815 and 1,254,684 rounds, respectively (see Table 1 and 2).

TABLE 1—LEVEL OF LIVE AND INERT MUNITIONS THAT COULD BE EXPENDED AT BT–9 2013–2014

Estimated munitions [1]	Estimated total No. of rounds	Estimated number of explosive rounds having an impact on the water	Net explosive weight (lb)
Small arms rounds excluding .50 cal	525,610	NA	NA
Small arms—.50 Cal	568,515	NA	NA
Large arms rounds—40 mm (live)	5,000	5,000	0.1199
Large arms rounds—40 mm (inert)	117,051	NA	NA
Rocket—2.57″ (live)	48	48	4.8
Rockets—5.0″ (live)	20	20	15.0
Rockets—2.75″ and 5″ (inert)	876	NA	N/A
Bombs and G911 grenades (live)	0	NA	0.5
Bombs and grenades (inert)	4,199	NA	NA
Missile—TOW	0	NA	NA
Missile—Hellfire	0	NA	NA
Pyrotechnics	4,496	N/A	NA
Total	1,225,815	.....	N/A

[1] Munitions may be expended from aircraft or small boats.

TABLE 2—LEVEL OF MUNITIONS THAT COULD BE EXPENDED AT BT–11 2013–2014

Proposed munitions [1]	Proposed total number of rounds
Small arms rounds excluding .50 cal	610,957
Small arms—.50 Cal	366,775
Large arms rounds—20 mm through 81 mm (inert)	240,334
Rockets—2.75″ and 5″ (inert)	5,592
Bombs and grenades (inert)	22,114
Pyrotechnics	8,912
Total	1,254,684

[1] Munitions may be expended from aircraft or small boats.

Comments and Responses

We published a notice of receipt of the Marine Corps' application and proposed Authorization in the **Federal Register** on Friday, March 29, 2013 (78 FR 19224). During the 30-day public comment period, we received comments from the Marine Mammal Commission (Commission) and four private citizens. These comments are online at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm.* Following are the comments and our responses.

Comment 1: The Commission recommended that we require the Marine Corps to: (1) Describe in detail the method by which it determined the zones of exposure for gunnery exercises that use large arms; and (2) specify if multiple types of rounds or ordnance would be used within a single exercise and describe in detail how it determined the zones of exposure for those exercises prior to issuing the incidental harassment authorization.

Response: The Marine Corps' application, as well as subsequent responses provided to the Commission describe how they derived safety zones for gunnery exercises. The method to estimate the number of marine mammals potentially taken by the specified activities is based on dolphin density, the amount and type of ordnance proposed, and distances to our harassment threshold criteria.

Briefly, the Marine Corps estimate the zones of exposure based on impulse, peak pressure, and sound exposure level thresholds (based on our explosive harassment criteria). During a gunnery exercise using large arms rounds, a person can fire munitions as individual rounds spaced in time, or rapid fire as a *burst* of individual rounds. Due to the tight spacing in time, the Marine Corps treats the individual rounds within a burst as a single detonation.

(1) For the energy metrics, they calculate the impact area of a burst using a source energy spectrum that is the source spectrum for a single detonation scaled by the number of rounds in a burst.

(2) For the pressure metrics, they calculate the impact area for a burst as equal to the impact area of a single round.

(3) For all metrics, the cumulative impact area of an event consisting of (N) bursts is the product of the impact area of a single burst and the number of bursts, as would be the case if the bursts are sufficiently spaced in time or location as to insure that each burst is affecting a different set of marine wildlife. Last, they model each explosive event for potential impacts to a derived density of marine mammals within the influence area. They sum the results of all individual events over the year to obtain their take estimate.

Comment 2: The Commission also requested that we require the Marine Corps to implement a plan to evaluate the effectiveness of all of its mitigation and monitoring measures before initiating or, at the very latest, in conjunction with the exercises covered by the incidental harassment authorization (i.e., night vision technology, remote-camera system, visual observations during range sweeps and cold passes).

Response: We have worked closely with the Marine Corps over the past two Authorization cycles to develop proper mitigation, monitoring, and reporting requirements designed to minimize and detect impacts from the specified activities. In order to ensure that we can make the findings necessary for issuance of an Authorization, we have worked with the Marine Corps to develop comprehensive and acceptable mitigation, monitoring, and reporting requirements including a Marine Mammal and Protected Species Monitoring Plan (Plan). We have determined that the current Plan and required monitoring and mitigation measures within the Authorization are adequate to satisfy the requirements of the MMPA.

Comment 3: The Commission also requested that we require the Marine Corps to use the passive acoustic monitoring system to supplement its visual observations as soon as practicable.

Response: The Marine Corps has contracted Duke University to develop and test a real-time passive acoustic monitoring system that will allow automated detection of bottlenose dolphin whistles. Duke University performed the work in two phases. First developing an automated signal detector (a software program) to recognize the whistles of dolphins at BT–9 and BT–11 and second assembling and deploying a prototype for real time monitoring. Phase II is currently in progress and the success of this effort will help direct future monitoring initiatives and activities within the MCAS Cherry Point Range Complex. The passive acoustic monitoring unit remains in prototype until the contractors have completed all testing and the Marine Corps are able to establish a baseline of information to develop standard operating procedures for future activities.

Comment 4: The Commission recommends the NMFS require the USMC to use either direct strike or dynamic Monte Carlo models to determine the probability of ordnance strike.

Response: The Commission recommended ''direct strike or dynamic Monte Carlo methods'' while noting that the result of using a new risk probability model would likely provide negligible changes from the model described in the application. Because any change would be negligible, we do not agree that this alternative method of modeling is necessary for purposes of issuing an MMPA incidental take authorization at this time.

Description of Marine Mammals in the Area of the Specified Activity

Forty marine mammal species occur within the nearshore and offshore waters of North Carolina; however, the majority of these species are solely oceanic in distribution. Of the 40 species, only one marine mammal species, the bottlenose dolphin (*Tursiops truncatus*), routinely frequents Pamlico Sound. The endangered West Indian manatee (*Trichechus manatus*), under the jurisdiction of the U.S. Fish and Wildlife Service, rarely occurs in the area (Lefebvre *et al,* 2001; DoN 2003).

Based on the best available data, the Marine Corps does not expect to encounter the following species because of these species rare and/or extralimital occurrence in the survey area including the North Atlantic right whale (*Eubalaena glacialis*); Atlantic spotted dolphin (*Stenella frontalis*) and common dolphin (*Delphinus delphis*). Of the 40 species that may be encountered, most are oceanic in distribution and do not venture into the shallow, brackish waters of southern Pamlico Sound. No suitable habitat exists for large whale species in the shallow Pamlico Sound or bombing target vicinity. Accordingly, we did not

consider these other species in greater detail. The specified activity has the potential to affect only one marine mammal species under our jurisdiction: The bottlenose dolphin. We refer the public to the previous **Federal Register** notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013) where we present information on this species.

Potential Effects of the Specified Activity on Marine Mammals

As mentioned previously, with respect to military readiness activities, Section 3(18)(B) of the MMPA defines ''harassment'' as: (i) Any act that injures or has the significant potential to injure a marine mammal or marine mammal stock in the wild [Level A Harassment]; or (ii) any act that disturbs or is likely to disturb a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns, including, but not limited to, migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered [Level B Harassment].

We have determined that Level B harassment to marine mammals (specifically bottlenose dolphins) could occur incidental to noise and detonations from munitions firing (all military readiness activities) at the bombing targets. These military readiness activities will result in increased noise levels, explosions, and munitions debris within bottlenose dolphin habitat. In the absence of planned mitigation and monitoring measures, it is possible that injury or mortality of bottlenose dolphins could occur; however, due to the implementation of the planned measures, we do not anticipate that harassment would rise to the level of injury (Level A harassment), serious injury, or mortality. Therefore, the Authorization solely authorizes Level B (behavioral) harassment incidental to the Marine Corp's training activities. We anticipate that bottlenose dolphins may undergo temporary threshold shift, masking, stress response, and altered behavioral patterns (e.g., traveling, resting, opportunistic foraging). The notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013) provided complete description of these impacts. In addition, we refer the reader to our proposed and final rulemaking for the Navy Cherry Point Range Complex (74 FR 11057, March 16, 2009 and 74 FR 28370, June 15, 2009 for a full assessment of marine mammal responses and disturbances when exposed to anthropogenic sound.

Potential Effects of the Specified Activity on Marine Mammal Habitat

We provided a detailed discussion of the potential effects of this action on marine mammal habitat in the notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013). Detonations of live ordnance would result in temporary changes to the water environment. Munitions would hit the targets and not explode in the water. However, because the targets are over the water (i.e., a ship's hull on a shoal), in water explosions could occur. An underwater explosion from these weapons could send a shock wave and blast noise through the water, release gaseous by-products, create an oscillating bubble, and cause a plume of water to shoot up from the water surface. However, these effects would be temporary and not expected to last more than a few seconds.

Similarly, no long term impacts with regard to hazardous constituents are expected to occur. MCAS Cherry Point has an active Range Environmental Vulnerability Assessment (REVA) program in place to monitor impacts to habitat from its activities. One goal of REVA is to determine the horizontal and vertical concentration profiles of heavy metals, explosives constituents, perchlorate nutrients, and dissolved salts in the sediment and seawater surrounding BT–9 and BT–11. The Marine Corps has sampled the explosive constituents (e.g., trinitrotoluene (TNT), cyclotrimethylenetrinitramine (RDX), and hexahydro-trinitro-triazine (HMX) in the sediment or water sample surrounding the BTs as described in Hazardous Constituents [Subchapter 3.2.7.2] of the MCAS Cherry Point Range Operations EA. At present, they have not detected these constituents in the sediment or water. Metals were not present above toxicity screening values. Perchlorate was detected in a few sediment samples above the detection limit (0.21 ppm), but below the reporting limit (0.6 ppm). The ongoing REVA would continue to evaluate potential munitions constituent migration from operational range areas to off-range areas and MCAS Cherry Point.

While we anticipate that the specified activity may result in marine mammals avoiding certain areas due to temporary ensonification, this impact to habitat and prey resources is temporary and reversible and considered in notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013), as behavioral modification. The main impact associated with the proposed activity would be temporarily elevated noise levels and the associated direct effects on marine mammals, previously discussed.

Summary of Previous Monitoring

The Marine Corps complied with the mitigation and monitoring required under the previous authorizations (2010–2012). In accordance with the 2010–11 IHA, USMC submitted a final monitoring report, which described the activities conducted and observations made. USMC did not record observations of any marine mammals during training exercises. The only recorded observations—which were of bottlenose dolphins—were on two occasions by maintenance vessels engaged in target maintenance. No marine mammals were observed during range sweeps, air to ground activities, surface to surface activities (small boats), or ad hoc via range cameras. We refer the reader to the notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013) for a full discussion of the previous monitoring results. The Marine Corps will submit a monitoring report for the 2012 training season which expired on December 31, 2012, to us by June 31, 2013. We will post the monitoring report on our Web site *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*.

Mitigation

In order to issue an incidental take authorization under section 101(a)(5)(D) of the MMPA, we must set forth the permissible methods of taking pursuant to such activity, and other means of effecting the least practicable adverse impact on such species or stock and its habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance, and the availability of such species or stock for taking for certain subsistence uses.

The NDAA of 2004 amended the MMPA as it relates to military-readiness activities and the incidental take authorization process such that ''least practicable adverse impact'' shall include consideration of personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity. The training activities described in the Marine Corp's application are military readiness activities.

We have evaluated the applicant's proposed mitigation measures and considered other measures in the context of ensuring that we prescribe the means of effecting the least practicable adverse impact on the affected marine mammal species and stocks and their habitat. Our evaluation of potential measures included

consideration of the following factors in relation to one another: (1) The manner in which, and the degree to which, the successful implementation of the measure is expected to minimize adverse impacts to marine mammals; (2) the proven or likely efficacy of the specific measure to minimize adverse impacts as planned; and (3) the practicability of the measure for applicant implementation, including consideration of personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity. We have determined that the mitigation measures described provide the means of effecting the least practicable adverse impacts on marine mammal species or stocks and their habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance while also considering personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity.

The Marine Corps, in collaboration with us, has worked to identify potential practicable and effective mitigation measures, which include a careful balancing of the likely benefit of any particular measure to the marine mammals with the likely effect of that measure on personnel safety, practicality of implementation, and impact on the ''military-readiness activity.'' These mitigation measures include:

(1) *Range Sweeps:* The VMR–1 squadron, stationed at MCAS Cherry Point, includes three specially equipped HH–46D helicopters. The primary mission of these aircraft, known as PEDRO, is to provide search and rescue for downed 2nd Marine Air Wing aircrews. On-board are a pilot, co-pilot, crew chief, search and rescue swimmer, and a medical corpsman. Each crew member has received extensive training in search and rescue techniques, and is therefore particularly capable at spotting objects floating in the water.

PEDRO crew would conduct a range sweep the morning of each exercise day prior to the commencement of range operations. The primary goal of the pre-exercise sweep is to ensure that the target area is clear of fisherman, other personnel, and protected species. The sweeps occur at 100–300 meters above the water surface, at airspeeds between 60–100 knots. The path of the sweep runs down the western side of BT–11, circles around BT–9 and then continues down the eastern side of BT–9 before leaving. The sweep typically takes 20–30 minutes to complete. The PEDRO crew communicates directly with range personnel and can provide immediate notification to range operators. The PEDRO aircraft would remain in the area of a sighting until clear if possible or as mission requirements dictate.

If the crew sights marine mammals during a range sweep, they would collect sighting data and enter it into the U.S. Marine Corps sighting database, web-interface, or report generator. They would relay this information to the training Commander. Sighting data includes the following (collected to the best of the observer's ability): (1) Species identification; (2) group size; (3) the behavior of marine mammals (e.g., milling, travel, social, foraging); (4) location and relative distance from the BT; (5) date, time and visual conditions (e.g., Beaufort sea state, weather) associated with each observation; (6) direction of travel relative to the BT; and (7) duration of the observation.

(2) *Cold Passes:* All aircraft participating in an air-to-surface exercise would be required to perform a ''cold pass'' immediately prior to ordnance delivery at the BTs both day and night. That is, prior to granting a ''First Pass Hot'' (use of ordnance), pilots would be directed to perform a low, cold (no ordnance delivered) first pass which serves as a visual sweep of the targets prior to ordnance delivery to determine if unauthorized civilian vessels or personnel, or protected species, are present. They conduct the cold pass with the aircraft (helicopter or fixed-winged) flying straight and level at altitudes of 200–3000 feet over the target area. The viewing angle is approximately 15 degrees. A blind spot exists to the immediate rear of the aircraft. Based upon prevailing visibility, a pilot can see more than one mile forward upon approach. The aircrew and range personnel make every attempt to ensure clearance of the area via visual inspection and remotely operated camera operations (see Monitoring and Reporting section). The Range Controller may deny or approve the First Pass Hot clearance as conditions warrant.

(3) *Delay of Exercises:* The Marine Corps would consider an active range ''fouled'' and not available for use if a marine mammal is present within 1,000 yards (914 m) of the target area at BT–9 or anywhere within Rattan Bay (BT–11). Therefore, if they observe a marine mammal within 1,000 yards (914 m) of the target at BT–9 or anywhere within Rattan Bay at BT–11 during the cold pass or from range camera detection, they would delay training until the marine mammal moves beyond and on a path away from 1,000 yards (914 m) from the BT–9 target or out of Rattan Bay at BT–11. This mitigation applies to both air-to-surface and surface-to-surface exercises.

(4) *Range Camera Use:* To increase the safety of persons or property near the targets, Range Operation and Control personnel monitor the target area through two tower mounted safety and surveillance cameras. The remotely operated range cameras are high resolution and, according to range personnel, allow a clear visual of a duck floating near the target. The cameras allow viewers to see animals at the surface and breaking the surface, but not underwater. The camera system has night vision (IR) capabilities with resolution levels almost as good as during daytime. Lenses on the camera system have a focal length of 250 mm to 1500 mm, with view angle of (2.2° x 1.65° in wide-view) and (0.55° x 41° in narrow-view) respectively. Using the night-time capabilities, with a narrow view, an observer could identify a 1 x 1 meter target out to three kilometers.

Again, in the event that a marine mammal is sighted within 1000 yards (914 m) of the BT–9 target, or anywhere within Rattan Bay, the target would be declared fouled. Operations may commence in the fouled area after the animal(s) have moved 1000 yards (914 m) from the BT–9 target and/or out of Rattan Bay.

(5) *Vessel Operation:* All vessels used during training operations would abide by the Service's Southeast Regional Viewing Guidelines designed to prevent harassment to marine mammals (*http://www.nmfs.noaa.gov/pr/education/southeast/*).

(6) *Stranding Network Coordination:* The Marine Corps would coordinate with the local NMFS Stranding Coordinator for any unusual marine mammal behavior and any stranding, beached live/dead, or floating marine mammals that may occur at any time during training activities or within 24 hours after completion of training.

Monitoring and Reporting

In order to issue an Authorization for an activity, section 101(a)(5)(D) of the MMPA states that we 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 Incidental Harassment 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.

Monitoring measures prescribed by us should accomplish one or more of the following general goals: (a) An increase in our understanding of how many marine mammals are likely to be exposed to munitions noise and explosions that we associate with specific adverse effects, such as behavioral harassment, threshold shift; (b) an increase in our understanding of how individual marine mammals respond (behaviorally or physiologically) to gunnery and bombing exercises (at specific received levels) expected to result in take; (c) an increase in our understanding of how anticipated takes of individuals (in different ways and to varying degrees) may impact the population, species, or stock (specifically through effects on annual rates of recruitment or survival); (d) an increased knowledge of the affected species; (e) an increase in our understanding of the effectiveness of certain mitigation and monitoring measures; (f) a better understanding and record of the manner in which the authorized entity complies with the Authorization; and (g) an increase in the probability of detecting marine mammals, both within the safety zone (thus allowing for more effective implementation of the mitigation) and in general.

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 expected to be present within the action area are as follows:

(1) *Protected Species Observer Training:* Pilots, operators of small boats, and other personnel monitoring for marine mammals would be required to take the Marine Species Awareness Training (Part 1 and 2), provided by the U.S. Navy. This training would make personnel knowledgeable of marine mammals, protected species, and visual cues related to the presence of marine mammals and protected species.

(2) *Weekly and Post-Exercise Monitoring:* The Marine Corps would conduct post-exercise monitoring the morning following an exercise, unless an exercise occurs on a Friday, in which case the post-exercise sweep would take place the following Monday. Weekly monitoring events would include a maximum of five pre-exercise and four post-exercise sweeps. The maximum number of days that would elapse between pre- and post-exercise monitoring events would be approximately three days, and would normally occur on weekends. If marine mammals are observed during this monitoring, sighting data identical to those collected by PEDRO crew would be recorded.

(3) *Long-Term Monitoring:* The Marine Corps has awarded Duke University Marine Lab (Duke) a contract to obtain abundance, group dynamics (e.g., group size, age census), behavior, habitat use, and acoustic data on the bottlenose dolphins which inhabit Pamlico Sound, specifically those around BT–9 and BT–11. Duke began conducting boat-based surveys and passive acoustic monitoring of bottlenose dolphins in Pamlico Sound in 2000 (Read *et al.,* 2003) and specifically at BT–9 and BT–11 in 2003 (Mayer, 2003). To date, boat-based surveys indicate that bottlenose dolphins may be resident to Pamlico Sound and use BT restricted areas on a frequent basis. Passive acoustic monitoring (PAM) provides more detailed insight into how dolphins use the two ranges, by monitoring for their vocalizations year-round, regardless of weather conditions or darkness. In addition to these surveys, Duke scientists are testing a real-time passive acoustic monitoring system at BT–9 that will allow automated detection of bottlenose dolphin whistles, providing yet another method of detecting dolphins prior to training operations. Although it is unlikely this PAM system would be active for purposes of implementing mitigation measures before an exercise prior to expiration of the proposed Authorization, it could be operational for future MMPA incidental take authorizations and would be evaluated for effectiveness at the appropriate time.

(4) *Reporting:* The Marine Corps will submit a report to us within 90 days after expiration of the Authorization or, if a subsequent incidental take authorization is requested, within 120 days prior to expiration of the Authorization. The report will summarize the type and amount of training exercises conducted, all marine mammal observations made during monitoring, and if mitigation measures were implemented. The report will also address the effectiveness of the monitoring plan in detecting marine mammals.

General Notification of Injured or Dead Marine Mammals

The Marine Corps will systematically observe training operations for injured or disabled marine mammals. In addition, the Marine Corps would monitor the principal marine mammal stranding networks and other media to correlate analysis of any dolphin strandings that could potentially be associated with Cherry Point training operations.

Marine Corps personnel will ensure that we are notified immediately or as soon as clearance procedures allow if an injured, stranded, or dead marine mammal is found during or shortly after, and in the vicinity of, any training operations. The Marine Corps will provide us with species or description of the animal(s), the condition of the animal(s) (including carcass condition if the animal is dead), location, time of first discovery, observed behaviors (if alive), and photo or video (if available).

In the event that an injured, stranded, or dead marine mammal is found by Marine Corps personnel that is not in the vicinity of, or found during or shortly after operations, the Marine Corps personnel will report the same information as listed above as soon as operationally feasible and clearance procedures allow.

General Notification of a Ship Strike

In the event of a vessel strike, at any time or place, the Marine Corps shall do the following:

- Immediately report to us the species identification (if known), location (lat/long) of the animal (or the strike if the animal has disappeared), and whether the animal is alive or dead (or unknown);
- Report to us as soon as operationally feasible the size and length of the animal, an estimate of the injury status (e.g., dead, injured but alive, injured and moving, unknown, etc.), vessel class/type and operational status;
- Report to us the vessel length, speed, and heading as soon as feasible; and
- Provide us a photo or video, if equipment is available.

Estimated Take by Incidental Harassment

The following provides the Marine Corps' model for take of dolphins from explosives (without consideration of mitigation and the conservative assumption that all explosives would land in the water and not on the targets or land) and potential for direct hits and our analysis of potential harassment from small vessel and aircraft operations.

The method to estimate the number of marine mammals potentially taken by the specified activities is based on bottlenose dolphin density, the amount and type of ordnance proposed, and distances to our harassment threshold criteria. We refer the reader to the notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013) for a

description of the acoustic criteria for underwater detonations (Table 3).

TABLE 3—EFFECTS, CRITERIA, AND THRESHOLDS FOR IMPULSIVE SOUNDS

Effect	Criteria	Metric	Threshold	Effect
Mortality	Onset of Extensive Lung Injury.	Goertner modified positive impulse.	indexed to 30.5 psi-msec (assumes 100 percent small animal at 26.9 lbs).	Mortality.
Injurious Physiological	50 percent Tympanic Membrane Rupture.	Energy flux density	1.17 in-lb/in^2 (about 205 dB re 1 microPa^2-sec).	Level A.
Injurious Physiological	Onset Slight Lung Injury	Goertner modified positive impulse.	indexed to 13 psi-msec (assumes 100 percent small animal at 26.9 lbs).	Level A.
Non-injurious Physiological	TTS	Greatest energy flux density level in any ⅓-octave band (>100 Hertz (Hz) for toothed whales and >10 Hz for baleen whales)—for total energy over all exposures.	182 dB re 1 microPa^2-sec	Level B.
Non-injurious Physiological	TTS	Peak pressure over all exposures.	23 psi	Level B.
Non-injurious Behavioral	Multiple Explosions Without TTS.	Greatest energy flux density level in any ⅓-octave (>100 Hz for toothed whales and >10 Hz for baleen whales)—for total energy over all exposures (multiple explosions only).	177 dB re 1 microPa^2-sec	Level B.

Take From Explosives

The Marine Corps conservatively modeled that all explosives would detonate at a 1.2 m (3.9 ft) water depth despite the training goal of hitting the target, resulting in an above water or on land explosion. For sources that are detonated at shallow depths, it is frequently the case that the explosion may breech the surface with some of the acoustic energy escaping the water column. The source levels presented in the table above have not been adjusted for possible venting nor does the subsequent analysis take this into account. Properties of explosive sources used at BT–9, including net explosive weight (NEW), peak one-third-octave (OTO) source level, the approximate frequency at which the peak occurs, and rounds per burst are described in Table 9. Refer to Table 10 for distances to our harassment threshold levels from these sources.

TABLE 4—SOURCE WEIGHTS AND PEAK SOURCE LEVELS

Source type	NEW	Peak OTO SL	Frequency of peak OTO SL	Rounds per burst
2.75-inch Rocket	4.8 pounds (lbs)	223.9 dB re: 1μPa	~ 1500 Hertz (Hz)	1
5-inch Rocket	15.0 lbs	228.9 dB re: 1μPa	~ 1000 Hz	1
40 mm	0.1199 lbs	227.8 dB re: 1μPa	~ 1100 Hz	5

TABLE 5—DISTANCES TO OUR HARASSMENT THRESHOLDS FROM EXPLOSIVE ORDNANCES

	Behavioral disturbance (177 dB energy)	TTS (23 psi)	Level A (13 psi-msec)	Mortality (31 psi-ms)
2.75-inch Rocket HE	326.6 meter (m) (1,071 feet (ft)).	172 m (564 ft)	47 m (154 ft)	27 m (89 ft).
5″ Rocket HE	397.7 m 1,034 ft	255 m (837 ft)	61 m (200 ft)	39 m (128 ft).
40 mm HE	144 m (472 ft)	N/A	10 m (33 ft)	5 m (16 ft).

In order to calculate take, the Marine Corps considered the distances to which animals could be harassed along with dolphin density. They used the density estimate from Read *et al.* (2003) to calculate take from munitions firing (0.183/square kilometer (km^2)) and based take calculations for munitions firing on 100 percent water detonation. Because the goal of training is to hit the targets and not the water, we consider these take estimates based on 100 percent water detonation of munitions to be conservative.

Based on dolphin density and amount of munitions expended, there is very low potential for Level A harassment, serious injury, and mortality and monitoring and mitigation measures are anticipated to further negate this potential. Accordingly, we are not proposing to issue these levels of take. In total, from firing of explosive ordnances, the Marine Corps has requested, and we propose to issue, the incidental take of 25 bottlenose

dolphins from Level B harassment (Table 6).

TABLE 6—NUMBER OF DOLPHINS POTENTIALLY TAKEN FROM EXPOSURE TO EXPLOSIVES BASED ON THRESHOLD CRITERIA

Ordnance type	Level B—Behavioral (177dB re 1microPa²-s)	Level B—TTS (23 psi)	Level A—Injurious (205 dB re 1microPa²-s or 13 psi)	Mortality (30.5 psi)
2.75″ Rocket HE	0.71	0.99	0.05	0.01
5″ Rocket HE	0.41	0.64	0.05	0.01
40 mm HE	9.46	11.07	0.16	0.0
Total	10.58	12.71	0.26	0.02

Take From Direct Hit

As described in the notice for the proposed Authorization (78 FR 19224, Friday, March 29, 2013), we estimate that the potential risk of a direct hit to an animal in the target area is discountable. The probability of hitting a bottlenose dolphin at the BTs can be derived as follows: Probability = dolphin's dorsal surface area times the density of dolphins. The estimated dorsal surface area of a bottlenose dolphin is 1.425 m^2 (or the average length of 2.85 m times the average body width of 0.5 m). Thus, using Read *et al.* (2003)'s density estimate of 0.183 dolphins/km^2, without consideration of mitigation and monitoring implementation, the probability of a dolphin being hit within BT–9 is 2.61 x 10^{-7} and within BT–11 is 9.4 x 10^{-8}. Using the proposed levels of ordnance expenditures at each in-water BT (78 FR 19224, Friday, March 29, 2013) and taking into account that only 36 percent of the ordnance deployed at BT–11 is over water, as described in the application, the estimated potential number of ordnance strikes on a marine mammal per year is 0.263 at BT–9 and 0.034 at BT–11. It would take approximately three years of ordnance deployment at the BTs before it would be likely or probable that one bottlenose dolphin would be struck by deployed inert ordnance. Again, these estimates are without consideration to proposed monitoring and mitigation measures.

The Marine Corps proposed three methods of exercise monitoring (i.e., PEDRO, cold pass, and range cameras). When considering the implementation of the mitigation and monitoring measures, the chance of a marine mammal being taken by direct hit is discountable.

Take From Vessel and Aircraft Presence

Interactions with vessels are not a new experience for bottlenose dolphins in Pamlico Sound. Pamlico Sound is heavily used by recreational, commercial (fishing, daily ferry service, tugs, etc.), and military (including the Navy, Air Force, and Coast Guard) vessels year-round. The NMFS' Southeast Regional Office has developed marine mammal viewing guidelines to educate the public on how to responsibly view marine mammals in the wild and avoid causing a take (*http://www.nmfs.noaa.gov/pr/education/southeast*). The guidelines recommend that vessels should remain a minimum of 50 yards from a dolphin, operate vessels in a predictable manner, avoid excessive speed or sudden changes in speed or direction in the vicinity of animals, and not to pursue, chase, or separate a group of animals. The Marine Corps would abide by these guidelines to the fullest extent practicable. The Marine Corps would not engage in high speed exercises should a marine mammal be detected within the immediate area of the BTs prior to training commencement and would never closely approach, chase, or pursue dolphins. Detection of marine mammals would be facilitated by personnel monitoring on the vessels and those marking success rate of target hits and monitoring of remote camera on the BTs (see Monitoring and Reporting section).

Based on the description of the action, the other activities regularly occurring in the area, the species that may be exposed to the activity and their observed behaviors in the presence of vessel traffic, and the implementation of measures to avoid vessel strikes, we determined that it is unlikely that the operation of vessels during surface-to-surface maneuvers will result in the take of any marine mammals, in the form of either behavioral harassment, injury, serious injury, or mortality.

Aircraft would move swiftly through the area and would typically fly approximately 914 m (2,998.7 ft) from the water's surface before dropping unguided munitions and above 4,572 m (2.8 miles) for precision-guided munitions bombing. While the aircraft may approach as low as 152 m (500 ft) to drop a bomb this is not the norm and would never been done around marine mammals. Regional whale watching guidelines advise aircraft to maintain a minimum altitude of 300 m (1,000 ft) above all marine mammals, including small odontocetes, and to not circle or hover over the animals to avoid harassment. Our approach regulations limit aircraft from flying below 300 m (1,000 ft) over a humpback whale (*Megaptera novaeangliae*) in Hawaii, a known calving ground, and limit aircraft from flying over North Atlantic right whales closer than 460 m (1,509 ft). Given that Marine Corps aircraft would not fly below 300 m (984 ft) on the approach, would not engage in hovering or circling the animals, and would not drop to the minimal altitude of 152 m (500 ft) if a marine mammal is in the area, we believe it unlikely that the operation of aircraft, as described above, will result in take of bottlenose dolphins in Pamlico Sound in any manner.

Negligible Impact Analysis and Determination

Pursuant to our regulations implementing the MMPA, an applicant is required to estimate the number of animals that will be ''taken'' by the specified activities (i.e., takes by harassment only, or takes by harassment, injury, and/or death). This estimate informs the analysis that we must perform to determine whether the activity will have a ''negligible impact'' on the species or stock. We have defined ''negligible impact'' in 50 CFR 216.103 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.'' 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 and manner of takes, alone, is not enough information

on which to base a negligible impact determination. We must also consider other factors, such as the likely nature of any responses (their intensity, duration, etc.), the context of any responses (critical reproductive time or location, migration, etc.), or any of the other variables mentioned in the first paragraph (if known), as well as the number and nature of estimated Level A takes, the number of estimated mortalities, and effects on habitat.

The Marine Corps has conducted gunnery and bombing training exercises at BT–9 and BT–11 for several years and, to date, the monitoring reports indicate that no dolphin injury, serious injury, or mortality has been attributed to these military training exercises. The Marine Corps has a history of notifying the NMFS stranding network when any injured or stranded animal comes ashore or is spotted by personnel on the water. Therefore, stranded animals have been examined by stranding responders, further confirming that it is unlikely training contributes to marine mammal injuries or deaths. Due to the implementation of the aforementioned proposed mitigation measures, no take by Level A harassment or serious injury or mortality is anticipated nor would any be authorized in the IHA. We are proposing, however, to authorize 25 Level B harassment takes associated with training exercises.

The Marine Corps has proposed a 1,000 yard (914 m) safety zone around BT–9 despite the fact that the distance to our explosive Level B harassment threshold is 228 yards (209 m). They also would consider an area fouled if any dolphins are spotted within Raritan Bay (where BT–11 is located)—triggering a shutdown of activities in that area. The Level B harassment takes allowed for in the Authorization would be of very low intensity and would likely result in dolphins being temporarily behaviorally affected by bombing or gunnery exercises. In addition, takes may be attributed to animals not using the area when exercises are occurring; however, this is difficult to calculate. Instead, we look if the specified activities occur during and within habitat important to vital life functions to better inform its negligible impact determination.

Read *et al.* (2003) concluded that dolphins rarely occur in open waters in the middle of North Carolina sounds and large estuaries, but instead are concentrated in shallow water habitats along shorelines. However, no specific areas have been identified as vital reproduction or foraging habitat. Scientific boat based surveys conducted throughout Pamlico Sound conclude that dolphins use the areas around the BTs more frequently than other portions of Pamlico Sound (Maher, 2003) despite the Marine Corps actively training in a manner identical to the specified activities described here for years.

As described in the *Affected Species* section of this notice, bottlenose dolphin stock segregation is complex with stocks overlapping throughout the coastal and estuarine waters of North Carolina. It is not possible for the Marine Corps to determine to which stock any individual dolphin taken during training activities belong as this can only be accomplished through genetic testing. However, it is likely that many of the dolphins encountered would belong to the Northern or Southern North Carolina Estuarine System stocks. These stocks have abundance estimates of 950 and 2,454, respectively. We authorize 25 takes of bottlenose dolphins in total; therefore, this number represents 2.6 and 1.0 percent, respectively, of those populations. This species is not listed as threatened or endangered under the ESA.

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 mitigation and monitoring measures, we find that the specified USMC Air Station Cherry Point BT–9 and BT–11 training activities would result in the incidental take of marine mammals, by Level B harassment only, and that the total taking from would have a negligible impact on the affected species or stocks.

Subsistence Harvest of Marine Mammals

Marine mammals are not taken for subsistence uses within Pamlico Sound; therefore, issuance of an IHA to the USMC for MCAS Cherry Point training exercises would not have an unmitigable adverse impact on the availability of the affected species or stocks for subsistence use.

Endangered Species Act (ESA)

No ESA-listed marine mammals are known to occur within the action area. Therefore, there is no requirement for us to consult under Section 7 of the ESA on the issuance of an Authorization under section 101(a)(5)(D) of the MMPA. However, ESA-listed sea turtles may be present within the action area.

On September 27, 2002, NMFS issued a Biological Opinion (BiOp) on *Ongoing Ordnance Delivery at Bombing Target 9 (BT–9) and Bombing Target 11 (BT–11) at Marine Corps Air Station, Cherry Point, North Carolina.* The BiOp, which is still in effect, concluded that that the USMC's proposed action will not result in adverse impacts to any ESA-listed marine mammals and is not likely to jeopardize the continued existence of the endangered green turtle (*Chelonia mydas*), leatherback turtle (*Dermochelys coriacea*), Kemp's ridley turtle (*Lepidochelys kempii*), or threatened loggerhead turtle (*Caretta caretta*). The Authorization will not result in effects beyond those considered in the 2002 BiOp and we do not anticipate the need for further Section 7 consultation for the Authorization or the underlying activities proposed by the Marine Corps. No critical habitat has been designated for these species in the action area; therefore, none will be affected.

National Environmental Policy Act (NEPA)

On February 11, 2009, the Marine Corps issued a Finding of No Significant Impact for its Environmental Assessment (EA) on MCAS Cherry Point Range Operations. Based on the analysis of the EA, the Marine Corps determined that the proposed action will not have a significant impact on the human environment. We adopted the Marine Corps' EA and signed a Finding of No Significant Impact on August 31, 2010. We have again reviewed the proposed application and public comments and determined that there are no substantial changes to the proposed action or new environmental impacts or concerns. Therefore, we have determined that a new or supplemental EA or Environmental Impact Statement is unnecessary. The EA referenced above is available for review at *http://www.nmfs.noaa.gov/pr/permits/incidental.htm.*

Authorization

We have issued an Incidental Harassment Authorization to the Marine Corps for the take of marine mammals incidental to various training exercises at Marine Corps Air Station (MCAS) Cherry Point Range Complex, North Carolina, July 1, 2013 through June 30, 2014, provided the previously mentioned mitigation, monitoring, and reporting requirements are incorporated.

Dated: July 10, 2013.

Donna S. Wieting,

Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2013–16878 Filed 7–12–13; 8:45 am]

BILLING CODE 3510–22–P

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Proposed Revision of the Corporation for National and Community Service Strategic Plan; Request for Input

AGENCY: Corporation for National and Community Service (CNCS).

ACTION: Request for Input on Proposed Update of the CNCS Strategic Plan.

SUMMARY: The Corporation for National and Community Service (CNCS) is revising its Strategic Plan. The current CNCS Strategic Plan was approved in 2011. All Federal Agencies are required to publish an updated Strategic Plan, concurrent with the publication of the FY 2015 President's Budget in February 2014. After the February 2014 publication of a strategic plan, agencies will next issue a new Strategic Plan in February 2018. CNCS's updated Strategic Plan will reflect the broad, long term outcomes that the CNCS aspires to achieve by implementing its mission.

We invite grantees, partners, future partners, and the public to submit written comments, as described below. Please see the Supplementary Information section below for information on developing your comments. The goal of this public comment process is solicit input on CNCS's updated Strategic Plan in accordance with CNCS's commitment to maintain high standards of transparency and openness.

As appropriate, public input received will be included in the updated Strategic Plan, however CNCS will be able not provide individual responses to the public comments that are received.

DATES: Written comments must be submitted to the individual and office listed in the **ADDRESSES** section by August 14, 2013.

ADDRESSES: You may submit comments by any of the following methods:

(1) *Electronically through the Corporation's email system: StrategicPlanInput@cns.gov.*

(2) *By mail sent to:* Corporation for National and Community Service; Marlene Zakai, Director of Strategic Initiatives, 1201 New York Avenue NW., Washington, DC 20525.

(2) By hand delivery or by courier to the CNCS mailroom at Room 8100 at the mail address given in paragraph (1) above, between 9:00 a.m. and 4:00 p.m. Eastern Time, Monday through Friday, except Federal holidays.

(3) *By fax to:* (202) 606–3462, Attention: Marlene Zakai, Director of Strategic Initiatives.

(4) Electronically through *www.regulations.gov.*

Individuals who use a telecommunications device for the deaf (TTY–TDD) may call 1–800–833–3722 between 8:00 a.m. and 8:00 p.m. Eastern Time, Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Questions regarding this revision of the Strategic Plan should be directed to Marlene Zakai by email at *StrategicPlanInput@cns.gov.* Persons with hearing or speech impairments may contact CNCS via TTY by calling the Federal Information Relay Service at (800) 877–8339.

Description of Requested Input

CNCS is inviting formal input from the public concerning the update of the current CNCS Strategic Plan. The goal of the Strategic Plan update is to accurately reflect CNCS's strategic and programmatic priorities for the next 4 years.

CNCS' current Strategic Plan [*http://www.nationalservice.gov/about/strategic-plan*] leverages the strength of grantees, participants, programs, state service commissions and the American public to build a network of programs that offer effective solutions in the six priority areas:

- Disaster Services
- Economic Opportunity
- Education
- Environmental Stewardship
- Healthy Futures
- Veterans and Military Families

We will produce these results by investing in effective local initiatives, engaging more Americans in service, supporting evidence-based programs, and leveraging public-private partnerships. In addition to these priority focus areas, CNCS has four strategic goals, with accompanying priority measures:

Goal 1: Increase the impact of national service on community needs in communities served by CNCS-supported programs.

Goal 2: Strengthen national service so that participants engaged in CNCS-supported programs consistently find satisfaction, meaning and opportunity.

Goal 3: Maximize the value we add to grantees, partners and participants.

Goal 4: Fortify management operations and sustain a capable, responsive and accountable organization.

In updating its Strategic Plan, CNCS is seeking to be even more effective in achieving Goals 1–4 and its impact in the six priority focus areas. Specifically, CNCS is requesting comments in the following areas:

- How might the Strategic Plan be updated to reflect current community priorities?
- What is working well and should be further enhanced?
- What has shown promise and should have a more prominent place in the updated plan?
- What is less relevant in today's environment, allowing resources to be focused elsewhere?

Dated: July 8, 2013.

Marlene Zakai,

Director of Strategic Initiatives.

[FR Doc. 2013–16775 Filed 7–12–13; 8:45 am]

BILLING CODE 6050–28–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Transmittal Nos. 13–26]

36(b)(1) Arms Sales Notification

AGENCY: Department of Defense, Defense Security Cooperation Agency.

ACTION: Notice.

SUMMARY: The Department of Defense is publishing the unclassified text of a section 36(b)(1) arms sales notification. This is published to fulfill the requirements of section 155 of Public Law 104–164 dated July 21, 1996.

FOR FURTHER INFORMATION CONTACT: Ms. B. English, DSCA/DBO/CFM, (703) 601–3740.

The following is a copy of a letter to the Speaker of the House of Representatives, Transmittals 13–26 with attached transmittal and policy justification.

Dated: July 10, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

DEFENSE SECURITY COOPERATION AGENCY
201 12TH STREET SOUTH, STE 203
ARLINGTON, VA 22202-5408

JUL 09 2013

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, we are forwarding herewith Transmittal No. 13-26, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to the Kingdom of Saudi Arabia for defense articles and services estimated to cost $1.2 billion. After this letter is delivered to your office, we plan to issue a press statement to notify the public of this proposed sale.

Sincerely,

William E. Landay III
Vice Admiral, USN
Director

Enclosures:
1. Transmittal
2. Policy Justification
3. Regional Balance (Classified Document Provided Under Separate Cover)

Transmittal No. 13–26

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act, as amended

(i) *Prospective Purchaser:* Kingdom of Saudi Arabia

(ii) *Total Estimated Value:*

Major Defense Equipment*	$0.0 billion.
Other	1.2 billion.
Total	1.2 billion.

* as defined in Section 47(6) of the Arms Export Control Act.

(iii) *Description and Quantity or Quantities of Articles or Services under Consideration for Purchase:* 30 Mark V patrol boats, 32 27mm guns, spare and repair parts, support equipment, personnel training and training equipment, publications and technical documentation, U.S. Government and contractor engineering, technical, and logistics support services, and other related elements of logistics support.

(iv) *Military Department:* Navy (SBR)

(v) *Prior Related Cases, if any:* None

(vi) *Sales Commission, Fee, etc., Paid, Offered, or Agreed to be Paid:* None

(vii) *Sensitivity of Technology Contained in the Defense Article or Defense Services Proposed to be Sold:* None

(viii) *Date Report Delivered to Congress:* 9 July 2013

POLICY JUSTIFICATION

Kingdom of Saudi Arabia—Mark V Patrol Boats

The Kingdom of Saudi Arabia has requested a possible sale of 30 Mark V patrol boats, 32 27mm guns, spare and repair parts, support equipment, personnel training and training

equipment, publications and technical documentation, U.S. Government and contractor engineering, technical, and logistics support services, and other related elements of logistics support. The estimated cost is $1.2 billion.

This proposed sale will contribute to the foreign policy and national security of the United States by helping to improve the security of Saudi Arabia which has been, and continues to be, an important force for stability in the Middle East. This sale of Mark V patrol boats will give the Royal Saudi Naval Forces (RSNF) an effective combat and threat deterrent capability to protect maritime infrastructure in the Saudi littorals. This acquisition will enhance the stability and security operations for boundaries and territorial areas encompassing the Saudi Arabian coastline.

The purchase of Mark V patrol boats represents an upgrade and modernization of the RSNF's existing patrol boat capability. The proposed sale will enhance interoperability between the U.S. and the Kingdom of Saudi Arabia and will contribute to the stability in the Kingdom of Saudi Arabia and the region. The Mark V patrol boats will provide additional capability to rapidly identify, engage, and defeat maritime security threats in the near-offshore region of the Saudi littorals. The boats will be used primarily to patrol and interdict intruders in Saudi territorial seas, and recognized economic exclusion zones. Saudi Arabia will have no difficulty absorbing these additional boats.

The proposed sale of this equipment and support will not alter the basic military balance in the region.

The principal contractor for this effort has not yet been determined. There are no known offset agreements proposed in connection with this potential sale.

Implementation of this proposed sale will require an additional three to four U.S. Government and contractor representatives to Saudi Arabia for a period of seven years to provide logistics and technical support and warranty work during delivery of the boats.

There will be no adverse impact on U.S. defense readiness as a result of this proposed sale.

[FR Doc. 2013–16893 Filed 7–12–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Board of Regents, Uniformed Services University of the Health Sciences; Quarterly Meeting Notice

AGENCY: Uniformed Services University of the Health Sciences (USU), DoD.

ACTION: Quarterly meeting notice.

SUMMARY: Under the provisions of the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.150, the Department of Defense announces the following meeting of the Board of Regents, Uniformed Services University of the Health Sciences.

DATES: Tuesday, July 30, 2013, from 8:00 a.m. to 11:30 a.m. (Open Session) and 11:30 a.m. to 1:00 p.m. (Closed Session).

ADDRESSES: Everett Alvarez Jr. Board of Regents Room (D3001), Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814.

FOR FURTHER INFORMATION CONTACT: S. Leeann Ori, Designated Federal Officer, 4301 Jones Bridge Road, Bethesda, Maryland 20814; telephone 301–295–3066.

SUPPLEMENTARY INFORMATION: *Purpose of the Meeting:* The purpose of the meeting is to review the operations of USU, particularly the academic affairs and provide advice to the USU President and the Director of Tricare Management Activity. These actions are necessary for the University to pursue its mission, which is to provide outstanding healthcare practitioners and scientists to the uniformed services, and to obtain institutional accreditation.

Agenda: The actions that will take place include the approval of minutes from the Board of Regents Meeting held May 17, 2013; recommendations regarding the approval of faculty appointments and promotions in the School of Medicine; recommendations regarding the awarding of master's and doctoral degrees in the biomedical sciences and public health; approval of awards and honors; a review of the USU mission, vision and values; and a Board recommendation regarding the DoD civilian hiring freeze. The President, USU will provide a report and information from both academic and administrative University officials will be presented during the meeting. A closed session will be held to discuss personnel actions and to conduct the annual assessment of the USU President.

Meeting Accessibility: Pursuant to Federal statute and regulations (5 U.S.C. 552b and 41 CFR 102–3.140 through 102–3.165) and the availability of space, the meeting is open to the public from 8:00 a.m. to 11:30 a.m. Seating is on a first-come basis. Members of the public wishing to attend the meeting should contact S. Leeann Ori at the address and phone number in **FOR FURTHER INFORMATION CONTACT.** Mrs. Ori can also provide base access procedures.

Pursuant to 5 U.S.C. 552b(c)(2) and 5 U.S.C. 552b(c)(6), the Department of Defense has determined that a portion of the meeting shall be closed to the public. The Under Secretary of Defense (Personnel and Readiness), in consultation with the Office of the DoD General Counsel, has determined in writing that a portion of the committee's meeting will be closed as it contains information related solely to the internal personnel rules and practices of the agency and the subject matter involves personal and private observations.

Written Statements: Interested persons may submit a written statement for consideration by the Board of Regents. Individuals submitting a written statement must submit their statement to the Designated Federal Officer at the address listed in **FOR FURTHER INFORMATION CONTACT.** If such statement is not received at least 5 calendar days prior to the meeting, it may not be provided to or considered by the Board of Regents until its next open meeting. The Designated Federal Officer will compile all timely submissions with the Board of Regents Chairman and ensure such submissions are provided to Board of Regents Members before the meeting.

Dated: July 10, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–16862 Filed 7–12–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Meeting of the Department of Defense Military Family Readiness Council (MFRC)

AGENCY: Department of Defense.

ACTION: Notice.

SUMMARY: Under the provisions of the Federal Advisory Committee Act of 1972 (5 U.S.C. Appendix, as amended), the Government in the Sunshine Act of

1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.150, the Department of Defense announces a Federal advisory committee meeting of the Department of Defense Military Family Readiness Council. The purpose of the Council meeting is to review and make recommendations to the Secretary of Defense regarding policy and plans; monitor requirements for the support of military family readiness by the Department of Defense; and evaluate and assess the effectiveness of the military family readiness programs and activities of the Department of Defense.

Pursuant to 5 U.S.C. 552b and 41 CFR 102–3.140 through 102–3.165, this meeting is open to the public, subject to the availability of space. Persons desiring to attend may contact Ms. Melody McDonald at 571–372–0880 or email *FamilyReadinessCouncil@osd.mil* no later than 5:00 p.m., on Friday, July 19, 2013 to arrange for escort inside the Pentagon to the Conference Room area.

Pursuant to 41 CFR 102–3.105(j) and 102–3.140, and section 10(a)(3) of the Federal Advisory Committee Act of 1972, interested persons may submit a written statement for consideration by the Council. Persons desiring to submit a written statement to the Council must notify the point of contact listed in **FOR FURTHER INFORMATION CONTACT** no later than 5:00 p.m., Friday, July 19, 2013.

DATES: August 5, 2013, from 1:30 p.m. to 4:00 p.m.

ADDRESSES: Pentagon Conference Center B6 (escorts will be provided from the Pentagon Metro entrance).

FOR FURTHER INFORMATION CONTACT: Ms. Melody McDonald or Ms. Betsy Graham, Office of the Deputy Assistant Secretary of Defense (Military Community & Family Policy), 4800 Mark Center Drive Alexandria, VA 22350–2300, Room 3G15. Telephones (571) 372–0880; (571) 372–0881 and/or email: *FamilyReadinessCouncil@osd.mil.*

SUPPLEMENTARY INFORMATION: The purpose of this meeting is to refine the Council recommendations that will be included in the 2013 Military Family Readiness Council report to the congressional defense committees and the Secretary of Defense.

Monday, August 5, 2013—Meeting Agenda

Welcome & Administrative Remarks
Overview of the DoD efforts to make Military Family Programs accessible to the National Guard, Reserve and geographically dispersed military members and their families
Update on the Quality of Life working group
Overview of Military Financial Readiness Programs
Closing Remarks

Note: Exact order may vary.

Dated: July 10, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–16875 Filed 7–12–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Office of Economic Adjustment; Notice of Cooperative Agreement

Federal Funding Opportunity Title: Research and Technical Assistance.

Announcement Type: Cooperative Agreement.

Catalog of Federal Domestic Assistance (CFDA) Number: 12.615.

Key Dates: The proposal submission deadline is thirty (30) days after the publication of this notice.

Executive Summary: This notice announces the opportunity to enter into a cooperative agreement with the Office of Economic Adjustment (OEA) for Research and Technical Assistance (RTA) and invites proposals to continue to provide economic data to Defense-impacted communities. The OEA is authorized by 10 U.S.C. 2391 to make grants to, or conclude cooperative agreements or enter into contracts with, a State or local government or any private entity to conduct research and provide technical assistance in support of the Defense Economic Adjustment Program, and to assist communities, businesses and workers responding to Defense changes under 10 U.S.C. 2391 and Executive Order 12788, as amended. OEA is the Department of Defense's primary source for assisting communities that are adversely impacted by Defense program changes, including base closures or realignments and contract or program reductions or cancellations. Awards provided under this announcement support the Defense Economic Adjustment Program by providing: (1) Analysis and dissemination of information; and (2) support to innovative approaches.

I. Funding Opportunity Description

OEA, a Department of Defense (DoD) Field Activity, is authorized to make grants to, or conclude cooperative agreements or enter into contracts with, state or local governments or any private entity, to conduct research and provide technical assistance in support of its program activities under 10 U.S.C. 2391 and Executive Order 12788, as amended.

On December 31, 2008, OEA published a Federal Funding Opportunity in the **Federal Register** (73 FR 80369–80371), and through a competitive process selected the University of Illinois—Chicago (University) to provide economic data for 56 Defense-impacted communities. The University conducted a multi-phase approach to provide data and analysis for these communities. Phase I entailed identification, collection, and preliminary analysis of baseline indicators that collectively formed the backbone of the project. Phase II entailed reaching out to communities and refining the baseline data indicators based on community needs. The University also produced a broad array of reports and analytical products; developed tools for the systematic analysis of communities' development trends and challenges; and provided detailed customized data and reports to communities. The University designed, manages, and hosts on their server the Web site *www.defensecommunitydata.com,* to share the baseline data tracked through the current cooperative agreement with the target communities, as well as Federal, state, and local agencies.

1. Description of opportunity—Pursuant to the Research and Technical Assistance program, OEA is soliciting proposals that will result in a cooperative agreement to provide economic indicators on a recurring basis to approximately 80 Defense-impacted locations engaged in defense economic adjustment. OEA works with communities/regions experiencing base closure, realignment, and reductions in or cancellations of DoD spending. Implementation of a community's plan to redevelop surplus property (base closure) or address reductions in defense procurement may be impacted by changing economic conditions, including, but not limited to, declining home values, rising unemployment, declining tax revenue, and housing/business starts. Specifically, OEA is seeking proposals to continue to provide information to its program customer base on: (1) Adjusted monthly and quarterly economic data for approximately 80 communities with Defense impacts; and (2) a national baseline for identified economic indicators. This information was and will continue to be developed with and for the affected communities, and posted on the Internet to further assist OEA's community, state, and other customers in the coordination and

delivery of adjustment assistance. OEA desires that the successful respondent host on their server and post on the Internet: (1) A seamless continuation of regional data for the following listed installations starting October 1, 2013; and (2) similar regional data for additional Defense-impacted communities (to be determined by OEA) to be posted on the Internet within 30 days of OEA notification to the successful recipient. Data developed under the current cooperative agreement will be made available to the selected recipient and can be viewed at *www.defensecommunitydata.com*. OEA reserves the right to continue this effort with the selected recipient for up to 3 additional years without further competition, subject to the availability of funds and successful performance.

2. Additional Information—The respondent must continue to track the existing data from the current cooperative agreement. These specific data elements can be obtained from the Data section of any community page on *www.defensecommunitydata.com* or from the agency contact noted in Section VII. The research and data must be dynamic, in that it must be updated on a recurring basis to reflect current local economic situations across a portfolio of regions. The respondent will be expected to engage the identified communities and provide specific information developed by the project directly to the respective communities. OEA encourages the respondent to consider partnering with public, private, and higher education sources for existing economic data or techniques for adjusting economic data to reflect local conditions.

3. List of BRAC 2005 military installations with a continuing need for regional economic data. OEA reserves the right to add to or change this list and to identify approximately 50 additional Defense-impacted communities for future data collection.

Base name	State
Army Reserve Personnel Command St. Louis.	MO
Brooks City Base	TX
Buckley Air Force Base Annex	CO
Deseret Chemical Depot	UT
Fort Gillem	GA
Fort McPherson	GA
Fort Monmouth	NJ
Fort Monroe	VA
General Mitchell Air Reserve Station	WI
Grand Forks Air Force Base	ND
Kansas Army Ammunition Plant	KS
Naval Air Station Brunswick	ME
Naval Air Station Corpus Christi/Naval Station Ingleside.	TX
Naval Air Station Willow Grove	PA
Naval Station Pascagoula	MS
Naval Supply Corps School Athens	GA
Naval Support Activity New Orleans	LA
Naval Weapons Station Seal Beach Concord Detachment.	CA
Newport Chemical Depot	IN
Onizuka Air Force Station	CA
Red River Army Depot/Lone Star Army Ammunition Plant.	TX
Riverbank Army Ammunition Plant	CA
Rock Island Arsenal	IL
Selfridge Army Activity	MI
Sheppard Air Force Base	TX
Umatilla Army Depot	OR
Walter Reed Army Medical Center	DC

II. Award Information

OEA is accepting proposals for a Research and Technical Assistance award. The proposals should pertain to the identified areas of interest and will be rated on content (relevance and appropriateness to OEA's core functions, qualifications of project personnel, responsiveness to this announcement, and budget). OEA will invite the successful respondent(s) to enter into a cooperative agreement under this announcement following a review of the proposals and determination of eligible respondents, which will commence after the 31st day following publication of this announcement.

III. Eligibility Information

Eligible respondents include any State or local government or private entity.

Eligible activities include research and technical assistance in support of Defense Economic Adjustment Program activities under 10 U.S.C. 2391 and Executive Order 12788, as amended, to assist communities, businesses, and workers adversely affected by Defense changes. OEA specifically seeks proposals to:

- Maintain/develop and present local economic indicator data for regions impacted by Defense downsizing to include regions impacted by reductions in or cancellations of DoD spending, based on the two elements identified in section I, subsection 1 of this announcement. Respondents must present how their proposal will cost effectively support the information available at *www.defensecommunitydata.com* and be an on-call resource for government data needs.

Proposals outside the identified areas of interest will not be considered.

IV. Application and Submission Information

The process requires the respondents to submit proposals within the advertised solicitation period (thirty (30) days).

The proposals must include a cover or transmittal letter and accompanying text that shall consist of no more than 10 pages (single-sided), comprising:

- An abstract of the proposed research or technical assistance;
- A description of the scope of work required to provide economic indicators on a recurring basis to include:
  - Specific economic indicators continued from the current cooperative agreement to reflect near real-time economic conditions;
  - methods for obtaining or developing the indicators;
  - the respondent's plan for engaging the impacted communities for each of the listed installations, and approximately 50 additional communities as may be designated by OEA from time to time, during development of the information and for evaluating the usefulness of information provided; and,
  - methods for distributing the information to the impacted communities.
- A proposed budget and accompanying budget justification;
- Detailed description of the project team and their relevant experience;
- A project schedule for completion of the work that meets OEA's desired timelines for provision of the data;
- A point of contact.

Proposals must be provided to: Director, Office of Economic Adjustment, electronically to: *rta.submit@osd.mil;* or by mail to: 2231 Crystal Drive Suite 520, Arlington, VA, 22202.

V. Application Review Information

1. Selection Criteria—In reviewing proposals under this notice, OEA considers and weights equally each of the following factors as a basis for evaluating an application:

- Overall conformance with proposal requirements and desired timelines for provision of the data;
- Overall quality of proposed research;
- Overall expertise, experience, qualifications and ability of investigators; and
- Overall cost.

2. Review and Selection Process—OEA will assign a Project Manager and notify the respondent(s) as soon as practicable following its review of the proposals and determination of eligibility, to advise and assist with the preparation of an application. The application will be reviewed for its completeness and accuracy, and, to the extent possible, an award notification

will be issued within fourteen (14) days of the receipt of a complete application.

VI. Award Administration Information

1. Award Notices—To the extent possible, successful applicants will be notified within fourteen (14) days of the receipt at OEA of a complete application whether or not they will receive an award. Upon notification of an award, applicants will receive an award agreement, signed by the Director of OEA on behalf of DoD. Awardees must review the award agreement and indicate their consent to its terms by signing and returning it to OEA.

2. Administrative and National Policy Requirements—

The Awardee and any consultant/contractor operating under the terms of a grantor cooperative agreement shall comply with all Federal, State, and local laws applicable to its activities including the following: 32 CFR part 33, ''Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments''; 2 CFR part 225, ''Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A–87)''; OMB Circular A–133, ''Audits of States, Local Governments, and Non-Profit Organizations,'' and 31 U.S.C. 7502(h) ''Requirements for Single Audits''; 2 CFR part 180, ''OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Nonprocurement)''; and 2 CFR part 1125, ''Nonprocurement Debarment and Suspension,''; 32 CFR part 26, subpart B, ''Requirements for Recipients Other Than Individuals''; 32 CFR part 26, ''Government wide Requirements for Drug-Free Workplace (Financial Assistance)''; 32 CFR part 32, ''Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations''; 32 CFR part 34, ''Administrative Requirements for Grants and Agreements with For-Profit Organizations''; OMB Circular A–21, ''Cost Principles for Educational Institutions''; OMB Circular A–122, ''Cost Principles for Non-Profit Organizations''; 32 CFR part 28, ''New Restrictions on Lobbying''; 2 CFR part 25, ''Universal Identifier and Central Contractor Registration'' (now found in the System for Award Management (SAM) at *www.sam.gov*).

3. Reporting—OEA requires interim performance reports and one final performance report for each award. The performance reports will contain information on the following:

- A comparison of actual accomplishments to the objectives established for the reporting period;
- Reasons for slippage if established objectives were not met;
- Additional pertinent information when appropriate;
- A comparison of actual and projected expenditures for the period; and
- The amount of awarded funds on hand at the beginning and end of the reporting period.

The final performance report must contain a summary of activities for the entire award period. All remaining required deliverables should be submitted with the final performance report. The final SF 269A, ''Financial Status Report,'' must be submitted to OEA within ninety (90) days after the end date of the award. Any funds actually advanced and not needed for award purposes shall be returned immediately to OEA.

OEA will provide a schedule for reporting periods and report due dates in the Award Agreement.

VII. Agency Contacts

For further information, to answer questions, or for help with problems, contact:

Nia Hope, Office of Economic Adjustment, 2231 Crystal Drive Suite 520, Arlington, VA 22202. O: (571) 213–6791.

Email: *nia.hope@wso.whs.mil*.

VIII. Other Information

The Office of Economic Adjustment Internet address is *http://www.oea.gov*.

Dated: July 9, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–16880 Filed 7–12–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

[Docket No.: ED–2013–ICCD–0064]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Guaranty Agency Financial Report

AGENCY: Federal Student Aid (FSA), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing an extension of a previously approved information collection.

DATES: Interested persons are invited to submit comments on or before August 14, 2013.

ADDRESSES: Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting Docket ID number ED–2013–ICCD–0064, or via postal mail, commercial delivery, or hand delivery. Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: Electronically mail *ICDocketMgr@ed.gov*. Please do not send comments here.

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: Guaranty Agency Financial Report.

OMB Control Number: 1845–0026.

Type of Review: Extension without change of an existing collection of information.

Respondents/Affected Public: State, Local, or Tribal Governments.

Total Estimated Number of Annual Responses: 744.

Total Estimated Number of Annual Burden Hours: 40,920.

Abstract: The Guaranty Agency Financial Report (GAFR), ED Form 2000, is used by the thirty-one (31) guaranty agencies under the Federal Family Education Loan (FFEL) program, authorized by Title IV, Part B of the Higher Education Act of 1965, as amended. Guaranty agencies use the Guaranty Agency Financial Report to: (1) Request reinsurance from the Department of Education; (2) request payment on death, disability, closed school, and false certification claims paid to lenders; (3) remit refunds to the Department for rehabilitated loans and consolidation loans; (4) remit to the Department default and wage garnishment collections. The Department of Education also uses report data to monitor the guaranty agency's financial activities (agency federal fund and agency operating fund) and each agency's federal receivable balance.

Dated: July 9, 2013.

Stephanie Valentine,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2013–16800 Filed 7–12–13; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No.: ED–2013–ICCD–0051]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; FFEL/Direct Loan/Perkins Military Service Deferment/Post-Active Duty Student Deferment Request

AGENCY: Federal Student Aid (FSA), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing an extension of a previously approved information collection.

DATES: Interested persons are invited to submit comments on or before August 14, 2013.

ADDRESSES: Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting Docket ID number ED–2013–ICCD–0051, or via postal mail, commercial delivery, or hand delivery. Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: Electronically mail *ICDocketMgr@ed.gov.* Please do not send comments here.

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: FFEL/Direct Loan/Perkins Military Service Deferment/Post-Active Duty Student Deferment Request.

OMB Control Number: 1845–0080.

Type of Review: Extension without change of an existing collection of information.

Respondents/Affected Public: Individuals or Households.

Total Estimated Number of Annual Responses: 16,000.

Total Estimated Number of Annual Burden Hours: 8,000.

Abstract: The Military Service/Post-Active Duty Student Deferment request form serves as the means by which a Federal Family Education Loan (FFEL), Perkins, or Direct Loan borrower requests a military service deferment and/or post-active duty student deferment and provides his or her loan holder with the information needed to determine whether the borrower meets the applicable deferment eligibility requirements. The form also serves as the means by which the U.S. Department of Education identifies Direct Loan borrowers who qualify for the Direct Loan Program's no accrual of interest benefit for active duty service members.

Dated: July 9, 2013.

Stephanie Valentine,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2013–16796 Filed 7–12–13; 8:45 a.m.]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

National Assessment Governing Board; Meeting

AGENCY: National Assessment Governing Board, ED.

ACTION: Notice of open and closed meeting sessions.

SUMMARY: This notice sets forth the schedule and proposed agenda for the upcoming meeting of the National Assessment Governing Board (Board) and also describes the specific functions of the Board. Notice of this meeting is required under Section 10(a)(2) of the Federal Advisory Committee Act. This notice is issued to provide members of the general public with an opportunity to attend and/or provide comments. Individuals who will need special accommodations in order to attend the meeting (e.g. interpreting services, assistive listening devices, materials in alternative format) should notify Munira Mwalimu at 202–357–6938 or at *Munira.Mwalimu@ed.gov* no later than July 26, 2013. We will attempt to meet requests after this date but cannot guarantee availability of the requested accommodation. The meeting site is accessible to individuals with disabilities.

DATES: August 1–August 3, 2013.

Times

August 1: Committee Meetings

Assessment Development Committee: Closed Session: 8:00 a.m.–1:45 p.m.

Ad Hoc Committee on NAEP Background Information: 2:00 p.m.–4:00 p.m.

Executive Committee: Open Session: 4:30 p.m.–5:15 p.m.; Closed Session: 5:15 p.m.–6:30 p.m.

August 2: Full Board and Committee Meetings

Full Board: Open Session: 8:30 a.m.–9:45 a.m.; Closed Session: 12:45 p.m.–1:45 p.m.; Open Session: 2:00 p.m.–5:00 p.m.

Committee Meetings:

Reporting and Dissemination Committee (R&D): Open Session: 10:00 a.m.–12:30 p.m.

Assessment Development Committee (ADC): Closed Session: 10:00 a.m.–12:30 p.m.

Committee on Standards, Design and Methodology (COSDAM): Open Session: 10:00 a.m.–11:20 a.m.; Closed Session: 11:20 a.m.–12:25 p.m.; Open session: 12:25 p.m.–12:30 p.m.

August 3: Full Board and Committee Meetings

Nominations Committee: Closed Session: 7:30 a.m.–8:15 a.m.

Full Board: Open Session: 8:30 a.m.–12:00 p.m.

Location: Royal Sonesta Harbor Court, 550 Light Street, Baltimore, MD 21202.

FOR FURTHER INFORMATION CONTACT: Munira Mwalimu, Executive Officer, National Assessment Governing Board, 800 North Capitol Street NW., Suite 825, Washington, DC, 20002–4233, Telephone: (202) 357–6938.

SUPPLEMENTARY INFORMATION: The National Assessment Governing Board (Board) is established under section 412 of the National Education Statistics Act of 1994, as amended.

The Board is established to formulate policy guidelines for the National Assessment of Educational Progress (NAEP). The Board's responsibilities include the following: selecting subject areas to be assessed, developing assessment frameworks and specifications, developing appropriate student achievement levels for each grade and subject tested, developing standards and procedures for interstate and national comparisons, developing guidelines for reporting and disseminating results, and releasing initial NAEP results to the public.

On August 1, 2013, the Assessment Development Committee (ADC) will meet in closed session from 8:00 a.m. to 1:45 p.m. to review secure NAEP test materials in three areas: (1) Science Interactive Computer Tasks (ICTs) at grades 4, 8, and 12 for the 2014 pilot test, in preparation for the 2015 NAEP Science assessment; (2) Science Hands-on Tasks (HOTs) at grades 4, 8, and 12 for the 2014 pilot test, in preparation for the 2015 NAEP Science assessment; and (3) Computer-based tasks and items at grade 8 for the 2014 Technology and Engineering Literacy (TEL) assessment. The review of these materials must be conducted in closed session because the ADC members will be provided with secure items and materials which are not yet available for release to the general public. Premature disclosure of the secure test items and materials would compromise the integrity and substantially impede implementation of the secure NAEP assessments and is therefore protected by exemption 9(B) of section 552b(c) of Title 5 of the United States Code.

On August 1, 2013, the Ad Hoc Committee on NAEP Background Information will meet in open session from 2:00 p.m. to 4:00 p.m. Thereafter, the Executive Committee will convene in open session from 4:30 p.m. to 5:15 p.m. and in closed session from 5:15 p.m. to 6:30 p.m. During the closed session, the Executive Committee will receive and discuss costs for specific activities under individual and collective current contracts, and independent government cost estimates from the National Center for Education Statistics (NCES) staff on various options for proposed item development, data collection, scoring and analysis, and reporting of the National Assessment of Educational Progress (NAEP) for 2013–2017, and the implications of the cost estimates and the available funds on future NAEP activities. The costs of specific activities budgeted under current contracts would disclose financial information that is proprietary, protected under Section 552b(c) (4) of Title 5 U.S.C. The discussion of independent government cost estimates for the NAEP 2013–2017 contracts is necessary for ensuring that NAEP contracts meet congressionally mandated goals and adhere to Board policies on NAEP assessments available at *www.nagb.org/policies.html.* This part of the meeting must be conducted in closed session because public disclosure of this information would likely have an adverse financial effect on the NAEP program by providing contractors attending an unfair advantage in procurement and contract negotiations for NAEP. Discussion of this information would be likely to significantly impede implementation of a proposed agency action if conducted in open session. Such matters are protected by exemption 9(B) of section 552b of Title 5 U.S.C.

On August 2, 2013, the full Board will meet in open session from 8:30 a.m. to 9:45 a.m., followed by a closed session from 12:45 p.m. to 1:45 p.m., and in open session from 2:00 p.m. to 5:00 p.m.

On August 2, 2013, from 8:30 a.m. to 9:45 a.m., the Board will review and approve the August 2–3, 2013 Board meeting agenda and meeting minutes from the May 17–18, 2013 Quarterly Board meeting. Thereafter, the Chairman will open the meeting and introduce the Maryland State Superintendent Lillian Lowery who will then provide welcome remarks and address the Governing Board. Following her remarks, Governing Board Member and Former CEO of Baltimore City Public Schools Andres Alonso will welcome the Board and provide welcome remarks.

This session will be followed by a report from the Executive Director of the Governing Board, and updates from the Commissioner of the National Center for Education Statistics (NCES) and the Director of the Institute of Education Sciences (IES). Thereafter, the Board will recess for Committee meetings from 10:00 a.m. to 12:30 p.m. The Reporting and Dissemination Committee will meet in open session from 10:00 a.m. to 12:30 p.m.

The Assessment Development Committee (ADC) will meet in closed session from 10:00 a.m. to 12:30 p.m. to continue its review of secure NAEP test materials in three areas: (1) Science Interactive Computer Tasks (ICTs) at grades 4, 8, and 12 for the 2014 pilot test, in preparation for the 2015 NAEP Science assessment; (2) Science Hands-on Tasks (HOTs) at grades 4, 8, and 12 for the 2014 pilot test, in preparation for the 2015 NAEP Science assessment; and (3) Computer-based tasks and items at grade 8 for the 2014 Technology and Engineering Literacy (TEL) assessment. The review of these materials must be conducted in closed session because the ADC members will be provided with secure items and materials which are not yet available for release to the general public. Premature disclosure of the secure test items and materials would compromise the integrity and substantially impede implementation of the secure NAEP assessments and is therefore protected by exemption 9(B) of section 552b(c) of Title 5 of the United States Code.

Following this review, the Committee will also receive an update on the TEL 2013 pilot test at grade 8 with preliminary data analyses and secure items shared at the session, followed by an update on reporting information from the 2012 grade 4 computer-based Writing pilot. This presentation will

include a demonstration of a Web site to convey the results, which have not yet been released to the public. Premature disclosure of the secure test items and materials that have not yet been released to the public would compromise the integrity and substantially impede implementation of the secure NAEP assessments and is therefore protected by exemption 9(B) of section 552b(c) of Title 5 of the United States Code.

The Committee on Standards, Design and Methodology (COSDAM) will meet in open session from 10:00 a.m. to 11:20 a.m., in closed session from 11:20 a.m. to 12:25 p.m., and thereafter in open session from 12:25 p.m. to 12:30 p.m. During the closed session, COSDAM members will receive a briefing on statistical analyses of results from the NAEP Technology and Engineering Literacy (TEL) pilot assessment. These data have not yet been released and therefore cannot be disclosed to the general public at this time. Premature disclosure of these secure data would significantly impede implementation of the NAEP program, and is therefore protected by exemption 9(B) of section 552b(c) of Title 5 U.S.C. From 12:25 p.m. to 12:30 p.m. in open session, COSDAM will identify future agenda items for discussion.

Following the Committee sessions, the full Board will meet in closed session from 12:45 p.m. to 1:45 p.m. to receive a briefing on the NAEP 2013 Reading and Mathematics results for Grades 4 and 8. The Board will receive an embargoed briefing on preliminary results which will include secure test items, embargoed assessment data, and results that cannot be discussed in an open meeting prior to their official approval and release. Premature disclosure of these results would significantly impede implementation of the NAEP assessment program, and is therefore protected by exemption 9(B) of section 552b(c) of Title 5 United States Code.

After this closed session briefing, the Board will meet in open session from 2:00 p.m. to 5:00 p.m. From 2:00 p.m.–2:45 p.m. the Board will receive a report of the Ad Hoc Committee on NAEP Background Information. From 2:45 p.m. to 3:45 p.m., the Board will receive a briefing and have discussions on the Common Core State Assessment Consortia. From 4:00 p.m. to 5:00 p.m., the Board will have policy discussions on Interpreting NAEP Results Using Preparedness Research Findings available at *http://www.nagb.gov/what-we-do/preparedness-research.html.* The August 2, 2013 Board meeting is scheduled to adjourn at 5:00 p.m.

On August 3, 2013, the Nominations Committee will meet in closed session from 7:30 a.m. to 8:15 a.m. to discuss the status of potential candidates for Board terms beginning October 1, 2013, followed by discussions on the 2014 nominations cycle. The Committee's discussions on Board nominations pertain solely to internal personnel rules and practices of an agency and information of a personal nature where disclosure would constitute an unwarranted invasion of personal privacy. As such, the discussions are protected by exemptions 2 and 6 of section 552b(c) of Title 5 of the United States Code.

On August 3, 2013, from 8:30 a.m. to 9:30 a.m. the full Board will receive a briefing on how NAEP survey questions are developed and used. Following these discussions, from 9:30 a.m. to 10:30 a.m., the Board will discuss topics related to future initiatives and the draft policy statement on the conduct and reporting of NAEP. The Board is scheduled to receive reports from the standing Committees and take action on Committee recommendations from 10:45 a.m. to 12:00 p.m. The August 3, 2013 meeting is scheduled to adjourn at 12:00 p.m.

A verbatim transcript of the meeting, consistent with the policy of section 5 U.S.C. 552b(c) will be available to the public within 14 days of the meeting. Records are kept of all Board proceedings and are available for public inspection at the U.S. Department of Education, National Assessment Governing Board, Suite #825, 800 North Capitol Street NW., Washington, DC, from 9:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.

Electronic Access to This Document: You may view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister/index.html.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free at 1–866–512–1800; or in the Washington, DC, area at (202) 512–0000. Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *www.gpoaccess.gov/nara/index.html.*

Dated: July 9, 2013.

Cornelia S. Orr,

Deputy Executive Director, National Assessment Governing Board (NAGB), U.S. Department of Education.

[FR Doc. 2013–16795 Filed 7–12–13; 11:15 am]

BILLING CODE 4000–01–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:

Filings Instituting Proceedings

Docket Numbers: RP13–1044–000.
Applicants: Algonquin Gas Transmission, LLC.
Description: Correct Typographical Error in Exhibit B to AFT–CL Service Agreement to be effective 8/1/2013.
Filed Date: 7/3/13.
Accession Number: 20130703–5041.
Comments Due: 5 p.m. e.t. 7/15/13.

Docket Numbers: RP13–1045–000.
Applicants: Gulf South Pipeline Company, LP.
Description: Amendment to Neg Rate Agmt (FPL 40097–4) to be effective 7/2/2013.
Filed Date: 7/3/13.
Accession Number: 20130703–5068.
Comments Due: 5 p.m. e.t. 7/15/13.

Docket Numbers: RP13–1046–000.
Applicants: Dominion Transmission, Inc.
Description: DTI—July 3, 2013 Nonconforming Service Agreement to be effective 8/1/2013.
Filed Date: 7/3/13.
Accession Number: 20130703–5131.
Comments Due: 5 p.m. e.t. 7/15/13.

Docket Numbers: RP13–1047–000.
Applicants: Northwest Pipeline LLC.
Description: NWP Name Change Filing to be effective 7/12/2013.
Filed Date: 7/3/13.
Accession Number: 20130703–5133.
Comments Due: 5 p.m. e.t. 7/15/13.

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.

Filings in Existing Proceedings

Docket Numbers: RP12–15–006.
Applicants: Gas Transmission Northwest LLC.

Description: Compliance to RP12–15–004 to be effective 11/11/2011.

Filed Date: 7/3/13.

Accession Number: 20130703–5132.

Comments Due: 5 p.m. e.t. 7/15/13.

Docket Numbers: RP13–940–001.

Applicants: Elba Express Company, L.L.C.

Description: Net Monthly Imbalance Clarification Compliance Filing to be effective 7/1/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5040.

Comments Due: 5 p.m. e.t. 7/15/13.

Any person desiring to protest in any of the above proceedings must file in accordance with Rule 211 of the Commission's Regulations (18 CFR 385.211) on or before 5:00 p.m. Eastern time on the specified comment date.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

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: July 5, 2013.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–16835 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #2

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER12–2178–001; ER12–2178–004; ER12–2178–005; ER12–2178–006; ER10–2172–012; ER10–2172–014; ER10–2172–016; ER10–2172–017; ER12–2311–003; ER12–2311–004; ER12–2311–005; ER12–2311–006; ER11–2016–007; ER11–2016–010; ER11–2016–011; ER11–2016–012; ER10–2184–012; ER10–2184–015; ER10–2184–017; ER10–2184–016; ER10–2183–009; ER10–2183–012; ER10–2183–013; ER10–2183–014; ER10–1048–009; ER10–1048–012; ER10–1048–013; ER10–1048–014; ER10–2176–013; ER10–2176–016; ER10–2176–017; ER10–2176–018; ER10–2192–012; ER10–2192–015; ER10–2192–016; ER10–2192–017; ER11–2056–006; ER11–2056–009; ER11–2056–010; ER11–2056–011; ER10–2178–012; ER10–2178–015; ER10–2179–016; ER10–2178–017; ER10–2174–012; ER10–2174–015; ER10–2174–016; ER10–2174–017; ER11–2014–009; ER11–2014–012; ER11–2014–013; ER11–2014–014; ER11–2013–009; ER11–2013–012; ER11–2013–013; ER11–2013–014; ER10–3308–011; ER10–3308–014; ER10–3308–015; ER10–3308–016; ER10–1017–008; ER10–1020–008; ER10–1020–011; ER10–1020–012; ER10–1020–013; ER10–1145–008; ER10–1145–011; ER10–1145–012; ER10–1145–013; ER10–1144–007; ER10–1144–010; ER10–1144–011; ER10–1144–012; ER10–1078–008; ER10–1078–011; ER10–1078–012; ER10–1078–013; ER10–1079–008; ER10–1080–008; ER10–1080–011; ER10–1080–012; ER10–1080–013; ER11–2010–009; ER11–2010–012; ER11–2010–013; ER11–2010–014; ER10–1081–008; ER10–1081–011; ER10–1081–012; ER10–1081–013; ER10–2180–015; ER10–2180–016; ER10–2180–017; ER11–2011–007; ER11–2011–011; ER11–2011–012; ER11–2011–013; ER12–2201–002; ER12–2201–004; ER12–2201–005; ER12–2201–006; ER12–2528–003; ER12–2528–004; ER12–2528–005; ER11–2009–008; ER11–2009–011; ER11–2009–012; ER11–2009–013; ER11–3989–007; ER11–3989–009; ER11–3989–010; ER11–3989–011; ER10–1143–008; ER10–1143–011; ER10–1143–012; ER10–1143–013; ER11–2780–006; ER11–2780–009; ER11–2780–010; ER11–2780–013; ER12–1829–004; ER12–1829–005; ER12–1829–006; ER11–2007–007; ER11–2007–010; ER11–2007–011; ER11–2007–012; ER12–1223–006; ER12–1223–009; ER12–1223–010; ER12–1223–011; ER11–2005–009; ER11–2005–012; ER11–2005–013; ER11–2005–014; ER10–2179–014; ER10–2179–016; ER10–2179–017; ER10–2179–018; ER10–2181–014; ER10–2181–016; ER10–2181–017; ER10–2181–018; ER10–2182–014; ER10–2182–016; ER10–2182–017; ER10–2182–018.

Applicants: Wind Capital Holdings, LLC, Wildcat Wind, LLC, Tuana Springs Energy, LLC, Shooting Star Wind Project, LLC, Safe Harbor Water Power Corporation, PECO Energy Company, Michigan Wind 1, LLC, Michigan Wind 2, LLC, Harvest II Wind Farm, LLC, Harvest WindFarm, LLC, Handsome Lake Energy, LLC, Exelon Wyman, LLC, Exelon Wind 4, LLC, Exelon West Medway, LLC, Exelon New Boston, LLC, Exelon Generation Company, LLC, Exelon Generation Company, LLC, Exelon Framingham, LLC, Exelon Energy Company, Criterion Power Partners, LLC, CR Clearing, LLC, Cow Branch Wind Power, L.L.C., Constellation Power Source Generation Inc., Constellation NewEnergy, Inc., Constellation Mystic Power, LLC, Constellation Energy Commodities Group Maine, LLC, Commonwealth Edison Company, CER Generation II, LLC, CER Generation, LLC, Cassia Gulch Wind Park, LLC, Beebe Renewable Energy, LLC, Baltimore Gas and Electric Company, AV Solar Ranch 1, LLC, R.E. Ginna Nuclear Power Plant, LLC, Baltimore Gas and Electric Company, High Mesa Energy, LLC, Tuana Springs Energy, LLC, Calvert Cliffs Nuclear Power Plant, LLC, Nine Mine Point Nuclear Station, LLC.

Description: Revised Appendix B to October 12, 2012, January 31, March 8 and April 26, 2013 Change in Status Filings of Exelon Entities.

Filed Date: 7/3/13.

Accession Number: 20130703–5188.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1901–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: 07–08–2013 SA 2477 Corn Belt-MidAm GFA 477 to be effective 7/9/2013.

Filed Date: 7/8/13.

Accession Number: 20130708–5017.

Comments Due: 5 p.m. e.t. 7/29/13.

Docket Numbers: ER13–1902–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: 07–08–2013 SA 2527 ITC-Consumers GIA (J161) to be effective 7/9/2013.

Filed Date: 7/8/13.

Accession Number: 20130708–5018.

Comments Due: 5 p.m. e.t. 7/29/13.

Docket Numbers: ER13–1903–000.

Applicants: MET New York Trading LLC.

Description: Application for Market-Based Rate Authority to be effective 9/3/2013.

Filed Date: 7/8/13.

Accession Number: 20130708–5064.

Comments Due: 5 p.m. e.t. 7/29/13.

Docket Numbers: ER13–1904–000.

Applicants: MET West Trading LLC.

Description: Application for Market-Based Rate Authority to be effective 9/3/2013.

Filed Date: 7/8/13.

Accession Number: 20130708–5070.

Comments Due: 5 p.m. e.t. 7/29/13.

Docket Numbers: ER13–1905–000.

Applicants: New York Independent System Operator, Inc.

Description: New York Independent System Operator, Inc. submits NYISO Joint Amended Restated LGIA No. 1774

Among NYISO, NYPA, and Marble River to be effective 6/19/2013.

Filed Date: 7/8/13.

Accession Number: 20130708–5086.

Comments Due: 5 p.m. e.t. 7/29/13.

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: July 8, 2013.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–16834 Filed 7–12–13; 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 electric rate filings:

Docket Numbers: ER13–1895–001.

Applicants: Midcontinent Independent System Operator, Inc.

Description: 07–04–2013 CFTC Amendment Filing to be effective 9/2/2013.

Filed Date: 7/5/13.

Accession Number: 20130705–5000.

Comments Due: 5 p.m. e.t. 7/26/13.

Docket Numbers: ER13–1891–000.

Applicants: Twin Buttes Wind LLC, Pacific Wind Development, LLC, Colorado Green Holdings LLC.

Description: Feeder Line Ownership Agreement to be effective 7/4/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5109.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1892–000.

Applicants: Pacific Wind Development, LLC.

Description: Feeder Line Ownership Agreement to be effective 7/4/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5112.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1893–000.

Applicants: Twin Buttes Wind LLC.

Description: Feeder Line Ownership Agreement to be effective 7/4/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5113.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1894–000.

Applicants: Southern California Edison Company.

Description: Amended Serv Agmt with San Gorgonio Farms for Devers-Mirage Project to be effective 6/1/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5125.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1895–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: 07–03–2013 CFTC Filing to be effective 9/2/2013.

Filed Date: 7/3/13.

Accession Number: 20130703–5143.

Comments Due: 5 p.m. e.t. 7/24/13.

Docket Numbers: ER13–1896–000.

Applicants: AEP Generation Resources Inc.

Description: Application of AEP Generation Resources Inc. for Market-Based Rate Authority to be effective 1/1/2014.

Filed Date: 7/5/13.

Accession Number: 20130705–5033.

Comments Due: 5 p.m. e.t. 7/26/13.

Docket Numbers: ER13–1897–000.

Applicants: SWG Arapahoe, LLC.

Description: Notice of Succession to be effective 7/6/2013.

Filed Date: 7/5/13.

Accession Number: 20130705–5038.

Comments Due: 5 p.m. e.t. 7/26/13.

Docket Numbers: ER13–1898–000.

Applicants: ITC Midwest LLC.

Description: Filing of Joint Use Pole Agreement with Grundy County to be effective 9/4/2013.

Filed Date: 7/5/13.

Accession Number: 20130705–5042.

Comments Due: 5 p.m. e.t. 7/26/13.

Docket Numbers: ER13–1899–000.

Applicants: Southern California Edison Company.

Description: IFA and Distribution Service Agreement with Dillon Wind to be effective 6/1/2013.

Filed Date: 7/5/13.

Accession Number: 20130705–5065.

Comments Due: 5 p.m. e.t. 7/26/13.

Docket Numbers: ER13–1900–000.

Applicants: Southern California Edison Company.

Description: IFA and Distribution Service Agreement with Wildflower Energy to be effective 6/1/2013.

Filed Date: 7/5/13.

Accession Number: 20130705–5075.

Comments Due: 5 p.m. e.t. 7/26/13.

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.

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Dated: July 8, 2013.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–16833 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR13–26–000]

Notice of Complaint; Chevron Products Company v. Enterprise TE Products Pipeline Company, LLC

Take notice that on July 3, 2013, pursuant to sections 13(1), 15(1) and 16(1) of the Interstate Commerce Act (ICA), 49 USC app. 8, 13(1), 15(1), and 16(1), Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission (Commission), 18 CFR 385.206, and Rules 343.1(a) and 343.2(c) of the Commission's Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.1(a) and 343.2(c), Chevron Products Company (Complainant) filed a formal complaint against Enterprise TE Products Pipeline Company, LLC (Respondent) challenging the lawfulness of the Respondent's FERC Tariff No. 55.28.0. Specifically, the Complainant alleges that Tariff 55.28.0, in providing that Respondent will no longer accept nominations for the transportation of distillates, violates the Settlement Agreement signed by the Respondent in

Docket No. IS12–203–000 and approved by the Commission on May 31, 2013.[1]

The Complainant certifies that copies of the complaint were served on the persons listed as the Issuer and Compiler of the Respondent's Tariff No. 55.28.0.

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. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

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 review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site 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 July 15, 2013.

Dated: July 5, 2013.

Kimberly D. Bose,

Secretary.

[FR Doc. 2013–16804 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

[1] *Enterprise TE Products Pipeline Company LLC,* 143 FERC ¶ 61,197 (2013).

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP13–477–000]

Columbia Gas Transmission, LLC; Notice of Intent to Prepare an Environmental Assessment and Request for Comments on Environmental Issues for the Proposed Smithfield III Expansion Project

The staff of the Federal Energy Regulatory Commission (FERC or Commission) will prepare an environmental assessment (EA) that will discuss the environmental impacts of the Smithfield III Expansion Project (Project) involving construction and operation of aboveground facilities by Columbia Gas Transmission, LLC (Columbia) in Greene and Washington Counties, Pennsylvania; and Monongalia, Wetzel, Gilmer, Roane, and Kanawha Counties, West Virginia. The Commission will use this EA in its decision-making process to determine whether the project is in the public convenience and necessity.

This notice announces the opening of the scoping process the Commission will use to gather input from the public and interested agencies on the project. Your input will help the Commission staff determine what issues they need to evaluate in the EA. Please note that the scoping period will close on August 7, 2013.

Comments on the Project may be submitted in written form or electronically, as described in the Public Participation section of this notice. This notice is being sent to the Commission's current environmental mailing for this Project. State and local government representatives are asked to notify their constituents of this proposed Project and encourage them to comment on their areas of concern.

If you are a landowner receiving this notice, a pipeline company representative may contact you about the acquisition of an easement to construct, operate, and maintain the proposed facilities. The company would seek to negotiate a mutually acceptable agreement. However, if the Commission approves the project, that approval conveys with it the right of eminent domain. Therefore, if easement negotiations fail to produce an agreement, the pipeline company could initiate condemnation proceedings where compensation would be determined in accordance with state law.

Columbia provided landowners with a fact sheet prepared by the FERC entitled ''An Interstate Natural Gas Facility On My Land? What Do I Need To Know?''. This fact sheet addresses a number of typically-asked questions, including the use of eminent domain and how to participate in the Commission's proceedings. It is also available for viewing on the FERC Web site (*www.ferc.gov*).

Summary of the Proposed Project

Columbia states that the Project would increase its transportation capacity by 444 MDth per day.

The Project would consist of the following facilities:

- New compressor station (Redd Farm Compressor Station) on Columbia's existing Line 1570 in Washington County, PA.
- Modifications at the Hero-Jollytown Valve Setting which would involve a new regulation setting;
- Modifications to the Smithfield Compressor Station consisting of upgrades to the existing reciprocating engine/compressor building ventilation systems, existing gas coolers, and installation of new gas coolers;
- Modifications to the Glenville Compressor Station by installing two gas-fired turbines, each rated at 7,800 horsepower (HP), and other auxiliary equipment; and
- Modifications at the Pigeon Valve Setting by removing and replacing the crossover piping and valve to enable gas to flow south.

The general location of the Project facilities is shown in Appendix 1.[1]

Land Requirements for Construction

Construction of the proposed facilities would disturb about 17.6 acres of land including the temporary workspace areas for all aboveground facility sites. With the exception of the construction of the Redd Farm compressor Station, Columbia would utilize areas within the fenced boundaries of the existing facilities for materials staging and construction activities, or previously cleared land immediately adjacent to these facilities.

The EA Process

The National Environmental Policy Act (NEPA) requires the Commission to take into account the environmental impacts that could result from an action

[1] The appendices referenced in this notice will not appear in the **Federal Register**. Copies of appendices were sent to all those receiving this notice in the mail and are available at *www.ferc.gov* using the link called ''eLibrary'' or from the Commission's Public Reference Room, 888 First Street NE., Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary, refer to the last page of this notice.

whenever it considers the issuance of a Certificate of Public Convenience and Necessity. NEPA also requires us [2] to discover and address concerns the public may have about proposals. This process is referred to as ''scoping.'' The main goal of the scoping process is to focus the analysis in the EA on the important environmental issues. By this notice, the Commission requests public comments on the scope of the issues to address in the EA. We will consider all filed comments during the preparation of the EA.

In the EA we will discuss impacts that could occur as a result of the construction and operation of the proposed project under these general headings:

- Geology and soils;
- Land use;
- Water resources, fisheries, and wetlands;
- Cultural resources;
- Vegetation and wildlife;
- Air quality and noise;
- Endangered and threatened species;
- Cumulative impacts; and
- Public safety.

We will also evaluate reasonable alternatives to the proposed Project or portions of the Project, and make recommendations on how to lessen or avoid impacts on the various resource areas.

The EA will present our independent analysis of the issues. The EA will be available in the public record through eLibrary. Depending on the comments received during the scoping process, we may also publish and distribute the EA to the public for an allotted comment period. We will consider all comments on the EA before making our recommendation to the Commission. To ensure your comments are considered, please carefully follow the instructions in the Public Participation section beginning on page 4.

With this notice, we are asking agencies with jurisdiction by law and/or special expertise with respect to the environmental issues of this project to formally cooperate with us in the preparation of the EA.[3] Agencies that would like to request cooperating agency status should follow the instructions for filing comments provided under the Public Participation section of this notice.

Consultations Under Section 106 of the National Historic Preservation Act

In accordance with the Advisory Council on Historic Preservation's implementing regulations for section 106 of the National Historic Preservation Act, we are using this notice to initiate consultation with applicable State Historic Preservation Office (SHPO), and to solicit their views and those of other government agencies, interested Indian tribes, and the public on the Project's potential effects on historic properties.[4] We will define the project-specific Area of Potential Effects (APE) in consultation with the SHPO as the project develops. On natural gas facility projects, the APE at a minimum encompasses all areas subject to ground disturbance (examples include construction right-of-way, contractor/pipe storage yards, compressor stations, and access roads). Our EA for this Project will document our findings on the impacts on historic properties and summarize the status of consultations under section 106.

Public Participation

You can make a difference by providing us with your specific comments or concerns about the Project. Your comments should focus on the potential environmental effects, reasonable alternatives, and measures to avoid or lessen environmental impacts. The more specific your comments, the more useful they will be. To ensure that your comments are timely and properly recorded, please send your comments so that the Commission receives them in Washington, DC on or before August 7, 2013.

For your convenience, there are three methods which you can use to submit your comments to the Commission. In all instances please reference the project docket number (CP13–477–000) with your submission. The Commission encourages electronic filing of comments and has expert staff available to assist you at (202) 502–8258 or *efiling@ferc.gov.*

(1) You can file your comments electronically using the eComment feature on the Commission's Web site (*www.ferc.gov*) under the link to Documents and Filings. This is an easy method for interested persons to submit brief, text-only comments on a project;

(2) You can file your comments electronically using the eFiling feature on the Commission's Web site (*www.ferc.gov*) under the link to Documents and Filings. With eFiling, you can provide comments in a variety of formats by attaching them as a file with your submission. New eFiling users must first create an account by clicking on ''eRegister.'' You must select the type of filing you are making. If you are filing a comment on a particular project, please select ''Comment on a Filing''; or

(3) You can file a paper copy of your comments by mailing them to the following address: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street NE., Room 1A, Washington, DC 20426.

Environmental Mailing List

The environmental mailing list includes federal, state, and local government representatives and agencies; elected officials; environmental and public interest groups; Native American Tribes; other interested parties; and local libraries and newspapers. This list also includes all affected landowners (as defined in the Commission's regulations) who are potential right-of-way grantors, whose property may be used temporarily for project purposes, or who own homes within certain distances of aboveground facilities, and anyone who submits comments on the Project. We will update the environmental mailing list as the analysis proceeds to ensure that we send the information related to this environmental review to all individuals, organizations, and government entities interested in and/or potentially affected by the proposed project.

If the EA is published for distribution, copies will be sent to the environmental mailing list for public review and comment. If you would prefer to receive a paper copy of the document instead of the CD version or would like to remove your name from the mailing list, please return the attached Information Request (Appendix 2).

Becoming an Intervenor

In addition to involvement in the EA scoping process, you may want to become an ''intervenor'' which is an official party to the Commission's proceeding. Intervenors play a more formal role in the process and are able to file briefs, appear at hearings, and be heard by the courts if they choose to appeal the Commission's final ruling. An intervenor formally participates in the proceeding by filing a request to intervene. Instructions for becoming an intervenor are in the User's Guide under the ''e-filing'' link on the Commission's Web site.

[2] ''We,'' ''us,'' and ''our'' refer to the environmental staff of the Commission's Office of Energy Projects.

[3] The Council on Environmental Quality regulations addressing cooperating agency responsibilities are at Title 40, Code of Federal Regulations, § 1501.6.

[4] The Advisory Council on Historic Preservation's regulations are at Title 36, Code of Federal Regulations, Part 800. Those regulations define historic properties as any prehistoric or historic district, site, building, structure, or object included in or eligible for inclusion in the National Register of Historic Places.

Additional Information

Additional information about the project is available from the Commission's Office of External Affairs, at (866) 208–FERC, or on the FERC Web site at *www.ferc.gov* using the ''eLibrary'' link. Click on the eLibrary link, click on ''General Search'' and enter the docket number, excluding the last three digits in the Docket Number field (i.e., CP13–477). Be sure you have selected an appropriate date range. For assistance, please contact FERC Online Support at *FercOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659. The eLibrary link also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission now offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/esubscribenow.htm.*

Finally, public meetings or site visits will be posted on the Commission's calendar located at *www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Dated: July 9, 2013.

Kimberly D. Bose,

Secretary.

[FR Doc. 2013–16850 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RD13–3–000]

Before Commissioners: Jon Wellinghoff, Chairman; Philip D. Moeller, John R. Norris, Cheryl A. LaFleur, and Tony Clark; Order Approving Reliability Standard: North American Electric Reliability Corporation

1. On December 31, 2012, as amended on January 4, 2013, the North American Electric Reliability Corporation (NERC) submitted a petition for approval of Reliability Standard EOP–004–2—Event Reporting (Petition). Reliability Standard EOP–004–2 identifies types of reportable events and thresholds for reporting, requires responsible entities to have an operating plan for reporting applicable events to NERC and other entities (including law enforcement), and requires reporting of threshold events within a 24 hour period. NERC requests that Reliability Standard EOP–004–2 become effective the first day of the first calendar quarter beginning six months following the effective date of a final order in this proceeding, and that it replace currently-effective Reliability Standards EOP–004–1—Disturbance Reporting and CIP–001–2a—Sabotage Reporting.

2. As explained below, pursuant to section 215(d) of the Federal Power Act (FPA),[1] we approve Reliability Standard EOP–004–2, and find that it is just, reasonable, not unduly discriminatory or preferential, and in the public interest. We further approve NERC's requested effective date for EOP–004–2, along with the retirement of existing Reliability Standards EOP–004–1 and CIP–001–2a.

I. Background

3. The Commission certified NERC as the Electric Reliability Organization (ERO), as defined in section 215 of the FPA, in July 2006.[2] In Order No. 693, the Commission reviewed an initial set of Reliability Standards as developed and submitted for review by NERC, and approved 83 standards as mandatory and enforceable, including the currently-effective Disturbance Reporting Reliability Standard, EOP–004–1.[3]

4. In Order No. 693, the Commission also approved Reliability Standard CIP–001–1—Sabotage Reporting. In addition, the Commission directed that NERC develop certain modifications to the standard, to further define the term sabotage and provide guidance on triggering events, specify baseline requirements for recognizing sabotage events, incorporate periodic review of sabotage reporting procedures, and require that applicable entities contact appropriate governmental authorities within a specified time period.[4]

5. Project 2009–1—Disturbance and Sabotage Reporting was initiated in April 2009, by PJM Interconnection, LLC, as a request for revision to existing standard CIP–001–1.[5] The standard drafting team developed EOP–004–2, Event Reporting, as a means of combining the requirements of EOP–004–1 and CIP–001 into a single reporting standard.[6]

II. Proposed Reliability Standard EOP–004–2 and NERC's Petition

6. NERC explains in its Petition that currently-effective Reliability Standard EOP–004–1 contains the requirements for reporting and analyzing disturbances, while CIP–001–2a addresses sabotage reporting. NERC states that proposed Reliability Standard EOP–004–2 merges EOP–004–1 and CIP–001–2a, and represents a significant improvement in the identification and reporting of events.[7] According to NERC, proposed Reliability Standard EOP–004–2 provides a comprehensive approach to reporting disturbances and events that have the potential to impact the reliability of the bulk electric system in accordance with several Commission directives.[8]

7. As proposed, EOP–004–2 would require the following:

- Responsible entities must have an operating plan for reporting applicable events to NERC and others (e.g., Regional Entities, applicable reliability coordinators, and law enforcement), including procedures for reporting the specific events at thresholds identified in Attachment 1 (Requirement R1);
- Responsible entities must report events as defined in their operating plan ''within 24 hours of recognition of meeting an event type threshold for reporting,'' or by the end of the next business day if the event occurs on a weekend (Requirement R2); and
- Responsible entities must validate contact information contained in the operating plan on an annual basis (Requirement R3).

8. Reliability Standard EOP–004–2 includes two attachments. Attachment 1 (Reportable Events) identifies types of events and thresholds for reporting, such as damage or destruction of a facility, physical threats to facilities, firm load loss, and generation loss. Attachment 2 is a standardized form for event reporting. NERC notes that in an

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[1] 16 U.S.C. 824o(d) (2006).

[2] *North American Electric Reliability Corp.,* 116 FERC ¶ 61,062, *order on reh'g and compliance,* 117 FERC ¶ 61,126 (2006), *order on compliance,* 118 FERC ¶ 61,190, *order on reh'g* 119 FERC ¶ 61,046 (2007), *aff'd sub nom. Alcoa Inc.* v. *FERC,* 564 F.3d 1342 (D.C. Cir. 2009).

[3] *Mandatory Reliability Standards for the Bulk-Power System,* Order No. 693, FERC Stats. & Regs. ¶ 31,242 at P 617, *order on reh'g,* Order No. 693–A, 120 FERC ¶ 61,053 (2007).

[4] Order No. 693, FERC Stats. & Regs. ¶ 31,242 at P 471. The Commission subsequently approved an interpretation of CIP–001–1 (Letter Order issued on Feb. 2, 2011 in Docket No. RR10–11–000, accepting NERC's clarification regarding the ''appropriate parties'' to which reports of a sabotage event must be made), as well as a regional modification to CIP–001–1a (Letter Order issued on August 2, 2011 in Docket RD11–6–000, approving a regional variance for ERCOT to add transmission owners and generator owners as responsible entities). Thus, the currently-effective version of the sabotage reporting standard is CIP–001–2a.

[5] NERC Petition at 7.

[6] *Id.* at 8.

[7] *Id.* at 5.

[8] *Id.* at 3.

effort to minimize administrative burden, U.S. entities may elect to use DOE Form OE–417 (Emergency Incident and Disturbance Report), rather than Attachment 2, to report under EOP–004–2.[9]

9. NERC asserts that the results-based approach of EOP–004–2 includes clear criteria for reporting and consistent reporting timelines. NERC also explains that the proposed reporting requirements will ''allow governmental authorities and critical infrastructure members the opportunity to react in a meaningful manner'' to disturbance or other event information, thereby ''support[ing] reliability principles and ultimately help[ing] to protect against future malicious physical attacks.''[10]

10. NERC notes, however, that the revised Reliability Standard does not further define the term ''sabotage'' as directed in Order No. 693. NERC explains that the standard drafting team determined that such a definition could be ambiguous and ''inherently subjective.''[11] NERC explains that the standard drafting team elected instead to develop a specific list of reportable events and thresholds (Attachment 1 of the standard), as a means of meeting the Commission's directive to provide guidance on reportable events. NERC asserts that the development of a list of reportable events and thresholds is an equally effective and efficient means of addressing the Commission's directive in Order No. 693.[12]

III. Notice of Filing, Interventions and Comments

11. Notices of NERC's Petition and its errata were issued on January 2 and January 7, 2013, respectively, with comments, protests and motions to intervene due on or before February 4, 2013. American Municipal Power, Inc. (AMP) filed a timely motion to intervene, on January 30, 2013.

12. On March 7, 2013, seven Independent System Operators and Regional Transmission Organizations (Joint ISOs/RTOs) filed a joint motion to intervene out-of-time and comments on NERC's Petition.[13] In support of their request for leave to intervene out-of-time, Joint ISOs/RTOs maintain that they only learned that a Notice of Proposed Rulemaking would not issue in the docket after the January 30, 2013 close of the intervention and comment period. Joint ISOs/RTOs maintain that their late comments will not prejudice NERC because ISOs and RTOs raised similar comments during the standards development process, and that late intervention will not prejudice any other party or otherwise disrupt this proceeding as the Commission has not yet issued a dispositive order.

13. Joint ISOs/RTOs assert that event reporting does not provide for ''reliable operations'' and, therefore, should not be incorporated in mandatory Reliability Standards. Joint ISOs/RTOs contend that event reporting is ''an *ex post* activity'' that provides only prospective benefits to system reliability.[14] Joint ISOs/RTOs argue that the Commission should ''distinguish between an obligation that is a 'requirement . . . to provide for reliable operation of the bulk-power system,' as those terms are defined in Section 215, and those obligations that do not, such as administrative record-keeping and ex-post reporting tasks.''[15] Joint ISOs/RTOs further maintain that the event reporting requirements in EOP–004–2 are redundant to other federal regulations, and that they expose registered entities to unnecessary liability and burden.[16] Based on these arguments, Joint ISOs/RTOs take the position that the Commission should not only reject EOP–004–2, but should also consider retiring or otherwise revisiting the existing Reliability Standards governing disturbance and sabotage reporting (EOP–004–1 and CIP–001–2a).

14. Joint ISOs/RTOs argue, in the alternative, that if the Commission approves EOP–004–2, the Commission should direct certain modifications.[17] In particular, Joint ISOs/RTOs advocate (1) limiting reportable events ''to those that give third parties the opportunity to act to mitigate the impact of the event'' such as vandalism;[18] and (2) limiting the scope of entities to receive reports to those that can act to mitigate the actual event. Joint ISOs/RTOs further maintain that certain thresholds for reportable events in Attachment 1 should be modified to remove ambiguities. Joint ISOs/RTOs provide one example of such ambiguity, claiming that, while Attachment 1 requires reporting when ''[d]amage or destruction of a Facility . . . results in actions to avoid a BES emergency,'' reliability coordinators and balancing authorities take actions on a daily basis to ''avoid a BES Emergency'' without knowing whether the underlying system conditions resulted from damage or destruction to a facility. According to Joint ISOs/RTOs, the reliability coordinator or balancing authority will often not have the information to determine whether to submit a report. Finally, Joint ISOs/RTOs assert that a strict 24-hour reporting obligation is overly-stringent and provides no reliability benefit since registered entities would have separately mitigated the event.

IV. Discussion

A. Procedural Matters

15. Pursuant to Rule 214 of the Commission's Rules of Practice and Procedure, 18 CFR 385.214, the timely, unopposed motion to intervene filed by AMP serves to make it a party to this proceeding. Pursuant to Rule 214(d) of the Commission's Rules of Practice and Procedure, 18 CFR 385.214(d) (2012), we will also grant Joint ISOs/RTOs' late-filed motion to intervene given their interest in the proceeding, the early stage of the proceeding, and the absence of undue prejudice or delay.

B. Commission Determination

16. Pursuant to section 215(d) of the FPA, we approve Reliability Standard EOP–004–2 as just, reasonable, not unduly discriminatory or preferential, and in the public interest.[19] We also approve NERC's proposed implementation plan for the revised standard, including the retirement of existing Reliability Standards EOP–004–1 and CIP–001–2a when EOP–004–2 becomes effective. Finally, we approve the proposed violation risk factors and violation severity levels incorporated in Reliability Standard EOP–004–2.

17. We find that EOP–004–2 enhances the reliability of the Bulk-Power System by requiring timely reporting of specific system disturbance or sabotage events, allowing for both a real-time operational benefit for near-term mitigation of the event, as well as a prospective benefit through subsequent analysis and investigation, including dissemination of lessons learned from the event. We conclude that EOP–004–2 represents an improvement over the currently-

[9] *Id.* at 16.

[10] *Id.* at 4.

[11] *Id.* at 8–9.

[12] *Id.* at 9.

[13] Joint ISOs/RTOs are the California Independent System Operator Corporation; Electric Reliability Council of Texas, Inc.; Ontario's Independent Electricity System Operator; ISO New England Inc.; Midwest Independent Transmission System Operator, Inc.; New York Independent System Operator, Inc.; and Southwest Power Pool, Inc.

[14] Comments of Joint ISOs/RTOs at 6.

[15] *Id.* at 5 (quoting from FPA section 215).

[16] *See id.* at 7.

[17] *Id.* at 8–14. Joint ISOs/RTOs acknowledge that, ''[i]f the Commission disagrees with the Joint ISOs/RTOs' position that event reporting should not be included in the Reliability Standards . . ., proposed standard EOP–004–2 is an improvement over the two events reporting standards it would replace . . . .'' *Id.* at 8.

[18] *Id.* at 9.

[19] 16 U.S.C. 824o(d)(2).

effective Reliability Standards, CIP–001–2a and EOP–004–1, in that it provides a comprehensive approach to reporting disturbances and events that have the potential to impact the reliability of the Bulk-Power System and provides greater clarity concerning reportable events. Further, we find that NERC has adequately addressed the Commission's directives pertaining to event reporting, including requiring the periodic update of reporting procedures. With regard to the Order No. 693 directives that NERC further refine the definition of ''sabotage'' and provide guidance on events that trigger reporting,[20] we find that NERC's development of Attachment 1, which lists specific types of reportable events and thresholds for reporting, represents an equally efficient and effective approach to address our underlying concern.

18. In addition, we are not persuaded by Joint ISOs/RTOs' arguments in support of their request that we either reject or direct modification of the proposed standard.

19. First, we reject Joint ISOs/RTOs' argument that event reporting is not a proper subject for Reliability Standards because it is prospective in nature and is not directly related to or otherwise supportive of ''reliable operations'' as that term is used in FPA section 215. The prospective benefits from certain aspects of the reporting requirements are not only valuable, but also a sufficient basis for imposition of a mandatory and enforceable reliability requirement. Events reporting allows entities to gain an early understanding of the scope of an event, enabling requests for assistance from other entities within the industry with appropriate expertise and from other governmental agencies who otherwise might not know about the event. While assistance would not always be in real time, operational planning and system planning can benefit from outside expertise to support planning for physical and cyber security, and even to support and improve day-ahead and week-ahead operational planning. Moreover, patterns of simple events can trigger further analysis and recognition of the possibility that corrective measures should be taken to prevent even more egregious events that might ensue if left unchecked.[21]

20. Moreover, EOP–004–2 has been designed to minimize redundancies and multiple reporting obligations to the extent possible, by allowing responsible entities to report an event either through submission of its Attachment 2 or DOE Form OE–417.[22]

21. Nor are we persuaded by Joint ISOs/RTOs that EOP–004–2, if adopted, requires modification. We find no reason to require NERC to limit reportable events to those that give third parties time to act to mitigate the event, or to limit the recipients of such reports to those that can act to mitigate actual, real-time events. It is unclear that such events could be readily identified, leading to greater confusion concerning reporting requirements and a possible loss of information about those mitigable events. More importantly, as noted above, we do not agree that FPA section 215 limits the scope of Reliability Standards to those that directly affect real-time operations, and therefore do not agree with the underlying basis for Joint ISOs/RTOs' proposed modification.

22. Further, based on the one example provided by Joint ISOs/RTOs, we are not persuaded that the triggering events delineated in Attachment 1 require clarification. Joint ISOs/RTOs contend that, while Attachment 1 requires reporting when ''[d]amage or destruction of a Facility . . . results in actions to avoid a BES emergency,'' reliability coordinators and balancing authorities may take actions to avoid a BES Emergency without knowing whether the underlying system conditions resulted from damage or destruction to a facility. Requirement R2 of EOP–004–2 requires reporting of an event ''within 24 hours of recognition of meeting an event type threshold. . . .'' NERC explains that the language of Requirement R2 is based on ''recognition'' of an event threshold because ''an entity may not be immediately aware of destruction or damage to a remote piece of equipment'' and ''requiring Responsible Entities to constantly monitor all equipment and property for destruction or damage would be a waste of resources. . . .''[23] We agree that NERC has developed a practical solution to reporting that, rather than creating ambiguity, provides a more clear and rational trigger for reporting.

23. Finally, we reject Joint ISOs/RTOs' objection that the 24-hour reporting window is too stringent. As indicated by the Attachment 2 standardized Event Reporting Form, entities are only required to provide limited, specified information pertaining to an event. No underlying investigation or analysis is required. If Joint ISOs/RTOs believe that improvements can be made to EOP–004–2, through clarifying language or other modifications as the industry gains experience with EOP–004–2's revised reporting requirements, they can seek to do so through NERC's standard development process.

24. Accordingly, we approve Reliability Standard EOP–004–2 pursuant to FPA section 215(d)(2), as we find that it is just, reasonable, not unduly discriminatory or preferential, and in the public interest. We also approve the associated violation risk factors and violation severity levels, NERC's requested effective date for EOP–004–2, and the retirement of existing Reliability Standards EOP–004–1 and CIP–001–2a.

V. Information Collection Statement

25. The Office of Management and Budget (OMB) regulations require approval of certain information collection requirements imposed by agency action.[24] Upon approval of a collection(s) of information, OMB will assign an OMB control number and an expiration date. Respondents subject to the filing requirements of this Order will not be penalized for failing to respond to these collections of information unless the collections of information display a valid OMB control number.

26. The Commission will submit these reporting and recordkeeping requirements to OMB for its review and approval under section 3507(d) of the Paperwork Reduction Act. This order is effective immediately; however, the revised information collection requirements will not be effective or enforceable until OMB approves the information collection changes described in this order. Comments are solicited within 60 days of the date this order is published in the **Federal Register** on the Commission's need for this information, whether the information will have practical utility, the accuracy of provided burden estimates, 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. Submit comments following the Commission's

[20] Order No. 693, FERC Stats. & Regs. ¶ 31,242 at P 471.

[21] We have previously approved Reliability Standards that do not affect ''real-time operations'' yet still support the reliable operation of the Bulk-Power System, including Reliability Standards within the several different transmission categories including personnel performance, training and qualifications (PER); transmission planning (TPL); and facility connection and coordination (FAC–001 and FAC–002).

[22] *See* NERC Petition at 16.

[23] NERC Petition at 13.

[24] 5 CFR 1320.11.

submission guidelines at *http://www.ferc.gov/help/submission-guide.asp* and reference Docket No. RD13–3.

27. Rather than creating entirely new obligations to report a system disturbance, the revised Reliability Standard, EOP–004–2, primarily clarifies the thresholds that can trigger a reporting obligation, and reduces the reporting burden for certain individual respondents due to the use of a simplified form in Attachment 2. However, the revised Reliability Standard would increase the reporting burden for some individual entities, because it would apply for the first time to transmission owners and generator owners. We do not anticipate a large increase in the number of respondents because the existing Reliability Standard applies to transmission operators and generator operators, which includes the majority of the entities registered as transmission owners and generator owners.

28. *Burden Estimate:* Our estimate below regarding the number of respondents is based on the NERC compliance registry as of March 2013. According to the registry, there are 7 transmission owners that are not also transmission operators, 128 generator owners that are not also generator operators, and 101 distribution providers that are not also registered as another functional entity covered by the current event reporting standards. Thus, we estimate that a total of 236 entities may be subject to the event reporting requirements of EOP–004–2 for the first time.[25]

29. The number of annual reports required could vary widely based on the individual entity and the extent of its facilities. The estimate below is based on an assumption that, on average, 25 percent of the entities covered by EOP–004–2 will have one reportable event per year. As demonstrated below, the primary increase in cost associated with the revised standard is expected in Year 1, when newly covered entities must develop an operating plan for reporting. In Years 2 and 3, an overall reduction in reporting and recordkeeping burden is expected, due to the simplified reporting form:

Type of respondent	Reporting/record-keeping req't	Number of respondents (A)	Number of responses per respondent (B)	Total number of responses (A) × (B) = (C)	Average burden hours per response (D)	Estimated total annual burden (C) × (D)	Estimated total annual cost (see below)
New Entities (GO, TO, DP).	Developing Operating Plan (Yr 1 Only).	236	1	236	8	1888	$113,280.00
	Reporting Event (Yr 1, 2, and 3).	59	1	59	0.17	10.03	601.80
Entities Subject to Existing Reporting Requirements.	Conforming Operating Plan to New Thresholds (Yr 1 Only).	1164	1	1164	2	2328	139,680.00
	Reporting Event (using new form) (Yrs 1, 2, and 3).	291	1	291	−0.33	−96.03	(5,761.80)
Total for Year 1[26].	.....	.....	.....	.....	.....	4,130	247,800
Total for each of Years 2 & 3.	.....	.....	.....	.....	.....	(81)	(5,160)

The estimated breakdown of annual cost is as follows:

- Year 1
  - New Entities, Development of Operating Plan: 236 entities * 1 response/entity * (8 hours/response * $60/hour[27]) = $113,280.
  - New Entities, Event Reporting: 59 entities * 1 response/entity * (.17 hours/response * $60/hour) = $601.80.
  - Current Responsible Entities, Conforming Operating Plan: 1164 entities * 1 response/entity * (2 hours/response * $60/hour) = $139,680.
  - Current Responsible Entities, Event Reporting Using New Event Reporting Form: 291 entities * 1 response/entity * [(.17 hours/response − .5 hours/response)[28] * $60/hour] = ($5,761.80).
- Year 2 and ongoing
  - New Entities, Using ''Event Reporting Form'': 59 entities * 1 response/entity * (.17 hours/response * $60/hour) = $601.80.
  - Old Entities, Using ''Event Reporting Form'': 291 entities * 1 response/entity * [(.17 hours/response − .5 hours/response) * $60/hour] = ($5,761.80).

Title: FERC–725A, Mandatory Reliability Standards for the Bulk Power System.

Action: Proposed collection of information.

OMB Control No: 1902–0244.

[25] Although distribution providers are included as responsible entities under the revised Reliability Standard, their reporting obligations will be *de minimis,* as explained in the Guidelines and Technical Basis attached to the revised standard. *See* NERC Petition, Ex. B at 13. For purposes of this analysis, however, we included distribution providers as part of the assumed number of reports per year.

[26] Year 1 costs include implementation costs for entities that must comply with the standard for the first time, plus the cost for entities that are currently subject to NERC event reporting requirements to review and make changes to their existing plans. The Year 1 total also includes the savings from the reduction in reporting time due to the new Event Reporting Form.

[27] For the burden categories above, the estimated hourly loaded cost (salary plus benefits) for an engineer was assumed to be $60/hour, based on salaries as reported by the Bureau of Labor Statistics (BLS) (*http://bls.gov/oes/current/naics2_22.htm*). Loaded costs are BLS rates divided by 0.703 and rounded to the nearest dollar (*http://www.bls.gov/news.release/ecec.nr0.htm*).

[28] It is estimated that the average time to complete the required event report under Reliability Standard EOP–004–1 is 30 minutes, versus an estimated 10 minutes under the proposed Reliability Standard, EOP–004–2.

Respondents: Business or other for profit, and/or not for profit institutions.

Frequency of Responses: On occasion.

Necessity of the Information: Reliability Standard EOP–004–2 satisfies certain prior directives of the Commission, including a requirement to provide further guidance and specificity about reportable incidents of sabotage. The revised Reliability Standard requires reporting of specified system disturbances and potential events of sabotage in a timely manner, thereby allowing NERC as the Electric Reliability Organization, governmental authorities and relevant electric industry entities the opportunity to react. The revised standard accordingly enhances reliability in real-time through the opportunity to mitigate the impact of a disturbance, and in the future through investigation, analysis, and dissemination of lessons learned.

30. Interested persons may obtain information on the reporting requirements by contacting: 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].

VI. Effective Date

31. This order will become effective upon issuance.

The Commission orders:

(A) Reliability Standard EOP–004–2 is hereby approved as just, reasonable, not unduly discriminatory, and in the public interest.

(B) NERC's proposed Violation Risk Factors and Violation Severity Levels and implementation plan for Reliability Standard EOP–004–2 are hereby approved, including the retirement of existing Reliability Standards EOP–004–1 and CIP–001–2a when EOP–004–2 goes into effect.

Issued: June 20, 2013.

By the Commission.

Kimberly D. Bose,

Secretary.

[FR Doc. 2013–16805 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RM98–1–000]

Records Governing Off-the-Record Communications; Public Notice

This constitutes notice, in accordance with 18 CFR 385.2201(b), of the receipt of prohibited and exempt off-the-record communications.

Order No. 607 (64 FR 51222, September 22, 1999) requires Commission decisional employees, who make or receive a prohibited or exempt off-the-record communication relevant to the merits of a contested proceeding, to deliver to the Secretary of the Commission, a copy of the communication, if written, or a summary of the substance of any oral communication.

Prohibited communications are included in a public, non-decisional file associated with, but not a part of, the decisional record of the proceeding. Unless the Commission determines that the prohibited communication and any responses thereto should become a part of the decisional record, the prohibited off-the-record communication will not be considered by the Commission in reaching its decision. Parties to a proceeding may seek the opportunity to respond to any facts or contentions made in a prohibited off-the-record communication, and may request that the Commission place the prohibited communication and responses thereto in the decisional record. The Commission will grant such a request only when it determines that fairness so requires. Any person identified below as having made a prohibited off-the-record communication shall serve the document on all parties listed on the official service list for the applicable proceeding in accordance with Rule 2010, 18 CFR 385.2010.

Exempt off-the-record communications are included in the decisional record of the proceeding, unless the communication was with a cooperating agency as described by 40 CFR 1501.6, made under 18 CFR 385.2201(e)(1)(v).

The following is a list of off-the-record communications recently received by the Secretary of the Commission. The communications listed are grouped chronologically, in ascending order. These filings are available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the eLibrary link. Enter the docket number, excluding the last three digits, in the docket number field to access the document. For assistance, please contact FERC, Online Support at *FERCOnlineSupport@ferc.gov* or toll free at (866)208–3676, or for TTY, contact (202)502–8659.

Docket No.	Filed date	Presenter or requester
CP13–83–000	06–10–13	Susan Thornton, Ph.D.[1]
Exempt:		
1. P–13590–000	05–28–13	FERC Staff.[2]
2. P–10808–000	06–17–13	Hon. Sander Levin.
3. ER12–959–000	06–18–13	Hon. Frank D. Lucas.
4. P–10808–000	06–18–13	Hon. Dave Camp.[3]
5. P–10808–000	06–27–13	Hon. Dave Camp.
6. CP09–30–000	07–03–13	Hon. Rodney P. Frelinghuysen.
7. EC13–114–000	07–08–13	Gov. Edmund G. Brown Jr.

[1] Email record.
[2] Email records dated 5/28, 5/30 and 6/11/2013. Phone records dated 6/3 and 6/5/2013.
[3] Email record.

Dated: July 9, 2013.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–16836 Filed 7–12–13; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9833–8]

Announcement of the Board of Directors for the National Environmental Education Foundation

AGENCY: Office of External Affairs and Environmental Education, Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The National Environmental Education Foundation (NEEF) was created by Section 10 of Public Law 101–619, the National Environmental Education Act of 1990. It is a private 501(c)(3) non-profit organization established to promote and support education and training as necessary tools to further environmental protection and sustainable, environmentally sound development. It provides the common ground upon which leaders from business and industry, all levels of government, public interest groups, and others can work cooperatively to expand the reach of environmental education and training programs beyond the traditional classroom. The Foundation supports a grant program that promotes innovative environmental education and training programs; it also develops partnerships with government and other organizations to administer projects that promote the development of an environmentally literate public. The Administrator of the U.S. Environmental Protection Agency, as required by the terms of the Act, announces the following appointment to the National Environmental Education Foundation Board of Trustees. The appointee is Shannon Schuyler, Corporate Responsibility Leader and Senior Managing Director of PricewaterhouseCoopers.

FOR FURTHER INFORMATION CONTACT: For information regarding this Notice of Appointment, please contact Mrs. Stephanie Owens, Deputy Associate Administrator, Office of External Affairs and Environmental Education (1701A), U.S. EPA 1200 Pennsylvania Ave. NW., Washington, DC 20460. General information concerning NEEF can be found on their Web site at: *http://www.neefusa.org.*

SUPPLEMENTARY INFORMATION:

Additional Considerations: Great care has been taken to assure that this new appointee not only has the highest degree of expertise and commitment, but also brings to the Board diverse points of view relating to environmental education. This appointment is a four-year term which may be renewed once for an additional four years pending successful re-election by the NEEF nominating committee.

This appointee will join the current Board members which include:

- Arthur Gibson (NEEF Chair), Vice President, Environment, Health and Safety, Baxter Healthcare Corporation
- JL Armstrong (NEEF Vice Chair), National Manager, Toyota Motor Sales, USA, Inc.
- Kenneth Strassner (NEEF Treasurer), Vice President, Global Environment, Safety, Regulatory and Scientific Affairs, Kimberly-Clark Corporation
- Diane Wood (NEEF Secretary), President, National Environmental Education Foundation
- Decker Anstrom, Former CEO, The Weather Channel Companies
- Raymond Ban, Executive Vice President, The Weather Channel
- Holly Cannon, Principal, Beveridge and Diamond, P.C.
- Megan Reilly Cayton, Co-Founder and CEO, Catrinka, LLC
- Phillipe Cousteau, Co-Founder and CEO, EarthEcho International
- Manuel Alberto Diaz, Partner, Lydecker Diaz, L.L.P.
- Trish Silber, President, Aliniad Consulting Partners, Inc.
- Bradley Smith, Dean, Huxley College of the Environment, Western Washington University
- Wonya Lucas, Former CEO, TV One

Background: Section 10(a) of the National Environmental Education Act of 1990 mandates a National Environmental Education Foundation. The Foundation is established in order to extend the contribution of environmental education and training to meeting critical environmental protection needs, both in this country and internationally; to facilitate the cooperation, coordination, and contribution of public and private resources to create an environmentally advanced educational system; and to foster an open and effective partnership among Federal, State, and local government, business, industry, academic institutions, community based environmental groups, and international organizations.

The Foundation is a charitable and nonprofit corporation whose income is exempt from tax, and donations to which are tax deductible to the same extent as those organizations listed pursuant to section 501(c) of the Internal Revenue Code of 1986. The Foundation is not an agency or establishment of the United States. The purposes of the Foundation are—

(A) Subject to the limitation contained in the final sentence of subsection (d) herein, to encourage, accept, leverage, and administer private gifts for the benefit of, or in connection with, the environmental education and training activities and services of the United States Environmental Protection Agency;

(B) to conduct such other environmental education activities as will further the development of an environmentally conscious and responsible public, a well-trained and environmentally literate workforce, and an environmentally advanced educational system;

(C) to participate with foreign entities and individuals in the conduct and coordination of activities that will further opportunities for environmental education and training to address environmental issues and problems involving the United States and Canada or Mexico.

The Foundation develops, supports, and/or operates programs and projects to educate and train educational and environmental professionals, and to assist them in the development and delivery of environmental education and training programs and studies.

The Foundation has a governing Board of Directors (hereafter referred to in this section as 'the Board'), which consists of 13 directors, each of whom shall be knowledgeable or experienced in the environment, education and/or training. The Board oversees the activities of the Foundation and assures that the activities of the Foundation are consistent with the environmental and education goals and policies of the Environmental Protection Agency and with the intents and purposes of the Act. The membership of the Board, to the extent practicable, represents diverse points of view relating to environmental education and training. Members of the Board are appointed by the Administrator of the Environmental Protection Agency.

Within 90 days of the date of the enactment of the National Environmental Education Act, and as appropriate thereafter, the Administrator will publish in the **Federal Register** an announcement of appointments of Directors of the Board. Such appointments become final and effective 90 days after publication in the **Federal Register**. The directors are appointed for terms of 4 years. The Administrator shall appoint an individual to serve as a director in the event of a vacancy on the Board within 60 days of said vacancy in the manner in which the original appointment was

made. No individual may serve more than 2 consecutive terms as a director.

Dated: June 28, 2013.

Bob Perciasepe,

Acting Administrator.

Shannon L. Schuyler

Ms. Schuyler has been Corporate Responsibility Leader and Senior Managing Director of PricewaterhouseCoopers since 2007. Ms. Schuyler was Alumni Relations Managing Director of PricewaterhouseCoopers since 2005, National HR Director since 2002, ABAS HR Leader since 2000, GRMS HR Leader since 1999, National Recruiting Leader since 1998, Cluster Recruiting Leader of Coopers & Lybrand LLP since 1996, Executive Recruiter of Jacobson Associates since 1995 and Freelance Communications work since 1994.

She serves on the board of the Society for Human Resource Management, Leadership Greater Chicago 2010 Fellow, MIND Resource Institute National Advisory Board, Women and the Green Economy Advisory Board, Boston College Center for Corporate Citizenship Advisory Committee, SAP Sustainability Executive Advisory Council and Taproot Board.

Ms. Schuyler earned a bachelor's degree in Arts—English at University of Michigan.

[FR Doc. 2013–16900 Filed 7–12–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9833–9]

Announcement of the Board of Directors for the National Environmental Education Foundation

AGENCY: Office of External Affairs and Environmental Education, Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The National Environmental Education Foundation (NEEF) was created by Section 10 of Public Law 101–619, the National Environmental Education Act of 1990. It is a private 501(c)(3) non-profit organization established to promote and support education and training as necessary tools to further environmental protection and sustainable, environmentally sound development. It provides the common ground upon which leaders from business and industry, all levels of government, public interest groups, and others can work cooperatively to expand the reach of environmental education and training programs beyond the traditional classroom. The Foundation supports a grant program that promotes innovative environmental education and training programs; it also develops partnerships with government and other organizations to administer projects that promote the development of an environmentally literate public. The Administrator of the U.S. Environmental Protection Agency, as required by the terms of the Act, announces the following appointment to the National Environmental Education Foundation Board of Trustees. The appointee is Carlos Alcazar, Chief Executive Officer of Hispanic Communications Network.

FOR FURTHER INFORMATION CONTACT: For information regarding this Notice of Appointment, please contact Mrs. Stephanie Owens, Deputy Associate Administrator, Office of External Affairs and Environmental Education (1701A), U.S. EPA, 1200 Pennsylvania Ave. NW., Washington, DC 20460. General information concerning NEEF can be found on their Web site at: *http://www.neefusa.org.*

SUPPLEMENTARY INFORMATION:

Additional Considerations: Great care has been taken to assure that this new appointee not only has the highest degree of expertise and commitment, but also brings to the Board diverse points of view relating to environmental education. This appointment is a four-year term which may be renewed once for an additional four years pending successful re-election by the NEEF nominating committee.

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- Kenneth Strassner (NEEF Treasurer), Vice President, Global Environment, Safety, Regulatory and Scientific Affairs, Kimberly-Clark Corporation
- Diane Wood (NEEF Secretary), President, National Environmental Education Foundation
- Decker Anstrom, Former CEO, The Weather Channel Companies
- Raymond Ban, Executive Vice President, The Weather Channel
- Holly Cannon, Principal, Beveridge and Diamond, P.C.
- Megan Reilly Cayton, Co-Founder and CEO, Catrinka, LLC
- Phillipe Cousteau, Co-Founder and CEO, EarthEcho International
- Manuel Alberto Diaz, Partner, Lydecker Diaz, L.L.P.
- Trish Silber, President, Aliniad Consulting Partners, Inc.
- Bradley Smith, Dean, Huxley College of the Environment, Western Washington University
- Wonya Lucas, Former CEO, TV One

Background: Section 10(a) of the National Environmental Education Act of 1990 mandates a National Environmental Education Foundation. The Foundation is established in order to extend the contribution of environmental education and training to meeting critical environmental protection needs, both in this country and internationally; to facilitate the cooperation, coordination, and contribution of public and private resources to create an environmentally advanced educational system; and to foster an open and effective partnership among Federal, State, and local government, business, industry, academic institutions, community based environmental groups, and international organizations.

The Foundation is a charitable and nonprofit corporation whose income is exempt from tax, and donations to which are tax deductible to the same extent as those organizations listed pursuant to section 501(c) of the Internal Revenue Code of 1986. The Foundation is not an agency or establishment of the United States. The purposes of the Foundation are—

(A) Subject to the limitation contained in the final sentence of subsection (d) herein, to encourage, accept, leverage, and administer private gifts for the benefit of, or in connection with, the environmental education and training activities and services of the United States Environmental Protection Agency;

(B) to conduct such other environmental education activities as will further the development of an environmentally conscious and responsible public, a well-trained and environmentally literate workforce, and an environmentally advanced educational system;

(C) to participate with foreign entities and individuals in the conduct and coordination of activities that will further opportunities for environmental education and training to address environmental issues and problems involving the United States and Canada or Mexico.

The Foundation develops, supports, and/or operates programs and projects to educate and train educational and environmental professionals, and to assist them in the development and

delivery of environmental education and training programs and studies.

The Foundation has a governing Board of Directors (hereafter referred to in this section as 'the Board'), which consists of 13 directors, each of whom shall be knowledgeable or experienced in the environment, education and/or training. The Board oversees the activities of the Foundation and assures that the activities of the Foundation are consistent with the environmental and education goals and policies of the Environmental Protection Agency and with the intents and purposes of the Act. The membership of the Board, to the extent practicable, represents diverse points of view relating to environmental education and training. Members of the Board are appointed by the Administrator of the Environmental Protection Agency.

Within 90 days of the date of the enactment of the National Environmental Education Act, and as appropriate thereafter, the Administrator will publish in the **Federal Register** an announcement of appointments of Directors of the Board. Such appointments become final and effective 90 days after publication in the **Federal Register**. The directors are appointed for terms of 4 years. The Administrator shall appoint an individual to serve as a director in the event of a vacancy on the Board within 60 days of said vacancy in the manner in which the original appointment was made. No individual may serve more than 2 consecutive terms as a director.

Dated: June 28, 2013.

Bob Perciasepe,

Acting Administrator.

Carlos Alcazar

Mr. Alcazar has been Chief Executive Officer and Executive Creative Director of Hispanic Communications Network since 2005. Mr. Alcazar was Vice President of Pearson, plc since 2001, Vice President, International of Viacom since 1992, and Technology Instructor and Bilingual Teacher at Los Angeles Unified School District since 1990.

He serves on the board of the National Fatherhood Initiative, World Affairs Council, Boy Scouts of America, Alliance for the Family, the Ready to Learn Partnership and the Latino Advisory Council of the Boys and Girls Club of America.

Mr. Alcazar earned a bachelor's degree in business administration in Political Science and Communications from University of California. He speaks Spanish and French.

[FR Doc. 2013–16903 Filed 7–12–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2007–0268; FRL–9833–5]

Updates to Protective Action Guides Manual: Protective Action Guides (PAGs) and Planning Guidance for Radiological Incidents

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed guidance; extension of comment period.

SUMMARY: The U.S. Environmental Protection Agency is announcing an extension of the public comment period for the proposed guidance ''PAG Manual: Protective Action Guides (PAGs) and Planning Guidance for Radiological Incidents'' (the proposed guidance is hereinafter referred to as ''PAGs''). The EPA published the proposed guidance in the **Federal Register**, which included a request for comment, on April 15, 2013. The public comment period was to end on July 15, 2013. The purpose of this notice is to extend the public comment period an additional 60 days.

DATES: Written comments must be received on or before September 16, 2013.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2007–0268, by one of the following methods:

- *www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *Email: a-and-r-docket@epa.gov.*
- *Mail:* Air and Radiation Docket and Information Center, U.S. Environmental Protection Agency, Mailcode: 2822T, 1200 Pennsylvania Ave. NW., Washington, DC 20460.
- *Hand Delivery:* EPA Docket Center, EPA West Building, Room 3334, 1301 Constitution Ave. NW., Washington, DC 20460. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OAR–2007–0268. The EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *www.regulations.gov* or email. The *www.regulations.gov* Web site is an ''anonymous access'' system, which means the EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an email comment directly to the Agency without going through *www.regulations.gov* your email address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, the EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If the EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, the Agency may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about the Agency's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.* For additional instructions on submitting comments, please refer to the notice of proposed rulemaking (Section XI, Public Participation, of the **SUPPLEMENTARY INFORMATION** section of the proposed rulemaking document).

Docket: All documents in the docket are listed in the *www.regulations.gov* index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *www.regulations.gov* or in hard copy at the Air and Radiation Docket and Information Center, EPA/DC, EPA West, Room 3334, 1301 Constitution Ave. 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 Docket is (202) 566–1742.

FOR FURTHER INFORMATION CONTACT: Sara DeCair, Radiation Protection Division, Center for Radiological Emergency Management, Mail Code 6608J, U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue NW., Washington, DC 20460; telephone number: (202) 343–9108 ; fax number: (202) 343–2304; email: *decair.sara@epa.gov.*

SUPPLEMENTARY INFORMATION:

A. What should I consider as I prepare my comments for the EPA?

1. *Submitting Confidential Business Information (CBI).* Do not submit this information to the EPA through *www.regulations.gov* or email. Clearly mark 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 marked as CBI will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for Preparing Your Comments.* When submitting comments, remember to:

- Identify the rulemaking by docket number, subject heading, **Federal Register** date and page number.
- Follow directions—the EPA may ask you to respond to specific questions or organize comments by referencing the chapter 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 it to be reproduced.
- Illustrate your concerns with specific examples 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.

B. How can I get copies of this document, the proposed rule and other related information?

The EPA has established a docket for this action under Docket ID No. EPA–HQ–OAR–2007–0268. The EPA has also developed a Web site for the proposed PAGs updates at: *http://www.epa.gov/radiation/rert/pags.html.* Please refer to the original **Federal Register** notice on the proposed guidance for detailed information on accessing information related to the proposal.

In response to requests for an extension, we are extending the public comment period for the PAGs updates through September 16, 2013. This extension will provide the public additional time to provide comment on the proposed guidance.

Dated: July 8, 2013.

Gina McCarthy,

Assistant Administrator, Office of Air and Radiation.

[FR Doc. 2013–16898 Filed 7–12–13; 8:45 am]

BILLING CODE 6560–50–P

EXPORT-IMPORT BANK OF THE UNITED STATES

[Public Notice: 2013–0034]

Application for Final Commitment for a Long-Term Loan or Financial Guarantee in Excess of $100 Million: AP087586XX

AGENCY: Export-Import Bank of the United States.

ACTION: Notice.

SUMMARY: This Notice is to inform the public, in accordance with Section 3(c)(10) of the Charter of the Export-Import Bank of the United States (''Ex-Im Bank''), that Ex-Im Bank has received an application for final commitment for a long-term loan or financial guarantee in excess of $100 million (as calculated in accordance with Section 3(c)(10) of the Charter). Comments received within the comment period specified below will be presented to the Ex-Im Bank Board of Directors prior to final action on this Transaction.

Reference: AP087586XX.

Purpose and Use

Brief description of the purpose of the transaction:

A direct loan to an Israel-based company to support the procurement of U.S. manufactured solar arrays as well as U.S. launch services and launch insurance.

Brief non-proprietary description of the anticipated use of the items being exported:

The loan will enable the Israeli based company to finance the solar arrays, launch, and insurance in support of a manufactured satellite. The satellite is expected to provide additional capacity to broadcasting and telecommunications companies in the company's existing customer base in Central and Eastern Europe, Africa, and the Middle East.

To the extent that Ex-Im Bank is reasonably aware, the item(s) being exported are not expected to produce exports or provide services in competition with the exportation of goods or provision of services by a United States industry.

Parties

Principal Supplier:

- Space Exploration Technologies Corp. of Hawthorne, California.
- Marsh Space Projects, New York, New York.
- ATK Space Systems Inc., Goleta, California.

Obligor: Space-Communication Limited.

Guarantor(s): None.

Description of Items Being Exported

To finance the construction of solar arrays, U.S. launch services, and launch insurance.

Information on Decision: Information on the final decision for this transaction will be available in the ''Summary Minutes of Meetings of Board of Directors'' on *http://exim.gov/newsandevents/boardmeetings/board/.*

Confidential Information: Please note that this notice does not include confidential or proprietary business information; information which, if disclosed, would violate the Trade Secrets Act; or information which would jeopardize jobs in the United States by supplying information that competitors could use to compete with companies in the United States.

DATES: Comments must be received on or before August 9, 2013 to be assured of consideration before final consideration of the transaction by the Board of Directors of Ex-Im Bank.

ADDRESSES: Comments may be submitted through Regulations.gov at W*WW.REGULATIONS.GOV*. To submit a comment, enter EIB–2013–0034 under the heading ''Enter Keyword or ID'' and select Search. Follow the instructions provided at the Submit a Comment screen. Please include your name, company name (if any) and EIB–2013–0034 on any attached document.

Cristopolis A. Dieguez,

Program Specialist, Office of the General Counsel.

[FR Doc. 2013–16783 Filed 7–12–13; 8:45 am]

BILLING CODE 6690–01–P

FEDERAL COMMUNICATIONS COMMISSION

[DA 13–1519]

Consumer Advisory Committee

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: The Commission announces the next meeting date, time, and agenda of its Consumer Advisory Committee (hereinafter the ''Committee''). The purpose of the Committee is to make recommendations to the Commission regarding matters within the jurisdiction of the Commission and to facilitate the participation of all consumers in proceedings before the Commission.

DATES: The next meeting of the Committee will take place on Friday, August 2, 2013, 9:00 a.m. to 4:00 p.m., at the Commission's Headquarters Building, Commission Meeting Room TW–C305.

ADDRESSES: Federal Communications Commission, 445 12th Street SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Scott Marshall, Consumer and Governmental Affairs Bureau, (202) 418–2809 (voice or Relay), or email *Scott.Marshall@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's document DA 13–1519 released July 3, 2013 announcing the agenda, date and time of the Committee's next meeting.

Meeting Agenda

At its August 2, 2013 meeting, the Committee will consider a further recommendation regarding inmate calling rates. The Committee may also consider other recommendations from its working groups, and may also receive briefings from FCC staff and outside speakers on matters of interest to the Committee. A limited amount of time will be available on the agenda for comments from the public. The public may ask questions of presenters via email *livequestions@fcc.gov* or via Twitter using the hashtab #fcclive. In addition, the public may also follow the meeting on Twitter @fcc or via the Commission's Facebook page at *www.facebook.com/fcc.* Alternatively, members of the public may send written comments to: Scott Marshall, Designated Federal Officer of the Committee at the address provided above.

The meeting is open to the public and the site is fully accessible to people using wheelchairs or other mobility aids. Sign language interpreters, open captioning, assistive listening devices, and Braille copies of the agenda and handouts will be provided on site.

Meetings are also broadcast live with open captioning over the Internet from the FCC Live Web page at *www.fcc.gov/live/.*

Simultaneous with the webcast, the meeting will be available through Accessible Event, a service that works with your web browser to make presentations accessible to people with disabilities. You can listen to the audio and use a screen reader to read displayed documents. You can also watch the video with open captioning. The Web site to access Accessible Event is *http://accessibleevent.com.* The Web page prompts for an Event Code which is 005202376. To learn about the features of Accessible Event, consult its User's Guide at: *http://accessibleevent.com/doc/user_guide/.* Other reasonable accommodations for people with disabilities are available upon request. The request should include a detailed description of the accommodation needed and contact information. Please provide as much advance notice as possible; last minute requests will be accepted, but may be impossible to fill. Send an email to *fcc504@fcc.gov* or call the Consumer and Governmental Affairs Bureau at 202–418–0530 (voice), 202–418–0432 (TTY).

Federal Communications Commission.

Mark Stone,

Deputy Bureau Chief, Consumer and Governmental Affairs Bureau.

[FR Doc. 2013–16889 Filed 7–12–13; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL DEPOSIT INSURANCE CORPORATION

Proposed Agency Information Collection Activities: Submission for OMB Review; Comment Request Re Occasional Qualitative Surveys

AGENCY: Federal Deposit Insurance Corporation (FDIC).

ACTION: Notice and request for comment.

SUMMARY: The FDIC, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), to comment on renewal of an existing information collection as required by the PRA. On May 10, 2013 (78 FR 27388), the FDIC solicited public comment for a 60-day period on renewal without change of its information collection entitled, ''Occasional Qualitative Surveys'' (OMB No. 3064–0127). No comments were received. Therefore, the FDIC hereby gives notice of submission of its request for renewal to OMB for review.

DATES: Comments must be submitted on or before August 14, 2013.

ADDRESSES: Interested parties are invited to submit written comments. All comments should refer to the name of the collection. Comments may be submitted by any of the following methods:

- *http://www.fdic.gov/regulations/laws/federal/notices.html.*
- *Email: comments@fdic.gov.*
- *Mail:* Leneta G. Gregorie (202.898.3719), Counsel, Federal Deposit Insurance Corporation, 550 17th Street NW., Room NY–5050, Washington, DC 20429.
- *Hand Delivery:* Comments may be hand-delivered to the guard station at the rear of the 550 17th Street Building (located on F Street), on business days between 7:00 a.m. and 5:00 p.m.

A copy of the comments may also be submitted to the FDIC Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For further information about this information collection, please contact Leneta G. Gregorie, by telephone at (202) 898–3719 or by mail at the address identified above.

SUPPLEMENTARY INFORMATION:

The FDIC is requesting OMB approval to renew the following information collection:

Title: Occasional Qualitative Surveys.

OMB Number: 3064–0127.

Estimated number of surveys per year: 15.

Estimated response time per survey: 1 hour.

Estimated number of respondents per survey: 850.

Total Annual Burden: 12,500 hours.

General Description of Collection: The information collected in these surveys is anecdotal in nature, that is, samples are not necessarily random, the results are not necessarily representative of a larger class of potential respondents, and the goal is not to produce a statistically valid and reliable database. Rather, the surveys are expected to yield anecdotal information about the particular experiences and opinions of members of the public, primarily staff at respondent banks or bank customers. The information is used to improve the way FDIC relates to its clients, to develop agendas for regulatory or statutory change, and in some cases to simply learn how particular policies or programs are working, or are perceived in particular cases.

Request for Comment

Comments are invited on: (a) Whether these collections of information are

necessary for the proper performance of the FDIC's functions, including whether the information has practical utility; (b) the accuracy of the estimate of the burden of the information collection, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology. All comments will become a matter of public record.

Dated at Washington, DC, this 10th day of July, 2013.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

[FR Doc. 2013–16840 Filed 7–12–13; 8:45 am]

BILLING CODE 6714–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 8, 2013.

A. Federal Reserve Bank of Atlanta (Chapelle Davis, Assistant Vice President) 1000 Peachtree Street NE., Atlanta, Georgia 30309:

1. *Banco De Credito E Inversiones, Empresas Juan Yarur S.A.C., Inversiones Petro S.A. Inversiones Baquio LTDA, Inversiones, Nueve, LTDA, and Administraciones Baquio LTDA,* all of Santiago, Chile; to become bank holding companies by acquiring 100 percent of the voting shares of CM Florida Holdings, Inc., Coral Gables, Florida, and City Nation Bank of Florida, Miami, Florida.

B. Federal Reserve Bank of Kansas City (Dennis Denney, Assistant Vice President) 1 Memorial Drive, Kansas City, Missouri 64198–0001:

1. *B.O.E. Bancshares, Inc.,* and B.O.E. Chickasha Corp, both in Lawton, Oklahoma, to acquire Chickasha Bancshares, Inc., and thereby indirectly acquire Chickasha Bank & Trust Company, both in Chickasha, Oklahoma.

Board of Governors of the Federal Reserve System, July 9, 2013.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2013–16768 Filed 7–12–13; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Sunshine Act; Notice of Meeting

TIME AND DATE: 8:30 a.m. (Eastern Time) July 22, 2013.

PLACE: 10th Floor Board Meeting Room, 77 K Street NE., Washington, DC 20002.

STATUS: Parts will be open to the public and parts closed to the public.

MATTERS TO BE CONSIDERED:

Parts Open to the Public

1. Approval of the Minutes of the June 24, 2013 Board Member Meeting.
2. Thrift Savings Plan Activity Reports by the Executive Director.
   a. Monthly Participant Activity Report.
   b. Monthly Investment Policy Report.
   c. Legislative Report.
3. Quarterly Vendor Financials.
4. Investment Manager.

Parts Closed to the Public

5. Security.
5. Litigation Review.
6. Personnel.

CONTACT PERSON FOR MORE INFORMATION: Kimberly Weaver, Director, Office of External Affairs (202) 942–1640.

Dated: July 11, 2013.

James B. Petrick,

Secretary, Federal Retirement Thrift Investment Board.

[FR Doc. 2013–17019 Filed 7–11–13; 4:15 pm]

BILLING CODE 6760–01–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0034; Docket 2013–0077; Sequence 1]

Federal Acquisition Regulation; Information Collection; Examination of Records by Comptroller General and Contract Audit

AGENCY: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for an extension to an existing OMB clearance.

SUMMARY: Under the provisions of the Paperwork Reduction Act, the Regulatory Secretariat will be submitting to the Office of Management and Budget (OMB) a request to review and approve an extension of a previously approved information collection requirement concerning the examination of records by comptroller general and contract audit.

DATES: Submit comments on or before September 13, 2013.

ADDRESSES: Submit comments identified by Information Collection 9000–0034 by any of the following methods:

- *Regulations.gov: http://www.regulations.gov.* Submit comments via the Federal eRulemaking portal by searching for OMB Control No. 9000–0034. Follow the instructions provided at the ''Submit a Comment'' screen. Please include your name, company name (if any), and ''Information Collection 9000–0034, Examination of Records by Comptroller General and Contract Audit'' on your attached document.
- *Fax:* 202–501–4067.
- *Mail:* General Services Administration, Regulatory Secretariat (MVCB), 1800 F Street NW., Washington, DC 20405. ATTN: Hada Flowers/IC 9000–0034, Examination of Records by Comptroller General and Contract Audit.

Instructions: Please submit comments only and cite Information Collection

9000–0034, in all correspondence related to this collection. All comments received will be posted without change to *http://www.regulations.gov,* including any personal and/or business confidential information provided.

FOR FURTHER INFORMATION CONTACT: Mr. Michael O. Jackson, Procurement Analyst, Contract Policy Branch, GSA, 202–208–4949 or email *michaelo.jackson@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. Purpose

The objective of this information collection, for the examination of records by Comptroller General and contract audit, is to require contractors to maintain certain records and to ensure the Comptroller General and/or agency have access to, and the right to, examine and audit records, which includes: books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form, for a period of three years after final payment. This information is necessary for examination and audit of contract surveillance, verification of contract pricing, and to provide reimbursement of contractor costs, where applicable. The records retention period is required by the statutory authorities at 10 U.S.C. 2313, 41 U.S.C. 254, and 10 U.S.C. 2306, and are implemented through the following clauses: Audit and Records—Negotiation clause, 52.215–2; Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items clause, 52.212–5; and Audit and Records—Sealed Bidding clause, 52.214–26. This information collection does not require contractor's to create or maintain any records that the contractor does not normally maintain in its usual course of business.

Public Comments

Public comments are particularly invited on: Whether this collection of information is necessary for the proper performance of functions of the Federal Acquisition Regulation (FAR), and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology and ways to enhance the quality, utility, and clarity of the information to be collected.

B. Annual Reporting Burden

For this information collection requirement data from Fiscal Year (FY) 2012 was retrieved from the Federal Procurement Data System—Next Generation (FPDS–NG).

The parameters for this information collection were based on the prescription from each of the applicable clauses. Resulting from a thorough review of each clause prescription, it was determined that the type of contracts associated with this information collection are: Negotiated awards over the simplified acquisition threshold (SAT) using commercial procedures; Negotiated awards over the SAT using other than commercial procedures; and, Sealed bid awards over $700,000. For negotiated awards over the SAT using commercial procedures, FPDS–NG shows 18,709 contracts (7,797 of those were awarded to unique vendors). For negotiated awards over the SAT using other than commercial procedures, FPDS–NG shows 14,085 contracts (6,731 of those were awarded to unique vendors). For sealed bid awards over $700,000, FPDS–NG shows 1,602 contracts (809 of those were awarded to unique vendors). This equates to a total of 34,396 total actions and a total of 15,337 unique vendors after you drill down the 34,396 actions looking only for the unique Data Universal Numbering System (DUNS) number. The 15,337 actions will be used as the number of estimated respondents per year.

It is estimated that number of responses per respondent is ten. This is derived by dividing the number of contract actions by the number of unique vendors (2.2 contracts), plus an average of three subcontracts per contract (considering the applicable clauses flows down to subcontractors). It is further estimated that the time required to read and prepare a response is 60 minutes.

Respondents: 15,337.
Responses per Respondent: 10.
Total number of responses: 153,370.
Hours per Response: 1.0.
Total Burden Hours: 153,370.

The 153,370 burden hours represent a significant increase over the 63,934 hours that was published in the information collection notice in the **Federal Register** at 75 FR 10268 on March 5, 2010, due to the increase in the estimated hours per response, by fifty minutes, from ten minutes to 1 hour.

Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat (MVCB), 1800 F Street NW., Washington, DC 20405, telephone 202–501–4755. Please cite OMB Control Number 9000–0034, Examination of Records by Comptroller General and Contract Audit, in all correspondence.

Dated: July 9, 2013.

Karlos Morgan,

Acting Director, Federal Acquisition Policy, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

[FR Doc. 2013–16918 Filed 7–12–13; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–13–13YQ]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 or send comments to LeRoy Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Institutional Awareness and Commitment to Ensuring Safe, Stable, and Nurturing Relationships and Environments for Children and Prevention Child Maltreatment—New—

National Center for Injury Prevention and Control (NCIPC)—Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Safe, stable, nurturing relationships and environments set children on a positive trajectory for optimal child development and health, provide a buffer against the effects of adverse child experiences, are fundamental to healthy brain development and have a positive impact on a broad range of health problems across the life course. Promoting safe, stable, nurturing relationships and environments may also reduce child maltreatment which is a significant public health problem affecting physical and emotional health throughout the lifespan.

NCIPC is funding five state health departments in Fiscal Year 2012 to coordinate and manage existing and new partnerships with other sectors to promote safe, stable, nurturing relationships and environments for children; and work with partners to identify strategies across sectors that promote safe, stable, nurturing relationships and environments. CDC requests OMB approval for two years to collect information that will establish the baseline level of state health departments' and partners' awareness and commitment to ensuring safe, stable, and nurturing relationships and environments for children and preventing child maltreatment.

This information will be collected from staff at health departments soon after receiving their award and from their partners at the start of each new partnership. Respondents will be 3 staff members from 5 health departments receiving funding and 3 staff members at approximately 11 organizations or agencies the health departments choose to partner with. Information will be collected once using SurveyMonkey®, an electronic web-based interface which is a secure Web site that meets the Safe Harbor and European Union data protection requirements. This ICR will only collect data pertaining to organizations. No individual identifiable information will be requested.

Each grantee will receive a personalized advance notification letter, followed by an email with a link to the SurveyMonkey® site. In turn, the grantee will send a personalized advance notification letter, followed by an email with a link to the SurveyMonkey® site to each new partner throughout the funding period.

The goal of the data collection is to assess awardee awareness and commitment so that CDC may establish state health departments' and partners' level of commitment at the start of the funding. This information will be compared to post-funding awareness and commitment data which, along with other data sources (i.e., changes in public awareness and commitment, and changes in policies and programs), will allow CDC to establish the success of this funding announcement.

Given five health departments with 10 partner organizations each and 3 staff at each organization responding, the total number of respondents for this project is 165 (83 respondents per year). Total project burden over the two years of data collection is 78 hours (39 hours per year).

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)	Total burden (in hrs.)
Grantees and their partners	Institutional awareness and commitment survey.	83	1	28/60	39 39

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–16769 Filed 7–12–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day 13–13ZC]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 or send comments to LeRoy Richardson, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Case Studies to Explore Interventions to Support, Build, and Provide Legacy Awareness for Young Breast Cancer Survivors—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Young breast cancer survivors (YBCS, defined as women diagnosed with breast cancer under 45 years old) may have a more difficult time coping with breast cancer treatment and aftercare when compared to older breast cancer survivors. For example, breast cancer can be more serious, treatment is often multimodal and more toxic, and side effects can be more severe for YBCS than for older women. As part of the Patient Protection and Affordable Care Act (H.R. 3590, 2010), Congress passed the Education and Awareness Requires Learning Young (EARLY) Act, Sec. 10413. The EARLY Act directed CDC to

develop and implement national campaigns to educate young women (particularly those at increased risk) and health care providers about breast cancer risk and early diagnosis. As a result of the EARLY Act, CDC established the Funding Opportunity Announcement, DP11–1111, *Developing Support and Educational Awareness for Young (< 45 years of age) Breast Cancer Survivors in the United States.* Subsequently, CDC awarded a three-year cooperative agreement to seven organizations that demonstrated a capacity to (1) reach YBCS, health care providers, and caregivers/families, (2) implement interventions that seek to provide support services, and (3) develop educational communication and awareness resources to support YBCS.

Other establishments within the U.S., such as local and national not-for-profit organizations and academic institutions, implement similar YBCS-focused interventions without funding from CDC's DP11–1111 cooperative agreement. Although these entities are not funded through CDC, they plan, develop, and employ similar tools, strategies, and interventions to reach or benefit these targeted young cancer-survivor populations.

CDC proposes to conduct exploratory case studies of organizations that provide support services and/or educational resources to YBCS, health care providers, and/or caregivers/families. Each selected organization will serve as a unique case and the unit of analysis. Information will be collected from up to 12 organizations: Seven case studies will be conducted with organizations that receive funding through CDC's DP11–1111 cooperative agreement, and up to five case studies will be conducted with other organizations that are implementing similar YBCS-focused activities and interventions but do not receive funding under DP11–1111. Information will be collected during a single site visit to each selected organization to conduct in-person interviews with key programmatic staff and to record on-site observations of program planning and implementation activities.

Case studies are intended to serve as an exploration of implementation activities, as well as to provide the context for implementation. Specifically, case study findings will help CDC to identify areas in which CDC can build upon existing and emerging efforts to provide support services and educational resources to YBCS, highlight barriers and facilitating factors to implementing interventions targeting YBCS, determine the added value of providing the DP11–1111 cooperative agreement (e.g., funding, technical assistance) to various entities, identify lessons learned that can be applied to future implementation of YBCS interventions, and better understand the sustainability of YBCS interventions following/in the absence of CDC funding.

CDC will be able to gain a deeper understanding of (1) implementation of the DP11–1111 cooperative agreement, (2) implementation of YBCS interventions, including barriers and facilitators to implementation, and (3) similarities and differences among organizations serving YBCS. Case study findings will be compiled and summarized in site-specific and cross-site reports to CDC. Information collected will help to enhance existing efforts to provide educational resources and support services to YBCS and inform replication of promising YBCS interventions in other settings.

Case study selection is based on a purposeful selection of CDC-funded and non-CDC funded organizations that support YBCS populations through educational or service programs. Potential organizations for this project include local or national not-for-profit organizations and academic institutions. Information will be collected using on-site observations and in-depth interviews (IDI) with each organization's key informants, such as Principal Investigators, Program Managers, Program Staff, and Program Partners. IDIs will last 1–2 hours each. Case study findings will be compiled and summarized in site-specific and cross-site reports to CDC. Information will be collected approximately two years after initiation of CDC's cooperative agreement, DP11–1111. OMB approval is requested for 12 months.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avg. burden per response	Total burden (in hrs)
Organizations that Receive CDC Funding.	IDI Guide for Program Directors/ Principal Investigators.	7	1	2	14
	IDI Guide for Program Managers	7	1	1	7
	IDI Guide for Program Staff Members.	35	1	1	35
	IDI Guide for Program Partners	21	1	1	21
Organizations that do not Receive CDC Funding.	IDI Guide for Program Directors/ Principal Investigators.	5	1	2	10
	IDI Guide for Program Managers	5	1	1	5
	IDI Guide for Program Staff Members.	25	1	1	25
	IDI Guide for Program Partners	15	1	1	15
Total	.....	.....	.....	.....	132

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–16770 Filed 7–12–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–13–0457]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Aggregate Reports for Tuberculosis Program Evaluation (OMB No. 0920–0457 Expiration 09/30/2013—Extension—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC, NCHHSTP, Division of Tuberculosis Elimination (DTBE) proposes extension of the Aggregate Reports for Tuberculosis Program Evaluation, previously approved under OMB No. 0920–0457. This request is for a 3-year clearance. There are no revisions to the report forms, data definitions, or reporting instructions. Changes within this information collection request (ICR) reflect an increase in the annual cost to the government. The increased cost is due to increases in salaries of personnel conducting data collection and analysis since the last ICR approval.

DTBE is the lead agency for tuberculosis elimination in the United States. To ensure the elimination of tuberculosis in the United States, CDC monitors indicators for key program activities, such as finding tuberculosis infections in recent contacts of cases and in other persons likely to be infected and providing therapy for latent tuberculosis infection. In 2000, CDC implemented two program evaluation reports for annual submission: Aggregate report of follow-up for contacts of tuberculosis, and Aggregate report of screening and preventive therapy for tuberculosis infection (OMB No. 0920–0457). The respondents for these reports are the 68 state and local tuberculosis control programs receiving federal cooperative agreement funding through DTBE. These reports emphasize treatment outcomes, high-priority target populations vulnerable to tuberculosis, and programmed electronic report entry, which transitioned to the National Tuberculosis Indicators Project (NTIP), a secure web-based system for program evaluation data, in 2010. No other federal agency collects this type of national tuberculosis data, and the Aggregate report of follow-up for contacts of tuberculosis, and Aggregate report of screening and preventive therapy for tuberculosis infection are the only data source about latent tuberculosis infection for monitoring national progress toward tuberculosis elimination with these activities. CDC provides ongoing assistance in the preparation and utilization of these reports at the local and state levels of public health jurisdiction. CDC also provides respondents with technical support for NTIP access (Electronic—100%, Use of Electronic Signatures—No). The annual burden to respondents is estimated to be 226 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Data clerks and Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases Form.	100	1 (electronic)	30/60
Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases Form.	18	1 (manual)	30/60
Data clerks	Follow-up and Treatment of Contacts to Tuberculosis Cases Form.	18	1 (manual)	3
Data clerks and Program Managers	Targeted Testing and Treatment for Latent Tuberculosis Infection.	100	1 (electronic)	30/60
Program Managers	Targeted Testing and Treatment for Latent Tuberculosis Infection.	18	1 (manual)	30/60
Data clerks	Targeted Testing and Treatment for Latent Tuberculosis Infection.	18	1 (manual)	3

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–16824 Filed 7–12–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–13–0861]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

A Controlled Evaluation of Expect Respect Support Groups (ERSG): Preventing and Interrupting Teen Dating Violence among At-Risk Middle and High School Students (0920–0861, Expiration 8/31/2013)—Extension—National Center for Injury Prevention and Control (NCIPC), Division of Violence Prevention (DVP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The prevalence and consequences of teen dating violence make it a public health concern that requires early and effective prevention. To date, only three prevention strategies—Safe Dates, the Youth Relationships Project, and 4th R—have demonstrated reductions in dating violence behaviors in rigorous, controlled evaluations. In order to protect young people and build an evidence-base of effective prevention strategies, evaluation of additional programs is needed, including those programs currently in the field. The Expect Respect Support Groups (ERSG; provided by SafePlace) program is currently being implemented in the Austin Independent School District and demonstrated promising results in an uncontrolled program evaluation, suggesting a controlled evaluation is warranted to more rigorously examine program effects.

This extension request is the controlled evaluation of ERSG, which began in September 2010; it has one primary aim and two exploratory aims. The primary aim is to evaluate the effectiveness of ERSG to prevent and reduce teen dating violence and increase healthy conflict resolution skills reported by at-risk male and female middle and high school students compared to at-risk students in control schools who do not receive ERSG. The exploratory aims are: (1) To evaluate whether or not the effectiveness of ERSG is enhanced by the presence of a universal, school-wide prevention programs, and (2) To examine moderators and mediators of targeted and universal teen dating violence interventions, such as biological sex and history of abuse at intake. Completion of this study and examination of the primary and exploratory aims associated with it will help to fill a research gap by adding results to the evidence base regarding whether ERSG is a promising program for reducing the prevalence of teen dating violence and increasing knowledge of healthy relationship skills.

The purpose of this request is to obtain Office of Management and Budget (OMB) approval to extend the data collection for A Controlled Evaluation of Expect Respect Support Groups (ERSG): Preventing and Interrupting Teen Dating Violence among At-Risk Middle and High School Students (OMB No.0920–0861, Expiration 8/31/2013). CDC seeks a three-year approval to continue the ERSG project. The ongoing evaluation employs a quasi-experimental/non-randomized design in which a convenience sample of participants in schools receiving universal and/or targeted prevention services are compared to students in control schools in which no dating violence prevention services are available. We will recruit 1,800 students (300 per year from intervention schools and 300 per year from control schools) over three waves of data collection. Of the 1,800 students recruited, we anticipate 1,200 will have complete data at the end of the study period. Control schools have been selected that have characteristics (e.g., risk status, socio-economic status) similar to the Austin Independent School District intervention schools.

Survey items collect information about emotional, physical, and sexual peer and dating violence victimization and perpetration, use of healthy relationship skills, relationships characteristics, peer relationships, demographics, and use of other teen dating violence prevention services, social desirability, and attitudes toward dating violence. These measures were developed in collaboration with scientists at the Centers for Disease Control and Prevention and (1) are adapted from validated measures of teen dating violence, and (2) reflect the behaviors of interest and theory of change of Expect Respect. The Reactive Proactive Questionnaire (Raine et al., 2006) has also been included in the instrument packet and will be used to determine if subtype of aggression moderates response to intervention.

Participation in this study is voluntary and intrusions to the participants' sense of privacy will be minimized by only using data collected from students who have agreed for us to do so (through student assent and signed distribution of passive parental consent forms) and having the data coded in such a way to protect subjects' privacy.

Finally, ERSG facilitators will take part in qualitative interviews planned for the middle (December) and end (May) of the second and third years of data collection. The goal of these interviews is to better understand the implementation process for ERSG.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Response burden (hours)	Total burden hours
Intervention and Control Schools	Intake assessment	800	1	15/60	200
	Baseline Survey	600	1	1	600
	Completion Survey	400	1	1	400
	Follow-up Survey 1 (12 month)	400	1	1	400
ERSG Facilitator	ERSG Facilitator Program Implementation Fidelity Measure.	8	2	15/60	4
ERSG Facilitator Supervisor ERSG Facilitator	ERSG Observational Program Implementation Fidelity Measure.	1	16	15/60	4

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Response burden (hours)	Total burden hours
ERSG Facilitator	Mid-Year Qualitative Interview with ERSG Facilitators.	8	1	45/60	6
	End of Year Qualitative Interview with ERSG Facilitators.	8	1	1	8
Total					1,622

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–16772 Filed 7–12–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; CMS Computer Match No. 2013–07; HHS Computer Match No. 1303; DoD–DMDC Match No. 18

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice of Computer Matching Program (CMP).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, this notice announces the establishment of a CMP that CMS plans to conduct with the Department of Defense (DoD), Defense Manpower Data Center (DMDC). We have provided background information about the proposed matching program in the ''Supplementary Information'' section below. Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the proposed matching program, CMS invites comments on all portions of this notice. See ''Effective Dates'' section below for comment period.

DATES: *Effective Dates:* Public comments are due 30 days after publication. The matching program shall become effective no sooner than 40 days after the report of the Matching Program is sent to OMB and Congress, or 30 days after publication in the **Federal Register,** whichever is later.

ADDRESSES: The public should send comments to: CMS Privacy Officer, Division of Privacy Policy, Privacy Policy and Compliance Group, Office of E-Health Standards & Services, Offices of Enterprise Management, CMS, Room S2–24–25, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9:00 a.m.–3:00 p.m., Eastern Time zone.

FOR FURTHER INFORMATION CONTACT: Aaron Wesolowski, Director, Verifications Policy & Operations Branch, Division of Eligibility and Enrollment Policy and Operations, Center for Consumer Information and Insurance Oversight, CMS, 7501 Wisconsin Avenue, Bethesda, MD 20814, Office Phone: (301) 492–4416, Facsimile: (443) 380–5531, Email: *Aaron.Wesolowski@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Description of the Matching Program

A. General

The Computer Matching and Privacy Protection Act of 1988 (Public Law (Pub. L.) 101–503), amended the Privacy Act (5 U.S.C. 552a) by describing the manner in which computer matching involving Federal agencies could be performed and adding certain protections for individuals applying for and receiving Federal benefits. Section 7201 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) further amended the Privacy Act regarding protections for such individuals. The Privacy Act, as amended, regulates the use of computer matching by Federal agencies when records in a system of records are matched with other Federal, state, or local government records. It requires Federal agencies involved in computer matching programs to:

1. Negotiate written agreements with the other agencies participating in the matching programs;
2. Obtain the Data Integrity Board approval of the match agreements;
3. Furnish detailed reports about matching programs to Congress and OMB;
4. Notify applicants and beneficiaries that the records are subject to matching; and,
5. Verify match findings before reducing, suspending, terminating, or denying an individual's benefits or payments.

B. CMS Computer Matches Subject to the Privacy Act

CMS has taken action to ensure that all CMPs that this Agency participates in comply with the requirements of the Privacy Act of 1974, as amended.

Dated: July 6, 2013.

Michelle Snyder,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

CMS Computer Match No. 2013–07
HHS Computer Match No. 1303
DoD–DMDC Match No. 18

NAME:

''Computer Matching Agreement between the Department of Health and Human Services, Centers for Medicare & Medicaid Services and the Department of Defense, Defense Manpower Data Center for the Determination of Eligibility for the Advance Premium Tax Credit and Cost Sharing Reductions under the Affordable Care Act.''

SECURITY CLASSIFICATION:

Unclassified.

PARTICIPATING AGENCIES:

Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), and Department of Defense (DoD), Defense Manpower Data Center (DMDC).

AUTHORITY FOR CONDUCTING MATCHING PROGRAM:

This Computer Matching Program (CMP) is executed to comply with the provisions of the Privacy Act of 1974 (5 U.S.C. 552a), as amended, the Office of Management and Budget (OMB) Circular A–130 entitled, ''Management of Federal Information Resources,'' at 61 FR 6428–6435 (February 20, 1996), and OMB guidelines pertaining to computer

matching at 54 FR 25818 (June 19, 1989) and 56 FR 18599 (April 23, 1991); and the computer matching portions of Appendix I to OMB Circular No. A–130 as amended at 61 Fed. Reg. 6428 (February 20, 1996).

PURPOSE(S) OF THE MATCHING PROGRAM:

This Computer Matching Agreement (CMA) establishes the terms, conditions, safeguards, and procedures under which DoD will provide records, information, or data to CMS for purposes of determining eligibility for advance payment of premium tax credits and cost sharing reductions under the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively, the ACA).

Under this CMA, DoD will assist CMS by providing certain DoD data which is needed to make Eligibility Determinations. Data will be matched for the purpose of assisting CMS or a State-based Exchange to determine eligibility for the following benefits: (1) An advance premium tax credit under 26 U.S.C. 36B and (2) a cost sharing reduction under Section 1402 of the ACA. Specifically, CMS will use DoD data to verify an Applicant or Enrollee's eligibility for TRICARE health care as required under § 1411(c) of the ACA, which constitutes minimum essential coverage as defined in section 5000A(f) of the Internal Revenue Code of 1986, 26 U.S.C. 5000A, as amended by § 1501 of the ACA. This data will be used by CMS in its capacity as a Federally-facilitated Exchange, and by State-based Exchanges that will receive the results of verifications using DoD data accessed through the CMS Data Services Hub.

DESCRIPTION OF RECORDS TO BE USED IN THE MATCHING PROGRAM: SYSTEM OF RECORDS MAINTAINED BY CMS

The matching program will be conducted with data maintained by CMS in the ''Health Insurance Exchanges (HIX) Program,'' System No. 09–70–0560, established at 78 FR 8538 on February 6, 2013, and amended at 78 FR 32256 on May 29, 2013.

The matching program will also be conducted with data maintained by DoD in the Defense Enrollment Eligibility Reporting System (DEERS), System No. DMDC 02 DoD, published November 21, 2012, 77 FR 69807, located at the EDS Service Management Center in Auburn Hills, MI.

INCLUSIVE DATES OF THE MATCH:

The CMP shall become effective no sooner than 40 days after the report of the Matching Program is sent to OMB and Congress, or 30 days after publication in the **Federal Register**, whichever is later. The matching program will continue for 18 months from the effective date and may be extended for an additional 12 months thereafter, if certain conditions are met.

[FR Doc. 2013–16845 Filed 7–12–13; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: New Runaway and Homeless Youth Management Information System (NEORHYMIS).

OMB No.: 0970–0123.

Description: The Runaway and Homeless Youth Act, as amended by Public Law 106–71 (42 U.S.C. 5701 et seq.), mandates that the Department of Health and Human Services (HHS) report regularly to Congress on the status of HHS-funded programs serving runaway and homeless youth. Such reporting is similarly mandated by the Government Performance and Results Act. Organizations funded under the Runaway and Homeless Youth program are required by statute (42 U.S.C. 5712, 42 U.S.C. 5714–2) to meet certain data collection and reporting requirements. These requirements include maintenance of client statistical records on the number and the characteristics of the runaway and homeless youth, and youth at risk of family separation, who participate in the project, and the services provided to such youth by the project.

Respondents: The Runaway and Homeless Youth Act, as amended by Public Law 106–71 (42 U.S.C. 5701 et seq.), mandates that the Department of Health and Human Services (HHS) report regularly to Congress on the status of HHS-funded programs serving runaway and homeless youth. Such reporting is similarly mandated by the Government Performance and Results Act. Organizations funded under the Runaway and Homeless Youth program are required by statute (42 U.S.C. 5712, 42 U.S.C. 5714–2) to meet certain data collection and reporting requirements. These requirements include maintenance of client statistical records on the number and the characteristics of the runaway and homeless youth, and youth at risk of family separation, who participate in the project, and the services provided to such youth by the project.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Youth Profile (TLP and BCP Only)	516	79	0.25	10,191
Street Outreach Report	149	9	0.05	67
Brief Contacts	184	114	0.05	1049
Turnaways	95	4	0.05	19
Data Transfer	516	2	0.50	516

Estimated Total Annual Burden Hours: 11,842.

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. Email address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary

for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2013–16842 Filed 7–12–13; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects:

Title: Renewal of Office of Community Services (OCS) Community Economic Development (CED) Standard Reporting Format

OMB No.: 0970–0386

Description: The Office of Community Services (OCS) will continue collecting key information about projects funded through the Community Economic Development (CED) program. The legislative requirement for this program is in Title IV of the Community Opportunities, Accountability and Training and Educational Services Act (COATS Human Services Reauthorization Act) of October 27, 1998, Public Law 105–285, section 680(b) as amended. The reporting format, Performance Progress Report (PPR), collects information concerning the outcomes and management of CED projects. OCS will use the data to critically review the overall design and effectiveness of the program.

The PPR will continue to be administered to all active grantees of the CED program. Grantees will be required to use this reporting tool for their semi-annual reports to be submitted twice a year. The current PPR replaced both the annual questionnaire and other semi-annual reporting formats, which resulted in an overall reduction in burden for the grantees while significantly improving the quality of the data collected by OCS. OCS seeks to renew this PPR to continue to collect quality data from grantees. To ensure the burden on grantees is not increased, all questions on the current PPR will remain the same—we propose adding only one question to the PPR regarding the total number of jobs grantees are creating with grant funds. Many grantees have asked about this element on the current PPR and currently do not have a place to report that information. This is information that most grantees are already collecting. Adding this field will allow grantees to provide this information in a consistent format and allow OCS to more accurately reflect the total number of jobs created through the CED program. Since grantees are already familiar with the current format and elements, and all questions on the PPR will remain the same (with one added question based on grantee feedback), there will be no additional burden on grantees.

Respondents: Current CED grantees.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Questionnaire for current OCS–CED grantees	170	2	1.50	510

Estimated Total Annual Burden Hours: 510

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. Email address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2013–16874 Filed 7–12–13; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0375]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Agreement for Shipment of Devices for Sterilization

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by August 14, 2013.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to *oira_submission@omb.eop.gov.* All comments should be identified with the OMB control number 0910–0131. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Daniel Gittleson, Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, 301–796–5156, *Daniel.Gittleson@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Agreement for Shipment of Devices for Sterilization—21 CFR 801.150(e) (OMB Control Number 0910–0131)—Extension

Under sections 501(c) and 502(a) of the Federal Food, Drug, and Cosmetic Act (the FD&C Act) (21 U.S.C. 351(c) and 352(a)), nonsterile devices that are labeled as sterile but are in interstate transit to a facility to be sterilized are adulterated and misbranded. FDA regulations in § 801.150(e) (21 CFR 801.150(e)) establish a control mechanism by which firms may manufacture and label medical devices as sterile at one establishment and ship the devices in interstate commerce for sterilization at another establishment, a practice that facilitates the processing of devices and is economically necessary for some firms. Under § 801.150(e)(1), manufacturers and sterilizers may sign an agreement containing the following: (1) Instructions for maintaining accountability of the number of units in each shipment, (2) acknowledgment that the devices that are nonsterile are being shipped for further processing, and (3) specifications for sterilization processing. This agreement allows the manufacturer to ship misbranded products to be sterilized without initiating regulatory action and provides FDA with a means to protect consumers from use of nonsterile products. During routine plant inspections, FDA normally reviews agreements that must be kept for 2 years after final shipment or delivery of devices (§ 801.150(a)(2)).

The respondents to this collection of information are device manufacturers and contract sterilizers. FDA's estimate of the reporting burden is based on actual data obtained from industry over the past several years where there are approximately 90 firms subject to this requirement. It is estimated that each of these firms on the average prepares 20 written agreements each year. This estimate varies greatly, from 1 to 100, because some firms provide sterilization services on a part-time basis for only one customer, while others are large facilities with many customers. The average time required to prepare each written agreement is estimated to be 4 hours. This estimate varies depending on whether the agreement is the initial agreement or an annual renewal, on the format each firm elects to use, and on the length of time required to reach agreement. The estimate applies only to those portions of the written agreement that pertain to the requirements imposed by this regulation. The written agreement generally also includes contractual agreements that are a customary and usual business practice. On the average, the total annual recordkeeping burden is 7,200 hours.

The recordkeeping requirements of § 801.150(a)(2) consist of making copies and maintaining the actual reporting requests which were required under the reporting section of this collection. To fulfill this requirement, FDA estimates it will take about 30 minutes to copy each package, for a total of 900 recordkeeping hours.

In the **Federal Register** of April 5, 2013 (78 FR 20658), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

Activity/21 CFR section	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Agreement and labeling requirements, § 801.150(e)	90	20	1,800	4	7,200

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2—ESTIMATED ANNUAL RECORDKEEPING BURDEN [1]

Activity/21 CFR section	Number of recordkeepers	Number of records per recordkeeper	Total annual records	Average Burden per Recordkeeping	Total hours
Record retention, § 801.150(a)(2)	90	20	1,800	[2] 0.5	900

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.
[2] 30 minutes.

Dated: July 10, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16867 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0812]

Electronic Study Data Submission; Data Standard Support; Availability of the Center for Drug Evaluation and Research Data Standards Program Documents

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Center for Drug Evaluation and Research (CDER) of the Food and Drug Administration (FDA) is announcing the availability of the CDER Data Standards Strategy (version 1.0) and the CDER Data Standards Strategy—Action Plan (version 1.0). This action is being taken to ensure that all interested stakeholders are aware that the data standards program documents are available and is intended to increase awareness of CDER's data standards plans, ongoing projects, and avenues of communication. Comments may be submitted to the email address listed below.

FOR FURTHER INFORMATION CONTACT: Office of Strategic Programs, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 1100, Silver Spring, MD 20993, 301–796–3800; email: *CDERDataStandards@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION:

On December 5, 2012, the CDER Data Standards Strategy (version 1.0) was released. Its purpose is to reinforce FDA's ongoing commitment to the development, implementation, and maintenance of a comprehensive data standards program to facilitate the efficient and effective review of regulatory submissions so that safe and effective products can get to market sooner. It is aligned with the objectives of FDA's Strategic Plan and the performance goals of the Prescription Drug User Fee Act V Reauthorization as captured in the FDA Safety and Innovation Act. The CDER Data Standards Strategy supersedes version 1.1 of the CDER Data Standards Plan, which was issued in December 2010.

The first release of the companion document to the Data Standards Strategy, the CDER Data Standards Strategy—Action Plan, was issued on March 20, 2013. The Action Plan provides internal and external stakeholders with an overview and progress of current relevant data standards initiatives. The plan will be updated quarterly to indicate progress of current projects as well as initiation of new projects.

These documents are available from the CDER Data Standards Program Web site at: *http://www.fda.gov/Drugs/DevelopmentApprovalProcess/FormsSubmissionRequirements/ElectronicSubmissions/ucm249979.htm.*

Dated: July 10, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16861 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0010]

Cooperative Agreement to Support the World Trade Organization's Standards and Trade Development Facility

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing its intention to receive and consider a single source application for the award of a cooperative agreement in fiscal year 2013 (FY 2013) to the World Trade Organization's (WTO) Standards and Trade Development Facility (STDF).

DATES: Important dates are as follows:

1. The application due date is August 1, 2013.
2. The anticipated start date is September 2013.
3. The expiration date is August 2, 2013.

ADDRESSES: Submit electronic applications to: *http://www.grants.gov.* For more information, see section III of the **SUPPLEMENTARY INFORMATION** section of this notice.

FOR FURTHER INFORMATION CONTACT: *Scientific/Programmatic Contact:* Julie Moss, Center for Food Safety and Applied Nutrition (HFS–550), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740, 240–402–2031, email: *julie.moss@fda.hhs.gov.*

Grants Management Contact: Kimberly Pendleton Chew, Office of Acquisitions and Grant Services (HFA–500), Food and Drug Administration, 5630 Fishers Lane, rm. 2105, Rockville, MD 20857, 301–827–9363, email: *kimberly.pendleton@fda.hhs.gov.*

For more information on this funding opportunity announcement (FOA) and to obtain detailed requirements, please refer to the full FOA located at *www.fda.gov/food/newsevents/default.htm.*

SUPPLEMENTARY INFORMATION:

I. Funding Opportunity Description

RFA–FD–13–036

93.103

A. Background

The STDF is a unique global partnership established by the Food and Agriculture Organization, World Organization for Animal Health, World Bank, World Health Organization (WHO) and the WTO. The STDF supports developing countries in building their capacity to implement international sanitary and phytosanitary (SPS) standards, guidelines, and recommendations as a means to improve their human, animal, and plant health status and ability to gain or maintain access to markets. In achieving its aims, the STDF acts as both a coordinating and a financing mechanism.

The STDF is a widely established knowledge platform for information exchange, sharing experiences and the identification and dissemination of good practice on SPS-related technical cooperation. Since 2004, over 60 projects and 52 project preparation grants have assisted developing countries to overcome SPS constraints, and gain and maintain market access. Over 50% have benefited least developed and other low-income countries.

The STDF utilizes a key decision-support tool, Multi-Criteria Decision Analysis (MCDA), to help establish SPS priorities and ensure resources are used as efficiently as possible. The use of the MCDA tool is unique within the STDF and is a highly-valued attribute; the MCDA tool facilitates an open and transparent discussion among public and private stakeholders about capacity-building needs and resources. The STDF is committed to the Paris Principles on Aid Effectiveness and to achieving the Millennium Development Goals.

With an increasingly diverse and complex global food supply, FDA's interest is to strengthen food safety systems globally to prevent food safety

problems rather than merely reacting to problems after they occur. FDA recognizes that it cannot do this alone. By leveraging with other WTO member countries and partnering with the STDF, FDA can broaden the reach of food safety capacity building efforts.

This cooperative agreement will allow FDA to deepen its international food safety capacity building partnerships, provide a wider scope of impact than exists currently and leverage resources with other countries.

B. Research Objectives

The purpose of this cooperative agreement is to:

1. Contribute to the knowledge base and development of food safety systems globally due to the increasingly diverse and complex food supply;
2. Enhance and broaden FDA's ability to address global food safety and public health issues associated with food;
3. Provide opportunities to leverage additional resources among WTO member countries;
4. Support FDA's Food Safety Modernization Act (FSMA) and its International Food Safety Capacity Building Plan, which emphasizes the concept of preventing food safety-related problems before they occur and the importance of establishing strong relationships and mutual support among all stakeholders, including multilateral organizations, to improve worldwide food safety.

C. Eligibility Information

Competition is limited to the STDF hosted by the WTO. The STDF is a global partnership with a well-established, trusted presence and is uniquely qualified to further the global food safety capacity building objectives of this cooperative agreement. STDF's mandate is to: (1) Increase awareness, mobilize resources, strengthen collaboration, identify and disseminate good practice; and (2) provide support and funding for the development and implementation of projects that promote compliance with international SPS requirements.

An independent external evaluation of the STDF in 2008 concluded that the STDF ''carries out an important role that no other single body would be able to accomplish.'' (Source: STDF Newsletter, Vol. 2, Issue 1, February 2009, accessible at: *www.standardsfacility.org*) As such, the STDF is uniquely equipped to fulfill the objectives of this cooperative agreement due to its diverse access to WTO members in both developed and developing countries and its ability to coordinate capacity building programs at a national, regional, and global level. Engaging the STDF through this cooperative agreement will provide FDA with ample opportunities to leverage additional resources among WTO member countries.

Overall, the objectives of the STDF are directly in line with the objectives of this cooperative agreement. This ability to advance the objectives of this cooperative agreement through member country engagement and leveraging is a requisite for success.

II. Award Information/Funds Available

A. Award Amount

The Center for Food Safety and Applied Nutrition intends to fund one award up to $750,000 total costs (direct plus indirect costs) for FY 2013. Future year amounts will depend on annual appropriations and successful performance.

B. Length of Support

The award will provide 1 year of support and include future recommended support for 4 additional years, contingent upon satisfactory performance in the achievement of project and program reporting objectives during the preceding year and the availability of Federal fiscal year appropriations.

III. Electronic Application, Registration, and Submission

Only electronic applications will be accepted. To submit an electronic application in response to this FOA, applicants should first review the full announcement located at *www.fda.gov/food/newsevents/default.htm.* (FDA has verified the Web site addresses throughout this document, but FDA is not responsible for any subsequent changes to the Web sites after this document publishes in the **Federal Register**.) For all electronically submitted applications, the following steps are required.

- Step 1: Obtain a Dun and Bradstreet (DUNS) Number
- Step 2: Register With System for Award Management (SAM)
- Step 3: Obtain Username & Password
- Step 4: Authorized Organization Representative (AOR) Authorization
- Step 5: Track AOR Status
- Step 6: Register With Electronic Research Administration (eRA) Commons Steps 1 through 5, in detail, can be found at *http://www07.grants.gov/applicants/organization_registration.jsp.* Step 6, in detail, can be found at *https://commons.era.nih.gov/commons/registration/registrationInstructions.jsp.* After you have followed these steps, submit electronic applications to: *http://www.grants.gov.*

Dated: July 10, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16860 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–D–0814]

Draft Guidance for Industry on Pediatric Study Plans: Content of and Process for Submitting Initial Pediatric Study Plans and Amended Pediatric Study Plans; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled ''Pediatric Study Plans: Content of and Process for Submitting Initial Pediatric Study Plans and Amended Pediatric Study Plans.'' This draft guidance is intended to provide information to industry on how to submit initial and amended pediatric study plans (PSPs) as required under the Federal Food, Drug, and Cosmetic Act (FD&C Act) as amended by the Food and Drug Administration Safety and Innovation Act (FDASIA).

DATES: Although you can comment on any guidance at any time (see 21 CFR 10.115(g)(5)), to ensure that the Agency considers your comment on this draft guidance before it begins work on the final version of the guidance, submit either electronic or written comments on the draft guidance by September 13, 2013.

ADDRESSES: Submit written requests for single copies of the draft guidance to the Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 2201, Silver Spring, MD 20993–0002, or Office of Communication, Outreach, and Development (HFM–40), Center for Biologics Evaluation and Research, Food and Drug Administration, 1401 Rockville Pike, Suite 200N, Rockville, MD 20852–1448. Send one self-addressed adhesive label to assist that office in processing your requests. See the **SUPPLEMENTARY INFORMATION** section

for electronic access to the draft guidance document.

Submit electronic comments on the draft guidance to *http://www.regulations.gov.* Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Rosemary Addy, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 22, Rm. 6312, Silver Spring, MD 20993–0002, 301–796–1640; or Stephen Ripley, Center for Biologics Evaluation and Research (HFM–17), Food and Drug Administration, 1401 Rockville Pike, Suite 200N, Rockville, MD 20852, 301–827–6210.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a draft guidance for industry entitled ''Pediatric Study Plans: Content of and Process for Submitting Initial Pediatric Study Plans and Amended Pediatric Study Plans.'' The purpose of this draft guidance is to assist sponsors in the submission of an initial PSP and any amendments to the PSP. Specifically, this guidance addresses FDA's current thinking regarding implementation of the requirement for sponsors to submit an initial PSP under section 505B of the FD&C Act as amended by FDASIA (Pub. L. 112–144, 126 Stat. 993 (enacted July 9, 2012)).

This draft guidance addresses topics related to the submission of an initial PSP and any amendments to the PSP, including who must submit an initial PSP, when a PSP must be submitted, what is expected to be included in an initial PSP, and what is expected to be included in a requested amendment to an initial PSP. The guidance also includes a template that should be used for submission of an initial PSP.

This draft guidance does not contain a discussion of general requirements for pediatric drug development under the Pediatric Research Equity Act. That topic is addressed in the draft guidance for industry entitled ''How to Comply With the Pediatric Research Equity Act.'' [1]

This draft guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the Agency's current thinking on the content of and process for submitting initial PSPs and amended PSPs. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. The Paperwork Reduction Act of 1995

This draft guidance includes information collection provisions that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520). The collections of information referenced in this draft guidance that are related to the burden on the submission of investigational new drug applications are covered under 21 CFR Part 312, including plans for pediatric studies under 21 CFR 312.47(b)(1)(iv) and waiver requests under 21 CFR 312.10, and have been approved under OMB control number 0910–0014. The collections of information referenced in this draft guidance that are related to the burden on the submission of new drug applications are covered under 21 CFR Part 314, including pediatric use information under 21 CFR 314.50(d)(7) and waiver requests under 21 CFR 314.90, and have been approved under OMB control number 0910–0001. The collections of information referenced in this draft guidance that are related to the burden on the submission of biologic license applications are covered under 21 CFR Part 601, including pediatric use information and waiver requests under 21 CFR 601.27, and have been approved under OMB control number 0910–0338.

Sponsors are already required to submit plans for pediatric studies and often provide the information outlined in this guidance pursuant to the regulations noted above. The new FDASIA provisions primarily serve to establish a more precise timeline for the submission of that information; however, some of the information may be considered a new collection of information. Federal law at 44 U.S.C. 3506(c)(2)(A) requires Federal Agencies to publish a 60-day notice in the **Federal Register** for each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA will publish a 60-day notice of the proposed collection of information in a future issue of the **Federal Register** for any information collections recommended in this guidance that may be considered new or that would represent material modifications to those previously approved collections of information found in FDA regulations or guidances.

III. Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see **ADDRESSES**). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov.*

IV. Electronic Access

Persons with access to the Internet may obtain the document at *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm*, *http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/default.htm,* or *http://www.regulations.gov.*

Dated: July 9, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16825 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

[1] When final, this guidance will represent the FDA's current thinking on this topic. For the most recent version of a guidance, check the FDA Drugs guidance Web page at *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2012–D–0322]

Draft Guidance for Industry on Arsenic in Apple Juice: Action Level; Supporting Document for Action Level for Arsenic in Apple Juice; A Quantitative Assessment of Inorganic Arsenic in Apple Juice; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled ''Arsenic in Apple Juice: Action Level'' and two supporting documents entitled ''Supporting Document for Action Level for Arsenic in Apple Juice'' (the draft supporting document) and ''A Quantitative Assessment of Inorganic Arsenic in Apple Juice'' (the risk assessment document). The supporting documents are referenced in the draft guidance. The

draft guidance identifies for the industry an action level for inorganic arsenic in apple juice that FDA considers protective of human health and achievable with the use of good manufacturing practices. It also describes FDA's intended sampling and enforcement approach.

DATES: Although you can comment on any guidance at any time (see 21 CFR 10.115(g)(5)), to ensure that the Agency considers your comment on the draft guidance before it begins work on the final version of the guidance, submit either electronic or written comments on the draft guidance by September 13, 2013.

ADDRESSES: Submit electronic comments on the draft guidance to *http://www.regulations.gov*. Submit written comments on the draft guidance to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852. Submit written requests for single copies of the draft guidance to the Office of Food Safety, Center for Food Safety and Applied Nutrition (HFS–317), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740. Send two self-addressed adhesive labels to assist that office in processing your request. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance.

FOR FURTHER INFORMATION CONTACT: Lauren Posnick Robin, Center for Food Safety and Applied Nutrition (HFS–317), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740, 240–402–1639.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of three documents, a draft guidance for industry entitled ''Arsenic in Apple Juice: Action Level'' and supporting documents referenced in the draft guidance, including a draft supporting document entitled ''Supporting Document for Action Level for Arsenic in Apple Juice'' and a risk assessment document entitled ''A Quantitative Assessment of Inorganic Arsenic in Apple Juice.'' The draft guidance identifies an action level for inorganic arsenic in apple juice of 10 micrograms/kilogram (µg/kg) or 10 parts per billion (ppb), and identifies FDA's intended sampling and enforcement approach. The draft supporting document reviews data on arsenic levels, health effects, and achievability, and explains FDA's rationale for identifying an action level for inorganic arsenic in apple juice of 10 µg/kg. The risk assessment document provides estimates of arsenic exposure and risk to humans at different hypothetical limits for inorganic arsenic in apple juice.

FDA considers the 10 µg/kg action level to be protective of human health and to be achievable with the use of good manufacturing practices, but FDA especially welcomes comments and information bearing on the achievability of 10 µg/kg, as compared with other potential action levels. Consistent with 21 CFR 109.6, FDA intends to consider the action level of 10 ug/kg or 10 ppb inorganic arsenic, in addition to other factors, when considering whether to bring enforcement action in a particular case.

The draft guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the Agency's current thinking on arsenic in apple juice. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternate approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may submit either electronic or written comments regarding this document according to the instructions in the **ADDRESSES** section of this document. It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the draft guidance, the draft supporting document, and the risk assessment document at either *http://www.fda.gov/FoodGuidances* or *http://www.regulations.gov*. Always access an FDA document using the FDA Web site listed previously to find the most current version of the guidance.

Dated: July 8, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16719 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0001]

Risk Communications Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Risk Communications Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the Agency on FDA's regulatory issues.

Date and Time: The meeting will be held on August 16, 2013, from 9 a.m. to 5 p.m.

Location: FDA White Oak Campus, 10903 New Hampshire Ave., Building 31 Conference Center, the Great Room (Rm. 1503), Silver Spring, MD 20993–0002. Information regarding special accommodations due to a disability, visitor parking, and transportation may be accessed at: *http://www.fda.gov/AdvisoryCommittees/default.htm*; under the heading ''Resources for You,'' click on ''Public Meetings at the FDA White Oak Campus.'' Please note that visitors to the White Oak Campus must enter through Building 1.

Contact Person: Luis G. Bravo, Risk Communication Staff, Office of Planning, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Rm. 3274, Silver Spring, MD 20993–0002, 240–402–5274, FAX: 301–847–8609, email: *RCAC@fda.hhs.gov,* or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area). A notice in the **Federal Register** about last minute modifications that impact a previously announced advisory committee meeting cannot always be published quickly enough to provide timely notice. Therefore, you should always check the Agency's Web site at *http://www.fda.gov/AdvisoryCommittees/default.htm* and scroll down to the appropriate advisory committee meeting link, or call the advisory committee information line to learn about possible modifications before coming to the meeting.

Agenda: On August 16, 2013, the Committee will discuss how FDA can communicate more effectively with

health care professionals and other stakeholders about the public health risks posed by counterfeit and unapproved drugs, in addition to safe purchasing practices, and how FDA can evaluate that communication and its impact.

FDA intends to make background material available to the public no later than 2 business days before the meeting. If FDA is unable to post the background material on its Web site prior to the meeting, the background material will be made publicly available at the location of the advisory committee meeting, and the background material will be posted on FDA's Web site after the meeting. Background material is available at *http://www.fda.gov/AdvisoryCommittees/Calendar/default.htm*. Scroll down to the appropriate advisory committee meeting link.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person on or before August 8, 2013. Oral presentations from the public will be scheduled between approximately 1 p.m. and 2 p.m. Those individuals interested in making formal oral presentations should notify the contact person and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation on or before July 31, 2013. Time allotted for each presentation may be limited. If the number of registrants requesting to speak is greater than can be reasonably accommodated during the scheduled open public hearing session, FDA may conduct a lottery to determine the speakers for the scheduled open public hearing session. The contact person will notify interested persons regarding their request to speak by August 1, 2013.

Persons attending FDA's advisory committee meetings are advised that the Agency is not responsible for providing access to electrical outlets.

FDA welcomes the attendance of the public at its advisory committee meetings and will make every effort to accommodate persons with physical disabilities or special needs. If you require special accommodations due to a disability, please contact Luis G. Bravo at least 7 days in advance of the meeting.

FDA is committed to the orderly conduct of its advisory committee meetings. Please visit our Web site at *http://www.fda.gov/AdvisoryCommittees/AboutAdvisoryCommittees/ucm111462.htm* for procedures on public conduct during advisory committee meetings.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: July 9, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16831 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0001]

Anesthetic and Analgesic Drug Products Advisory Committee; Cancellation

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The meeting of the Anesthetic and Analgesic Drug Products Advisory Committee scheduled for July 17, 2013, is cancelled. This meeting was announced in the **Federal Register** of May 17, 2013 (78 FR 29142 to 29143). This meeting has been canceled due to new information submitted to the application. The Agency intends to continue evaluating the application and, as needed, will announce future meeting dates in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Caleb Briggs, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 31, Rm. 2417, Silver Spring, MD 20993–0002, 301–796–9001, FAX: 301–847–8533, email: *AADPAC@fda.hhs.gov*, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), and follow the prompts to the desired center or product area. Please call the Information Line for up-to-date information on this meeting.

Dated: July 9, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16823 Filed 7–12–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects (Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995), the Health Resources and Services Administration (HRSA) announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this Information Collection Request must be received within 60 days of this notice.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance Officer, Room 10–29, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call the HRSA Information Collection Clearance Officer at (301) 443–1984.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the information request collection title for reference.

Information Collection Request Title: National Hospital Organ Donation Campaign's Activity Scorecard. OMB No. 0915-xxxx—New.

Need and Proposed Use of the Information: HRSA's Healthcare Systems Bureau, Division of Transplantation administers the Workplace Partnership for Life program under the authority of Section 377A(a) of the Public Health Service (PHS) Act, (42 U.S.C. 274f-1). The Workplace Partnership for Life program seeks to increase the number of registered organ, eye, and tissue donors and to increase awareness about organ donation. HRSA launched a challenge to hospitals nationwide to assist in this effort by conducting donor education and donor

registry enrollment events in their hospitals and communities. The nation's 58 organ procurement organizations (OPOs), who already work with hospitals on clinical aspects of transplantation, are invited to participate in HRSA's National Hospital Organ Donation Campaign to increase the number of enrollments in state donor registries. The Campaign supports OPOs by providing fresh communications materials, facilitating the sharing of best practices, leveraging the influence of national associations and organizations related to hospitals and organ donation, and offering the additional incentive of national-level recognition to hospitals.

The National Hospital Organ Donation Campaign's Activity Scorecard is one piece of this campaign. A campaign leadership committee comprised of representatives from OPOs, Donate Life America (DLA) affiliates, and hospitals helped conceptualize the Activity Scorecard which is based on the committee's experience of hospital receptivity to friendly competition and the opportunity to be recognized among their peers. The Activity Scorecard provides hospitals that wish to participate in the campaign with ideas for outreach activities. Each activity on the programmable PDF is assigned a particular number of points based on the activity's potential for generating registrations.

Hospitals can complete the Activity Scorecard and submit it by email or fax it to HRSA or to their OPO or DLA. This is a voluntary activity. Hospitals can participate in the campaign without using the Activity Scorecard. HRSA anticipates that most hospitals enrolled in the campaign (currently 802) will submit a completed Activity Scorecard once a year.

Most importantly, the Activity Scorecard provides incentive for hospitals to conduct activities that will increase the number of registered donors throughout the nation. A list of hospitals that reach these levels will be shared with all campaign participants during monthly webinars, in monthly campaign e-newsletters from HRSA, and in communications pieces sent out by the campaign's ten national partners, which include the American Hospital Association, the Association of Organ Procurement Organizations, and the American Society of Transplant Surgeons. In addition, OPOs, DLA affiliates, participating state hospital associations, HRSA, and the national partners can use the results to recognize hospital participation and successes. The ''write-in'' option that allows hospitals to list additional activities will help to identify best practices that can be shared with all hospital partners on monthly webinars.

Likely Respondents: A hospital representative, most often the organ donation champion identified by the OPO, can download the form from *organdonor.gov* or receive it from their OPO or Donate Life America (DLA) affiliate.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this Information Collection Request are summarized in the table below.

Total Estimated Annualized burden hours:

Form Name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Name of instrument	802	1	802	1	802
Total	802	1	802	1	802

HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Dated: July 8, 2013.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

[FR Doc. 2013–16894 Filed 7–12–13; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Statement of Organization, Functions and Delegations of Authority

This notice amends Part R of the Statement of Organization, Functions and Delegations of Authority of the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) (60 FR 56605, as amended November 6, 1995; as last amended at 78 FR 38720–38723 dated June 27, 2013).

This notice reflects organizational changes in the Health Resources and Services Administration (HRSA). This notice updates the functional statements for the Office of Communications and the Office of Management. Specifically, this notice: (1) Transfers the Freedom of Information Act function from the Office of Communications (RA6) to the Office of Management (RB4), Division of Policy and Information Coordination (RB41); and (2) updates the functional statements for the Office of Communications, the Office of Management, and the Division of Policy and Information Coordination.

Chapter RA6—Office of Communications

Section RA6–20, Functions

Delete the functional statement for the Office of Communications (RA6) and replace in its entirety with the following:

The Office of Communications (RA6) provides leadership and general policy and program direction, and conducts and coordinates communications and public affairs activities of the agency.

Specifically, the Office of Communications: (1) Serves as focal point for coordination of agency communications activities with those of other health agencies within the Department of Health and Human Services and with field, state, local, voluntary, and professional organizations; (2) develops and implements national communications initiatives to inform and educate the public, health care professionals, policy makers, and the media; (3) coordinates, researches, writes, and prepares speeches and audiovisual presentations for the HRSA Administrator and staff; (4) provides communication and public affairs expertise and staff advice and support to the Administrator in program and policy formulation and execution consistent with policy direction established by the Assistant Secretary for Public Affairs; (5) develops and implements policies and procedures related to external media relations and internal employee communications including those for the development, review, processing, quality control, and dissemination of agency communications materials, including exhibits and those disseminated electronically; (6) serves as Communications and Public Affairs Officer for the agency including establishment and maintenance of productive relationships with the news media; (7) serves as focal point for intergovernmental affairs for the agency; and (8) manages audio, visual, and multimedia activities in support of communications efforts through multiple media formats.

Chapter RB4—Office of Management

Section RB4–20, Functions

Delete the functional statement for the immediate Office of Management (RB4) and the Division of Policy and Information Coordination (RB41) and replace in its entirety with the following:

Office of Management (RB4)

Provides HRSA-wide leadership, program direction, and coordination of all phases of administrative management. Specifically, the Office of Management: (1) Provides management expertise, staff advice, and support to the Administrator in program and policy formulation and execution; (2) provides administrative management services including human resources, property management, space planning, safety, physical security, and general administrative services; (3) conducts HRSA-wide workforce analysis studies and surveys; (4) plans, directs, and coordinates HRSA's activities in the areas of human resources management, including labor relations, personnel security, and performance; (5) coordinates the development of policy and regulations; (6) oversees the development of annual operating objectives and coordinates HRSA work planning and appraisals; (7) directs and coordinates the agency's organizations, functions and delegations of authority programs; (8) administers the agency's Executive Secretariat and committee management functions; (9) provides staff support to the agency Chief Travel Official; (10) provides staff support to the Deputy Ethics Counselor; (11) directs, coordinates, and conducts workforce development activities for the agency; and (12) coordinates the implementation of the Freedom of Information Act for the agency.

Division of Policy and Information Coordination (RB41)

(1) Advises the Administrator and other key agency officials on cross-cutting policy issues and assists in the identification and resolution of cross-cutting policy issues and problems; (2) establishes and maintains tracking systems that provide HRSA-wide coordination and clearance of policies, regulations and guidelines; (3) plans, organizes and directs the Executive Secretariat with primary responsibility for preparation and management of written correspondence; (4) arranges briefings for Department officials on critical policy issues and oversees the development of necessary briefing documents; (5) coordinates the preparation of proposed rules and regulations relating to HRSA programs and coordinates review and comment on other Department regulations and policy directives that may affect HRSA programs; (6) oversees and coordinates the committee management activities; and (7) coordinates the review and publication of **Federal Register** Notices; and (8) coordinates the implementation of the Freedom of Information Act for the agency.

Section RB4–30, Delegations of Authority

All delegations of authority and re-delegations of authority made to HRSA officials that were in effect immediately prior to this reorganization, and that are consistent with this reorganization, shall continue in effect pending further re-delegation.

This reorganization is effective upon date of signature.

Dated: July 9, 2013.

Mary K. Wakefield,

Administrator.

[FR Doc. 2013–16899 Filed 7–12–13; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Submission for OMB Review; 30-day Comment Request; NIH Office of Intramural Training & Education Application

SUMMARY: Under the provisions of Section 3507(a)(1)(D) of the Paperwork Reduction Act of 1995, the National Institutes of Health (NIH) has submitted to the Office of Management and Budget (OMB) a request for review and approval of the information collection listed below. This proposed information collection was previously published in the **Federal Register** on March 24, 2013, page 17935–17936 and allowed 60-days for public comment. One public comment was received. The purpose of this notice is to allow an additional 30 days for public comment. The Office of the Director (OD), National Institutes of Health, may not conduct or sponsor, and the respondent is not required to respond to, an information collection that has been extended, revised, or implemented on or after October 1, 1995, unless it displays a currently valid OMB control number.

Direct Comments to OMB: Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the: Office of Management and Budget, Office of Regulatory Affairs, *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974, Attention: NIH Desk Officer.

Comment Due Date: Comments regarding this information collection are best assured of having their full effect if received within 30-days of the date of this publication.

FOR FURTHER INFORMATION CONTACT: To obtain a copy of the data collection plans and instruments or request more information on the proposed project contact: Dr. Patricia Wagner; Director of Admissions & Registrar; Office of Intramural Training & Education; National Institutes of Health; 2 Center Drive: Building 2/Room 2E06; Bethesda, Maryland 20892–0234; or call 240–476–3619 or Email your request, including your address to: *wagnerpa@od.nih.gov.* Formal requests for additional plans and

instruments must be requested in writing.

Proposed Collection: NIH Office of Intramural Training & Education Application, 0925–0299 Revision, Office of the Director (OD), National Institutes of Health (NIH).

Need and Use of Information Collection: The Office of Intramural Training & Education (OITE) administers a variety of programs and initiatives to recruit pre-college through post-doctoral educational level individuals into the National Institutes of Health Intramural Research Program (NIH–IRP) to facilitate develop into future biomedical scientists. The proposed information collection is necessary in order to determine the eligibility and quality of potential awardees for traineeships in these programs. The applications for admission consideration include key areas such as: Personal information, eligibility criteria, contact information, student identification number, training program selection, scientific discipline interests, educational history, standardized examination scores, reference information, resume components, employment history, employment interests, dissertation research details, letters of recommendation, financial aid history, sensitive data, future networking contact, travel information, as well as feedback questions about interviews and application submission experiences. Sensitive data collected on the applicants, race, gender, ethnicity, disability, and recruitment method, are made available only to OITE staff members or in aggregate form to select NIH offices and are not used by the admission committee for admission consideration; optional to submit.

OMB approval is requested for 3 years. There are no costs to respondents other than their time. The total estimated annualized burden hours are 18,354.00.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Estimated number of respondents	Estimated number of responses annually per respondent	Estimated total annual burden hours	Estimated total annual burden hours
Summer Internship Program in Biomedical Research (SIP)	6,820.0	1.0	1.0	6,820.00
Biomedical Engineering Summer Internship Program (BESIP)	80.0	1.0	1.0	80.00
Post-baccalaureate Training Program (PBT)	1,885.0	1.0	1.0	1,885.00
Community College Summer Enrichment Program (CCSEP)	100.0	1.0	1.0	100.00
Technical Training Program (PBT)	115.0	1.0	1.0	115.00
Graduate Partnerships Program (GPP)—Application (Select Institutional Partnerships)	250.0	1.0	1.0	250.00
Graduate Partnerships Program (GPP)—Registration (Select Institutional Partnerships + Individual Partnership)	140.0	1.0	1.0	140.00
National Graduate Student Research Conference (NGSRC)	800.0	1.0	1.0	800.00
Undergraduate Scholarship Program (UGSP)	200.0	1.0	1.0	200.00
Alumni Database	1,900.0	1.0	1.0	1,900.00
UGSP—Certificate of Eligibility (Completed by Applicant)	200.0	1.0	3/60	10.00
UGSP—Certificate of Eligibility (Completed by University Staff)	200.0	1.0	15/60	50.00
UGSP—Deferment Form (Completed by Applicant)	40.0	1.0	3/60	2.00
UGSP—Deferment Form (Completed by University Staff)	40.0	1.0	15/60	10.00
Reference Recommendation Letters for All Programs	23,235.0	1.0	15/60	5,808.75
Survey—Race-Ethnicity-Gender-Birth Year (25% Response Rate)	3,073.0	1.0	3/60	153.65
Survey—Time to Complete Application Form (4% Response Rate)	492.0	1.0	3/60	24.60
Survey—GPP Interview Experience (60% Response Rate)	30.0	1.0	10/60	5.0
Totals	39,600.0	N/A	N/A	18,354.00

Dated: July 1, 2013.

Richard Wyatt,

Executive Director, Office of Intramural Research, OD, National Institutes of Health.

[FR Doc. 2013–16887 Filed 7–12–13; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Cancer Institute Special Emphasis Panel, July 30, 2013, 9:00 a.m.–4:00 p.m., National Cancer Institute, 9609 Medical Center Drive, Room 2W908 Rockville, MD, 20850 which was published in the **Federal Register** on June 17, 2013, 78FR36201.

This notice is being amended to change the meeting format from a face to face meeting to a teleconference. Also the meeting date and time are now 10:30 a.m. to 12:00 p.m. on August 12, 2013. The meeting is closed to the public.

Dated: July 9, 2013.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2013–16791 Filed 7–12–13; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for Office of Management and Budget (OMB) Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Government Paperwork Elimination Act (GPEA) 44 U.S.C. 3504. To request a copy of these documents, call the SAMHSA Reports Clearance Officer at (240) 276–1243.

Project: Mandatory Guidelines for Federal Workplace Drug Testing Programs (OMB No. 0930–0158)—Revision

SAMHSA will request OMB approval for the Federal Drug Testing Custody and Control Form (Federal CCF) for federal agency and federally regulated drug testing programs which must comply with the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs (73 FR 71858) dated November 25, 2008, and OMB approval for the information provided by test facilities (i.e., laboratories and Instrumented Initial Test Facilities, IITFs) for the National Laboratory Certification Program (NLCP).

The Federal CCF is used by all federal agencies and employers regulated by the Department of Transportation (DOT) to document the collection and chain of custody of drug testing specimens at the collection site, for the test facility to report results, and for the Medical Review Officer (MRO) to make a determination. The current OMB-approved Federal CCF has an August 31, 2013 expiration date. In accordance with the GPEA, OMB set terms of clearance for the extension of the current Federal CCF as follows: Prior to the next approval of this package, the Agency (SAMHSA) shall provide a progress update on adoption of electronic forms in an effort to reduce burden. SAMHSA is encouraged to explore ways to convert the Federal Drug Testing Custody and Control Form (Federal CCF) into an electronic form.

In an effort to comply with the stated terms of the clearance requirement set forth by OMB, SAMHSA will authorize the use of an electronic Federal CCF. SAMHSA has resubmitted the Federal CCF with no content revisions to the form for OMB approval. The only revisions are to enable the form to be used as a paper form or as an electronic form.

- The first change to the Federal CCF is to allow the Public Burden Statement to be a separate page of an electronic Federal CCF. The Public Burden Statement must appear on all federal government forms that place a reporting burden on gathering information.
- The second change is to allow the Federal CCF instructions and the Privacy Act Statement to be on a separate page or pages of an electronic Federal CCF.
- The third change is to allow the bottle labels/seals to be printed separately, and not as a part of Copy 1 of the Federal CCF.
- The fourth change is to revise the Federal CCF Instructions to allow the use of an electronic form.

Below is a copy of the Federal CCF:

BILLING CODE 4162–20–P

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No. _____

Collector Fax No. _____

OMB No. 0930-0158

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark | Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark | ☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

(PRINT) Collector's Name (First, MI, Last) | Date (Mo/Day/Yr) | Time of Collection AM PM | Name of Delivery Service

SPECIMEN BOTTLE(S) RELEASED TO:

RECEIVED AT IITF:

X _____ Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) | Date (Mo/Day/Yr)

IITF Name and Address (if not above):

Primary Specimen Bottle Seal Intact ☐ YES ☐ NO If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S) RELEASED TO:

TRANSFER FROM IITF TO LAB. *I certify that the specimen identified on this form was handled using chain of custody procedures and resealed in accordance with applicable Federal requirements.*

X _____ Signature | (PRINT) Name (First, MI, Last) | Date (Mo/Day/Yr) | Name of Delivery Service

SPECIMEN BOTTLE(S) RELEASED TO:

RECEIVED AT LAB:

X _____ Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) | Date (Mo/Day/Yr)

Primary Specimen Bottle Seal Intact ☐ YES ☐ NO If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY

☐ **NEGATIVE** ☐ **POSITIVE** for: ☐ Marijuana Metabolite (Δ9-THCA) ☐ 6-Acetylmorphine ☐ Methamphetamine ☐ MDMA
☐ DILUTE ☐ Cocaine Metabolite (BZE) ☐ Morphine ☐ Amphetamine ☐ MDA
☐ PCP ☐ Codeine ☐ MDEA

☐ **REJECTED FOR TESTING** ☐ **ADULTERATED** ☐ **SUBSTITUTED** ☐ **INVALID RESULT**

REMARKS: _____

Test Facility (if different from above) : _____

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Federal requirements.

X _____ Signature of Certifying Technician/Scientist | (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) | Date (Mo/Day/Yr)

STEP 5B: COMPLETED BY SPLIT TESTING LABORATORY

☐ **SPLIT SPECIMEN TESTED; SEE LABORATORY REPORT** _____ Split Testing Laboratory (Name, City, State)

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

0000001 SPECIMEN ID NO. A | PLACE OVER CAP | 0000001 SPECIMEN BOTTLE SEAL | Date (Mo/Day/Yr) | Donor's Initials

0000001 SPECIMEN ID NO. B (SPLIT) | PLACE OVER CAP | 0000001 SPECIMEN BOTTLE SEAL | Date (Mo/Day/Yr) | Donor's Initials

COPY 1 - TEST FACILITY COPY

Paper CCF: Back of Copy 1–4

Electronic CCF: Separate Page

Public Burden Statement

Public Burden Statement: 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 OMB control number for this project is 0930–0158. Public reporting burden for this collection of information is estimated to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this

collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2–1057, Rockville, Maryland, 20857.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone No. and Fax No.

OMB No. 0930-0158

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark	Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark	☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

_____ (PRINT) Collector's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr) _____ AM PM Time of Collection

SPECIMEN BOTTLE(S) RELEASED TO:

_____ Name of Delivery Service

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor _____ (PRINT) Donor's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

Daytime Phone No. (_____) _____ Evening Phone No. (_____) _____ Date of Birth ___/___/___ (Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

☐ **NEGATIVE** ☐ **POSITIVE** for: _____
☐ DILUTE

☐ **REFUSAL TO TEST** because – check reason(s) below: ☐ **TEST CANCELLED**
☐ ADULTERATED (adulterant/reason): _____
☐ SUBSTITUTED
☐ OTHER: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

☐ **RECONFIRMED** for: _____ ☐ **TEST CANCELLED**

☐ **FAILED TO RECONFIRM** for: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

COPY 2 - MEDICAL REVIEW OFFICER COPY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark	Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark	☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

(PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) ___/___/___ Time of Collection _____ AM PM

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service _____

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor _____ (PRINT) Donor's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

Daytime Phone No. (_____) _____ Evening Phone No. (_____) _____ Date of Birth ___/___/___ (Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

☐ **NEGATIVE** ☐ **POSITIVE** for: _____
☐ DILUTE

☐ **REFUSAL TO TEST** because – check reason(s) below: ☐ **TEST CANCELLED**
☐ ADULTERATED (adulterant/reason): _____
☐ SUBSTITUTED
☐ OTHER: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

☐ **RECONFIRMED** for: _____ ☐ **TEST CANCELLED**

☐ **FAILED TO RECONFIRM** for: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

COPY 3 - COLLECTOR COPY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark	Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark	☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

(PRINT) Collector's Name (First, MI, Last) ____ Date (Mo/Day/Yr) ___/___/___ Time of Collection ____ AM PM

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor (PRINT) Donor's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

Daytime Phone No. (____) _____ Evening Phone No. (____) _____ Date of Birth ___/___/___ (Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

☐ **NEGATIVE** ☐ **POSITIVE** for: _____
☐ DILUTE

☐ **REFUSAL TO TEST** because – check reason(s) below: ☐ **TEST CANCELLED**
☐ ADULTERATED (adulterant/reason): _____
☐ SUBSTITUTED
☐ OTHER: _____

REMARKS: _____

X _____ Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

☐ **RECONFIRMED** for: _____ ☐ **TEST CANCELLED**

☐ **FAILED TO RECONFIRM** for: _____

REMARKS: _____

X _____ Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

COPY 4 - EMPLOYER COPY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark	Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark	☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

(PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) ___/___/___ Time of Collection ___ AM ___ PM

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service _____

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor _____ (PRINT) Donor's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

Daytime Phone No. (_____) _____ Evening Phone No. (_____) _____ Date of Birth ___/___/___ (Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

☐ **NEGATIVE** ☐ **POSITIVE** for: _____
☐ DILUTE

☐ **REFUSAL TO TEST** because – check reason(s) below: ☐ **TEST CANCELLED**
☐ ADULTERATED (adulterant/reason): _____
☐ SUBSTITUTED
☐ OTHER: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

☐ **RECONFIRMED** for: _____ ☐ **TEST CANCELLED**

☐ **FAILED TO RECONFIRM** for: _____

REMARKS: _____

X _____ Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) ___/___/___ Date (Mo/Day/Yr)

COPY 5 - DONOR COPY

BILLING CODE 4162–20–C

Paper CCF: Back of Copy 5

Electronic CCF: Separate Page

Instructions for Completing the Federal Drug Testing Custody and Control Form for Urine Specimen Collection

When Making Entries on a Paper CCF, use Black or Blue ink pen and Press Firmly

Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory are on the top of the Federal CCF and the Specimen Identification (I.D.) number on the top of the Federal CCF matches the Specimen I.D. number on the labels/seals.

STEP 1:

• Collector ensures that the required information is in STEP 1. Collector enters a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee I.D. number.

• Collector gives collection container to Donor and instructs Donor to provide a specimen. Collector notes any unusual behavior or appearance of Donor in the remarks line in STEP 2. If the Donor's conduct at any time during the collection process clearly indicates an attempt to tamper with the specimen, Collector notes the conduct in the remarks line in STEP 2 and takes action as required.

STEP 2:

• Collector checks specimen temperature within 4 minutes after receiving the specimen from Donor, and marks the appropriate temperature box in STEP 2. If the temperature is outside the acceptable range, Collector enters a remark in STEP 2 and takes action as required.

• Collector inspects the specimen and notes any unusual findings in the remarks line in STEP 2 and takes action as required. Any specimen with unusual physical characteristics (e.g., unusual color, presence of foreign objects or material, unusual odor) cannot be sent to an IITF and must be sent to an HHS-certified laboratory for testing, as required.

• Collector determines the volume of specimen in the collection container. If the volume is acceptable, Collector proceeds with the collection. If the volume is less than required by the federal agency, Collector takes action as required, and enters remarks in STEP 2. If no specimen is collected by the end of the collection process, Collector checks the *None Provided* box, enters a remark in STEP 2, discards Copy 1, and distributes remaining copies as required.

• Collector checks the Split or Single specimen collection box. If the collection is observed, Collector checks the Observed box and enters a remark in STEP 2.

STEP 3:

• Donor watches Collector pour the specimen from the collection container into the specimen bottle(s), place the cap(s) on the specimen bottle(s), and affix the label(s)/seal(s) on the specimen bottle(s).

• Collector dates the specimen bottle label(s) after placement on the specimen bottle(s).

• Donor initials the specimen bottle label(s) after placement on the specimen bottle(s).

• Collector instructs the Donor to read and complete the certification statement in STEP 5 on Copy 2 (signature, printed name, date, phone numbers, and date of birth). If Donor refuses to sign the certification statement, Collector enters a remark in STEP 2 on Copy 1.

STEP 4:

• Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service) and places the sealed specimen bottle(s) in a leak-proof plastic bag.

• *Paper CCF:* Collector places Copy 1 in the leak-proof plastic bag. *Electronic CCF:* Collector places printed copy of Copy 1 in the leak-proof plastic bag and/or places package label (with Specimen I.D., test facility name and contact information, and collection site name and contact information) on the outside of the bag.

• Collector seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required.

Privacy Act Statement: (For Federal Employees Only)

Submission of the information on the Federal Drug Testing Custody and Control Form is voluntary. However, incomplete submission of the information, refusal to provide a specimen, or substitution or adulteration of a specimen may result in delay or denial of your application for employment/appointment or may result in removal from the federal service or other disciplinary action.

The authority for obtaining the specimen and identifying information contained herein is Executive Order 12564 (''Drug-Free Federal Workplace''), 5 U.S.C. 3301 (2), 5 U.S.C. 7301, and Section 503 of Public Law 100–71, 5 U.S.C. 7301 note. Under provisions of Executive Order 12564 and 5 U.S.C. 7301, test results may only be disclosed to agency officials on a need-to-know basis. This may include the agency Medical Review Officer (MRO), the administrator of the Employee Assistance Program, and a supervisor with authority to take adverse personnel action. This information may also be disclosed to a court where necessary to defend against a challenge to an adverse personnel action.

Submission of your SSN is not required by law and is voluntary. Your refusal to furnish your number will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited, pursuant to Executive Order 9397, for purposes of associating information in agency files relating to you and for purposes of identifying the specimen provided for testing for the presence of illegal drugs. If you refuse to indicate your SSN, a substitute number or other identifier will be assigned, as required, to process the specimen.

Public Burden Statement

Public Burden Statement: 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 OMB control number for this project is 0930–0158. Public reporting burden for this collection of information is estimated to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2–1057, Rockville, Maryland, 20857.

The number of respondents has been reduced from 7.1 to a total of 6.1 million; which reduces the total burden hours of −240,480.

Prior to an inspection, each test facility is required to submit specific information regarding its procedures. Collecting this information prior to an inspection allows the inspectors to thoroughly review and understand the testing procedures before arriving at the test facility.

The NLCP application form has not been revised compared to the previous form.

The annual total burden estimates for the Federal Drug Testing Custody and Control Form, the NLCP application, the NLCP inspection checklist, and NLCP

recordkeeping requirements are shown in the following table.

Number of form/respondents	Burden/responses (hours)	Responses/respondent	Total burden hours
Custody and Control Form			
Donor	.08	6,150,000	512,500
Collector	.07	6,150,000	410,000
Laboratory	.05	6,150,000	307,500
Medical Review Officer	.05	6,150,000	307,500
Laboratory Application	3.0	3	9
Laboratory Inspection Checklist	2.0	35	70
Laboratory Recordkeeping	250.0	35	8750
Total			1,546,329

Written comments and recommendations concerning the proposed information collection should be sent by August 14, 2013 to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via email to: *OIRA_Submission@omb.eop.gov.* Although commenters are encouraged to send their comments via email, commenters may also fax their comments to: 202–395–7285. Commenters may also mail them to: Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 10102, Washington, DC 20503.

Summer King,

Statistician.

[FR Doc. 2013–16794 Filed 7–12–13; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Announcement of Requirements and Registration for the ''Stay Covered Challenge'' and the ''Churn Marketing Research Methodology Development Challenge''

Authority: 15 U.S.C. 3719.

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the U.S. Department of Health and Human Services, is announcing a new opportunity for individuals and organizations to help solve a critical problem in today's health environment. Specifically, there are high levels of involuntary breaks in health insurance coverage among the non-elderly population in the United States. These breaks are referred to as ''churning''—when people transition from one source of insurance coverage to another when eligibility for assistance changes. Churning makes programs more complicated and costly to administer and can interrupt continuity of care, create gaps in coverage, reduce health plans' incentive to invest in their members' long-term wellness, and interfere with the accurate and comprehensive measurement of health care quality.

According to a study by the Urban Institute, a total of 29.4 million people will have their eligibility status change each year beginning in 2014 [1]. This challenge aligns with SAMHSA's mission to reduce the impact of mental and substance use disorders on America's communities. SAMHSA recognizes that enrollment in health insurance plays a significant role in fulfilling this mission, from preventive health care to behavioral health treatment and recovery. The National Survey on Drug Use and Health estimates that of the individuals currently uninsured and expected to be covered under the Affordable Care Act, 11 million will have a behavioral health need. The literature on the causes of breaks in coverage (i.e., income, housing volatility), and the high prevalence of behavioral health conditions among the uninsured, points to an interrelationship between behavioral health symptoms and difficulties complying with administrative requirements in applying for and maintaining continuous coverage.

Additionally, churning has a significant amount of administrative as well as health costs, and there is a disproportionate impact of this problem among individuals with behavioral health disorders. Therefore, SAMHSA is announcing two challenge projects to help develop innovative solutions to the barriers to developing a communications strategy targeting individuals who experience churn.

The statutory authority for this challenge competition is section 105 of the America Creating Opportunities to Meaningfully Promote Excellence in Technology, Education, and Science Reauthorization Act of 2010 (COMPETES Act).

DATES: Challenge submissions accepted until August 31, 2013.

FOR FURTHER INFORMATION CONTACT: Kevin J. Malone, 1 Choke Cherry Road, Room 8–1014, Rockville, MD 20857, Office: 240.276.2239, Email: *kevin.malone@samhsa.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Subject of Challenge Competitions

SAMHSA is interested in identifying individuals from a marketing perspective who experience churn, and in developing innovative strategies for targeting them. SAMHSA has access to relatively good data on the individuals who are covered by Medicaid, based on disability, and the providers and community-based organizations that serve them. However, SAMHSA has very little capacity to identify the individuals among the uninsured who were disenrolled but remain eligible.

SAMHSA's strategy is to use the following two challenges to strengthen communication with individuals in both phases of the process (prior to losing coverage, and once an individual has been disenrolled), thereby reducing incidences of churn and minimizing the period between coverage if it does happen.

1. The ''Stay Covered Challenge'' calls for the development of a marketing/outreach campaign designed for use by

providers and community-based organizations in targeting individuals in Medicaid *due to disability*. For example, competitors should consider developing marketing materials communicating the importance of maintaining eligibility by responding to communications from the Medicaid agency, and by communicating to the agency about housing changes or other changes of circumstance that might impact program eligibility. The materials submitted as a part of the challenge competition will be evaluated as to how useful they would be in (1) targeting individuals experiencing or at risk of churn; *and (2) fostering the use of the materials by* the full range of providers and community-based organizations serving Medicaid populations with behavioral health needs.

2. As there is very limited data available on the recently disenrolled but eligible population, the ''Churn Marketing Research Methodology Development Challenge'' asks competitors to develop a research methodology on how to identify actionable marketing data on this group. The challenge will not involve the development of communications materials targeting these individuals. This challenge tasks researchers with developing a methodology for identifying the marketing communications profile of uninsured individuals who have been disenrolled from coverage affordability programs but remain eligible for enrollment.

SAMHSA asks that applicants consider the following components in their methodology for identifying this target population:

- Thorough description of data set and data collection protocols, rationale for database selection, and limitations of the data set
- Sample selection criteria accurately meets criteria
- Analytic design plan includes: selecting sample based on criteria and running descriptive statistical tests on the data
- Description of the variables (level of measurement of each) and description of variable measurement (is the method reliable and valid)
- Differences in Medicaid and Health Exchange Enrollment policies across states, including eligibility criteria and administrative requirements
- Differences between individuals experiencing churn for different reasons (e.g. criminal justice involvement vs. relocation).

''Stay Covered Challenge''

Eligibility Rules for Participating in the Competition: To be eligible to win a prize under this challenge, an individual or entity

1. Shall have registered to participate in the competition under the rules promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA);
2. Shall have complied with all the requirements under this section;
3. In the case of a private entity, shall be incorporated in and maintain a primary place of business in the United States, and in the case of an individual, whether participating singly or in a group, must be a citizen or permanent resident of the United States; and
4. May not be a federal entity or federal employee acting within the scope of their employment;
5. May not be an HHS employee working on their application or submission during assigned duty hours;
6. May not be an employee of the Substance Abuse and Mental Health Services Administration;
7. Federal grantees may not use federal funds to develop COMPETES Act challenge applications unless consistent with the purpose of their grant award; and
8. Federal contractors may not use federal funds from a contract to develop COMPETES Act challenge applications or to fund efforts in support of a COMPETES Act challenge submission.

An individual or entity will not be deemed ineligible because the individual or entity used federal facilities or consulted with federal employees during a competition if the facilities and employees are made available to all individuals and entities participating in the competition on an equitable basis.

Registered participants will be required to agree to assume any and all risks and waive claims against the Federal Government and its related entities, except in the case of willful misconduct, for any injury, death, damage, or loss of property, revenue, or profits, whether direct, indirect, or consequential, arising from their participation in a competition, whether the injury, death, damage, or loss arises through negligence or otherwise.

All participants are required to provide written consent to the rules upon or before submitting an entry.

Registration Process for Participants: To register for this challenge participants should:

- Access the *www.challenge.gov* Web site and search for the ''Stay Covered Challenge.''
  - A registration link for the challenge can be found on the landing page under the challenge description.

Amount of Prize for the ''Stay Covered Challenge''

- Total: $50,000 in prizes
- First Place: $30,000
- Second Place: $15,000
- Third Place: $5,000

Awards may be subject to federal income taxes and HHS will comply with IRS withholding and reporting requirements, where applicable.

Basis Upon Which Winners Will Be Selected: The judging panel will make selections based upon the following criteria (*100 points total*):

1. Consideration of Medicaid and Health Exchange Enrollment processes in each state, including current mechanisms states and health plans use to communicate with enrollees regarding recertification (*25 points*).
2. Development of (1) Messages encouraging providers and community based organizations to reach out to persons experiencing or at risk of churn, and (2) messages for use by providers and CBOs in reaching out to persons experiencing or at risk of churn, on those eligible for Medicaid due to disability (*25 points*).
3. Demonstration of creative and innovative uses of multiple platforms of media, including but not limited to social media, mobile/smart phones, television, radio, and other traditional forms of outreach (*25 points*).
4. Demonstration of the potential to improve the health status of individuals with behavioral health needs which will be measured by the likelihood of increased coverage among this population as the result of these efforts. (*25 points*).

Additional Information: Ownership of intellectual property is determined by the following:

- Each entrant retains title and full ownership of their submission. Entrants reserve all intellectual property rights not expressly granted under the challenge agreement.
- By participating in the challenge, each entrant agrees to sponsor and administrate a limited, non-exclusive, royalty free, worldwide, license and right to reproduce, publically perform, publically display, and use the submission without limitation, for advertising and promotional purposes relating to the challenge.

''Churn Marketing Research Methodology Development Challenge''

Eligibility Rules for Participating in the Competition: To be eligible to win a prize under this challenge, an individual or entity

(1) Shall have registered to participate in the competition under the rules

promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(2) Shall have complied with all the requirements under this section;

(3) In the case of a private entity, shall be incorporated in and maintain a primary place of business in the United States, and in the case of an individual, whether participating singly or in a group, must be a citizen or permanent resident of the United States; and

(4) May not be a federal entity or federal employee acting within the scope of their employment

(5) May not be an HHS employee working on their application or submission during assigned duty hours;

(6) May not be an employee of the Substance Abuse and Mental Health Services Administration;

(7) Federal grantees may not use federal funds to develop COMPETES Act challenge applications unless consistent with the purpose of their grant award; and

(8) Federal contractors may not use federal funds from a contract to develop COMPETES Act challenge applications or to fund efforts in support of a COMPETES Act challenge submission.

An individual or entity will not be deemed ineligible because the individual or entity used federal facilities or consulted with federal employees during a competition if the facilities and employees are made available to all individuals and entities participating in the competition on an equitable basis.

Registered participants will be required to agree to assume any and all risks and waive claims against the Federal Government and its related entities, except in the case of willful misconduct, for any injury, death, damage, or loss of property, revenue, or profits, whether direct, indirect, or consequential, arising from their participation in a competition, whether the injury, death, damage, or loss arises through negligence or otherwise.

All participants are required to provide written consent to the rules upon or before submitting an entry.

Registration Process for Participants: To register for this challenge participants should: Access the *www.challenge.gov* Web site and search for the ''Churn Marketing Research Methodology Development Challenge.''

○ A registration link for the challenge can be found on the landing page under the challenge description.

Amount of Prize for the ''Churn Marketing Research Methodology Development Challenge''

- Total: $50,000 in prizes
- First Place: $30,000
- Second Place: $15,000
- Third Place: $5,000

Awards may be subject to federal income taxes and HHS will comply with IRS withholding and reporting requirements, where applicable.

Basis Upon Which Winner Will Be Selected: Applications should be no longer than 10 pages and include the following (*100 points total*):

1. Understanding the problem, including references from the available literature (*20 points*).

2. Description of the data, methods of analysis, characteristics of the population (*60 points*).

a. Data sets to be used and the applicant's access to the data—(*10 points*).

b. Methods of defining the population of interest—''churners''—(*20 points*)

c. Methods of defining the demographic, psychographic, and economic characteristics— (*15 points*)

d. Table shells (may be presented in an Appendix)—(*15 points*)

3. Personnel qualifications, including data analysis and technical resources available (resume may be presented in an Appendix)—(*20 points*)

Additional Information: Ownership of intellectual property is determined by the following:

▪ Each entrant retains title and full ownership of their submission. Entrants reserve all intellectual property rights not expressly granted under the challenge agreement.

▪ By participating in the challenge, each entrant agrees to sponsor and administrate a limited, non-exclusive, royalty free, worldwide, license and right to reproduce, publically perform, publically display, and use the submission without limitation, for advertising and promotional purposes relating to the challenge.

Source:

[1] Buettgens, M., Nichols, A., & Dorn, S. (2012). Churning Under the ACA and State Policy Options for Mitigation. *Prepared for Robert Wood Johnson Foundation, Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf.*

Cathy J. Friedman,

Public Health Analyst, SAMHSA.

[FR Doc. 2013–16871 Filed 7–12–13; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2013–0516]

Boston Area Maritime Security Advisory Committee; Vacancies

AGENCY: Coast Guard, DHS.

ACTION: Solicitation for Membership.

SUMMARY: This notice requests individuals interested in serving on the Boston Area Maritime Security Committee to submit their applications for membership, to the Captain of the Port, Boston, MA.

DATES: Requests for membership should reach the U.S. Coast Guard Captain of the Port Boston on or before August 14, 2013.

ADDRESSES: Applications for membership should be submitted to the Captain of the Port Boston at the following address: Commander (sx), USCG Sector Boston, 427 Commercial Street, Boston, MA 02109 or by email to *Phillip.C.Smith@uscg.mil.*

FOR FURTHER INFORMATION CONTACT: For questions about submitting an application or about the Boston Area Maritime Security Advisory Committe in general, contact Mr. Phillip C. Smith at 617–223–3008 or by email to *Phillip.C.Smith@uscg.mil.*

SUPPLEMENTARY INFORMATION:

Authority

Section 102 of the Maritime Transportation Security Act (MTSA) of 2002 (Pub. L. 107–295) added section 70112 to Title 46 of the U.S. Code, and authorized the Secretary of the Department in which the Coast Guard is operating to establish Area Maritime Security Advisory Committees (AMSCs) for any port area of the United States. (See 33 U.S.C. 1226; 46 U.S.C.; 33 CFR 1.05–1, 6.01; Department of Homeland Security Delegation No. 0170.1). MTSA includes a provision exempting these AMSCs from the Federal Advisory Committee Act, Public Law 92–436, 86 Stat. 470 (5 U.S.C. App. 2).

Boston AMSC Purpose

The AMSCs shall assist the Captain of the Port in the development, review, update, and exercising of the Area Maritime Security Plan for their area of responsibility. Such matters may include, but are not limited to: Identifying critical port infrastructure and operations; Identifying risks (threats, vulnerabilities, and consequences); Determining mitigation strategies and implementation methods;

Developing strategies to facilitate the recovery of the MTS after a Transportation Security Incident; Developing and describing the process to continually evaluate overall port security by considering consequences and vulnerabilities, how they may change over time, and what additional mitigation strategies can be applied; and Providing advice to, and assisting the Captain of the Port in developing and maintaining the AMS Plan.

AMSC Composition

The composition of an AMSC, to include the Boston AMSC and its subcommittees, is controlled by 33 CFR 103.305. Accordingly, members may be selected from the Federal, Territorial, or Tribal government; the State government and political subdivisions of the State; local public safety, crisis management, and emergency response agencies; law enforcement and security organizations; maritime industry, including labor; other port stakeholders having a special competence in maritime security; and port stakeholders affected by security practices and policies. Also, members of the Boston AMSC must have at least 5 years of experience related to maritime or port security operations.

AMSC Membership

The Boston AMSC has 29 members who represent Federal, State, local, and industry stakeholders from Massachusetts. We are seeking to fill 7 positions with this solicitation.

Applicants may be required to pass an appropriate security background check prior to appointment to the committee. Members' terms of office will be for 5 years; however, a member is eligible to serve additional terms of office. Members will not receive any salary or other compensation for their service on an AMSC.

Request for Applications

Those seeking membership are not required to submit formal applications to the local Captain of the Port, however, because we do have an obligation to ensure that a specific number of members have the prerequisite maritime security experience, we encourage the submission of resumes highlighting experience in the maritime and security industries.

In support of the USCG policy on gender and ethnic nondiscrimination, we encourage qualified women and men of all racial and ethnic groups to apply.

Dated: June 21, 2013.

J.C. O'Connor III,

Captain, U.S. Coast Guard, Federal Maritime Security Coordinator Boston.

[FR Doc. 2013–16802 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2013–0521]

Termination of Radiotelephone Medium Frequency 2182 kHz Watchkeeping, 2187.5 kHz Digital Selective Calling Channel Guard, and 2670 kHz Broadcasts

ACTION: Notice.

SUMMARY: The United States Coast Guard is announcing that it will no longer maintain a watch on 2182 kHz, will no longer guard the Digital Selective Calling (DSC) channel 2187.5 kHz, and will no longer transmit Marine Information Broadcasts on 2670 kHz. The minimal use of these channels by mariners for distress and safety coupled with antenna site deterioration, costly upkeep, and extensive maintenance required to support the medium frequency (MF) system have led to a Coast Guard decision to terminate the MF services and direct the public mariner to use more modern safety and distress services which can be more reliably received by the Coast Guard.

DATES: The termination announced in this notice is effective on August 1, 2013.

FOR FURTHER INFORMATION CONTACT: For questions on this Notice, contact Larry S. Solomon, Spectrum Management and Telecommunications Policy Counsel (Commandant CG–652) telephone: 202–475–3556; email: *larry.s.solomon@uscg.mil*.

SUPPLEMENTARY INFORMATION: The frequency 2182 kHz (which is in the frequency band generally referred to as medium frequency (MF)), was designated more than 65 years ago at the International Telecommunications Union Radio Conference (Atlantic City, 1947) as an international radiotelephone distress frequency. Shore stations that operated in this MF band, and ships subject to the International Convention for the Safety of Life at Sea Ch. IV, Reg. 5 (SOLAS) were required to maintain a watch on this frequency.

Beginning in 1987, the International Telecommunications Union Radio Regulations and SOLAS were amended to incorporate this MF radiotelephone watchkeeping requirement within the Global Maritime Distress and Safety System (GMDSS), an internationally agreed-upon set of satellite and terrestrial communications systems used to increase safety and facilitate the location and rescue of distressed ships, boats and aircraft. Under GMDSS, ship and shore exclusive watchkeeping on MF 2182 kHz was no longer a requirement, but instead became only one of several frequencies available for distress communications.

No domestic regulations exist requiring the Coast Guard to provide MF distress safety watchkeeping services, although Federal Communications Commission regulations in 47 CFR Part 80 mandate certain carriage requirements in order to communicate in an emergency. SOLAS requires the Coast Guard to provide, as it deems practical and necessary, appropriate shore-based facilities for GMDSS services including those in the 1.6–4 MHz range (SOLAS). The Coast Guard, in cooperation with other agencies and organizations, provides each of the other five services listed in SOLAS regulations, including satellite communications, support for 406 MHz satellite emergency position-indicating radio beacons (EPIRBs), VHF communications through Rescue 21, high frequency radiocommunications, and NAVTEX [1] broadcasts of maritime safety information.

While many countries terminated 2182 kHz watchkeeping from shore when GMDSS was implemented in 1999, the Coast Guard continued its watch on this frequency to support smaller vessels not subject to SOLAS that operate between approximately 20 and 100 miles from shore. Advancements in satellite, digital, very high frequency (VHF), and high frequency (HF) radio communication equipment, including satellite service provider competition, have improved service and reduced costs of this equipment causing MF radiotelephone to become obsolete.

In addition, a detailed review of several Coast Guard MF sites revealed significant antenna ground deterioration and infrastructure support degradation, leaving the Coast Guard at risk for not being able to receive or respond to maritime distress calls on 2182 kHz or 2187.5 kHz, and not being able to transmit effectively on 2670 kHz. Early last year, as a result of physical site surveys, the Coast Guard confirmed the

[1] NAVTEX is a broadcast warning system that delivers navigational warnings, meteorological warnings and forecasts, and other marine safety information.

significant site deterioration and, therefore, the unreliability of receiving MF distress transmissions at many locations. The Coast Guard provided notifications of the situation to mariners using Local Notice to Mariners and radio broadcasts. The Coast Guard did not receive any adverse reaction to those notifications.

The site deterioration, costly upkeep, and extensive maintenance required to support this legacy MF system, as well as the relatively minimal use by mariners, has led the Coast Guard to decide to discontinue support of the MF system. The Coast Guard will discontinue all watchkeeping and transmissions on MF channels, namely the 2182 kHz voice channel, the 2187.5 kHz Digital Selective Calling (DSC) channel and Marine Information Broadcasts (MIBs) on 2670 kHz.

Mariners have several increasingly low cost and commonly available alternatives to using MF distress and non-distress channels. Instead of relying on 2182 kHz voice and 2187.5 kHz DSC, mariners can tune their existing HF radios to other GMDSS radiotelephone distress voice frequencies the Coast Guard monitors (i.e., 4125, 6215, 8291, or 12290 kHz voice), use satellite-based communication for EPIRB and voice communications, or use HF radios equipped with DSC. The information in the 2670 kHz broadcasts (weather forecasts and warnings, Notice to Mariners, and urgent marine information broadcasts) will continue to be available from other broadcast sources (e.g., SafetyNet [2], NAVTEX, VHF) and online. The Coast Guard urges mariners to use these other alternatives to the MF channels for distress calls, DSC calls, and information broadcasts.

Mariners should not need to purchase any new equipment to make this change from 2182 kHz to other GMDSS distress frequencies. Most radiocommunications equipment carried by vessels is able to operate in the 2–27.5 MHz range in addition to the VHF radiotelephone also carried by ships. While some older radios may not tune to other frequencies, these radios are no longer sold, parts are not available for repairing them and they are not typically found on vessels. Therefore, the overwhelming majority of vessels simply need to tune their radios from 2182 kHz to another GMDSS distress frequency (such as 4125, 6215, 8291, or 12290 kHz). Because VHF frequencies may not be reliable more than 20 nautical miles from shore, any vessel that operates more than 20 nautical miles from the coast should carry radiocommunications equipment capable of tuning to distress frequencies other than VHF to ensure the vessel is able to make a distress call when needed.

All vessel owners and operators are strongly advised to check their communication equipment regularly to ensure it is properly installed, operating and tuned to the most reliable distress channels. For more information visit the Coast Guard's Navigation Center Web site at *www.navcen.uscg.gov*.

Authority

This notice is issued under authority of 14 U.S.C. 93(a)(16) and 5 U.S.C. 552(a).

Dated: July 9, 2013.

Alfredo Mistichelli,

U.S. Coast Guard, Acting Chief, Office of Information Assurance and Spectrum Policy, Commandant (CG–65).

[FR Doc. 2013–16801 Filed 7–12–13; 8:45 am]

BILLING CODE 9110–04–P

[2] SafetyNET is a satellite-based broadcast warning system that delivers high seas navigational warnings, meteorological warnings and forecasts, ice reports, and other marine safety information.

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Agency Information Collection Activities: African Growth and Opportunity Act Certificate of Origin

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: 30-Day notice and request for comments; Extension of an existing information collection: 1651–0082.

SUMMARY: U.S. Customs and Border Protection (CBP) 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: African Growth and Opportunity Act Certificate of Origin (AGOA). This is a proposed extension of an information collection that was previously approved. CBP is proposing that this information collection be extended with a change to the burden hours. This document is published to obtain comments from the public and affected agencies. This information collection was previously published in the **Federal Register** (78 FR 26650) on May 7, 2013, 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 1320.10.

DATES: Written comments should be received on or before August 14, 2013 to be assured of consideration.

ADDRESSES: Interested persons are invited to submit written comments on this 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 U.S. Customs and Border Protection, Department of Homeland Security, and sent via electronic mail to *oira_submission@omb.eop.gov* or faxed to (202) 395–5806.

FOR FURTHER INFORMATION CONTACT: Maria Lloyd, U.S. Customs and Border Protection, Regulations and Rulings, Office of International Trade, 90 K Street NE., 10th Floor, Washington, DC 20229–1177, at 202–325–0369.

SUPPLEMENTARY INFORMATION: CBP invites the general public and affected Federal agencies to submit written comments and suggestions on proposed and/or continuing information collection requests pursuant to the Paperwork Reduction Act of 1995 (Pub. L. 104–13). Your comments should address one of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency/component, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies/components estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collections of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological techniques or other forms of information.

Title: African Growth and Opportunity Act Certificate of Origin.

OMB Number: 1651–0082.

Form Number: None.

Abstract: The African Growth and Opportunity Act (AGOA) was adopted by the United States with the enactment of the Trade and Development Act of 2000 (Pub. L. 106–200). The objectives of AGOA are (1) to provide for extension of duty-free treatment under the Generalized System of Preferences (GSP) to import sensitive articles normally excluded from GSP duty treatment, and (2) to provide for the entry of specific textile and apparel articles free of duty and free of any

quantitative limits from the countries of sub-Saharan Africa.

For preferential treatment under AGOA, the exporter is required to prepare a certificate of origin and provide it to the importer. The certificate of origin includes information such as contact information for the importer; exporter and producer; the basis for which preferential treatment is claimed; and a description of the imported merchandise. The importers are required to have the certificate in their possession at the time of the claim, and to provide it to U.S. Customs and Border Protection (CBP) upon request. The collection of this information is provided for in 19 CFR 10.214, 10.215, and 10.216.

Instructions for complying with this regulation are posted on CBP.gov Web site at: *http://www.cbp.gov/linkhandler/cgov/trade/priority_trade/textiles/tbts/TBT2001/TBT-01-008.ctt/TBT-01-008.doc*.

Current Actions: This submission is being made to extend the expiration date and to revise the burden hours as a result of updated estimates of the number of AGOA certificates of origin that are prepared and/or submitted to CBP. There are no changes to the information collected or to the AGOA certificate of origin.

Type of Review: Extension with a change to the burden hours.

Affected Public: Businesses.

Estimated Number of Respondents: 210.

Estimated Number of Responses per Respondent: 107.

Estimated Total Annual Responses: 22,494.

Estimated Time per Response: 20 minutes.

Estimated Total Annual Burden Hours: 7,648.

Dated: July 10, 2013.

Tracey Denning,

Agency Clearance Officer, U.S. Customs and Border Protection.

[FR Doc. 2013–16897 Filed 7–12–13; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–HQ–EA–2013–N136; FF09D00000–FXGO1664091HCC05D–134]

Wildlife and Hunting Heritage Conservation Council

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of teleconference.

SUMMARY: We, the U.S. Fish and Wildlife Service, announce a public teleconference of the Wildlife and Hunting Heritage Conservation Council (Council).

DATES: *Teleconference:* Tuesday, July 30, 2013, 2–3:30 p.m. (Eastern daylight time). For deadlines and directions on registering to listen to the teleconference, submitting written material, and giving an oral presentation, please see ''Public Input'' under **SUPPLEMENTARY INFORMATION.**

FOR FURTHER INFORMATION CONTACT: Joshua Winchell, Council Coordinator, 4401 North Fairfax Drive, Mailstop 3103–AEA, Arlington, VA 22203; telephone (703) 358–2639; fax (703) 358–2548; or email *joshua_winchell@fws.gov.*

SUPPLEMENTARY INFORMATION: In accordance with the requirements of the Federal Advisory Committee Act, 5 U.S.C. App., we announce that Wildlife and Hunting Heritage Conservation Council will hold a teleconference.

Background

Formed in February 2010, the Council provides advice about wildlife and habitat conservation endeavors that:

1. Benefit wildlife resources;
2. Encourage partnership among the public, sporting conservation organizations, States, Native American tribes, and the Federal Government; and
3. Benefit recreational hunting.

The Council advises the Secretary of the Interior and the Secretary of Agriculture, reporting through the Director, U.S. Fish and Wildlife Service (Service), in consultation with the Director, Bureau of Land Management (BLM); Director, National Park Service (NPS); Chief, Forest Service (USFS); Chief, Natural Resources Service (NRCS); and Administrator, Farm Services Agency (FSA). The Council's duties are strictly advisory and consist of, but are not limited to, providing recommendations for:

1. Implementing the Recreational Hunting and Wildlife Resource Conservation Plan—A Ten-Year Plan for Implementation;
2. Increasing public awareness of and support for the Wildlife Restoration Program;
3. Fostering wildlife and habitat conservation and ethics in hunting and shooting sports recreation;
4. Stimulating sportsmen and women's participation in conservation and management of wildlife and habitat resources through outreach and education;
5. Fostering communication and coordination among State, tribal, and Federal governments; industry; hunting and shooting sportsmen and women; wildlife and habitat conservation and management organizations; and the public;
6. Providing appropriate access to Federal lands for recreational shooting and hunting;
7. Providing recommendations to improve implementation of Federal conservation programs that benefit wildlife, hunting, and outdoor recreation on private lands; and
8. When requested by the Designated Federal Officer in consultation with the Council Chairperson, performing a variety of assessments or reviews of policies, programs, and efforts through the Council's designated subcommittees or workgroups.

Background information on the Council is available at *http://www.fws.gov/whhcc.*

Meeting Agenda

The Wildlife and Hunting Heritage Conservation Council will consider a letter to the Secretaries of Agriculture and the Interior regarding:

(a) The process the Bureau of Land Management and the U.S. Forest Service employ in the development and implementation of land and travel management plans for the allowance and furtherance of recreational shooting and the use of motorized big game retrieval, where appropriate; and

(b) The participation of the Bureau of Land Management and the U.S. Forest Service in the 2006 Federal Lands Hunting, Fishing and Shooting Sports Roundtable Memorandum of Understanding (MOU).

The final agenda will be posted on the Internet at *http://www.fws.gov/whhcc.*

Public Input

If you wish to	You must contact the Council Coordinator (see **FOR FURTHER INFORMATION CONTACT**) no later than
Listen to the teleconference	Monday, July 22, 2013.

If you wish to	You must contact the Council Coordinator (see **FOR FURTHER INFORMATION CONTACT**) no later than
Submit written information or questions before the teleconference for the council to consider during the teleconference.	Monday, July 22, 2013.
Give an oral presentation during the teleconference	Monday, July 22, 2013.

Submitting Written Information or Questions

Interested members of the public may submit relevant information or questions for the Council to consider during the teleconference. Written statements must be received by the date listed in ''Public Input'' under **SUPPLEMENTARY INFORMATION**, so that the information may be made available to the Council for their consideration prior to this teleconference. Written statements must be supplied to the Council Coordinator in one of the following formats: One hard copy with original signature, and one electronic copy via email (acceptable file formats are Adobe Acrobat PDF, MS Word, MS PowerPoint, or rich text file).

Giving an Oral Presentation

Individuals or groups requesting to make an oral presentation during the teleconference will be limited to 3 minutes per speaker, with no more than a total of 30 minutes for all speakers. Interested parties should contact the Council Coordinator, in writing (preferably via email; see **FOR FURTHER INFORMATION CONTACT**), to be placed on the public speaker list for this teleconference. To ensure an opportunity to speak during the public comment period of the teleconference, members of the public must register with the Council Coordinator. Registered speakers who wish to expand upon their oral statements, or those who had wished to speak but could not be accommodated on the agenda, may submit written statements to the Council Coordinator up to 30 days subsequent to the teleconference.

Meeting Minutes

Summary minutes of the teleconference will be maintained by the Council Coordinator (see **FOR FURTHER INFORMATION CONTACT**) and will be available for public inspection within 90 days of the meeting and will be posted on the Council's Web site at *http://www.fws.gov/whhcc.*

Rowan W. Gould,

Acting Deputy Director.

[FR Doc. 2013–16881 Filed 7–12–13; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

[124A2100RM.AADD003200.A087C222.999900.AR.DED.97C22214.001]

Advisory Board for Exceptional Children

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice of Meeting.

SUMMARY: The Bureau of Indian Education (BIE) is announcing that the Advisory Board for Exceptional Children (Advisory Board) will hold its next meeting in Albuquerque, New Mexico. The purpose of the meeting is to meet the mandates of the Individuals with Disabilities Education Act of 2004 (IDEA) for Indian children with disabilities.

DATES: The Advisory Board will meet on Thursday, July 18, 2013, from 8:30 a.m. to 4:00 p.m. and Friday, July 19, 2013 from 8:30 a.m. to 4:00 p.m. Mountain Time. Orientation for new members will be held Wednesday, July 17, 2013, from 9:00 a.m. to 4:00 p.m. Mountain Time.

ADDRESSES: The meeting will be held at the Manuel Lujan, Jr. Building, 1011 Indian School Road NW., Room 231–232, Albuquerque, New Mexico 87104. Telephone 505–563–5383.

FOR FURTHER INFORMATION CONTACT: Sue Bement, Designated Federal Officer, Bureau of Indian Education, Division of Performance and Accountability (DPA), 1011 Indian School Road NW., Suite 332, Albuquerque, New Mexico 87104; telephone number (505) 563–5274 or email *sue.bement@bie.edu.*

SUPPLEMENTARY INFORMATION: In accordance with the Federal Advisory Committee Act, the BIE is announcing that the Advisory Board will hold its next meeting in Albuquerque, New Mexico. The Advisory Board was established under the Individuals with Disabilities Act of 2004 (20 U.S.C. 1400 *et seq.*) to advise the Secretary of the Interior, through the Assistant Secretary—Indian Affairs, on the needs of Indian children with disabilities. The meetings are open to the public.

The following items will be on the agenda:

- Remarks from Acting BIE Director;
- Report from Acting Associate Deputy Director, DPA/BIE;
- Report from, Supervisory Education Specialist, Special Education, DPA/BIE;
- BIE Data Summit Review;
- Discussion and selection of Advisory Board Priorities;
- Public Comment (via conference call, July 19, 2013, meeting only*); and
- BIE Advisory Board-Advice and Recommendations.

*During the July 19, 2013 meeting, time has been set aside for public comment via conference call from 1:00–1:30 p.m. Mountain Time. The call-in information is: Conference Number 1–888–417–0376, Passcode 1509140.

Dated: July 10, 2013.

Kevin K. Washburn,

Assistant Secretary—Indian Affairs.

[FR Doc. 2013–16886 Filed 7–12–13; 8:45 am]

BILLING CODE 4310–6W–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–415 and 731–TA–933–934 (Second Review)]

Polyethylene Terephthalate Film, Sheet, and Strip From India and Taiwan; Notice of Commission Determinations To Conduct Full Five-Year Reviews

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice that it will proceed with full reviews pursuant to section 751(c)(5) of the Tariff Act of 1930 (19 U.S.C. 1675(c)(5)) to determine whether revocation of the countervailing duty order on polyethylene terephthalate film, sheet, and strip (''PET'' film) from India and the antidumping duty orders on PET film from India and Taiwan would be likely to lead to continuation or recurrence of material injury within a reasonably foreseeable time. A schedule for the review will be established and announced at a later date. For further information concerning the conduct of these reviews and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A, D, E, and F (19 CFR part 207).

DATES: *Effective Date:* July 5, 2013.

FOR FURTHER INFORMATION CONTACT: Michael Szustakowski (202–205–3169), Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter 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 (*http://www.usitc.gov*). The public record for these reviews may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION: On July 5, 2013, the Commission determined that it should proceed to full reviews in the subject five-year reviews pursuant to section 751(c)(5) of the Act. The Commission found the domestic interested party group response to its notice of institution (78 F.R. 19524, April 2, 2013) to be adequate and that the respondent interested party group response with respect to Taiwan was adequate and decided to conduct a full review with respect to the antidumping duty order concerning PET film from Taiwan. The Commission found that the respondent interested party group response with respect to the reviews on the orders on PET film from India was inadequate. However, the Commission determined to conduct full reviews concerning the antidumping and countervailing duty orders on PET film from India to promote administrative efficiency in light of its decision to conduct a full review with respect to the order on PET film from Taiwan. A record of the Commissioners' votes, the Commission's statement on adequacy, and any individual Commissioner's statements will be available from the Office of the Secretary and at the Commission's Web site.

Authority: These reviews are being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.62 of the Commission's rules.

By order of the Commission.
Issued: July 10, 2013.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–16869 Filed 7–12–13; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–886]

Certain TV Programs, Literary Works for TV Production and Episode Guides Pertaining to Same; Institution of Investigation Pursuant to 19 U.S.C. 1337

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 June 7, 2013, under section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337, on behalf of E.T. Radcliffe, LLC of Dallas, Texas and Emir Tiar of Coto De Caza, California. Supplements to the Complaint were filed June 25, 2013 and June 27, 2013. 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 TV programs, literary works for TV production and episode guides pertaining to same by reason of infringement of U.S. Copyright PAU003415849 (''the '849 copyright''); U.S. Copyright TXU001832727 (''the '727 copyright''); and U.S. Copyright PAU003639268 (''the '268 copyright''), and that an industry in the United States exists as required by subsection (a)(2) of section 337. The complaint further alleges violations of section 337 based upon the importation, the sale for importation, and the sale within the United States after importation of certain TV programs, literary works for TV production and episode guides pertaining to same, by reason of unfair methods of competition and unfair acts, the threat or effect of which is to destroy or substantially injure an industry in the United States.

The complainants request 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 *http://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

FOR FURTHER INFORMATION CONTACT: The Office of Unfair Import Investigations, U.S. International Trade Commission, telephone (202) 205–2560.

Authority: The authority for institution of this investigation is contained in section 337 of the Tariff Act of 1930, as amended, and in section 210.10 of the Commission's Rules of Practice and Procedure, 19 CFR 210.10 (2013).

Scope of Investigation: Having considered the complaint, the U.S. International Trade Commission, on July 9, 2013, *ordered that*—

(1) Pursuant to subsection (b) of section 337 of the Tariff Act of 1930, as amended, an investigation be instituted to determine:

(a) 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 TV programs, literary works for TV production and episode guides pertaining to same by reason of infringement of the '849 copyright; the '727 copyright; and the '268 copyright, and whether an industry in the United States exists as required by subsection (a)(2) of section 337;

(b) whether there is a violation of subsection (a)(1)(A) 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 TV programs, literary works for TV production and episode guides pertaining to same, by reason of unfair methods of competition and unfair acts, the threat or effect of which is to destroy or substantially injure an industry in the United States;

(2) 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 complainants are:

E.T. Radcliffe, LLC, 1445 Ross Avenue, Suite 2700, Dallas, TX 75202.

Emir Tiar, 31785 Via Coyote, Coto De Caza, CA 92679.

(b) The respondents are the following entities alleged to be in violation of section 337, and are the parties upon which the complaint is to be served:

The Walt Disney Company, 500 South Buena Vista Street, Burbank, CA 91521.

Thunderbird Films, Inc., 10675 Santa Monica Boulevard, Suite B, Los Angeles, CA 90025.

Mindset Television, Inc., 708–1155 Pender Street, Vancouver, British Columbia, V6E 2P4, Canada.

(c) The Office of Unfair Import Investigations, U.S. International Trade Commission, 500 E Street SW., Suite 401, Washington, DC 20436; and

(3) 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: July 10, 2013.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–16885 Filed 7–12–13; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–800]

Certain Wireless Devices With 3G Capabilities and Components Thereof; Notice of Request for Statements on the Public Interest

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the presiding administrative law judge has issued a Recommended Determination on Remedy and Bonding in the above-captioned investigation. The Commission is soliciting comments on public interest issues raised by the recommended relief, specifically a limited exclusion order against certain wireless devices with 3G capabilities and components thereof imported by respondents Huawei Technologies Co., Ltd. of Shenzhen, China; FutureWei Technologies, Inc. d/b/a Huawei, Technologies (USA) of Plano, Texas; Huawei Device USA, Inc. of Plano, Texas (''Huawei Device''); Nokia Corporation of Espoo, Finland; Nokia Inc. of White Plains, New York (''Nokia Inc.''); ZTE Corporation of Shenzhen, China; and ZTE (USA) Inc. of Richardson, Texas, and cease and desist orders against Huawei Device and Nokia Inc. This notice is soliciting public interest comments from the public only. Parties are to file public interest submissions pursuant to 19 CFR 210.50(a)(4).

FOR FURTHER INFORMATION CONTACT: Panyin A. Hughes, Office of the General Counsel, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436, telephone (202) 205–3042. The public version of the complaint can be accessed on the Commission's electronic docket (EDIS) at *http://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 (*http://www.usitc.gov*). The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://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: Section 337 of the Tariff Act of 1930 provides that if the Commission finds a violation it shall exclude the articles concerned from the United States:

> unless, after considering the effect of such exclusion upon the public health and welfare, competitive conditions in the United States economy, the production of like or directly competitive articles in the United States, and United States consumers, it finds that such articles should not be excluded from entry.

19 U.S.C. 1337(d)(1). A similar provision applies to cease and desist orders. 19 U.S.C. 1337(f)(1).

The Commission is interested in further development of the record on the public interest in these investigations. Accordingly, members of the public are invited to file submissions of no more than five (5) pages, inclusive of attachments, concerning the public interest in light of the administrative law judge's Recommended Determination on Remedy and Bonding issued in this investigation on March 1, 2013. Comments should address whether issuance of a limited exclusion order 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 recommended orders are used in the United States;

(ii) identify any public health, safety, or welfare concerns in the United States relating to the recommended 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 recommended exclusion order and/or a cease and desist order within a commercially reasonable time; and

(v) explain how the limited exclusion order would impact consumers in the United States.

Written submissions must be filed no later than by close of business on August 7, 2013.

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 section 210.4(f) of the Commission's Rules of Practice and Procedure (19 CFR 210.4(f)). Submissions should refer to the investigation number (''Inv. No. 337–TA–800'') in a prominent place on the cover page and/or the first page. (*See* Handbook for Electronic Filing Procedures, *http://www.usitc.gov/secretary/fed_reg_notices/rules/handbook_on_electronic_filing.pdf*). 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. A redacted non-confidential version of the document must also be filed simultaneously with the any confidential filing. All non-confidential written submissions will be available for public inspection at the Office of the Secretary and on EDIS.

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 sections 201.10 and 210.50 of the Commission's Rules of Practice and Procedure (19 CFR 201.10, 210.50).

By order of the Commission.

Issued: July 10, 2013.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–16870 Filed 7–12–13; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Extension to Public Comment Period for Consent Decree Under the Clean Water Act

On June 6, 2013, the Department of Justice lodged a proposed Consent Decree with the United States District Court for the Southern District of Florida in the lawsuit entitled *United States, State of Florida and State of Florida Department of Environmental Protection* v. *Miami-Dade County,* Civil Action No. 1:12–cv–24400–FAM. The Consent Decree resolves all of the United States', State of Florida's, and State of Florida Department of Environmental Protection's claims against Miami-Dade County (''Miami-Dade'') in this case. The proposed Consent Decree includes an estimated $1.6 billion in capital improvements to Miami-Dade's wastewater collection and transmission system over the next 15 years, including sewer assessment, rehabilitation, repair, and replacement work on force mains, sewer lines, manholes, and pumps, and rehabilitation of all three wastewater treatment plants. Miami-Dade has also agreed to implement a number of EPA sewer maintenance and repair programs which EPA believes will dramatically reduce the incidence and severity of sanitary sewer overflows. Miami-Dade also has agreed to pay a penalty of $978,100, of which $511,800 will be paid to the United States, and $466,300 will be paid to Florida. Miami-Dade has also agreed to complete a Supplemental Environmental Project valued at $2,047,200.

The prior notice indicated that the Department of Justice would receive comments concerning the settlement for a period of thirty (30) days from the date of publication of the notice on June 12, 2012. Having received a request for an extension of the initial comment period and given the public interest in this settlement, the United States is extending the comment period for an additional thirty (30) days.

The Department of Justice will receive, for a period of sixty (60) days from June 12, 2013, any comments relating to the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and should refer to *United States, State of Florida and State of Florida Department of Environmental Protection* v. *Miami-Dade County,* Civil Action No. 1:12–cv–24400–FAM, D.J. Ref. No. 90–5–1–1–4022/1. All comments must be submitted no later than August 11, 2013. Comments may be submitted by email or by mail:

To submit comments:	*Send them to:*
By E-mail	*pubcomment-ees.enrd@usdoj.gov.*
By mail	Assistant Attorney General, U.S. DOJ—ENRD, P.O. Box 7611, Washington, DC 20044–7611.

During the public comment period, the Consent Decree may be examined and downloaded at this Justice Department Web site: *http://www.usdoj.gov/enrd/Consent_Decrees.html.* We will provide a paper copy of the Consent Decree upon written request and payment of reproduction costs. Please mail your request and payment to: Consent Decree Library, U.S. DOJ—ENRD, P.O. Box 7611, Washington, DC 20044–7611.

Please enclose a check or money order for $81 (25 cents per page reproduction cost) payable to the United States Treasury. For a paper copy of the Consent Decree without the appendices, the cost is $25.25.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2013–16797 Filed 7–12–13; 8:45 am]

BILLING CODE 4410–CW–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[OMB Number 1117–0042]

Agency Information Collection Activities: Proposed Collection; Comments Requested: National Clandestine Laboratory Seizure Report

ACTION: 60-Day Notice.

The Department of Justice (DOJ), Drug Enforcement Administration (DEA), 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. The proposed information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted until September 13, 2013. This process is conducted in accordance with 5 CFR 1320.10.

If you have comments, especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Clark R. Fleming, Field Division Counsel, El Paso Intelligence Center, 11339 SSG Sims Blvd., El Paso, TX 79908.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- 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;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of Information Collection 1117–0042

(1) *Type of Information Collection:* Extension of a currently approved collection.

(2) *Title of the Form/Collection:* National Clandestine Laboratory Seizure Report.

(3) *Agency form number, if any and the applicable component of the Department sponsoring the collection:*

Form number: EPIC Form 143.

Component: El Paso Intelligence Center, Drug Enforcement Administration, U.S. Department of Justice.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract:*

Primary: State, Local or Tribal Government.

Other: None.

Abstract: Records in this system are used to provide clandestine laboratory seizure information to the El Paso Intelligence Center, Drug Enforcement Administration, and other Law enforcement agencies, in the discharge of their law enforcement duties and responsibilities.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* There are one thousand two hundred sixty-seven (1267) total respondents for this information collection. Eight thousand eight hundred seventy-eight (8878) responded using paper at 1 hour a response and four thousand five hundred twenty-four (4524) responded electronically at 1 hour a response, for thirteen thousand four hundred two (13,402) annual responses.

(6) *An estimate of the total public burden (in hours) associated with the collection:* It is estimated that there are 13,402 annual burden hours associated with this collection.

If additional information is required contact: Jerri Murray, Department Clearance Officer, Policy and Planning Staff, Justice Management Division, Department of Justice, Two Constitution Square, 145 N Street NE., Suite 3W–1407B, Washington, DC 20530.

Dated: July 10, 2013.

Jerri Murray,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2013–16866 Filed 7–12–13; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF JUSTICE

Office of Justice Programs

[OMB Number 1121—NEW]

Agency Information Collection Activities; Proposed Collection; Comments Requested: Juvenile Justice Reform and Reinvestment Initiative Stakeholder Survey Under OMB's Partnership Fund

ACTION: 60 Day Notice.

The Department of Justice (DOJ), Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 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. The proposed information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for ''sixty days'' until September 13, 2013. This process is conducted in accordance with 5 CFR 1320.10.

If you have comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Kristen Kracke, (202) 616–3649, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice, 810 Seventh Street NW., Washington, DC 20531.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

—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;

—Enhance the quality, utility, and clarity of the information to be collected; and

—Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of This Information Collection Back to Top

(1) *Type of information collection:* Original Web-based Survey.

(2) *The title of the form/collection:* Juvenile Justice Reform and Reinvestment Initiative.

(3) *The agency form number, if any, and the applicable component of the Department sponsoring the collection:* The Office of Juvenile Justice and Delinquency Prevention, United States Department of Justice.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract:* Milwaukee County, Wisconsin; Iowa; and Delaware Juvenile Justice Service Providers. Local government and Not-for-profit institutions, Business or other for-profit in each of these three jurisdictions will be affected.

Abstract: This survey is being conducted as a part of an evaluation of OJJDPs JJRRI Demonstration Program. In 2012, OJJDP commissioned a 36-month evaluation of the Juvenile Justice Reform and Reinvestment Initiative (JJRRI) Demonstration Program. The JJRRI Demonstration Program provides funds to three states and/or local administering agencies for juvenile justice to develop and implement an integrated set of evidence-based and cost-measurement tools that will enable them to make informed decisions about resources and services for juvenile-justice involved youth.

The Urban Institute (UI) is conducting a comprehensive evaluation of JJRRI to determine whether the initiative has had the intended effect of improving program- and cost-effectiveness. As part of this evaluation, UI will conduct two web-based surveys with key stakeholders at each site to measure changes in attitudes towards evidence-based practices as a result of the JJRRI Demonstration Program.

The main objective of this web-based survey is to measure juvenile justice stakeholder—agency leadership and staff—support for use and knowledge of Evidence-Based Practice's in the three sites selected to be JJRRI Demonstration Programs. Two surveys will be conducted by UI to measure stakeholder

support and knowledge of evidence-based practices. The first survey will assess baseline attitudes of EBPs. The second survey will measure the extent to which context and attitudes change through the initiative.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond/reply:* It is estimated that 480 respondents will complete a 20 minute questionnaire.

(6) *An estimate of the total public burden (in hours) associated with the collection:* Approximately 160 hours.

If additional information is required, contact: Jerri Murray, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE., Suite 2E–508, Washington, DC 20530.

Dated: July 9, 2013.

Jerri Murray,

Department Clearance Officer for PRA, Department of Justice.

[FR Doc. 2013–16781 Filed 7–12–13; 8:45 am]

BILLING CODE 4410–18–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (13–079)]

NASA Advisory Council; Education and Public Outreach Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–463, as amended, the National Aeronautics and Space Administration announces a meeting of the Education and Public Outreach (EPO) Committee of the NASA Advisory Council (NAC). This Committee reports to the NAC.

DATES: Tuesday, July 30, 2013, 8:30 a.m. to 5:00 p.m., Local Time.

ADDRESSES: NASA Headquarters, Room 2E39, 300 E Street SW., Washington, DC 20546.

FOR FURTHER INFORMATION CONTACT: This meeting will also take place telephonically and via WebEx. Any interested person should contact Ms. Erika G. Vick, Executive Secretary for the Education and Public Outreach Committee, National Aeronautics and Space Administration, Washington, DC, at *Erika.vick-1@nasa.gov*, no later than 12:00 p.m. Local Time, July 26, 2013, to get further information about participating via teleconference and/or WebEx. Presentations from previous committee meetings can be found at *http://www.nasa.gov/offices/nac/EPO_Meetings.html.*

SUPPLEMENTARY INFORMATION: The agenda for the meeting includes the following topics:

- NASA Education Current Activities and Plans
- NASA Communications Current Activities and Plans
- The Educational Global Climate Modeling Project
- International Space Station (ISS) 101
- Asteroid Grand Challenge
- Current/Planned Planetary Science Milestones

The meeting will be open to the public up to the seating capacity of the room. It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants. Attendees will be requested to sign a register and to comply with NASA security requirements, including the presentation of a valid picture ID, green card, or passport to Security before access to NASA Headquarters. Foreign nationals attending this meeting will be required to provide a copy of their passport and visa in addition to providing the following information no less than 10 working days prior to the meeting: Full name; gender, date/place of birth; citizenship; visa information (number, type, expiration date); passport information (number, country, expiration date); employer/affiliation information (name of institution, address, country, telephone); title/position of attendee; and home address to Ms. Erika Vick via fax at (202) 358–4332 or by email at *Erika.vick-1@nasa.gov.* U.S. citizens and Permanent Residents (green card holders) are requested to submit their name and affiliation 3 working days prior to the meeting to Ms. Erika G. Vick.

Patricia D. Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 2013–16914 Filed 7–12–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (13–078)]

NASA Advisory Council; Human Exploration and Operations Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–462, as amended, the National Aeronautics and Space Administration (NASA) announces a meeting of the Human Exploration and Operations Committee of the NASA Advisory Council (NAC). This Committee reports to the NAC.

DATES: Monday, July 29, 2013, 10:00 a.m.–2:00 p.m.; and Tuesday, July 30, 2013, 9:00 a.m.–3:30 p.m., Local Time.

ADDRESSES: NASA Headquarters, Program Review Center, Room 9H40, 300 E Street SW., Washington, DC 20546.

FOR FURTHER INFORMATION CONTACT: Dr. Bette Siegel, Human Exploration and Operations Mission Directorate, NASA Headquarters, Washington, DC 20546, (202) 358–2245, fax (202) 358–2946, or *bette.siegel@nasa.gov.*

SUPPLEMENTARY INFORMATION: The meeting will be open to the public up to the capacity of the room. This meeting is also available telephonically and by WebEx. Any interested person may call the USA toll free conference call number (877) 546–1574 or toll number (212) 547–0312, pass code 7677920, to participate in this meeting by telephone. The WebEx link is *https://nasa.webex.com/*, the meeting number is 994 521 512, and the password is July 29–30!

The agenda for the meeting includes the following topics:

—Status of Human Exploration and Operations
—Status of Exploration Systems Development
—Status of International Space Station
—Status of Commercial Crew and Cargo
—Status of Center for the Advancement of Science in Space (CASIS) and NAC Research Subcommittee
—Technology Briefing—Joint Session with NAC Technology and Innovation Committee

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants. Attendees will be requested to sign a register and to comply with NASA security

requirements, including the presentation of a valid picture ID to Security before access to NASA Headquarters. Foreign nationals attending this meeting will be required to provide a copy of their passport and visa in addition to providing the following information no less than 10 working days prior to the meeting: Full name; gender; date/place of birth; citizenship; visa information (number, type, expiration date); passport information (number, country, expiration date); employer/affiliation information (name of institution, address, country, telephone); title/position of attendee; and home address to Dr. Bette Siegel via email at *bette.siegel@nasa.gov* or by fax at (202) 358–2946. U.S. citizens and Permanent Residents (green card holders) are requested to submit their name and affiliation 3 working days prior to the meeting to Dr. Bette Siegel.

Patricia D. Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 2013–16910 Filed 7–12–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (13–080)]

NASA Advisory Council; Commercial Space Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–462, as amended, the National Aeronautics and Space Administration (NASA) announces a meeting of the Commercial Space Committee of the NASA Advisory Council (NAC). This Committee reports to the NAC. The meeting will be held for the purpose of soliciting, from the scientific community and other persons, scientific and technical information relevant to program planning.

DATES: Tuesday, July 30, 2013, 9:15 a.m.–5:25 p.m., Local Time.

ADDRESSES: NASA Headquarters, Conference Room 1Q39, 300 E Street SW., Washington, DC 20546.

FOR FURTHER INFORMATION CONTACT: Mr. David M. Lengyel, Human Exploration and Operations Mission Directorate, NASA Headquarters, Washington, DC 20546, (202) 358–0391, fax (202) 358–2946, or *dlengyel@hq.nasa.gov*.

SUPPLEMENTARY INFORMATION: The meeting will be open to the public up to the capacity of the room. This meeting is also available telephonically and by WebEx. Any interested person may call the USA toll free conference call number (888) 323–3509 or toll number (415) 228–4885, pass code 3340929, to participate in this meeting by telephone. The WebEx link is *https://nasa.webex.com/*, the meeting number is 990 899 527, and the password is Partners2013*. The agenda for the meeting includes the following topics:

—Commercial Crew Update and Collaborations for Commercial Space Capabilities

—Aeronautics Research Mission Directorate Lessons Learned

—Use of Prizes

—International Space Station Utilization Status and Plans

—Description of NASA's Agency Level Commercialization Study Update

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants. Attendees will be requested to sign a register and to comply with NASA security requirements, including the presentation of a valid picture photo ID, green card, or passport to Security before access to NASA Headquarters. Foreign nationals attending this meeting will be required to provide a copy of their passport and visa in addition to providing the following information no less than 10 working days prior to the meeting: Full name; gender; date/place of birth; citizenship; visa information (number, type, expiration date); passport information (number, country, expiration date); employer/affiliation information (name of institution, address, country, telephone); title/position of attendee; and home address to Mr. David M. Lengyel via email at *dlengyel@hq.nasa.gov* or by fax at (202) 358–2885. U.S. citizens and Permanent Residents (green card holders) are requested to submit their name and affiliation 3 working days prior to the meeting to Mr. David M. Lengyel.

Patricia D. Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 2013–16908 Filed 7–12–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL SCIENCE FOUNDATION

Advisory Committee for Mathematical and Physical Sciences #66; Notice of Meeting; Correction

SUMMARY: The National Science Foundation published a Notice of Meeting for the July 18 Advisory Committee for Mathematical and Physical Sciences in the **Federal Register** on June 21, 2013. This notice corrects the operated assistance teleconference telephone number and the password.

FOR FURTHER INFORMATION CONTACT: Dr. Kelsey Cook, Staff Associate and MPSAC Designated Federal Officer, Directorate for Mathematical and Physical Sciences, National Science Foundation, 4201 Wilson Blvd., Arlington, VA 22230 Telephone #: 703–292–7490, 703–292–8800—*kcook@nsf.gov* or Caleb Autrey, Science Assistant, Directorate for Mathematical and Physical Sciences, National Science Foundation, 4201 Wilson Blvd., Arlington, VA 22230 Telephone #: 703–292–5137—*cautrey@nsf.gov.*

Correction

In the **Federal Register** of June 21, 2013, on page 37590, in the third column, the last paragraph under ''Place'' should read:

Operated Assisted teleconference service is available for this meeting. Call 1–866–844–9416. The Operator will ask for the password which is ''mps advisory.'' You will be connected to the audio portion of the meeting.

Dated: July 9, 2013.

Susanne Bolton,

Committee Management Officer.

[FR Doc. 2013–16799 Filed 7–12–13; 8:45 am]

BILLING CODE 7555–01–P

NATIONAL SCIENCE FOUNDATION

National Science Board; Sunshine Act Meetings; Notice

The National Science Board's Committee on Education and Human Resources, pursuant to NSF regulations (45 CFR part 614), the National Science Foundation Act, as amended (42 U.S.C. 1862n–5), and the Government in the Sunshine Act (5 U.S.C. 552b), hereby gives notice in regard to the scheduling of a teleconference for the transaction of National Science Board business and other matters specified, as follows:

DATE AND TIME: Wednesday, July 17, 2013, from 2:00–3:00 p.m. e.d.t.

SUBJECT MATTER: (1) Chairman's opening remarks; (2) topics and possible speakers for the August Board meeting;

and (3) activities committees undertake in order to produce NSB reports.

STATUS: Open.

LOCATION: This meeting will be held by teleconference at the National Science Board Office, National Science Foundation, 4201 Wilson Blvd., Arlington, VA 22230. A public listening room will be available for this teleconference meeting. All visitors must contact the Board Office (call 703–292–7000 or send an email message to *nationalsciencebrd@nsf.gov*) at least 24 hours prior to the teleconference for the public room number and to arrange for a visitor's badge. All visitors must report to the NSF visitor desk located in the lobby at the 9th and N. Stuart Streets entrance on the day of the teleconference to receive a visitor's badge.

UPDATES AND POINT OF CONTACT: Please refer to the National Science Board Web site *www.nsf.gov/nsb* for additional information. Meeting information and updates (time, place, subject matter or status of meeting) may be found at *http://www.nsf.gov/nsb/notices/*. Point of contact for this meeting is: Jack Meszaros, 4201Wilson Blvd., Arlington, VA 22230. Telephone: (703) 292–7000.

Ann Bushmiller,

Senior Counsel to the National Science Board.

[FR Doc. 2013–17021 Filed 7–11–13; 4:15 pm]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. NRC–2013–0116]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of pending NRC action to submit an information collection request to the Office of Management and Budget (OMB) and solicitation of public comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) invites public comment about our intention to request the OMB's approval for renewal of an existing information collection that is summarized below. We are required to publish this notice in the **Federal Register** under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

Information pertaining to the requirement to be submitted:

1. *The title of the information collection:* Policy Statement for the ''Criteria for Guidance of States and NRC in Discontinuance of NRC Regulatory Authority and Assumption Thereof By States Through Agreement,'' Maintenance of Existing Agreement State Programs, Request for Information Through the Integrated Materials Performance Evaluation Program (IMPEP) Questionnaire, and Agreement State Participation in IMPEP.

2. *Current OMB approval number:* 3150–0183.

3. *How often the collection is required:* Every four years for completion of the IMPEP questionnaire in preparation for an IMPEP review. One time for new Agreement State applications. Annually for participation by Agreement States in the IMPEP reviews and fulfilling requirements for Agreement States to maintain their programs.

4. *Who is required or asked to report:* All Agreement States (37 Agreement States who have signed Agreements with NRC under Section 274b. of the Atomic Energy Act (Act)) and any non-Agreement State seeking to sign an Agreement with the Commission.

5. *The number of annual respondents:* 38 (37 existing Agreement States plus 1 applicant).

6. *The number of hours needed annually to complete the requirement or request:* 285,143 hours (an average of 7,504 hours per respondent). This includes 477 hours to complete the IMPEP questionnaires; 2,750 hours to prepare new Agreement State applications, 396 hours for participation in IMPEP reviews; and 281,520 hours for maintaining Existing Agreement State programs.

7. *Abstract:* The States wishing to become Agreement States are requested to provide certain information to the NRC as specified by the Commission's Policy Statement, ''Criteria for Guidance of States and NRC in Discontinuance of NRC Regulatory Authority and Assumption Thereof By States Through Agreement.'' The Agreement States need to ensure that the radiation control program under the Agreement remains adequate and compatible with the requirements of Section 274 of the Act and must maintain certain information. The NRC conducts periodic evaluations through IMPEP to ensure that these programs are compatible with the NRC's program, meet the applicable parts of the Act, and adequate to protect public health and safety.

Submit, by September 13, 2013, comments that address the following questions:

1. Is the proposed collection of information necessary for the NRC to properly perform its functions? Does the information have practical utility?

2. Is the burden estimate accurate?

3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?

4. How can the burden of the information collection be minimized, including the use of automated collection techniques or other forms of information technology?

The public may examine and have copied for a fee publicly-available documents, including the draft supporting statement, at the NRC's Public Document Room, Room O–1F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852. The OMB clearance requests are available at the NRC's Web site: *http://www.nrc.gov/public-involve/doc-comment/omb/*.

The document will be available on the NRC home page site for 60 days after the signature date of this notice. Comments submitted in writing or in electronic form will be made available for public inspection. Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed. Comments submitted should reference Docket No. NRC–2013–0116. You may submit your comments by any of the following methods: Electronic comments: Go to *http://www.regulations.gov* and search for Docket No. NRC–2013–0116. Mail comments to NRC's Clearance Officer, Tremaine Donnell (T–5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Questions about the information collection requirements may be directed to the NRC's Clearance Officer, Tremaine Donnell (T–5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–6258, or by email: *INFOCOLLECTS.Resource@NRC.GOV*.

Dated at Rockville, Maryland, this 9th day of July, 2013.

For the Nuclear Regulatory Commission.

Tremaine Donnell,

NRC Clearance Officer, Office of Information Services.

[FR Doc. 2013–16780 Filed 7–12–13; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–361 and 50–362; NRC–2013–0155]

Application and Amendment to Facility Operating License Involving Proposed No Significant Hazards Consideration Determination; San Onofre Nuclear Generating Station, Units 2 and 3

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of withdrawal.

ADDRESSES: Please refer to Docket ID NRC–2013–0155 when contacting the NRC about the availability of information regarding this document. You may access information related to this document, which the NRC possesses and are publicly available, using any of the following methods:

- *Federal rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2013–0155. Address questions about NRC dockets to Carol Gallagher; telephone: 301–492–3668; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual(s) listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may access publicly available documents online in the NRC Library at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents*'' and then select ''*Begin Web-based ADAMS Search.*'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced in this notice (if that document is available in ADAMS) is provided the first time that a document is referenced.
- *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: Brian Benney, Senior Project Manager, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–2767; email: *Brian.Benney@nrc.gov.*

SUPPLEMENTARY INFORMATION: The U.S. Nuclear Regulatory Commission (NRC) has granted the request of Southern California Edison (the licensee) to withdraw its application dated July 29, 2011 (ADAMS Accession No. ML11215A090), as supplemented by letters dated September 14, 2012, September 27, 2012, September 28, 2012, November 5, 2012, February 15, 2013, March 19, 2013, and April 11, 2013 (ADAMS Accession Nos.: ML12263A300, ML12275A418, ML12272A092, ML12310A408, ML13051A451, ML13081A019, and ML13105A199, respectively), for proposed amendments to Facility Operating License Nos. NPF–10 and NPF–15 for the San Onofre Nuclear Generating Station (SONGS), Units 2 and 3, respectively, located in San Diego County, California.

The proposed amendments would have revised a number of Technical Specification (TS) requirements, to allow the licensee to use AREVA 16x16 reactor fuel on a permanent basis in SONGS, Units 2 and 3. These changes included revising TS 5.7.1.5, Core Operating Limits Report (COLR), to update the methodology reference list to support the core design with the new AREVA fuel; revising TS 4.2.1, Fuel Assemblies, to include the description of the new fuel cladding material (M5); revising TS 2.1.1.2, Reactor Safety Limits, to identify a fuel centerline melt safety limit for the AREVA fuel with corresponding adjustments made to account for the burnable absorber fuel rods; and incorporating fuel burnup limits consistent with AREVA M5 clad fuel assemblies into the SONGS licensing basis.

The Commission had previously issued a Notice of Consideration of Issuance of Amendment published in the **Federal Register** on February 14, 2012 (76 FR 8292). However, by letter dated July 1, 2013 (ADAMS Accession No. ML13183A412), the licensee withdrew the proposed change.For further details with respect to this action, see the application for amendment dated July 29, 2011, as supplemented by letters dated September 14, 2012, September 27, 2012, September 28, 2012, November 5, 2012, February 15, 2013, March 19, 2013, and April 11, 2013, and the licensee's letter dated July 1, 2013, which withdrew the application for license amendment.

Dated at Rockville, Maryland, this 8th day of July, 2013.

For the Nuclear Regulatory Commission.

Brian Benney,

Senior Project Manager, SONGS Special Projects Branch, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2013–16854 Filed 7–12–13; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

Submission for OMB Review; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Extension:

Rule 6h–1, SEC File No. 270–497; OMB Control No. 3235–0555.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (''PRA''), the Securities and Exchange Commission (''Commission'') has submitted to the Office of Management and Budget (''OMB'') a request for approval of extension of the previously approved collection of information provided for in Rule 6h–1 (17 CFR 240.6h–1) under the Securities Exchange Act of 1934, as amended (''Act'') (15 U.S.C. 78a *et seq.*).

Section 6(h) of the Act (15 U.S.C. 78f(h)) requires national securities exchanges and national securities associations that trade security futures products to establish listing standards that, among other things, require that: (i) Trading in such products not be readily susceptible to price manipulation; and (ii) the market on which the security futures product trades has in place procedures to coordinate trading halts with the listing market for the security or securities underlying the security futures product. Rule 6h–1 implements these statutory requirements and requires that (1) the final settlement price for each cash-settled security futures product fairly reflect the opening price of the underlying security or securities, and (2) the exchanges and associations trading security futures products halt trading in any security futures product for as long as trading in the underlying security, or trading in 50% of the underlying securities, is halted on the listing market.

It is estimated that approximately 1 respondent per year, consisting of a designated contract market not already registered as a national securities exchange under Section 6(g) of the Exchange Act that seeks to list or trade security futures products, will incur an average burden of 10 hours per year to comply with this rule, for a total burden of 10 hours. At an average cost per hour of approximately $379, the resultant total internal cost of compliance for all respondents is $3,790 per year (1 respondent × 10 hours/respondent × $379/hour).

Compliance with Rule 6h–1 is mandatory. Any listing standards

established pursuant to Rule 6h–1 would be filed with the Commission as proposed rule changes pursuant to Section 19(b) of the Act, and would be published in the **Federal Register.**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information under the PRA unless it displays a currently valid OMB control number.

The public may view background documentation for this information collection at the following Web site: *www.reginfo.gov.* Comments should be directed to: (i) Desk Officer for the Securities and Exchange Commission, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503, or by sending an email to: *Shagufta_Ahmed@omb.eop.gov;* and (ii) Thomas Bayer, Director/Chief Information Officer, Securities and Exchange Commission, c/o Remi Pavlik-Simon, 6432 General Green Way, Alexandria, VA 22312 or send an email to: *PRA_Mailbox@sec.gov.* Comments must be submitted to OMB within 30 days of this notice.

Dated: July 10, 2013.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16859 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 30593; 812–14150]

FlexShares Trust, et al.; Notice of Application

July 9, 2013.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of an application to amend prior orders [1] under section 6(c) of the Investment Company Act of 1940 (''Act'') granting an exemption from sections 2(a)(32), 5(a)(1), 22(d) and 22(e) of the Act and rule 22c–1 under the Act, and under sections 6(c) and 17(b) of the Act for an exemption from sections 17(a)(1) and (2) of the Act, and under section 12(d)(1)(J) of the Act for an exemption from sections 12(d)(1)(A) and (B) of the Act (''Prior Orders'').

SUMMARY OF APPLICATION: Applicants seek to amend the Prior Orders to permit the Funds (as defined in the applications for the Prior Orders) to issue Shares in less than Creation Unit size to investors participating in the Distribution Reinvestment Program (as defined below).

APPLICANTS: FlexShares Trust (the ''Trust''), Northern Trust Investments, Inc. (the ''Adviser''), and Foreside Fund Services, LLC (''Foreside'').

DATES: *Filing Dates:* The application was filed on April 12, 2013, and amended on July 3, 2013.

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 August 5, 2013 and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, 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: Elizabeth M. Murphy, Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090. Applicants, Trust and Adviser, c/o Peter K. Ewing, 50 S. LaSalle Street, Chicago, IL 60603, Foreside, Three Canal Plaza, Suite 100, Portland, ME 04101.

FOR FURTHER INFORMATION CONTACT: Marilyn Mann, Special Counsel, at (202) 551–6813 or Mary Kay Frech, Branch Chief, at (202) 551–6821 (Division of Investment Management, Exemptive Applications Office).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site 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.

Applicants' Representations

1. The Trust is registered under the Act as an open-end management investment company with multiple series and organized as a Maryland statutory trust. The Adviser is an Illinois state banking corporation that is registered under the Investment Advisers Act of 1940 and serves as investment adviser to the 13 series of the Trust (''Existing Funds''), all of which rely on one of the Prior Orders. The distributor for the Existing Funds is Foreside, a Delaware limited liability company. Applicants request relief for the Existing Funds and for any additional Funds, as defined in the Prior Applications.

2. The Prior Applications stated that the Funds would not make the DTC book-entry dividend reinvestment service available for use by Beneficial Owners for reinvestment of their cash proceeds. The Prior Applications also stated that ''[b]rokers may, however, offer a dividend reinvestment service which uses dividends to purchase Shares on the secondary market at market value.'' In addition, the Prior Applications included several representations and a condition noting that Shares could be acquired from the Funds and the Funds would issue Shares in Creation Units only. The applicants seek an order amending the Prior Orders (''Amended Order'') so that the representations and condition A.2 specifically permit the Funds to operate the ''Distribution Reinvestment Program,'' as described below.[2]

3. The Trust will make the DTC book-entry Dividend Reinvestment Service (''DTC Dividend Reinvestment Service'') available for use by the beneficial owners of Shares (''Beneficial Owners'') through DTC Participants for reinvestment of their cash dividends.[3] DTC Participants whose customers participate in the program will have the distributions of their customers automatically reinvested in additional whole Shares issued by the applicable Fund at NAV per Share. Shares will be issued at NAV under the DTC Dividend Reinvestment Service regardless of whether the Shares are trading in the secondary market at a premium or discount to NAV as of the time NAV is calculated. Thus, Shares may be purchased through the DTC Dividend Reinvestment Service at prices that are higher (or lower) than the contemporaneous secondary market trading price. Applicants state that the

[1] Northern Trust Investments, Inc., Investment Company Act Release Nos. 29752 (Aug. 10, 2011) (notice) and 29782 (Sept. 6, 2011) (order); Northern Trust Investments, Inc., Investment Company Act Release Nos. 30045 (Apr. 24, 2012) (notice) and 30068 (May 22, 2012) (order); Northern Trust Investments, Inc., Investment Company Act Release Nos. 30211 (Sept. 24, 2012) (notice) and (30240 (Oct. 23, 2012) (order). All capitalized terms not otherwise defined in the application have the meanings ascribed to them in the applications for the Prior Orders (the ''Prior Applications'').

[2] All entities that currently intend to rely on the Amended Order are named as applicants. Any other entity that relies on the Amended Order in the future will comply with the terms and conditions of the application.

[3] Some DTC Participants may not elect to utilize the DTC Dividend Reinvestment Service. Beneficial Owners will be encouraged to contact their broker to ascertain the availability of the DTC Dividend Reinvestment Service through such broker.

DTC Dividend Reinvestment Service differs from dividend reinvestment services offered by broker-dealers in two ways. First, in dividend reinvestment programs typically offered by broker-dealers, the additional shares are purchased in the secondary market at current market prices at a date and time determined by the broker-dealer at its discretion. Shares purchased through the DTC Dividend Reinvestment Service are purchased directly from the fund on the date of the distribution at the NAV per share on such date. Second, in dividend reinvestment programs typically offered by broker-dealers, shareholders are typically charged a brokerage or other fee in connection with the secondary market purchase of shares. Applicants state that brokers typically do not charge customers any fees for reinvesting distributions through the DTC Dividend Reinvestment Service.

4. Applicants state that the DTC Dividend Reinvestment Service will be operated by DTC in exactly the same way it runs such service for other open-end management investment companies. The initial decision to participate in the DTC Dividend Reinvestment Service is made by the DTC Participant. Once a DTC Participant elects to participate in the DTC Dividend Reinvestment Service, it offers its customers the option to participate. Beneficial Owners will have to make an affirmative election to participate by completing an election notice. Before electing to participate, Beneficial Owners will receive disclosure describing the terms of the DTC Dividend Reinvestment Service and the consequences of participation. This disclosure will include a clear and concise explanation that under the Distribution Reinvestment Program, Shares will be issued at NAV, which could result in such Shares being acquired at a price higher or lower than that at which they could be sold in the secondary market on the day they are issued (this will also be clearly disclosed in the Prospectus). Brokers providing the DTC Dividend Reinvestment Service to their customers will determine whether to charge Beneficial Owners a fee for this service. Applicants represent that brokers typically do not charge a fee for the DTC Dividend Reinvestment Service.

5. The Prospectus will make clear to Beneficial Owners that the Distribution Reinvestment Program is optional and that its availability is determined by their broker, at its own discretion. Broker-dealers are not required to utilize the DTC Dividend Reinvestment Service, and may instead offer a dividend reinvestment program under which Shares are purchased in the secondary market at current market prices or no dividend reinvestment program at all.

Applicants' Legal Analysis

1. Section 6(c) of the Act provides that the Commission may exempt any person, security or transaction, or any class of persons, securities or transactions, from any provision of the Act, if and to the extent that 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.

2. Applicants seek to amend the Prior Orders to specifically permit the Funds to operate the Distribution Reinvestment Program. The only difference between the terms and conditions in the Prior Orders and the Amended Order relates to a Fund issuing Shares in less than Creation Unit size under the Distribution Reinvestment Program. Applicants represent that the relief granted in the Prior Orders under section 6(c) remains 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.

3. Applicants state that the Distribution Reinvestment Program is reasonable and fair because it is voluntary and each Beneficial Owner will have in advance accurate and explicit information that makes clear the terms of the Distribution Reinvestment Program and the consequences of participation. The Distribution Reinvestment Program does not involve any overreaching on the part of any person concerned because it operates the same for each Beneficial Owner who elects to participate, and is structured in the public interest because it is designed to give those Beneficial Owners who elect to participate a convenient and efficient method to reinvest distributions without paying a brokerage commission. In addition, although brokers providing the Distribution Reinvestment Program could charge a fee, applicants represent that typically brokers do not charge for this service.

4. Applicants do not believe that the issuance of Shares under the Distribution Reinvestment Program will have a material effect on the overall operation of the Funds, including on the efficiency of the arbitrage mechanism inherent in ETFs. In addition, applicants do not believe that providing Beneficial Owners with an added optional benefit (the ability to reinvest in Shares at NAV) will change the Beneficial Owners' expectations about the Funds or the fact that individual Shares trade at secondary market prices. Applicants believe that Beneficial Owners (other than Authorized Participants) generally expect to buy and sell individual Shares only through secondary market transactions at market prices and that such owners will not be confused by the Distribution Reinvestment Program. Therefore, applicants believe that the Distribution Reinvestment Program meets the standards for relief under section 6(c) of the Act.

Applicants' Conditions

Applicants agree that the Amended Order will be subject to the same conditions as those imposed by the Prior Orders, except that condition A.2 is revised in its entirety as follows:

Neither the Trust nor any Fund will be advertised or marketed as an open-end investment company or a mutual fund. Any advertising material that describes the purchase or sale of Creation Units or refers to redeemability will prominently disclose that Shares are not individually redeemable and that owners of Shares may acquire those Shares from a Fund (other than pursuant to the Distribution Reinvestment Program) and tender those Shares for redemption to a Fund in Creation Units only.

For the Commission, by the Division of Investment Management, under delegated authority.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16858 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 30594; 812–13941]

NGAM Advisors, LP, et al.; Notice of Application

July 9, 2013.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of an application for an order under section 6(c) of the Investment Company Act of 1940 (''Act'') for an exemption from sections 2(a)(32), 5(a)(1), 22(d) and 22(e) of the Act and rule 22c-1 under the Act, under sections 6(c) and 17(b) of the Act for an exemption from sections 17(a)(1) and (a)(2) of the Act, and under section 12(d)(1)(J) of the Act for an exemption from sections 12(d)(1)(A) and (B) of the Act.

APPLICANTS: NGAM Advisors, LP (''NGAMA'' or the ''Adviser''), Natixis ETF Trust (the ''Trust'') and NGAM Distribution, LP (''NGAMD'' or the ''Distributor'').

SUMMARY OF APPLICATION: Applicants request an order that permits: (a) Series of certain actively managed open-end management investment companies to issue exchange-traded shares (''Shares'') redeemable in large aggregations only (''Creation Units''); (b) secondary market transactions in Shares to occur at negotiated market prices; (c) certain series to pay redemption proceeds, under certain circumstances, more than seven days after the tender of Shares for redemption; (d) certain affiliated persons of the series to deposit securities into, and receive securities from, the series in connection with the purchase and redemption of Creation Units (collectively, the ''ETF Relief''); and (e) certain registered management investment companies and unit investment trusts outside of the same group of investment companies as the series to acquire Shares (the ''12(d)(1) Relief'').

DATES: *Filing Dates:* The application was filed on August 15, 2011, and amended on February 8, 2012, July 16, 2012, December 4, 2012, and May 23, 2013.

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 August 5, 2013, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, 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: Elizabeth M. Murphy, Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090. Applicants: c/o Coleen Downs Dineen, NGAM Advisors, L.P., 399 Boylston Street, Boston, MA 02116–9848.

FOR FURTHER INFORMATION CONTACT: Jaea F. Hahn, Senior Counsel, at (202) 551–6870 or Jennifer L. Sawin, Branch Chief, at (202) 551–6821 (Division of Investment Management, Exemptive Applications Office).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site 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.

Applicants' Representations

1. The Trust is a Massachusetts business trust and will be registered as an open-end management investment company under the Act. The Trust is authorized to offer an unlimited number of series, and will create Funds (defined below) that will operate pursuant to the terms and conditions of the application. It is anticipated that the initial Fund will be a foreign equity fund whose investment objective is to seek long-term capital growth.

2. NGAMA, a Delaware partnership, is registered with the Commission as an investment adviser under the Investment Advisers Act of 1940 (''Advisers Act''). NGAMA or an entity controlling, controlled by or under common control with NGAMA (each, together with any successor thereto, included as an ''Adviser'') will serve as investment adviser to each Fund.[1] An Adviser may retain one or more sub-advisers (each, a ''Sub-Adviser'') for a Fund. Any Adviser and any Sub-Adviser is or will be registered under the Advisers Act or, in the case of a Sub-Adviser, not subject to such registration.

3. NGAMD, a Delaware partnership and an affiliate of NGAMA, is a broker-dealer registered under the Securities Exchange Act of 1934 (''Exchange Act'') that will act as the distributor and principal underwriter of the Funds.[2] The Distributor will be identified as such in the current prospectus of each Fund (''Prospectus'') and will comply with the terms of the application.

4. Applicants request that the ETF Relief apply to future series of the Trust or of other open-end management investment companies that may be created in the future that are actively-managed exchange-traded funds (''ETFs'') that (i) primarily invest in debt and equity securities, including shares of other investment companies, (ii) are advised by an Adviser, and (iii) comply with the terms and conditions of the ETF Relief (such ETFs, individually, a ''Fund'' and collectively, the ''Funds'').[3] Each Fund will have distinct investment strategies that are different from those of other Funds.

5. Applicants also request that the 12(d)(1) Relief, exempting certain transactions from Sections 12(d)(l)(A) and 12(d)(l)(B) of the Act, and under Sections 6(c) and 17(b) of the Act exempting certain transactions from Section 17(a) of the Act, apply to (i) the Funds and to (ii) series of the Trust or of other open-end management investment companies that operate as ETFs whose portfolio securities will be selected to correspond generally to the price and yield performance of a specified index and are advised by an Adviser (''Index Series''),[4] (iii) Acquiring Funds,[5] and (iv) any principal underwriter of a Fund or any broker-dealer registered under the Securities Exchange Act of 1934, as amended (''Exchange Act'') selling Shares to Acquiring Funds (''Brokers'').[6] Acquiring Funds do not include Funds.

6. Each Fund will attempt to achieve its investment objective by utilizing an ''active'' management strategy based on investments in equity and debt securities, as appropriate, including shares of other open-end and/or closed-end investment companies and/or ETFs.[7] If a Fund invests in derivatives, then (a) the Fund's Board will periodically review and approve the Fund's use of derivatives and how the Fund's investment adviser assesses and manages risk with respect to the Fund's use of derivatives and (b) the Fund's disclosure of its use of derivatives in its offering documents and periodic reports

[1] For the purposes of the application, a ''successor'' is limited to an entity that would result from reorganization into another jurisdiction or a change in the type of business organization.

[2] In the future, another broker-dealer registered under the Exchange Act may act as distributor and principal underwriter (included in the term ''Distributor''). No Distributor, Fund, Trust, Adviser, or Sub-Adviser will be affiliated with any Listing Market. A ''Listing Market'' is a national securities exchange, as defined in section 2(a)(26) of the Act, on which Shares of a Fund trade at negotiated prices in the secondary market.

[3] All entities that currently intend to rely on the order are named as applicants. Any other entity that relies on the order in the future will comply with the terms and conditions of the application.

[4] For purposes of the requested 12(d)(1) Relief, Index Series are included as Funds.

[5] An ''Acquiring Fund'' is a registered management investment company or unit investment trust that is not advised or sponsored by the Adviser or an entity controlling, controlled by or under common control with the Adviser, and not part of the same ''group of investment companies'' as defined in Section 12(d)(l)(G)(ii) of the Act as the Funds. Each Acquiring Fund relying on the 12(d)(1) Relief to invest in a Fund will enter into an ''Acquiring Fund Agreement'' (defined below) with the Fund. An Acquiring Fund may rely on the order only to invest in Funds and not in any other registered investment company.

[6] Any future principal underwriter of a Fund will be a broker-dealer registered under the Exchange Act and will comply with the terms and conditions of the application.

[7] In no case, however, will such a Fund rely on the exemption from section 12(d)(1) being requested in the application.

will be consistent with relevant Commission and staff guidance. Funds may invest in ''Depositary Receipts''. A Fund will not invest in any Depositary Receipts that the Adviser or any Sub-Adviser deems to be illiquid or for which pricing information is not readily available.[8] The Funds may invest in equity securities or fixed income securities traded in the U.S. or non-U.S. markets. Funds that invest in equity and fixed income securities traded in the U.S. market are ''Domestic Funds.'' Funds that invest in equity securities or fixed income securities traded in the U.S. or non-U.S. markets are ''Global Funds''. Funds that invest solely in foreign equity and foreign fixed income securities are ''Foreign Funds''.

7. Shares of each Fund will be issued in Creation Units of 25,000 or more Shares and Applicants anticipate that the price of a Share will range from $20 to $200. All orders to purchase Creation Units must be placed with the Distributor by or through a participant in the Depository Trust Company (''DTC Participant'') that has entered into a ''Participant Agreement'' with the Distributor (an ''Authorized Participant'').[9] Purchase orders for Shares will be processed either through a manual clearing process (the ''DTC Process'') or through an enhanced clearing process (''the NSCC Process'') available only to those DTC Participants that also are participants in the Continuous Net Settlement (''CNS'') System of the National Securities Clearing Corporation (''NSCC''), a clearing agency registered with the Commission and affiliated with DTC.

8. Shares will be purchased and redeemed in Creation Units and generally on an in-kind basis. Except where the purchase or redemption will include cash under the limited circumstances specified below, purchasers will be required to purchase Creation Units by making an in-kind deposit of specified instruments (''Deposit Instruments''), and shareholders redeeming their Shares will receive an in-kind transfer of specified instruments (''Redemption Instruments'').[10] On any given Business Day [11] the names and quantities of the instruments that constitute the Deposit Instruments and the names and quantities of the instruments that constitute the Redemption Instruments will be identical, and these instruments may be referred to, in the case of either a purchase or redemption, as the ''Creation Basket.'' In addition, the Creation Basket will correspond pro rata to the positions in a Fund's portfolio (including cash positions),[12] except: (a) In the case of bonds, for minor differences when it is impossible to break up bonds beyond certain minimum sizes needed for transfer and settlement, (b) for minor differences when rounding is necessary to eliminate fractional shares or lots that are not tradeable round lots; [13] or (c) TBA Transactions,[14] short positions in securities (''Short Positions'') and other positions that cannot be transferred in kind [15] will be excluded from the Creation Basket.[16] If there is a difference between the net asset value (''NAV'') attributable to a Creation Unit and the aggregate market value of the Creation Basket exchanged for the Creation Unit, the party conveying instruments with the lower value will also pay to the other an amount in cash equal to that difference (the ''Balancing Amount'').

9. Purchases and redemptions of Creation Units may be made in whole or in part on a cash basis, rather than in kind, solely under the following circumstances: (a) To the extent there is a Balancing Amount, as described above; (b) if, on a given Business Day, a Fund announces before the open of trading that all purchases, all redemptions or all purchases and redemptions on that day will be made entirely in cash; (c) if, upon receiving a purchase or redemption order from an Authorized Participant, the Fund determines to require the purchase or redemption, as applicable, to be made entirely in cash; [17] (d) if, on a given Business Day, the Fund requires all Authorized Participants purchasing or redeeming Shares on that day to deposit or receive (as applicable) cash in lieu of some or all of the Deposit Instruments or Redemption Instruments, respectively, solely because: (i) Such instruments are not eligible for transfer through either the NSCC Process or the DTC Process; or (ii) in the case of Global Funds or Foreign Funds, such instruments are not eligible for trading due to local trading restrictions, local restrictions on securities transfers or other similar circumstances; or (e) if the Fund permits an Authorized Participant to deposit or receive (as applicable) cash in lieu of some or all of the Deposit Instruments or Redemption Instruments, respectively, solely because: (i) Such instruments are, in the case of the purchase of a Creation Unit, not available in sufficient quantity; (ii) such instruments are not eligible for trading by an Authorized Participant or the investor on whose behalf the Authorized Participant is acting; or (iii) a holder of Shares of a Global Fund or Foreign Fund would be subject to unfavorable income tax treatment if the holder receives redemption proceeds in kind.[18]

10. Each Business Day, before the open of trading on that Fund's Listing Market, each Fund will cause to be published through the NSCC the names and quantities of the instruments comprising the Creation Basket, as well as the estimated Balancing Amount (if any), for that day. The published Creation Basket will apply until a new Creation Basket is announced on the following Business Day, and there will

[8] Depositary Receipts are typically issued by a financial institution, a ''Depository'', and evidence ownership in a security or pool of securities that have been deposited with the Depositary. No affiliated persons of Applicants, or of any Adviser, Fund, or Sub-Adviser, will serve as Depository for any Depositary Receipts held by a Fund.

[9] DTC Participants may include broker-dealers, banks, trust companies and clearing companies.

[10] The Funds must comply with the federal securities laws in accepting Deposit Instruments and satisfying redemptions with Redemption Instruments, including that the Deposit Instruments and Redemption Instruments are sold in transactions that would be exempt from registration under the Securities Act of 1933 (''Securities Act''). In accepting Deposit Instruments and satisfying redemptions with Redemption Instruments that are restricted securities eligible for resale pursuant to Rule 144A under the Securities Act, the Funds will comply with the conditions of Rule 144A.

[11] Each Fund will sell and redeem Creation Units on any day the Trust is open for business, including as required by section 22(e) of the Act (each, a ''Business Day'').

[12] The portfolio used for this purpose will be the same portfolio used to calculate the Fund's NAV for that Business Day.

[13] A tradeable round lot for a security will be the standard unit of trading in that particular type of security in its primary market.

[14] A TBA Transaction is a method of trading mortgage-backed securities. In a TBA Transaction, the buyer and seller agree on general trade parameters such as agency, settlement date, par amount and price. The actual pools delivered are determined two days prior to the settlement date.

[15] This includes instruments that can be transferred in kind only with the consent of the original counterparty to the extent the Fund does not intend to seek such consents.

[16] Because these instruments will be excluded from the Creation Basket, their value will be reflected in the determination of the Balancing Amount (defined below).

[17] In determining whether a particular Fund will sell or redeem Creation Units entirely on a cash or in-kind basis (whether for a given day or a given order), the key consideration will be the benefit that would accrue to the Fund and its investors. For instance, in bond transactions, the Adviser may be able to obtain better execution than Share purchasers because of the Adviser's size, experience and potentially stronger relationships in the fixed income markets. Purchases of Creation Units either on an all cash basis or in-kind are expected to be neutral to the Funds from a tax perspective. In contrast, cash redemptions typically require selling portfolio holdings, which may result in adverse tax consequences for the remaining Fund shareholders that would not occur with an in-kind redemption. As a result, tax considerations may warrant in-kind redemptions.

[18] A ''custom order'' is any purchase or redemption of Shares made in whole or in part on a cash basis in reliance on clause (e)(i) or (e)(ii).

be no intra-day changes to the Creation Basket except to correct errors in the published Creation Basket. The Listing Market will disseminate every 15 seconds throughout its regular trading hours the Fund's estimated NAV, which is an amount per Share representing the current value of the Fund's Portfolio Positions.

11. An investor purchasing or redeeming a Creation Unit from a Fund may be charged a fee (''Transaction Fee'') to protect existing shareholders of the Funds from the dilutive costs associated with the purchase and redemption of Creation Units.[19] All orders to purchase Creation Units must be placed with the Distributor by or through an Authorized Participant and the Distributor will transmit all purchase orders to the relevant Fund. The Distributor will maintain a record of Creation Units purchases and will send confirmations of such purchases. The Distributor will coordinate the production and distribution of Prospectuses to broker-dealers. Applicants will arrange for dealers selling Shares in the secondary market to provide purchasers with a Prospectus.

12. Shares will be listed on the Listing Market and traded at prices based on a current bid-offer market.[20] No secondary sales will be made to brokers or dealers at a concession by the Distributor or by a Fund. Transactions involving the sale of Shares on the Listing Market, which will not involve a Fund, will be subject to customary brokerage commissions and charges.

13. Applicants expect that purchasers of Creation Units will include institutional investors and arbitrageurs. Applicants expect that arbitrage opportunities created by the ability to continually purchase or redeem Creation Units at their NAV per Share should ensure that the Shares will not trade in the secondary market at a material discount or premium in relation to their NAV. Applicants expect that secondary market purchasers of Shares will include both institutional and retail investors.

14. Shares will not be individually redeemable and owners of Shares may acquire those Shares from a Fund, or tender such shares for redemption to the Fund, in Creation Units only. To redeem, an investor must accumulate enough Shares to constitute a Creation Unit. As discussed above, redemptions of Creation Units may be made in whole or in part on a cash basis, rather than in kind, solely pursuant to the procedures discussed in section III.B.1 of the application.

15. The Trust will not, nor will any Fund, be marketed or otherwise held out as a ''mutual fund.'' Instead, each Fund will be marketed as an ''actively-managed exchange-traded fund.'' All marketing materials that describe the features or method of obtaining, buying or selling Creation Units, or Shares traded on the Listing Market, or refer to redeemability, will prominently disclose that Shares are not individually redeemable.

16. The Funds' Web site, which will be publicly available at no charge, will include the Prospectus and additional quantitative information updated on a daily basis, including, on a per Share basis for each Fund, the prior Business Day's NAV and the market closing price or mid-point of the bid/ask spread at the time of the calculation of such NAV (''Bid/Ask Price''), and a calculation of the premium or discount of the market closing price or Bid/Ask Price against such NAV. On each Business Day, before commencement of trading in Shares on a Fund's Listing Market, the Fund will disclose on its Web site the identities and quantities of the securities and other assets and positions (including Short Positions) (together, the ''Portfolio Positions'') held by the Fund that will form the basis for the Fund's calculation of NAV at the end of that Business Day.[21]

Applicants' Legal Analysis

1. Applicants request an order under section 6(c) of the Act for an exemption from sections 2(a)(32), 5(a)(1), 22(d) and 22(e) of the Act and rule 22c–1 under the Act, under sections 6(c) and 17(b) of the Act for an exemption from sections 17(a)(1) and 17(a)(2) of the Act, and under section 12(d)(1)(J) of the Act for an exemption from sections 12(d)(1)(A) and (B) of the Act.

2. Section 6(c) of the Act provides that the Commission may exempt any person, security or transaction, or any class of persons, securities or transactions, from any provisions of the Act, if and to the extent that 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 17(b) of the Act provides that the Commission may approve the sale of securities to an investment company and the purchase of securities from an investment company, in both cases by an affiliated person of such company, if the Commission finds that the terms of the transaction, including the consideration to be paid or received, are reasonable and fair and do not involve overreaching on the part of any person concerned, and the proposed transaction is consistent with the policies of each registered investment company concerned and the general purposes 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.

Sections 5(a)(1) and 2(a)(32) of the Act

3. Section 5(a)(1) of the Act defines an ''open-end company'' as a management investment company that is offering for sale or has outstanding any redeemable security of which it is the issuer. Section 2(a)(32) of the Act defines a redeemable security as any security, other than short-term paper, under the terms of which the holder, upon its presentation to the issuer, is entitled to receive approximately a proportionate share of the issuer's current net assets, or the cash equivalent. Because Shares will not be individually redeemable, applicants request an order that would permit each Fund to redeem Shares in Creation Units only. Applicants state that investors may purchase Shares in Creation Units from each Fund and redeem Creation Units from each Fund. Applicants further state that because the market price of Creation Units will be disciplined by arbitrage opportunities, investors should be able to sell Shares in the secondary market at prices that do not vary materially from their NAV.

[19] Higher transaction fees may be assessed for investors purchasing or redeeming in cash, or for investors purchasing or redeeming through the DTC Process than through the NSCC Process due to the higher fees charged to the Fund by DTC.

[20] If Shares are listed on Nasdaq or a similar electronic Listing Market (including NYSE Arca), one or more member firms of that Listing Market will act as market maker (''Market Maker'') and maintain a market for Shares trading on the Listing Market. On Nasdaq, no particular Market Maker would be contractually obligated to make a market in Shares. However, the listing requirements on Nasdaq, for example, stipulate that at least two Market Makers must be registered in Shares to maintain a listing. In addition, on Nasdaq and NYSE Arca, registered Market Makers are required to make a continuous two-sided market or subject themselves to regulatory sanctions. No Market Maker will be an affiliated person, or an affiliated person of an affiliated person, of the Funds, except within Section 2(a)(3)(A) or (C) of the Act due to ownership of Shares, as described below.

[21] Under accounting procedures followed by the Funds, trades made on the prior Business Day (''T'') will be booked and reflected in NAV on the current Business Day (''T+1''). Accordingly, the Funds will be able to disclose at the beginning of the Business Day the portfolio that will form the basis for the NAV calculation at the end of the Business Day.

Section 22(d) of the Act and Rule 22c–1 under the Act

4. Section 22(d) of the Act, among other things, prohibits a dealer from selling a redeemable security that is currently being offered to the public by or through a principal underwriter, except at a current public offering price described in the prospectus. Rule 22c–1 under the Act generally requires that a dealer selling, redeeming, or repurchasing a redeemable security do so only at a price based on its NAV. Applicants state that secondary market trading in Shares will take place at negotiated prices, not at a current offering price described in the Prospectus, and not at a price based on NAV. Thus, purchases and sales of Shares in the secondary market will not comply with section 22(d) of the Act and rule 22c–1 under the Act. Applicants request an exemption under section 6(c) from these provisions.

5. Applicants assert that the concerns sought to be addressed by section 22(d) of the Act and rule 22c–1 under the Act with respect to pricing are equally satisfied by the proposed method of pricing Shares. Applicants maintain that while there is little legislative history regarding section 22(d), its provisions, as well as those of rule 22c–1, appear to have been designed to (a) Prevent dilution caused by certain riskless-trading schemes by principal underwriters and contract dealers, (b) prevent unjust discrimination or preferential treatment among buyers resulting from sales at different prices, and (c) assure an orderly distribution system of investment company shares by eliminating price competition from brokers offering shares at less than the published sales price and repurchasing shares at more than the published redemption price.

6. Applicants believe that none of these purposes will be thwarted by permitting Shares to trade in the secondary market at negotiated prices. Applicants state that (a) secondary market trading in Shares does not involve Fund assets and cannot result in dilution of an investment in Shares, and (b) to the extent different prices exist during a given trading day, or from day to day, such variances occur as a result of third-party market forces, such as supply and demand. Therefore, applicants assert that secondary market transactions in Shares will not lead to discrimination or preferential treatment among purchasers. Finally, applicants contend that the proposed distribution system will be orderly because arbitrage activity should ensure that the difference between the market price of Shares and their NAV remains narrow.

Section 22(e) of the Act

7. Section 22(e) of the Act generally prohibits a registered investment company from suspending the right of redemption or postponing the date of payment of redemption proceeds for more than seven days after the tender of a security for redemption. Applicants observe that settlement of redemptions of Creation Units of Foreign Funds and Global Funds is contingent not only on the settlement cycle of the U.S. securities markets but also on the delivery cycles present in foreign markets in which those Funds invest. Applicants have been advised that, under certain circumstances, the delivery cycles for transferring Portfolio Positions to redeeming investors, coupled with local market holiday schedules, will require a delivery process of up to 14 calendar days. Applicants therefore request relief from section 22(e) in order to provide payment or satisfaction of redemptions within the maximum number of calendar days required for such payment or satisfaction in the principal local markets where transactions in the Portfolio Positions of each Foreign Fund or Global Fund customarily clear and settle, but in all cases no later than 14 calendar days following the tender of a Creation Unit.

8. Applicants state that section 22(e) was designed to prevent unreasonable, undisclosed and unforeseen delays in the actual payment of redemption proceeds. Applicants assert that the requested relief will not lead to the problems that section 22(e) was designed to prevent. Applicants state that allowing redemption payments for Creation Units of a Fund to be made within a maximum of 14 calendar days would not be inconsistent with the spirit and intent of section 22(e). Applicants state the SAI will disclose those local holidays (over the period of at least one year following the date of the SAI), if any, that are expected to prevent the delivery of redemption proceeds in seven calendar days and the maximum number of days needed to deliver the proceeds for each affected Foreign Fund or Global Fund. Applicants are not seeking relief from section 22(e) with respect to Foreign Funds and Global Funds that do not effect redemptions in-kind.

Section 12(d)(1) of the Act

9. Section 12(d)(1)(A) of the Act prohibits a registered investment company from acquiring shares of an investment company if the securities represent more than 3% of the total outstanding voting stock of the acquired company, more than 5% of the total assets of the acquiring company, or, together with the securities of any other investment companies, more than 10% of the total assets of the acquiring company. Section 12(d)(1)(B) of the Act prohibits a registered open-end investment company, its principal underwriter, or any other broker or dealer from selling the investment company's shares to another investment company if the sale will cause the acquiring company to own more than 3% of the acquired company's voting stock, or if the sale will cause more than 10% of the acquired company's voting stock to be owned by investment companies generally.

10. Applicants request relief to permit Acquiring Funds to acquire Shares in excess of the limits in section 12(d)(1)(A) of the Act and to permit the Funds, their principal underwriters and any Broker to sell Shares to Acquiring Funds in excess of the limits in section 12(d)(l)(B) of the Act. Applicants submit that the proposed conditions to the requested relief address the concerns underlying the limits in section 12(d)(1), which include concerns about undue influence, excessive layering of fees and overly complex structures.

11. Applicants submit that their proposed conditions address any concerns regarding the potential for undue influence. To limit the control that an Acquiring Fund may have over a Fund, applicants propose a condition prohibiting an investment adviser as defined in section 2(a)(20)(A) of the Act of an Acquiring Management Company (''Acquiring Fund Advisor''), sponsor of an Investing Trust (''Sponsor''), any person controlling, controlled by, or under common control with the Acquiring Fund Advisor or Sponsor, and any investment company or issuer that would be an investment company but for sections 3(c)(1) or 3(c)(7) of the Act that is advised or sponsored by the Acquiring Fund Advisor, the Sponsor, or any person controlling, controlled by, or under common control with the Acquiring Fund Advisor or Sponsor (''Acquiring Fund's Advisory Group'') from controlling (individually or in the aggregate) a Fund within the meaning of section 2(a)(9) of the Act. The same prohibition would apply to any sub-adviser (an investment adviser within the meaning of section 2(a)(20)(B) of the Act) to an Acquiring Management Company (''Acquiring Fund Sub-Advisor''), any person controlling, controlled by or under common control with the Acquiring Fund Sub-Advisor, and any investment company or issuer

that would be an investment company but for sections 3(c)(1) or 3(c)(7) of the Act (or portion of such investment company or issuer) advised or sponsored by the Acquiring Fund Sub-Advisor or any person controlling, controlled by or under common control with the Acquiring Fund Sub-Advisor (''Acquiring Fund's Sub-Advisory Group'').

12. Applicants propose a condition to ensure that no Acquiring Fund or Acquiring Fund Affiliate [22] (except to the extent it is acting in its capacity as an investment adviser to a Fund) will cause a Fund to purchase a security in an offering of securities during the existence of an underwriting or selling syndicate of which a principal underwriter is an Underwriting Affiliate (''Affiliated Underwriting''). An ''Underwriting Affiliate'' is a principal underwriter in any underwriting or selling syndicate that is an officer, director, member of an advisory board, Acquiring Fund Advisor, Acquiring Fund Sub-Advisor, employee or Sponsor of the Acquiring Fund, or a person of which any such officer, director, member of an advisory board, Acquiring Fund Advisor, Acquiring Fund Sub-Advisor, employee or Sponsor is an affiliated person, except any person whose relationship to the Fund is covered by section 10(f) of the Act is not an Underwriting Affiliate).

13. Applicants propose several conditions to address the potential for layering of fees. Applicants note that the board of directors or trustees (''Board'') of any Acquiring Management Company, including a majority of the directors or trustees who are not ''interested persons'' within the meaning of section 2(a)(19) of the Act (''Independent Trustees''), will be required to find that any fees charged under the Acquiring Management Company's advisory contract(s) are based on services provided that will be in addition to, rather than duplicative of, services provided under the advisory contract(s) of any Fund in which the Acquiring Management Company may invest. Applicants also state that any sales charges and/or service fees charged with respect to shares of an Acquiring Fund will not exceed the limits applicable to a fund of funds as set forth in NASD Conduct Rule 2830.[23]

14. Applicants submit that the proposed arrangement will not create an overly complex fund structure. Applicants note that a Fund will be prohibited from acquiring securities of any investment company or company relying on section 3(c)(1) or 3(c)(7) of the Act in excess of the limits contained in section 12(d)(1)(A) of the Act, except to the extent permitted by exemptive relief from the Commission permitting the Fund to purchase shares of other investment companies for short-term cash management purposes.

15. To ensure that an Acquiring Fund is aware of the terms and conditions of the requested order, the Acquiring Funds must enter into an agreement with the respective Funds (the ''Acquiring Fund Agreement'') that will include an acknowledgement from the Acquiring Fund that it may rely on the order only to invest in a Fund and not in any other investment company.

Sections 17(a)(1) and (2) of the Act

16. Section 17(a) of the Act generally prohibits an affiliated person of a registered investment company, or an affiliated person of such a person (''second tier affiliate''), from selling any security to or purchasing any security from the company. Section 2(a)(3) of the Act defines ''affiliated person'' to include any person directly or indirectly owning, controlling, or holding with power to vote, 5% or more of the outstanding voting securities of the other person and any person directly or indirectly controlling, controlled by, or under common control with, the other person. Section 2(a)(9) of the Act defines ''control'' as the power to exercise a controlling influence over the management or policies of a company and provides that a control relationship will be presumed where one person owns more than 25% of another person's voting securities. The Funds may be deemed to be controlled by the Advisers and hence affiliated persons of each other. In addition, the Funds may be deemed to be under common control with any other registered investment company (or series thereof) advised by an Adviser (an ''Affiliated Fund'').

17. Applicants request an exemption under sections 6(c) and 17(b) of the Act from sections 17(a)(1) and 17(a)(2) of the Act to permit in-kind purchases and redemptions of Creation Units by persons that are affiliated persons or second tier affiliates of the Funds solely by virtue of one or more of the following: (a) Holding 5% or more, or in excess of 25% of the outstanding Shares of one or more Funds; (b) having an affiliation with a person with an ownership interest described in (a); or (c) holding 5% or more, or more than 25% of the Shares of an Affiliated Fund.[24] Applicants also request, as part of the requested 12(d)(1) Relief, an exemption in order to permit a Fund to sell its Shares to and redeem its Shares from, and engage in the in-kind transactions that would accompany such sales and redemptions with, certain Acquiring Funds of which the Funds are affiliated persons or a second-tier affiliates.[25]

18. Applicants assert that no useful purpose would be served by prohibiting such affiliated persons from making in-kind purchases or in-kind redemptions of Shares of a Fund in Creation Units. Except with respect to cash as determined in accordance with the procedures described in section III.B.1 of the application, the Deposit Instruments and Redemption Instruments for a Fund will be the same and will correspond pro rata to the positions in the Fund's portfolio, and in-kind purchases and redemptions will be on the same terms, for all persons regardless of the identity of the purchaser or redeemer. Both the deposit procedures for in-kind purchases of Creation Units and the redemption procedures for in-kind redemptions will be effected in exactly the same manner for all purchases and redemptions. Deposit Instruments and Redemption Instruments will be valued in the same manner as those Portfolio Positions currently held by the relevant Funds. Applicants do not believe that in-kind purchases and redemptions will result in abusive self-dealing or overreaching of the Fund.

19. Applicants also submit that the sale of Shares to and redemption of

[22] An ''Acquiring Fund Affiliate'' is defined as the Acquiring Fund Advisor, Acquiring Fund Sub-Advisor(s), any Sponsor, promoter or principal underwriter of an Acquiring Fund and any person controlling, controlled by or under common control with any of these entities. ''Fund Affiliate'' is an investment adviser, promoter, or principal underwriter of a Fund or any person controlling, controlled by or under common control with any of these entities.

[23] Any reference to NASD Conduct Rule 2830 includes any successor or replacement rule that may be adopted by the Financial Industry Regulatory Authority.

[24] Applicants are not seeking relief from section 17(a) for, and the requested relief will not apply to, transactions where a Fund could be deemed an affiliated person, or an affiliated person of an affiliated person, of an Acquiring Fund because an investment adviser to the Funds is also an investment adviser to an Acquiring Fund.

[25] Applicants expect most Acquiring Funds will purchase Shares in the secondary market and will not purchase Creation Units directly from a Fund. To the extent that purchases and sales of Shares occur in the secondary market and not through principal transactions directly between an Acquiring Fund and a Fund, relief from Section 17(a) would not be necessary. However, the requested relief would apply to direct sales of Shares in Creation Units by a Fund to an Acquiring Fund and redemptions of those Shares. The requested relief is also intended to cover any in-kind transactions that would accompany such sales and redemptions.

Shares from an Acquiring Fund meets the standards for relief under sections 17(b) and 6(c) of the Act. Applicants note that any consideration paid for the purchase or redemption of Shares directly from a Fund will be based on the NAV of the Fund in accordance with policies and procedures set forth in the Fund's registration statement.[26] Applicants also state that the proposed transactions are consistent with the general purposes of the Act and appropriate in the public interest.

Applicants' Conditions

Applicants agree that any order of the Commission granting the requested relief will be subject to the following conditions:

A. Actively-Managed Exchange-Traded Fund Relief

1. Neither the Trust nor any Fund will be advertised or marketed as an open-end investment company or mutual fund. Any advertising material that describes the purchase or sale of Creation Units or refers to redeemability will prominently disclose that the Shares are not individually redeemable and that owners of the Shares may acquire those Shares from the Fund and tender those Shares for redemption to the Fund in Creation Units only.

2. The Web site for the Funds, which is and will be publicly accessible at no charge, will contain, on a per Share basis for each Fund, the prior Business Day's NAV and the market closing price or Bid/Ask Price, and a calculation of the premium or discount of the market closing price or Bid/Ask Price against such NAV.

3. As long as a Fund operates in reliance on the Order, its Shares will be listed on a Listing Market.

4. On each Business Day, before commencement of trading in Shares on a Fund's Listing Market, the Fund will disclose on its Web site the identities and quantities of the Portfolio Positions held by the Fund that will form the basis for the Fund's calculation of NAV per Share at the end of the Business Day.

5. The Adviser or any Sub-Advisers, directly or indirectly, will not cause any Authorized Participant (or any investor on whose behalf an Authorized Participant may transact with the Fund) to acquire any Deposit Instrument for a Fund through a transaction in which the Fund could not engage directly.

6. The requested relief to permit ETF operations will expire on the effective date of any Commission rule under the Act that provides relief permitting the operation of actively-managed exchange-traded funds.

B. Section 12(d)(1) Relief

7. The members of an Acquiring Fund's Advisory Group will not control (individually or in the aggregate) a Fund within the meaning of Section 2(a)(9) of the Act. The members of an Acquiring Fund's Sub-Advisory Group will not control (individually or in the aggregate) a Fund within the meaning of Section 2(a)(9) of the Act. If, as a result of a decrease in the outstanding voting securities of a Fund, the Acquiring Fund's Advisory Group or the Acquiring Fund's Sub-Advisory Group, each in the aggregate, becomes a holder of more than 25 percent of the outstanding voting securities of a Fund, it will vote its Shares of the Fund in the same proportion as the vote of all other holders of that Fund's Shares. This condition does not apply to the Acquiring Fund's Sub-Advisory Group with respect to a Fund for which the Acquiring Fund Sub-Adviser or a person controlling, controlled by, or under common control with the Acquiring Fund Sub-Adviser acts as the investment adviser within the meaning of Section 2(a)(20)(A) of the Act.

8. No Acquiring Fund or Acquiring Fund Affiliate will cause any existing or potential investment by the Acquiring Fund in a Fund to influence the terms of any services or transactions between the Acquiring Fund or an Acquiring Fund Affiliate and the Fund or a Fund Affiliate.

9. The board of trustees or directors of an Acquiring Management Company, including a majority of the Independent Trustees, will adopt procedures reasonably designed to ensure that the Acquiring Fund Advisor and any Acquiring Fund Sub-Advisor are conducting the investment program of the Acquiring Management Company without taking into account any consideration received by the Acquiring Management Company or an Acquiring Fund Affiliate from a Fund or a Fund Affiliate in connection with any services or transactions.

10. Once an investment by an Acquiring Fund in Shares exceeds the limits of Section 12(d)(1)(A)(i) of the Act, the Board, including a majority of the Independent Trustees, will determine that any consideration paid by the Fund to an Acquiring Fund or an Acquiring Fund Affiliate in connection with any services or transactions: (i) Is fair and reasonable in relation to the nature and quality of the services and benefits received by the Fund; (ii) is within the range of consideration that the Fund would be required to pay to another unaffiliated entity in connection with the same services or transactions; and (iii) does not involve overreaching on the part of any person concerned. This condition does not apply with respect to any services or transactions between a Fund and its investment adviser(s), or any person controlling, controlled by or under common control with such investment adviser(s).

11. No Acquiring Fund or Acquiring Fund Affiliate (except to the extent it is acting in its capacity as an investment adviser to a Fund) will cause the Fund to purchase a security in any Affiliated Underwriting.

12. The Board, including a majority of the Independent Trustees, will adopt procedures reasonably designed to monitor any purchases of securities by the Fund in an Affiliated Underwriting, once an investment by an Acquiring Fund in the securities of the Fund exceeds the limit of section 12(d)(1)(A)(i) of the Act, including any purchases made directly from an Underwriting Affiliate. The Board will review these purchases periodically, but no less frequently than annually, to determine whether the purchases were influenced by the investment by the Acquiring Fund in the Fund. The Board will consider, among other things: (i) Whether the purchases were consistent with the investment objectives and policies of the Fund; (ii) how the performance of securities purchased in an Affiliated Underwriting compares to the performance of comparable securities purchased during a comparable period of time in underwritings other than Affiliated Underwritings or to a benchmark such as a comparable market index; and (iii) whether the amount of securities purchased by the Fund in Affiliated Underwritings and the amount purchased directly from an Underwriting Affiliate have changed significantly from prior years. The Board will take any appropriate actions based on its review, including, if appropriate, the institution of procedures designed to ensure that purchases of securities in Affiliated Underwritings are in the best interest of shareholders of the Fund.

13. Each Fund will maintain and preserve permanently in an easily accessible place a written copy of the procedures described in the preceding condition, and any modifications to

[26] Applicants acknowledge that the receipt of compensation by (a) an affiliated person of an Acquiring Fund, or an affiliated person of such person, for the purchase by the Acquiring Fund of Shares of the Fund or (b) an affiliated person of a Fund, or an affiliated person of such person, for the sale by the Fund of its Shares to an Acquiring Fund, may be prohibited by section 17(e)(1) of the Act. The Acquiring Fund Agreement also will include this acknowledgment.

such procedures, and will maintain and preserve for a period of not less than six years from the end of the fiscal year in which any purchase in an Affiliated Underwriting occurred, the first two years in an easily accessible place, a written record of each purchase of securities in Affiliated Underwritings, once an investment by an Acquiring Fund in the securities of the Fund exceeds the limit of section 12(d)(1)(A)(i) of the Act, setting forth from whom the securities were acquired, the identity of the underwriting syndicate's members, the terms of the purchase, and the information or materials upon which the determinations of the Board were made.

14. Before investing in Shares of a Fund in excess of the limits in section 12(d)(1)(A), each Acquiring Fund and the Fund will execute an Acquiring Fund Agreement stating, without limitation, that their boards of directors or boards of trustees and their investment adviser(s), or their Sponsors or trustees (''Trustee''), as applicable, understand the terms and conditions of the Order, and agree to fulfill their responsibilities under the Order. At the time of its investment in Shares of a Fund in excess of the limit in section 12(d)(1)(A)(i), an Acquiring Fund will notify the Fund of the investment. At such time, the Acquiring Fund will also transmit to the Fund a list of the names of each Acquiring Fund Affiliate and Underwriting Affiliate. The Acquiring Fund will notify the Fund of any changes to the list of the names as soon as reasonably practicable after a change occurs. The Fund and the Acquiring Fund will maintain and preserve a copy of the Order, the Acquiring Fund Agreement, and the list with any updated information for the duration of the investment and for a period of not less than six years thereafter, the first two years in an easily accessible place.

15. The Acquiring Fund Advisor, Trustee or Sponsor, as applicable, will waive fees otherwise payable to it by the Acquiring Fund in an amount at least equal to any compensation (including fees received pursuant to any plan adopted under Rule 12b–1 under the Act) received from the Fund by the Acquiring Fund Advisor, Trustee or Sponsor, or an affiliated person of the Acquiring Fund Advisor, Trustee or Sponsor, other than any advisory fees paid to the Acquiring Fund Advisor, Trustee, or Sponsor, or its affiliated person by the Fund, in connection with the investment by the Acquiring Fund in the Fund. Any Acquiring Fund Sub-Advisor will waive fees otherwise payable to the Acquiring Fund Sub-Advisor, directly or indirectly, by the Acquiring Management Company in an amount at least equal to any compensation received from a Fund by the Acquiring Fund Sub-Advisor, or an affiliated person of the Acquiring Fund Sub-Advisor, other than any advisory fees paid to the Acquiring Fund Sub-Advisor or its affiliated person by the Fund, in connection with any investment by the Acquiring Management Company in the Fund made at the direction of the Acquiring Fund Sub-Advisor. In the event that the Acquiring Fund Sub-Advisor waives fees, the benefit of the waiver will be passed through to the Acquiring Management Company.

16. Any sales charges and/or service fees charged with respect to shares of an Acquiring Fund will not exceed the limits applicable to a fund of funds as set forth in NASD Conduct Rule 2830.

17. No Fund relying on the 12(d)(1) Relief will acquire securities of any other investment company or company relying on section 3(c)(1) or 3(c)(7) of the Act in excess of the limits contained in section 12(d)(1)(A) of the Act, except to the extent permitted by exemptive relief from the Commission permitting the Fund to purchase shares of other investment companies for short-term cash management purposes.

18. Before approving any advisory contract under section 15 of the Act, the board of trustees or directors of each Acquiring Management Company, including a majority of the Independent Trustees, will find that the advisory fees charged under such advisory contract are based on services provided that will be in addition to, rather than duplicative of, the services provided under the advisory contract(s) of any Fund in which the Acquiring Management Company may invest. These findings and their basis will be recorded fully in the minute books of the appropriate Acquiring Management Company.

For the Commission, by the Division of Investment Management, under delegated authority.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16856 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 30592; 812–14118]

Bridge Builder Trust and Olive Street Investment Advisers, LLC; Notice of Application

July 9, 2013.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of an application under section 6(c) of the Investment Company Act of 1940 (''Act'') for an exemption from section 15(a) of the Act and rule 18f–2 under the Act, as well as from certain disclosure requirements.

SUMMARY OF APPLICATION: Applicants request an order that would permit them to enter into and materially amend sub-advisory agreements without shareholder approval and that would grant relief from certain disclosure requirements.

APPLICANTS: Bridge Builder Trust (the ''Trust'') and Olive Street Investment Advisers (the ''Adviser'') (collectively, ''Applicants'').

DATES: *Filing Dates:* The application was filed February 1, 2013, and amended on June 18, 2013.

HEARING OR NOTIFICATION OF HEARING: An order granting the application 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 August 5, 2013, and should be accompanied by proof of service on the applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, 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: Elizabeth M. Murphy, Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090. Applicants: The Trust: Joseph C. Neuberger, 2020 East Financial Way, Suite 100, Glendora, CA 91741; The Adviser: James A. Tricarico, Olive Street Investment Advisers, LLC, 12555 Manchester Road, St. Louis, MO 63131.

FOR FURTHER INFORMATION CONTACT: Jennifer L. Sawin, Branch Chief, at (202) 551–6724 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site 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.

Applicants' Representations

1. The Trust, a Delaware statutory trust, is registered under the Act as an open-end management investment company. The Trust is organized as a series trust and currently consists of one series, which will be advised by the Adviser.[1] The Adviser is a limited liability company organized under Missouri law. The Adviser is, and any future Adviser will be, registered as an investment adviser under the Investment Advisers Act of 1940 (''Advisers Act''). The Adviser will serve as the investment adviser to the Funds pursuant to an investment advisory agreement with the Trust or Fund (the ''Advisory Agreement'').[2] Each Advisory Agreement was approved or will be approved by the Fund's board of trustees (the ''Board''), including a majority of the trustees who are not ''interested persons,'' as defined in section 2(a)(19) of the Act, of the Trust, the Fund, or the Adviser (''Independent Trustees''), and by the Fund's shareholder(s) in the manner required by sections 15(a) and 15(c) of the Act and rule 18f–2 under the Act. The terms of each Advisory Agreement will comply with section 15(a) of the Act.

2. Under the terms of each Advisory Agreement, the Adviser will provide the Funds with overall management services and will continuously review, supervise and administer each Fund's investment program, subject to the supervision of, and policies established by the Board. For the investment management services it will provide to each Fund the Adviser will receive the fee specified in the Advisory Agreement from such Fund, based on the average daily net assets of the Fund. The Advisory Agreement permits the Adviser, subject to the approval of the Board, to delegate certain responsibilities to one or more sub-advisers (''Sub-Advisers'') to provide investment advisory services to the Funds. As of the date of the amended application, the Adviser had not entered into sub-advisory agreements with any Sub-Advisers (''Sub-Advisory Agreements''). Each Sub-Adviser will be an investment adviser as defined in section 2(a)(20) of the Act and, if required, registered with the Commission as an ''investment adviser'' under the Advisers Act. The Adviser evaluates, allocates assets to and oversees the Sub-Advisers, and makes recommendations about their hiring, termination and replacement to the Board, at all times subject to the authority of the Board. The Adviser will compensate the Sub-Advisers out of the advisory fee paid by a Fund to the Adviser under the Advisory Agreement.

3. Applicants request an order to permit the Adviser, subject to Board approval, to select certain Sub-Advisers to manage all or a portion of the assets of a Fund or Funds pursuant to a Sub-Advisory Agreement and materially amend existing Sub-Advisory Agreements without obtaining shareholder approval. The requested relief will not extend to any Sub-Adviser that is an affiliated person, as defined in section 2(a)(3) of the Act, of the Trust, a Fund, or the Adviser, other than by reason of serving as a sub-adviser to one or more of the Funds (''Affiliated Sub-Adviser'').

4. Applicants also request an order exempting the Funds from certain disclosure provisions described below that may require the Applicants to disclose fees paid by the Adviser or a Fund to each Sub-Adviser. Applicants seek an order to permit a Fund to disclose (as both a dollar amount and a percentage of the Fund's net assets): (a) The aggregate fees paid to the Adviser and any Affiliated Sub-Adviser; and (b) the aggregate fees paid to Sub-Advisers other than Affiliated Sub-Advisers (collectively, ''Aggregate Fee Disclosure''). Any Fund that employs an Affiliated Sub-Adviser will provide separate disclosure of any fees paid to the Affiliated Sub-Adviser.

Applicants' Legal Analysis

1. Section 15(a) of the Act provides, in relevant part, that is unlawful for any person to act as an investment adviser to a registered investment company except pursuant to a written contract that has been approved by a vote of a majority of the company's outstanding voting securities. Rule 18f–2 under the Act provides that each series or class of stock in a series investment company affected by a matter must approve that matter if the Act requires shareholder approval.

2. Form N–1A is the registration statement used by open-end investment companies. Item 19(a)(3) of Form N–1A requires disclosure of the method and amount of the investment adviser's compensation.

3. Rule 20a–1 under the Act requires proxies solicited with respect to a registered investment company to comply with Schedule 14A under the Securities Exchange Act of 1934 (''1934 Act''). Items 22(c)(1)(ii), 22(c)(1)(iii), 22(c)(8) and 22(c)(9) of Schedule 14A, taken together, require a proxy statement for a shareholder meeting at which the advisory contract will be voted upon to include the ''rate of compensation of the investment adviser,'' the ''aggregate amount of the investment adviser's fees,'' a description of the ''terms of the contract to be acted upon,'' and, if a change in the advisory fee is proposed, the existing and proposed fees and the difference between the two fees.

4. Regulation S–X sets forth the requirements for financial statements required to be included as part of a registered investment company's registration statement and shareholder reports filed with the Commission. Sections 6–07(2)(a), (b), and (c) of Regulation S–X require a registered investment company to include in its financial statement information about investment advisory fees.

5. Section 6(c) 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 provisions of the Act, or from any rule thereunder, 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. Applicants state that the requested relief meets this standard for the reasons discussed below.

6. Applicants assert that the shareholders expect the Adviser, subject to the review and approval of the Board, to select the Sub-Advisers who are best

[1] Applicants request relief with respect to any existing and any future series of the Trust or any other registered open-end management company that: (a) Is advised by the Adviser or a person controlling, controlled by, or under common control with the Adviser or its successor (each, also an ''Adviser''); (b) uses the manager of managers structure described in the application; and (c) complies with the terms and conditions of the requested order (any such series, a ''Fund'' and collectively, the ''Funds''). The only existing registered open-end management investment company that currently intends to rely on the requested order is named as an Applicant, and the only series that currently intends to rely on the requested order as a Fund is the Bridge Builder Bond Fund. For purposes of the requested order, ''successor'' is limited to an entity that results from a reorganization into another jurisdiction or a change in the type of business organization. If the name of any Fund contains the name of a Sub-Adviser (as defined below), that name will be preceded by the name of the Adviser.

[2] ''Advisory Agreement'' includes advisory agreements with an Adviser for the Bridge Builder Bond Fund and any future Funds.

suited to achieve the Fund's investment objectives. Applicants assert that, from the perspective of the shareholder, the role of the Sub-Advisers is substantially equivalent to that of the individual portfolio managers employed by traditional investment company advisory firms. Applicants state that requiring shareholder approval of each Sub-Advisory Agreement would impose unnecessary delays and expenses on the Funds and may preclude the Funds from acting promptly when the Adviser and Board consider it appropriate to hire Sub-Advisers or amend Sub-Advisory Agreements. Applicants note that the Advisory Agreements and any Sub-Advisory Agreements with Affiliated Sub-Advisers will remain subject to the shareholder approval requirements of section 15(a) of the Act and rule 18f–2 under the Act.

7. If a new Sub-Adviser is retained in reliance on the requested order, the applicable Fund will inform its shareholders of the hiring of a new Sub-Adviser pursuant to the following procedures (''Modified Notice and Access Procedures''): (a) Within 90 days after a new Sub-Adviser is hired for the Fund, the Fund will send its shareholders either a Multi-manager Notice or a Multi-manager Notice and Multi-manager Information Statement; [3] and (b) the Fund will make the Multi-manager Information Statement available on the Web site identified in the Multi-manager Notice no later than when the Multi-manager Notice (or Multi-manager Notice and Multi-manager Information Statement) is first sent to shareholders, and will maintain it on that Web site for at least 90 days. Applicants assert that a proxy solicitation to approve the appointment of new Sub-Advisers would provide no more meaningful information to shareholders than the proposed Multi-manager Information Statement. Moreover, as indicated above, the applicable Board would comply with the requirements of sections 15(a) and 15(c) of the Act before entering into or amending Sub-Advisory Agreements.

8. Applicants assert that the requested disclosure relief will benefit shareholders of the Funds because it will improve the Adviser's ability to negotiate the fees paid to Sub-Advisers. Applicants state that the Adviser may be able to negotiate rates that are below a Sub-Adviser's ''posted'' amounts if the Adviser is not required to disclose the Sub-Advisers' fees to the public.

Applicants' Conditions

Applicants agree that any order granting the requested relief will be subject to the following conditions:

1. Before a Fund may rely on the order requested in the application, the operation of the Fund in the manner described in the application will be approved by a majority of the Fund's outstanding voting securities, as defined in the Act, or, in the case of a Fund whose public shareholders purchase shares on the basis of a prospectus containing the disclosure contemplated by condition 2 below, by the sole initial shareholder before offering the Fund's shares to the public.

2. The prospectus for each Fund will disclose the existence, substance, and effect of any order granted pursuant to the application. Each Fund will hold itself out to the public as employing the manager of managers structure described in the application. The prospectus will prominently disclose that the Adviser has ultimate responsibility (subject to oversight by the Board) to oversee the Sub-Advisers and recommend their hiring, termination, and replacement.

3. Funds will inform shareholders of the hiring of a new Sub-Adviser (other than an Affiliated Sub-Adviser) within 90 days after the hiring of that new Sub-Adviser pursuant to the Modified Notice and Access Procedures.

4. The Adviser will not enter into a Sub-Advisory Agreement with any Affiliated Sub-Adviser without that agreement, including the compensation to be paid thereunder, being approved by the shareholders of the applicable Fund.

5. At all times, at least a majority of the Board will be Independent Trustees, and the nomination and selection of new or additional Independent Trustees will be placed within the discretion of the then-existing Independent Trustees.

6. When a Sub-Adviser change is proposed for a Fund with an Affiliated Sub-Adviser, the Board, including a majority of the Independent Trustees, will make a separate finding, reflected in the applicable Board minutes, that such change is in the best interests of the Fund and its shareholders and does not involve a conflict of interest from which the Adviser or the Affiliated Sub-Adviser derives an inappropriate advantage.

7. Independent legal counsel, as defined in rule 0–1(a)(6) under the Act, will be engaged to represent the Independent Trustees. The selection of such counsel will be within the discretion of the then existing Independent Trustees.

8. Each Adviser will provide the Board, no less frequently than quarterly, with information about the profitability of the Adviser on a per-Fund basis. The information will reflect the impact on profitability of the hiring or termination of any Sub-Adviser during the applicable quarter.

9. Whenever a Sub-Adviser is hired or terminated, the Adviser will provide the Board with information showing the expected impact on the profitability of the Adviser.

10. The Adviser will provide general management services to a Fund, including overall supervisory responsibility for the general management and investment of the Fund's assets and, subject to review and approval of the Board, will (i) set a Fund's overall investment strategies; (ii) evaluate, select and recommend Sub-Advisers to manage all or part of a Fund's assets; (iii) when appropriate, allocate and reallocate a Fund's assets among multiple Sub-Advisers; (iv) monitor and evaluate the performance of Sub-Advisers; and (v) implement procedures reasonably designed to ensure that the Sub-Advisers comply with a Fund's investment objective, policies and restrictions.

11. No trustee or officer of the Trust, or of a Fund, or director or officer of the Adviser, will own directly or indirectly (other than through a pooled investment vehicle that is not controlled by such person) any interest in a Sub-Adviser, except for (i) ownership of interests in the Adviser or any entity that controls, is controlled by, or is under common control with the Adviser; or (ii) ownership of less than 1% of the outstanding securities of any class of equity or debt of a publicly traded company that is either a Sub-Adviser or an entity that controls, is controlled by, or is under common control with a Sub-Adviser.

12. Each Fund will disclose in its registration statement the Aggregate Fee Disclosure.

[3] A ''Multi-manager Notice'' will be modeled on a Notice of Internet Availability as defined in rule 14a–16 under the Exchange Act, and specifically will, among other things: (a) Summarize the relevant information regarding the new Sub-Adviser; (b) inform shareholders that the Multi-manager Information Statement is available on a Web site; (c) provide the Web site address; (d) state the time period during which the Multi-manager Information Statement will remain available on that Web site; (e) provide instructions for accessing and printing the Multi-manager Information Statement; and (f) instruct the shareholder that a paper or email copy of the Multi-manager Information Statement may be obtained, without charge, by contacting the Fund.

A ''Multi-manager Information Statement'' will meet the requirements of Regulation 14C, Schedule 14C and Item 22 of Schedule 14A under the Exchange Act for an information statement, except as modified by the requested order to permit Aggregate Fee Disclosure. Multi-manager Information Statements will be filed electronically with the Commission via the EDGAR system.

13. In the event the Commission adopts a rule under the Act providing substantially similar relief to that in the order requested in the application, the requested order will expire on the effective date of that rule.

For the Commission, by the Division of Investment Management, under delegated authority.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16855 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting.

FEDERAL REGISTER CITATION OF PREVIOUS ANNOUNCEMENT: [78 FR 40780, July 8, 2013].

STATUS: Closed Meeting.

PLACE: 100 F Street NE., Washington, DC

DATE AND TIME OF PREVIOUSLY ANNOUNCED MEETING: July 10, 2013 at 4:00 p.m.

CHANGE IN THE MEETING: Additional Item.

The following matter will also be considered during the 4:00 p.m. Closed Meeting scheduled for Wednesday July 10, 2013:

a personnel matter.

The General Counsel of the Commission, or her designee, has certified that, in her opinion, one or more of the exemptions as set forth in 5 U.S.C. 552b(c)(2) and (6) and 17 CFR 200.402(a)(2) and (6), permit consideration of the scheduled matter at the Closed Meeting.

Commissioner Aguilar, as duty officer, voted to consider the item listed for the Closed Meeting in closed session, and determined that no earlier notice thereof was possible.

At times, changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact the Office of the Secretary at (202) 551–5400.

Dated: July 10, 2013.

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2013–16937 Filed 7–11–13; 11:15 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69955; File No. SR–OCC–2013–804]

Self-Regulatory Organizations; The Options Clearing Corporation; Notice of Filing of an Advance Notice in Connection With a Proposed Change to its Operations in the Form of a Private Offering by OCC of Senior Unsecured Debt Securities

July 10, 2013.

Pursuant to Section 806(e)(1) of the Payment, Clearing, and Settlement Supervision Act of 2010 (''Clearing Supervision Act'') [1] and Rule 19b–4(n)(1)(i) [2] of the Securities Exchange Act of 1934 (''Exchange Act'') notice is hereby given that on June 10, 2013, The Options Clearing Corporation (''OCC'') filed with the Securities and Exchange Commission (''Commission'') the advance notice as described in Items I and II below, which Items have been substantially prepared by OCC.[3] The Commission is publishing this notice to solicit comments on the advance notice from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Advance Notice

OCC is proposing to change its operations in the form of a private offering of senior unsecured debt securities (''Offering'').

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Advance Notice

In its filing with the Commission, OCC included statements concerning the purpose of and basis for the advance notice and discussed any comments it received on the advance notice. The text of these statements may be examined at the places specified in Item IV below. The clearing agency has prepared summaries, set forth in section A below, of the most significant aspects of such statements.[4]

(A) Advance Notices Filed Pursuant to Section 806(e) of the Clearing Supervision Act

Description of Change

OCC states that the proposed Offering would provide OCC with access to additional liquidity for working capital needs and general corporate purposes. The aggregate principal amount of the senior unsecured debt securities placed in the Offering is expected to be up to $100 million. The proceeds of the Offering would be among the financial resources used to satisfy the requirements applicable to OCC under CFTC regulations.

Among other things, OCC states that CFTC regulation Section 39.11(a)(2) [5] requires a derivatives clearing organization (''DCO'') to hold an amount of financial resources that, at a minimum, exceeds the total amount that would enable the DCO to cover its operating costs for a period of at least one year, calculated on a rolling basis. In turn, CFTC regulation Section 39.11(e)(2) [6] provides that these financial resources must include unencumbered, liquid financial assets (*i.e.,* cash and/or highly liquid securities), equal to at least six months' operating costs. OCC states that the Offering is intended to contribute to OCC's compliance with the financial resources requirement under CFTC regulation Section 39.11(a)(2) [7] and the liquidity requirements prescribed by CFTC regulation Section 39.11(e)(2).[8] OCC states that the proceeds of the offering would be invested in instruments such as reverse repurchase agreements in which working capital may be invested under OCC's By-Laws.

Under the proposal, OCC would issue senior unsecured debt securities through the Offering, which would be structured as a private placement for which a broker-dealer registered with the Securities and Exchange Commission under the Exchange Act would act as the exclusive placement agent. Under the terms of the Offering, OCC would be required to use any capital raised to finance its working capital needs or for general corporate purposes.

According to OCC, one of the conditions of OCC's proposed Offering is the execution of definitive agreements. These agreements are expected to include a number of conditions related to OCC's performance under such agreements including, without limitation, certain covenants and default provisions.

OCC states that the Offering would involve a variety of customary fees and expenses payable by OCC to the placement agent and the noteholders, including but not limited to: (1) A placement agent fee calculated as a

[1] 12 U.S.C. 5465(e)(1).

[2] 17 CFR 240.19b–4(n)(1)(i).

[3] OCC is a designated financial market utility and is required to file advance notices with the Commission. *See* 12 U.S.C. 5465(e).

[4] The Commission has modified the text of the summaries prepared by the clearing agency.

[5] 17 CFR 39.11(a)(2).

[6] 17 CFR 39.11(e)(2).

[7] 17 CFR 39.11(a)(2).

[8] 17 CFR 39.11(e)(2).

percentage of the aggregate principal amount of debt securities sold in the Offering; and (2) other costs and expenses incurred by the placement agent in relation to its activities in connection with the Offering including, but not limited to, travel expenses and reasonable fees of counsel. These fees and expenses may be paid out of the proceeds of the Offering.

Anticipated Effect on and Management of Risk

OCC states that any impact of the Offering on the risks presented by OCC would be to reduce such risks by providing an additional source of liquidity for the protection of OCC, its clearing members, and the options market in general. OCC states that the Offering would provide OCC with additional liquidity for working capital needs and general corporate purposes and thereby assist OCC in satisfying the CFTC's requirements with respect to liquidity under CFTC regulation Section 39.11.[9]

OCC states that, like any debt offering, the Offering would involve risks. According to OCC, one risk associated with the Offering relates to the need for OCC to maintain sufficient cash flow to support ongoing interest payments to the noteholders. OCC states this risk is mitigated by its conservative fiscal practices under which clearing and other fees are assessed at a level designed to ensure that OCC has more than sufficient funds to operate and satisfy liabilities, and refunds are paid to clearing members only when it is clear that excess funds are available. Clearing member refunds would be effectively subordinated to interest payments on the notes sold in the Offering.

OCC states that the Offering involves a risk of OCC's defaulting by failing to make timely payment of principal or interest or to comply with financial covenants, which would allow the noteholders to take legal action against OCC to recover any losses resulting from a default. However, OCC states that the risk of default from a payment failure is mitigated because, as discussed above, OCC does not expect to have difficulty making interest payments. Similarly, OCC states that the tests included in the financial covenants will be established at reasonable levels, making it unlikely that OCC would default by violating these covenants. In addition, because the Offering would involve the issuance of unsecured notes, OCC states that it would not be at risk of the noteholders' liquidating OCC assets in the event of OCC's default.

The agreement with noteholders also requires OCC to make the noteholders ''whole'' in the event OCC elects to prepay any outstanding principal. According to OCC, this ''make-whole'' covenant poses risk to the extent OCC is unable to immediately pay the outstanding interest payments. OCC would mitigate the risk of having to make a large make-whole payment by either electing not to call the notes prior to termination or by waiting to call the notes until the make-whole premium has been reduced by the passage of time to a smaller amount. OCC expects to need the additional liquidity for the term of the notes and to issue the notes at a time of favorable market conditions, and accordingly OCC does not expect to call the notes prior to termination.

According to OCC, one risk of obtaining capital through the Offering as opposed to an unsecured line of credit is that OCC will incur more expense in connection with the Offering given that it must pay interest expense on the entire outstanding note balance as opposed to a comparatively smaller commitment fee on a line of credit. However, OCC states that this risk is justified by the difficulty in obtaining an unsecured line of credit of a size comparable to that of the Offering. Moreover, OCC states the risk is mitigated by OCC's investment of the proceeds, which generates income to offset the interest expense. In addition, by obtaining capital through the Offering OCC avoids the funding risk associated with a line of credit.

III. Date of Effectiveness of the Advance Notice and Timing for Commission Action

OCC may implement the proposed change pursuant to Section 806(e)(1)(G) of the Clearing Supervision Act [10] if it has not received an objection to the proposed change within 60 days of the later of (i) the date that the Commission received the advance notice or (ii) the date the Commission receives any further information it requested for consideration of the notice. The clearing agency shall not implement the proposed change if the Commission has any objection to the proposed change.

The Commission may extend the period for review by an additional 60 days if the proposed change raises novel or complex issues, subject to the Commission providing the clearing agency with prompt written notice of the extension. A proposed change may be implemented in less than 60 days from the date of receipt of the advance notice, or the date the Commission receives any further information it requested, if the Commission notifies the clearing agency in writing that it does not object to the proposed change and authorizes the clearing agency to implement the proposed change on an earlier date, subject to any conditions imposed by the Commission.

The clearing agency shall post notice on its Web site of proposed changes that are implemented.

The proposal shall not take effect until all regulatory actions required with respect to the proposal are completed.[11]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. 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–OCC–2013–804 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–OCC–2013–804. 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 Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the advance notice that are filed with the Commission, and all written communications relating to the advance notice 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 Web site 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

[9] 17 CFR 39.11.

[10] 12 U.S.C. 5465(e)(1)(G).

[11] OCC also filed the proposals contained in this advance notice as a proposed rule change under Section 19(b)(1) of the Exchange Act and Rule 19b–4 thereunder. *See supra* note 3.

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 OCC and on OCC's Web site (*http://theocc.com/about/publications/bylaws.jsp*). All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–OCC–2013–804 and should be submitted on or before August 5, 2013.

By the Commission.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16864 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69954; File No. SR–NSCC–2013–802]

Self-Regulatory Organizations; National Securities Clearing Corporation; Notice of Filing Amendment No. 2 to an Advance Notice, as Previously Modified by Amendment No. 1, To Institute Supplemental Liquidity Deposits to Its Clearing Fund Designed To Increase Liquidity Resources To Meet Its Liquidity Needs

July 9, 2013.

On March 21, 2013, National Securities Clearing Corporation (''NSCC'') filed with the Securities and Exchange Commission (''Commission'') advance notice SR–NSCC–2013–802 (''Advance Notice'') pursuant to Section 806(e)(1) of the Payment, Clearing, and Settlement Supervision Act of 2010 (''Clearing Supervision Act'') [1] and Rule 19b–4(n)(1)(i) [2] thereunder.[3] On April 19, 2013, NSCC filed with the Commission Amendment No. 1 to the Advance Notice.[4] The Advance Notice, as modified by Amendment No. 1, was published for comment in the **Federal Register** on May 1, 2013.[5] On May 20, 2013, the Commission extended the period of review of the Advance Notice, as modified by Amendment No. 1.[6] As of July 9, 2013, the Commission had received fourteen comment letters on the proposal contained in the Advance Notice and its related Proposed Rule Change,[7] including NSCC's response to the comment letters received as of June 10, 2013.[8]

Pursuant to Section 806(e)(1) of the Clearing Supervision Act [9] and Rule 19b–4(n)(1)(i) [10] thereunder, notice is hereby given that on June 11, 2013, NSCC filed with the Commission Amendment No. 2 to the Advance Notice, as previously modified by Amendment No. 1.[11] The Commission is publishing this notice to solicit comments on the Advance Notice, as modified by Amendment No. 2, from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Advance Notice

The Advance Notice, as modified by Amendment No. 2, is a proposal by NSCC to amend its Rules and Procedures (''Rules'') to provide for a supplemental liquidity funding obligation (''SLD Proposal''), as described below. NSCC filed Amendment No. 2 to the Advance Notice, as previously modified by Amendment No. 1, in order to mitigate potential cash outlay burdens, respond to transparency concerns raised by NSCC members (''Members''), clarify the implementation timeframe, and describe the reports that would be provided to Members so that they can anticipate their supplemental liquidity obligations to NSCC under the SLD Proposal (''Supplemental Liquidity Obligations'').

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Advance Notice

In its filing with the Commission, NSCC included statements concerning the purpose of and basis for the Advance Notice, as modified by Amendment No. 2, and discussed any comments it received on the Advance Notice, as amended. The text of these statements may be examined at the places specified in Item IV below. NSCC has prepared summaries, set forth in sections (A), (B), and (C) immediately below, of the most significant aspects of these statements.[12]

(A) Advance Notices Filed Pursuant to Section 806(e) of the Payment, Clearing and Settlement Supervision Act

1. Description of Change

Original SLD Proposal

The original proposal contained in the Advance Notice, as modified by Amendment No. 1 (''Original SLD Proposal''), would change the Rules to add a new Rule 4A, in order to establish a supplemental liquidity funding obligation designed to cover the liquidity exposure attributable to those Members and families of affiliated Members (''Affiliated Families'') that regularly incur the largest gross settlement debits over a settlement cycle during both times of normal trading activity (''Regular Activity Periods'') and times of increased trading and settlement activity that arise around quarterly triple options expiration dates (''Quarterly Options Expiration Activity Periods'').

[1] 12 U.S.C. 5465(e)(1).

[2] 17 CFR 240.19b–4(n)(1)(i).

[3] NSCC also filed the proposal contained in the Advance Notice as proposed rule change SR–NSCC–2013–02 (''Proposed Rule Change'') under Section 19(b)(1) of the Securities and Exchange Act of 1934 (''Exchange Act'') and Rule 19b–4 thereunder. Release No. 34–69313 (Apr. 4, 2013), 78 FR 21487 (Apr. 10, 2013). On April 19, 2013, NSCC filed Amendment No. 1 to the Proposed Rule Change, which, on May 22, 2013, the Commission provided notice of and designated a longer period of review for Commission action on the Proposed Rule Change, as modified by Amendment No. 1. Release No. 34–69620 (May 22, 2013), 78 FR 32292 (May 29, 2013). On June 11, 2013, NSCC filed Amendment No. 2 to the Proposed Rule Change, which the Commission published notice of with an order instituting proceedings to determine whether to approve or disapprove the Proposed Rule Change. Release No. 34–69951 (July 9, 2013). The proposal in the Advance Notice, as amended, and the Proposed Rule Change, as amended, shall not take effect until all regulatory actions required with respect to the proposal are completed.

[4] *See* Release No. 34–69451 (Apr. 25, 2013), 78 FR 25496 (May 1, 2013).

[5] *Id.*

[6] Release No. 34–69605 (May 20, 2013), 78 FR 31616 (May 24, 2013). Absent a request by the Commission to NSCC to provide additional information on the Advance Notice pursuant to Section 806(e)(1)(D) of the Clearing Supervision Act, *see* 12 U.S.C. 5465(e)(1)(D), the Commission shall have until July 19, 2013 to issue an objection or non-objection to the Advance Notice, as amended. *See* Release No. 34–69605 (May 20, 2013), 78 FR 31616 (May 24, 2013), and *see* 12 U.S.C. 5465(e)(1)(E) and (G).

[7] *See* Comments Received on File Nos. SR–NSCC–2013–02 (*http://sec.gov/comments/sr-nscc-2013-02/nscc201302.shtml*) and SR–NSCC–2013–802 (*http://sec.gov/comments/sr-nscc-2013-802/nscc2013802.shtml*). Since the proposal contained in the Advance Notice was also filed as a Proposed Rule Change, *see* Release No. 34–69313, *supra* note 3, the Commission is considering all public comments received on the proposal regardless of whether the comments are submitted to the Advance Notice, as amended, or the Proposed Rule Change, as amended.

[8] NSCC also received a comment letter directly prior to filing the Advance Notice and related Proposed Rule Change with the Commission, which NSCC provided to the Commission in Amendment No. 1 to the filings. *See* Exhibit 2 to File No. SR–NSCC–2013–802 (*http://sec.gov/rules/sro/nscc/2013/34-69451-ex2.pdf*).

[9] 12 U.S.C. 5465(e)(1).

[10] 17 CFR 240.19b–4(n)(1)(i).

[11] Defined terms that are not defined in this notice are defined in Amended Exhibit 5 to the Advance Notice, available at *http://sec.gov/rules/sro/nscc.shtml*, under File No. SR–NSCC–2013–802, Additional Materials.

[12] The Commission has modified the text of the summaries prepared by NSCC to primarily focus on the Advance Notice.

The Supplemental Liquidity Obligation of a Member or Affiliated Family with respect to a Regular Activity Period (''Regular Activity Liquidity Obligation'') or a Quarterly Options Expiration Activity Period (''Special Activity Liquidity Obligation'') would be imposed on the 30 Members or Affiliated Families who generate the largest aggregate liquidity needs over a settlement cycle that would apply in the event of a closeout (i.e., over a period from date of default through the following three settlement days), based upon a historical look-back period.

NSCC states that the calculations for both the Regular Activity Liquidity Obligation and the Special Activity Liquidity Obligation are designed so that NSCC has adequate liquidity resources to enable it to settle transactions, notwithstanding the default of the Member or Affiliated Family presenting the largest liquidity need during Regular Activity Periods, as well as during Quarterly Options Expiration Activity Periods. The Supplemental Liquidity Obligations imposed on Members of Affiliated Families would be apportioned among the Members in that Affiliated Family in proportion to the liquidity risk (or peak exposure) they present to NSCC.

NSCC states that the SLD Proposal is designed to supplement NSCC's liquidity resources and work in tandem with NSCC's committed credit facility (''Credit Facility''), which it maintains as a liquidity resource (in addition to the NSCC Clearing Fund) should a Member or Affiliated Family default. The Regular Activity Liquidity Obligations would be calculated and imposed semi-annually, the first of which would be made to coincide with the annual renewal of the Credit Facility and the second of which would be made six months thereafter. NSCC states that the SLD Proposal seeks to strike a balance between reliance on the Credit Facility to reduce the burden on Members or Affiliated Families for cash outlay, while at the same time obligating those Members or Affiliated Families who expose NSCC to the largest liquidity risks to fund their fair share of the liquidity ''differential.''

NSCC states that the SLD Proposal contains both obligations and incentives. For example, a cash deposit in respect of a Regular Activity Liquidity Obligation (e.g., in the Original SLD Proposal, the obligation of a Member or Affiliated Family to make a ''Regular Activity Supplemental Deposit'') would be reduced by any liquidity such Members or their affiliates provided as commitments under the Credit Facility. To the extent that NSCC is successful in raising significant amounts of its needed liquidity though the Credit Facility—whether from Members, their affiliates making commitments on their behalf, or non-affiliated lenders—NSCC states that a diversified lender facility serves to mitigate the liquidity risk of NSCC and its membership as a whole, while reducing the cash outlay obligations of the top 30 Members and Affiliated Families.

NSCC states that the cash deposit in respect of a Special Activity Liquidity Obligation (''Special Activity Supplemental Deposit'') was structured in the Original SLD Proposal to address any additional liquidity shortfalls (i.e., over and above NCSS's other available liquidity resources) that arose during the heightened trading activity around the Quarterly Options Expiration Period. As such, these additional Special Activity Supplemental Deposits would be required to be maintained on deposit with NSCC only through the completion of the related settlement cycle and for a few days thereafter.

Both prior to the submission of the Advance Notice, and since, NSCC states that it has engaged in significant outreach to its Members to discuss the SLD Proposal, which outreach, NSCC believes, has been key to the development and evolution of the SLD Proposal over the past 18 months. NSCC is cognizant of the concerns raised by Members who have submitted comments regarding the Advance Notice and related Proposed Rule Change, and, according to NSCC, this Amendment No. 2 seeks to address those concerns.

Proposed Enhancements to the Original SLD Proposal

NSCC is proposing to amend the Original SLD Proposal with enhancements that NSCC believes are collectively designed to mitigate potential cash outlay burdens, as well as respond to transparency concerns raised by Members, by clarifying the implementation timeframe of the proposed change and the reporting that would be provided to Members under this revised SLD Proposal (''Revised SLD Proposal'').

First, NSCC would allow its Members to designate a commercial lender—whether or not affiliated with that Member—to commit as a lender to the Credit Facility as a designee of the Member, subject to satisfaction of reasonable lender criteria.[13] NSCC states that this commitment would reduce the Member's Regular Activity Liquidity Obligation cash requirement by the amount of any such commitment. Therefore, under the Revised SLD Proposal, NSCC states that all Members, whether or not they have affiliated banks, are equally incentivized to seek lenders to maximize the size of the Credit Facility. NSCC states that this change effectively eliminates any perceived discrimination in the Original SLD Proposal between those Members that have bank affiliates and those that do not. This change is reflected in the proposed Rule 4A by the inclusion of a new definition for ''Designated Lender,'' and corresponding adjustments to the calculation formula.

Second, any ''excess'' Credit Facility commitments made by Members directly or through their Designated Lenders (i.e., the amount of any commitment by a Member or its Designated Lender that exceeds the Member's calculated Regular Activity Liquidity Obligation) would be allocated ratably among all Regular Activity Liquidity Providers, which NSCC states would reduce their cash Regular Activity Supplemental Deposit requirements, in the same way that commitments of non-affiliated lenders are applied under the Original SLD Proposal. This change is reflected in adjustments to the calculation formula in Sections 5 and 9 of the proposed Rule 4A.

Third, under the Revised SLD Proposal, the seasonal/peak facility that NSCC believes currently addresses NSCC's liquidity needs over Quarterly Options Expiration Activity Periods would be extended to cover monthly options expiration periods and would be calculated and collected 12 times a year instead of four (''Monthly Options Expiration Activity Period''). NSCC states, based on its review of available historical quantitative information, that the effect of this change would be to reduce the size of the Regular Activity Liquidity Obligations under the Revised SLD Proposal. Additionally, NSCC states that by treating all liquidity obligations derived from Monthly Options Expiration Activity Periods (where there is greater activity fluctuation than during other periods) as Special Activity Liquidity Obligations, the Revised SLD Proposal would provide greater stability and predictability to the size of the Regular Activity Liquidity Obligations. NSCC's analyses based upon historical data estimates that expanding this seasonal/

[13] NSSC states that such criteria would be designed to cover issues such as credit risk, concentration risk, and lender diversity, so as to ensure the continued robust viability of the line of credit.

peak facility to cover all Monthly Options Expiration Activity Periods could reduce the size of the aggregate Regular Activity Liquidity Obligations by up to 20 percent. NSCC also states that recalibrating the Special Activity Liquidity Obligations on a monthly basis results in allocating the liquidity burdens among those Members and Affiliated Families more equitably, since only those Members whose monthly options-related activity generate liquidity needs in excess of NSCC's then available liquidity resources would be obligated to fund such additional amounts.[14] NSCC states that this change is reflected in a revised definition of ''Options Expiration Activity Period,'' and clarifications to the calculation formula of the Special Activity Liquidity Obligations, as well as to related definitions to ensure the formula—and the allocation among affected Members—operates as intended.

Fourth, the Revised SLD Proposal includes a new definition for ''Other Qualifying Liquid Resources.'' NSCC states that this new defined term would permit NSCC to take any such additional or alternative liquidity resources that it may obtain in the future into account when calculating Regular Activity Liquidity Obligations and to use them to reduce the amount of cash, if any, that Members would otherwise be obligated to deposit as Regular Activity Supplemental Deposits. This change is reflected both with the inclusion of the new definition of ''Other Qualifying Liquid Resources,'' and with corresponding modifications to the calculation formula.

Fifth, as regards Members' voluntarily prefunding Regular Activity Liquidity Obligations and Special Activity Liquidity Obligations, NSCC would monitor Members' prefunding activity to understand the impact such prefunded amounts have on the amount of its committed liquidity resources. NSCC states that the Revised SLD Proposal provides NSCC with some discretion when including prefunded deposits within its calculated liquidity resources, so as to provide some flexibility in the event it becomes too reliant on voluntary prefunding to meet its minimum liquidity needs. NSCC states that this change to the Original SLD Proposal would address any concern that NSCC would not have sufficient liquid resources to effect settlement if prefunding is unavailable when actually needed.

Additional Revisions to the Original SLD Proposal

Reporting. NSCC states that it understands and agrees that Members have to be able to evaluate risks of their membership and be able to plan for their liquidity obligations. NSCC also states that it is critical that Members understand the risks that their own activity presents to NSCC and be prepared to monitor their own activity and alter their behavior if they want to minimize the liquidity risk they present to NSCC. While NSCC states that robust reporting has always been a key element of the Original SLD Proposal, the Revised SLD Proposal clarifies in a new Section 31 of proposed Rule 4A the information that NSCC would provide to Members. Such information would be provided to all Members, not just the top 30 Members and Affiliated Families, at least monthly. NSCC states that these reports would show Members the liquidity exposure they present to NSCC to enable them to monitor their activity and the ''Regular Activity Peak Liquidity Exposure'' that results from their activity. Information provided in these reports would include:

- The Regular Activity Peak Liquidity Exposure of the Member on each Business Day of the preceding month;
- NSCC's largest Regular Activity Peak Liquidity Need for the preceding month;
- in the case of an Unaffiliated Member, for each Business Day of the preceding month, the percentage that the Regular Activity Peak Liquidity Exposure of the Member bears to the aggregate Regular Activity Peak Liquidity Exposures of all Regular Activity Liquidity Providers (the percentage for a Member that is not a Regular Activity Liquidity Provider for that month would be zero); and
- in the case of an Affiliated Family, for each Business Day of the preceding month, the percentage that the aggregate Regular Activity Peak Liquidity Exposures of all Members of that Affiliated Family bears to the aggregate Regular Activity Peak Liquidity Exposures of all Regular Activity Liquidity Providers (Affiliated Families that are not Regular Activity Liquidity Providers for that month would be zero percentage).

Technical Clarifications and Changes. The Revised SLD Proposal includes certain technical changes and clarifications that NSCC states it designed to align notice, payment, and cash return timeframes, and to clarify the operation of the calculation formulas to ensure they operate as intended.

Implementation Timeframe and Funding Notice. While the SLD Proposal would be effective upon the completion of all required regulatory approvals, Members would not be obligated to fund their Regular Activity Liquidity Obligations or Special Activity Liquidity Obligations until the Monthly Options Expiration Activity Period in September 2013. Moreover, Members would be provided with notice of their initial Regular Activity Liquidity Obligations no later than 30 days prior to the date on which that amount must be deposited with NSCC. At that time, NSCC's risk management staff would also provide to affected Members their Special Activity Peak Liquidity Exposure within the look-back period. Specific implementation dates would be provided by NSCC by Important Notice.

NSCC states that its risk management staff would continue to work with Members to help them understand the Revised SLD Proposal and to develop tools that NSCC believes would enable Members to forecast the liquidity exposure they present to NSCC. NSCC states that its risk management staff would also use the reports that would be provided under new Section 31 or proposed Rule 4A to guide ongoing discussions with Members regarding the types of actions that could mitigate those Members' peak liquidity exposure. In addition, under the Revised SLD Proposal (as in the Original SLD Proposal), NSCC states that Members would be able to manage their exposures by making prefund deposits where they project their own activity would increase their liquidity exposure. For example, if a Member that would be a Special Activity Liquidity Provider anticipates that its Special Activity Peak Liquidity Exposure at any time during a particular Options Expiration Activity Period would be greater than the amount calculated by NSCC, then it could make an additional cash deposit to the Clearing Fund (in excess of its Required Deposit) that it designates as a ''Special Activity Prefund Deposit.''

In order to give Members sufficient time to plan for annual Credit Facilities renewals and to line up designated liquidity providers for the Credit Facility, NSCC states that its risk staff would provide Members with an impact analysis of their projected Supplemental Liquidity Obligations beginning on

[14] NSCC states that since the allocation formula ratably applies the excess amount needed due to activity during Special Activity Periods based upon the affected Member's Special Activity Peak Liquidity Exposure, then to the extent that a Member's Special Activity Peak Liquidity Exposure (as defined) is less than or equal to NSCC's other available resources, that Member's share of the Special Activity Peak Liquidity Need will be zero.

November 31 of each year.[15] NSCC states that the information provided would show the potential impact on affected Members based on different Credit Facility funding levels.

In response to the more general concern regarding refinancing risk and NSCC's reliance on the Credit Facility, NSCC states that it would continue to explore additional financing sources. NSCC states that it would review and evaluate the financing options available to it and the related costs of those options, and would expect to present the findings of that review to the NSCC Board prior to the next renewal of the Credit Facility in May 2014. When sizing and approving the fee and costs structure of the renewal Credit Facility, NSCC states that the NSCC Board would be able to take into account those potential additional financing sources and consider the consequent impact on Members' cash Regular Activity Supplemental Deposit and Special Activity Supplemental Deposit obligations. The items that would be included in this review are:

- Analysis of the availability, size, cost, and credit risk necessary to obtain the additional commitments under the Credit Facility likely to reduce the Regular Activity Supplemental Deposit requirements to zero;
- analysis of the availability, size, cost, and credit risk to obtain a new multi-year committed facility to replace the existing Credit Facility;
- an understanding of the aggregate costs, if any, for Members to designate commercial lenders to commit to the Credit Facility as their designees;
- analysis of the availability, size, cost, and potential depth of a capital markets funding among Members and/or third parties as an additional liquidity resource, including the viability of offering the funding to Members or mandating their participation in such funding; and
- a summary of the steps that Members have taken to reduce their NSCC liquidity profile, and whether this should be factored into the historical analysis used to determine NSCC's Regular Activity Period liquidity needs and Members' share of that need.

NSCC states that it would update its Members on the results of this review and the determination of the NSCC Board. NSCC states that it would also update its Members with information regarding future liquidity initiatives designed to increase NSCC's liquidity resources and potentially reduce supplemental deposit requirements, including the rationale behind these initiatives, how these initiatives fit within NSCC's liquidity risk tolerance, and the likely impact of the initiatives.

NSCC states that the Revised SLD Proposal contributes to NSCC's goal of ensuring that NSCC has adequate liquidity resources to meet its settlement obligations, notwithstanding the default of its Members or Affiliated Families that pose the largest aggregate liquidity exposure over the relevant settlement cycle, as required by Commission Rule 17Ad–22(b)(3).[16]

2. Anticipated Effect on Management of Risk

As described above, NSCC is proposing to amend the Advance Notice, as modified by Amendment No. 1, in order to mitigate potential cash outlay burdens, and respond to transparency concerns raised by Members by clarifying the implementation timeframe of the SLD Proposal and the reporting that would be provided to Members under the SLD Proposal. NSCC believes that the SLD Proposal, as amended hereby, has been designed to ameliorate any unintended impact on competition that may be perceived, and it does not believe that the proposed amendments change the anticipated effect on and management of risk, as described in the original Advance Notice filed by NSCC on March 21, 2013.[17]

(B) Comments on Competition

1. Competition Concerns Raised by Commenters

Bank Affiliates. NSCC states that some commenters raised concerns on competition grounds that the Original SLD Proposal permitted Members and Affiliated Families with bank affiliates to reduce or potentially eliminate their required cash Required Activity Supplemental Deposits by the amounts of the commitments of such bank affiliates under the Credit Facility while Members and Affiliated Families without bank affiliates could not do so. As indicated above, NSCC states that this limitation to bank affiliates has been eliminated from the SLD Proposal. NSCC states that any Member or Affiliated Family could designate a Designated Lender and receive an offset for the commitment of such Designated Lender.

The Top 30 Cut-Off. NSCC states that some commenters raised concerns on competition grounds that Supplemental Liquidity Obligations are only imposed on the 30 largest Members and Affiliated Families rather than on the entire membership. NSCC states that, based on an analysis of Members, NSCC made a business determination that the top 30 Members or Affiliated Families would most appropriately capture the liquidity exposure over and above available NSCC Clearing Fund liquidity. NSCC states that its liquidity analyses show that the liquidity requirements attributable to the top 30 Members and Affiliated Families account for the vast majority of NSCC's liquidity needs. According to NSCC, as of the end of February 2013, the top 30 Members and Affiliated Families represented approximately 85% of the total membership by peak liquidity needs over the prior six-month period. NSCC states that the analyses also show that the remaining membership's peak liquidity demands are covered by the required deposits to the NSCC Clearing Fund. Therefore, NSCC states the SLD Proposal appropriately places the burden of providing liquidity on those Members and Affiliated Families who present the largest liquidity risk. While NSCC does not believe it would be appropriate to require the entire membership to bear the burden of the liquidity needs that are generated by NSCC's largest trading firms, it does note that all Members currently do bear the cost of the Credit Facility as an operating expense that NSCC factors into its overall fee structure, as well as their share of the NSCC Clearing Fund. NSCC states that as a whole, NSCC believes this collective liquidity funding approach represents a fair apportionment of NSCC's aggregate liquidity needs amongst its membership.

Impact on a Sector of the Market. NSCC states that some commenters raised concerns on competition grounds that the SLD Proposal may cause increased concentration of clearing activity by requiring smaller firms to clear through larger financial institutions. NSCC states that implicit in these comments is a concern that smaller, less well-capitalized firms have less access to funding than do larger, well capitalized firms. NSCC states, however, that no Member, because of its low capital business model or limited access to funding, should have the right to impose on NSCC (and the rest of the membership) the burden of bearing the risks of that Member's clearing activities. Moreover, NSCC states that the SLD Proposal provides incentives for Members to manage the liquidity risks of their business; by doing so they

[15] NSCC states that given the timing of the calculation look-back periods, information provided in November will necessarily be estimates.

[16] *See* 17 CFR 240.17Ad–22(b)(3).

[17] *See* Release No. 34–69451 (Apr. 25, 2013), 78 FR 25496 (May 1, 2013).

could reduce the share of their obligation under the SLD Proposal.

NSCC also states that some commenters claim that the risk posed by brokers with business in mostly agency-based transactions was overstated by NSCC in crafting the SLD Proposal because those firms settle transactions on a delivery-versus-payment (''DVP'') basis. NSCC states, however, that agency brokers that execute market transactions that clear at NSCC are obligated, as principals, to settle those transactions at NSCC irrespective of whether their institutional customers complete the institutional delivery DVP side of the transaction (which occurs outside of NSCC). According to NSCC, it, as the central counterparty, remains obligated to complete the other side of the market transaction if the agency broker fails. NSCC states that institutional customers of the agency brokers are not NSCC Members and have no contractual obligation with NSCC to complete those trades if the agency broker fails. Therefore, NSCC states that if an agency broker fails, NSCC (and its other Members) face the risk that the institutional customer will take its own market action, and NSCC will incur the liquidity obligation of completing the market settlement. NSCC states that it must consider this risk in crafting its risk management strategies, and agency brokers are not immune from the risk of failure, as recent events have shown that they, like other firms, remain subject to market events, as well as technology and other risks.

NSCC states that these comments raise a concern that Members are being asked share the burden of funding the liquidity needs that are dependent on the actions, including trading levels, of other Members, and thus the amounts are not within the contributing Member's control. NSCC states that from a fairness perspective, however, that proportionate share of the affected Member's liquidity burden (whether it be an agency broker or otherwise) would always be less than the Member's own peak liquidity needs, and each Member is in the best position to monitor and manage the liquidity risks presented by its own activity.

2. Modifications to the Proposed Change Address Competition Concerns

NSCC is an operating subsidiary of The Depository Trust & Clearing Corporation (''DTCC''), which NSCC states is a user-owned, user-governed holding company for NSCC, two other registered clearing agencies, a derivatives clearing organization joint venture, and a number of other companies that provide a variety of post-trade processing and information services. NSCC states that it and the other registered clearing agencies in the DTCC group provide the critical infrastructure for the clearance and settlement of securities transactions in the United States. These registered clearing agencies operate as utilities for their users, allowing such users to compete against each other (for the benefit of their retail and institutional customers) on the basis of performance and price and not on the basis of any relative advantage with respect to clearing and settlement services.

As a clearinghouse for securities transactions and a central counterparty, NSCC states that it has no reason, interest, or intent to discriminate among its Members—certainly not to give any of its Members a competitive advantage or impose on any of its Members a competitive disadvantage in their operations. NSCC states that although it strives for complete neutrality in its interface with Members, it may be that clearing agency rules of general application to all Members could have a disparate effect on Members with diverse business models and strategies. NSCC states that any such disparate effects arising out of choices made by individual Members in terms of their business models and strategies (including their relative levels of capitalization) should not be seen as due to action by the clearing agency having an impact or imposing a burden on competition.

Although NSCC states that it is always mindful of the effect that its Rules may have on individual Members, NSCC states that it must also be concerned with (i) the interests of its membership as a whole, (ii) its general obligations under Section 17A(b)(3) of the Exchange Act ''to facilitate the prompt and accurate clearance and settlement of securities transactions and derivatives agreements, contracts, and transactions'' and ''to safeguard securities and funds in its custody or control,'' and (iii) the particular requirements of Rule 17Ad-22(b)(3) relating to the financial resources that a clearing agency which is a central counterparty (like NSCC) must maintain to cover the default of the participant family presenting the largest exposure to the clearing agency in extreme but plausible market conditions.

NSCC states that these concerns and the interests of its Members, including their interests relating to issues of competition and the effect of the proposed change on competition among Members and between Members and other financial market participants, can be reconciled. But, NSCC states that individual Members that may be affected by the proposed change—designed to assure that NSCC has the liquidity it needs to safely operate a clearing and settlement business and meet its obligations as a registered clearing agency and central counterparty under the Exchange Act—must also recognize that some accommodation may be required on their part.

Nevertheless, in response to comments submitted on the proposed change in the form in which it was originally filed in the Advance Notice, and dialogue with a number of other Members who did not submit comments but otherwise provided their input to NSCC, NSCC states that it has revised the proposed change in a number of respects that bear upon the issue of competition and whether the proposed change would have an impact or impose any burden on competition.

First, the Original SLD Proposal provided that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for the amount of its commitment and the commitment of any affiliate of the Regular Activity Liquidity Provider under the Credit Facility. The Revised SLD Proposal provides that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for the amount of its commitment, the commitment of any affiliate, and the commitment of any Designated Lender of the Regular Activity Liquidity Provider under the Credit Facility. As a result, NSCC states that any distinction between Members with bank affiliates and Members without bank affiliates, and any perceived advantage for Members with bank affiliates over Members without bank affiliates, has been eliminated.

Second, the SLD Proposal has been refined to provide that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for both (i) its pro rata share of the commitments of lenders under the Credit Facility that are not Members or their Designated Lenders and (ii) its pro rata share of the commitments of Members and their Designated Lenders above the amounts of their Regular Activity Liquidity Obligations. As a result of this change, NSCC states that the obligation of Regular Activity Liquidity Providers to provide Regular Activity Supplemental Deposits will be ratably reduced by the amount of such ''excess.''

Third, the Options Expiration Activity Period has been redefined to mean the days around all monthly options

expiration dates (12 per year) rather than just triple options expiration dates (four per year). As a result of this change, NSCC states that more periods of increased activity would be excluded by NSCC from the calculation of its Regular Activity Peak Liquidity Need, thereby reducing the Regular Activity Liquidity Obligations of Regular Activity Liquidity Providers.

NSCC states that participation in the Credit Facility is available to financial institutions that have the resources and operational capabilities to be lenders under the Credit Facility, subject to satisfaction of reasonable lender criteria. Although the Credit Facility was renewed on May 14, 2013 for an additional term of 364 days, NSCC states that there are mechanisms in the Credit Facility to increase the commitments of existing lenders and admit new lenders at any time during the term. Accordingly, NSCC states that at the time when the SLD Proposal becomes effective and before the time that any Member may have to satisfy a Regular Activity Liquidity Obligation, such Member would have an opportunity to either join the Credit Facility itself as a lender (if it has the authority to be a lender) or enter into arrangements with a bank to be its Designated Lender—in either case thereby reducing or eliminating the need for it to make a cash Regular Activity Supplemental Deposit to the Clearing Fund.

3. Impact on Competition

NSCC states that for the reasons stated above, it believes the changes that have been made to the Original SLD Proposal eliminate or substantially ameliorate the impact that the SLD Proposal might have on competition.

(C) Clearing Agency's Statement on Comments on the Advance Notice Received from Members, Participants, or Others

While written comments on the Advance Notice, as modified by Amendment No. 2, were not solicited, as noted above, NSCC engaged significant outreach and discussion with affected Members in developing the SLD Proposal.

Written comments on the Advance Notice, as amended, have been filed with the Commission and are available on the Commission's Web site. NSCC states that this Amendment No. 2 addresses some of the issues raised by those comments. NSCC's formal response to the written comments has been submitted separately to the Commission in accordance with the process for submitting comments.

III. Date of Effectiveness of the Advance Notice and Timing for Commission Action

The clearing agency may implement the proposed change pursuant to Section 806(e)(1)(G) of the Clearing Supervision Act [18] if it has not received an objection to the proposed change within 60 days of the later of (i) the date that the Commission received the advance notice or (ii) the date the Commission receives any further information it requested for consideration of the notice. The clearing agency shall not implement the proposed change if the Commission has any objection to the proposed change.

The Commission may extend the period for review by an additional 60 days if the proposed change raises novel or complex issues, subject to the Commission providing the clearing agency with prompt written notice of the extension. A proposed change may be implemented in less than 60 days from the date of receipt of the advance notice, or the date the Commission receives any further information it requested, if the Commission notifies the clearing agency in writing that it does not object to the proposed change and authorizes the clearing agency to implement the proposed change on an earlier date, subject to any conditions imposed by the Commission. The clearing agency shall post notice on its Web site of proposed changes that are implemented.

The proposal shall not take effect until all regulatory actions required with respect to the proposal are completed.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the Advance Notice, as amended, is consistent with the Clearing Supervision 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 No. SR–NSCC–2013–802 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File No. SR–NSCC–2013–802. 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 Web site (*http://www.sec.gov/rules/sro.shtml*.) Copies of the submission, all subsequent amendments, all written statements with respect to the Advance Notice, as amended, that are filed with the Commission, and all written communications relating to the Advance Notice, as amended, 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 Web site 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 filings also will be available for inspection and copying at the principal office of NSCC and on NSCC's Web site at *http://dtcc.com/legal/rule_filings/nscc/2013.php*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File No. SR–NSCC–2013–802 and should be submitted on or before August 5, 2013.

By the Commission.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16821 Filed 7–12–13; 8:45 am]

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[18] 12 U.S.C. 5465(e)(1)(G).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69948; File No. SR–CBOE–2013–041]

Self-Regulatory Organizations; Chicago Board Options Exchange, Incorporated; Order Approving a Proposed Rule Change, as Modified by Amendment Nos. 1 and 2, To Amend Rule 6.53(u), Relating to Qualified Contingent Cross Orders

July 9, 2013.

I. Introduction

On March 28, 2013, the Chicago Board Options Exchange, Incorporated

(''Exchange'' or ''CBOE'') 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 amend CBOE Rule 6.53(u) to allow Qualified Contingent Cross (''QCC'') Orders with more than one option leg to be entered in $0.01 increments. The proposed rule change was published for comment in the **Federal Register** on April 16, 2013.[3] CBOE filed Amendment No. 1 to the proposal on April 18, 2013.[4] CBOE filed Amendment No. 2 to the proposal on May 29, 2013.[5] On June 5, 2013, the Commission published notice of and solicited comment on the proposed rule change, as modified by Amendment Nos. 1 and 2, and extended the time period for Commission action on the proposal to July 15, 2013.[6] The Commission received no comments regarding the proposal, as amended. This order approves the proposed rule change, as modified by Amendment Nos. 1 and 2.

II. Description of the Proposal

Currently, CBOE Rule 6.53(u) states that QCC Orders may only be entered in the standard increments applicable to simple orders in the options class under CBOE Rule 6.42.[7] CBOE Rule 6.42 provides trading increments of $0.01, $0.05, or $0.10 for individual option series, and orders to buy or sell a single option series must be entered in the trading increment applicable to the series. CBOE Rule 6.42(4) allows bids and offers on complex orders to be expressed in any increment, regardless of the minimum increment otherwise applicable to the individual legs of the complex order. CBOE proposes to amend CBOE Rule 6.53(u) to permit QCC orders with more than one option leg to be entered in the increments specified for complex orders under CBOE Rule 6.42, *i.e.,* $0.01 increments.[8]

CBOE believes that, because a QCC Order with multiple option legs is a form of complex order, these QCC Orders also should be permitted to be entered in $0.01 increments, a change the Exchange states would place QCC Orders with multiple options legs on the same footing as other types of complex orders.[9] CBOE states that the pricing of a complex order, whether or not it is a QCC Order, is based on the relative price of one option leg to another (as opposed to the outright price of a single option), and therefore that the standard increment of trading of the individual legs of a complex order is less relevant to the pricing of the complex order.[10] In addition, CBOE notes that, under CBOE Rule 6.53(u)(ii), each option leg of a complex QCC Order must: (1) Provide price improvement over a public customer order resting in the electronic book; and (2) be at or between the NBBO.[11] CBOE also states that it has never had to reject a complex QCC Order because it would have violated either of these principles.[12] Finally, CBOE believes that allowing QCC Orders with multiple options legs to be entered in $0.01 increments will provide an opportunity for price improvement at a smaller increment level.[13]

III. Discussion and Commission Findings

After careful review, the Commission finds that the proposed rule change, as modified by Amendment Nos. 1 and 2, is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange and, in particular, with Section 6(b) of the Act.[14] In particular, the Commission finds that the proposed rule change is consistent with Sections 6(b)(5) [15] and 6(b)(8),[16] which require, among other things, that the rules of a national securities exchange be designed to promote just and equitable principles of trade, to prevent fraudulent and manipulative acts, to remove impediments to and perfect the mechanism for a free and open market and a national market system, and, in general, to protect investors and the public interest, and that the rules of an exchange do not impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. In addition, the Commission finds that the proposed rule change is consistent with Section 11A(a)(1)(C) of the Act,[17] in which Congress found that it is in the public

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 69360 (April 10, 2013), 78 FR 22591.

[4] In Amendment No. 1, CBOE added an additional paragraph at the end of the purpose section stating that: (1) A QCC Order with multiple legs is a form of a complex order and should be able to be entered in $0.01 increments, as non-QCC complex orders can currently be entered in $0.01 increments; and (2) such orders still cannot trade unless they are at or between the NBBO and the opportunity to trade QCC Orders with multiple legs in $0.01 increments provides an opportunity for price improvement at this smaller increment level. The paragraph added in Amendment No. 1 was deleted and replaced by language added in Amendment No. 2. *See* note 5 *infra.*

[5] In Amendment No. 2, CBOE replaced the paragraph added by Amendment No. 1 with two paragraphs at the end of the purpose section stating that: (1) Were it not for language in CBOE Rule 6.53(u) that limits the entry of QCC Orders to the standard increments applicable to simple orders in the options class of each leg, QCC Orders with multiple legs would be allowed to be traded in $0.01 increments under CBOE Rule 6.42; (2) the nature of the pricing of a complex order, whether a QCC Order or otherwise, is such that the pricing is based on the relative price of one option versus another and thus the standard increment of trading of a complex order's individual options legs is less relevant to the pricing of the complex order; (3) the proposed amendment to permit QCC Orders with more than one option leg to be entered in the increments specified for complex orders under CBOE Rule 6.42 (*i.e.,* $0.01 increments) would put the trading of QCC Orders with multiple legs on the same footing as the trading of other types of complex orders; (4) pursuant to CBOE Rule 6.53(u)(ii), each options leg of a complex QCC Order cannot trade unless each leg provides price improvement over a public customer order resting in the electronic book and is at or between the NBBO, and to date, CBOE has never had to reject a submitted complex QCC Order because it would have violated either of these principles; and (5) permitting the trading of QCC Orders with multiple legs in $0.01 increments would provide an opportunity for price improvement at this smaller increment level.

[6] *See* Securities Exchange Act Release No. 69675 (May 30, 2013), 78 FR 33868.

[7] A QCC Order is an order to buy (or sell) at least 1,000 standard option contracts or 10,000 mini-option contracts that is identified as being part of a qualified contingent trade coupled with a contra-side order to sell (or buy) an equal number of contracts. A ''qualified contingent trade,'' or ''QCT,'' is a transaction consisting of two or more component orders, executed as agent or principal, where: (1) At least one component is an NMS stock, as defined in Rule 600 of Regulation NMS under the Act; (2) all components are effected with a product or price contingency that either has been agreed to by all the respective counterparties or arranged for by a broker-dealer as principal or agent; (3) the execution of one component is contingent upon the execution of all other components at or near the same time; (4) the specific relationship between the component orders (*e.g.,* the spread between the prices of the component orders) is determined by the time the contingent order is placed; (5) the component orders bear a derivative relationship to one another, represent different classes of shares of the same issuer, or involve the securities of participants in mergers or with intentions to merge that have been announced or cancelled; and (6) the transaction is fully hedged (without regard to any prior existing position) as a result of other components of the contingent trade. *See* CBOE Rule 6.53(u)(i). The six requirements are substantively identical to the six elements of a QCT under the Commission's QCT exemption. *See* Securities Exchange Act Release Nos. 54389 (August 31, 2006), 71 FR 52829 (September 7, 2006) (''Original QCT Exemption'') and 57620 (April 4, 2008), 73 FR 19271 (April 9, 2008) (''CBOE QCT Exemption''). The current QCT exemption (*i.e.,* as modified by the CBOE QCT Exemption) is referred to herein as the ''NMS QCT Exemption.''

[8] QCC Orders with one option leg would continue to trade in the standard increment applicable to simple orders in the option class. *See* CBOE Rule 6.53(u).

[9] *See* Amendment No. 2.

[10] *See id.*

[11] *See id.*

[12] *See id.*

[13] *See id.*

[14] 15 U.S.C. 78f(b). In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[15] 15 U.S.C. 78f(b)(5).

[16] 15 U.S.C. 78f(b)(8).

[17] 15 U.S.C. 78k–1(a)(1)(C).

interest and appropriate for the protection of investors and the maintenance of fair and orderly markets to assure, among other things, the economically efficient execution of securities transactions.

In 2011, the Commission approved CBOE's proposal to establish rules providing for the trading of QCC Orders on CBOE,[18] which followed the Commission's approval of a proposal by the International Stock Exchange, LLC (''ISE'') to trade QCC Orders.[19] In the ISE Order, the Commission noted that the parties to a contingent trade are focused on the spread or ratio between the transaction prices for each of the component instruments (*i.e.,* the net price of the entire contingent trade), rather than the absolute price of any single component.[20] Under the requirements of the NMS QCT Exemption, the spread or ratio between the relevant instruments must be determined at the time the order is placed, and this spread or ratio stands regardless of the market prices of the individual orders at their time of execution.[21] As the Commission noted in the Original QCT Exemption, ''the difficulty of maintaining a hedge, and the risk of falling out of hedge, could dissuade participants from engaging in contingent trades, or at least raise the cost of such trades.'' [22] Thus, the Commission found that, if each stock leg of a qualified contingent trade were required to meet the trade-though provisions of Rule 611 of Regulation NMS, such trades could become too risk and costly to be employed successfully and noted that the elimination or reduction of this trading strategy potentially could remove liquidity from the market.[23]

CBOE's QCC Orders allow a Trading Permit Holder to cross the options leg(s) of a qualified contingent trade in a Regulation NMS stock on CBOE immediately, without exposure, provided that the requirements of CBOE Rule 6.53(u) are satisfied. In approving CBOE's proposal, the Commission stated that QCC Orders could facilitate the execution of qualified contingent trades, which the Commission previously had found to be beneficial to the market as a whole by contributing to the efficient functioning of the securities markets and the price discovery process.[24] The Commission noted that QCC Orders would provide assurance to parties to stock-option qualified contingent trades that their hedge would be maintained by allowing the options component of the qualified contingent trade to be executed as a clean cross.[25]

The CBOE QCC Approval Order stated further that, although the Commission believed that order exposure is generally beneficial to the options markets in that it provides an incentive to options market makers to provide liquidity and therefore plays an important role in ensuring competition and price discovery in the options markets, the Commission also has recognized that contingent trades can be ''useful trading tools for investors and other market participants, particularly those who trade the securities of issuers involved in mergers, different classes of shares of the same issuers, convertible securities, and *equity derivatives such as options* [italics added]'',[26] and that ''[t]hose who engage in contingent trades can benefit the market as a whole by studying the relationships between prices of such securities and executing contingent trades when they believe such relationships are out of line with what they believe to be fair value.'' [27] Thus, the Commission believed that transactions that meet the specified requirements of the NMS QCT Exemption could be of benefit to the market as a whole, contributing to the efficient functioning of the securities markets and the price discovery process.[28]

In the CBOE QCC Approval Order, the Commission stated that the benefits provided by the exposure requirement and by qualified contingent trades, such as QCC Orders, required the Commission to weigh the relative merits of both for the options markets.[29] The Commission found that CBOE's rule, by requiring a QCC Order to be: (1) Part of a qualified contingent trade under Regulation NMS; (2) for at least 1,000 contracts; (3) executed at a price at or between the NBBO; and (4) cancelled if there is a public customer order on the electronic book, struck an appropriate balance for the options markets in that it was narrowly drawn and established a limited exception to the general principle of exposure and retained the general principle of customer priority in the options markets.[30] The Commission noted, further, that the requirement that a QCC Order be part of a qualified contingent trade that satisfies each of the six underlying requirements of the NMS QCT Exemption, and the requirement that a QCC Order be for a minimum size of 1,000 contracts, further limited the use of QCC Orders by ensuring that only transactions of significant size would be able to avail themselves of the order type.[31]

The Commission believes that the analysis in the CBOE QCC Approval Order applies equally to the current proposal. By allowing QCC Orders with more than one option leg to trade in $0.01 increments, rather than in the standard increment applicable to single leg orders in the options class, the proposal could facilitate the execution of QCC Orders with multiple option legs by providing additional price points at which these orders would be able to be executed, which, in turn, could facilitate the execution of qualified contingent trades. As discussed above, the Commission previously has found that transactions that meet the specified requirements of the NMS QCT Exemption could benefit the market as a whole by contributing to the efficient functioning of the securities markets and the price discovery process. Further, as discussed above, QCC Orders provide assurance to the parties to a stock-option qualified contingent trade that their hedge will be maintained by allowing the options component of the order to be executed as a clean cross. By allowing QCC Orders with multiple option legs to be executed in $0.01 increments, the proposal could further facilitate the execution of the option component of a stock-option qualified contingent trade.

The Commission notes that CBOE Rule 6.53(u) will continue to require that QCC Orders, including those with

[18] *See* Securities Exchange Act Release No. 64653 (June 13, 2011), 76 FR 35491 (June 17, 2011) (order approving CBOE–2011–041) (''CBOE QCC Approval Order'').

[19] *See* Securities Exchange Act Release No. 63955 (February 24, 2011), 76 FR 11533 (March 2, 2011) (order approving ISE–2010–73) (''ISE Order'').

[20] *See* ISE Order at 11540.

[21] *See id. See also supra* note 7.

[22] *See* Original QCT Exemption at 52831.

[23] *See id.*

[24] *See* CBOE QCC Approval Order at 35492, citing Original QCT Exemption, *supra* note 7.

[25] *See* CBOE QCC Approval Order at 35492.

[26] *See* CBOE QCC Approval Order at 35492, citing Original QCT Exemption at 52830–31.

[27] *See id.*

[28] *See* CBOE QCC Approval Order at 35492, citing CBOE QCT Exemption at 19273.

[29] *See* CBOE QCC Approval Order at 35492.

[30] *See id.*

[31] *See* CBOE QCC Approval Order at 35492–93. The CBOE QCC Approval Order also noted CBOE's representation that, to effect proprietary orders (including QCC Orders) electronically from on the floor of the Exchange, members must qualify for an exemption from Section 11(a)(1) of the Act, 15 U.S.C. 78k(a)(1), which concerns proprietary trading on an exchange by an exchange member. Among other things and as discussed in greater detail in the CBOE QCC Approval Order, CBOE recognized that Trading Permit Holders effecting QCC Orders and relying on the ''G'' exemption for yielding priority to non-members under Section 11(a)(1)(G) of the Act and Rule 11a1–1(T) thereunder would be required to yield priority to any interest, not just public customer orders, in the electronic book at the same price to ensure that non-member interest is protected. *See* CBOE QCC Approval Order at 35493.

multiple option legs, be: (1) Part of a qualified contingent trade under Regulation NMS; (2) for at least 1,000 standard option contracts; [32] (3) executed at a price at or between the NBBO; and (4) cancelled if there is a public customer order at the same price resting on the electronic book. Thus, the Commission believes that the proposal continues to strike an appropriate balance for the options market in that it is narrowly drawn and in that it establishes a limited exception to the general principle of exposure and retains the general principle of customer priority in the options markets.[33]

For the foregoing reasons, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) [34] and 6(b)(8) [35] of the Act. Further, the Commission finds that the proposed rule change is consistent with Section 11A(a)(1)(C) of the Act.[36]

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[37] that the proposed rule change (SR–CBOE–2013–041), as modified by Amendment Nos. 1 and 2, is approved.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[38]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16818 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

[32] For mini-option contracts, the minimum size is 10,000 contracts. *See* CBOE Rule 6.53(u).

[33] *See* CBOE QCC Approval Order at 35492.

[34] 15 U.S.C. 78f(b)(5).

[35] 15 U.S.C. 78f(b)(8).

[36] 15 U.S.C. 78k–1(a)(1)(C).

[37] 15 U.S.C. 78s(b)(2).

[38] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69952; File No. SR–NYSEMKT–2013–61]

Self-Regulatory Organizations; NYSE MKT LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending NYSE MKT Rules 504 and 509—Equities With Respect to DMM Quoting Requirements Applicable to Nasdaq Stock Market Securities Traded on the Exchange Pursuant to A Grant of Unlisted Trading Privileges

July 9, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that, on June 26, 2013, NYSE MKT LLC (the ''Exchange'' or ''NYSE MKT'') 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 Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend NYSE MKT Rules 504 and 509—Equities with respect to DMM quoting requirements applicable to Nasdaq Stock Market (''Nasdaq'') securities traded on the Exchange pursuant to a grant of unlisted trading privileges. The text of the proposed rule change is available on the Exchange's Web site 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 Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend NYSE MKT Rules 504 and 509—Equities with respect to DMM quoting requirements applicable to Nasdaq securities traded on the Exchange pursuant to a grant of unlisted trading privileges. NYSE MKT Rules 500–525—Equities, as a pilot program, govern the trading of any Nasdaq-listed security on the Exchange pursuant to unlisted trading privileges (''UTP Pilot Program'').[3] The UTP Pilot Program includes any security listed on Nasdaq that (i) is designated as an ''eligible security'' under 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 Privilege Basis, as amended (''UTP Plan''),[4] and (ii) has been admitted to dealings on the Exchange pursuant to a grant of unlisted trading privileges in accordance with Section 12(f) of the Act [5] (collectively, ''Nasdaq Securities'').[6]

Designated Market Maker units (''DMM units'') [7] registered in one or more Nasdaq Securities must comply with all ''DMM rules,'' as defined in NYSE MKT Rule 98—Equities,[8] and the

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The UTP Pilot Program is currently scheduled to expire on the earlier of Commission approval to make such pilot permanent or January 31, 2014. *See* Securities Exchange Act Release No. 69814 (June 20, 2013) (SR–NYSEMKT–2013–53) (Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending NYSE MKT Rule 500—Equities to Extend the Operation of the Pilot Program that Allows Nasdaq Stock Market (''Nasdaq'') Securities to be Traded on the Exchange Pursuant to a Grant of Unlisted Trading Privileges). *See also* Securities Exchange Act Release No. 62479 (July 9, 2010), 75 FR 41264 (July 15, 2010) (SR–NYSEAmex–2010–31). See also Securities Exchange Act Release Nos. 62857 (September 7, 2010), 75 FR 55837 (September 14, 2010) (SR–NYSEAmex–2010–89); 63601 (December 22, 2010), 75 FR 82117 (December 29, 2010) (SR–NYSEAmex–2010–124); 64746 (June 24, 2011), 76 FR 38446 (June 30, 2011) (SR–NYSEAmex–2011–45); 66040 (December 23, 2011), 76 FR 82324 (December 30, 2011) (SR–NYSEAmex–2011–104); 67497 (July 25, 2012), 77 FR 45404 (July 31, 2012) (SR–NYSEMKT–2012–25); and 68561 (January 2, 2013), 78 FR 1290 (January 8, 2013) (SR–NYSEMKT–2012–86).

[4] *See* Securities Exchange Act Release No. 58863 (October 27, 2008), 73 FR 65417 (November 3, 2008) (File No. S7–24–89). The Exchange's predecessor, the American Stock Exchange LLC, joined the UTP Plan in 2001. *See* Securities Exchange Act Release No. 55647 (April 19, 2007), 72 FR 20891 (April 26, 2007) (S7–24–89). In March 2009, the Exchange changed its name to NYSE Amex LLC, and in May 2012, the Exchange subsequently changed its name to NYSE MKT LLC. *See* Securities Exchange Act Release Nos. 59575 (March 13, 2009), 74 FR 11803 (March 19, 2009) (SR–NYSEALTR–2009–24) and 67037 (May 21, 2012), 77 FR 31415 (May 25, 2012 (SR–NYSE Amex-2012–32),

[5] 15 U.S.C. 781.

[6] ''Nasdaq Securities'' is included within the definition of ''security'' as that term is used in the NYSE MKT Rules—Equities. *See* NYSE MKT Rule 3—Equities. In accordance with this definition, Nasdaq Securities are admitted to dealings on the Exchange on an ''issued,'' ''when issued,'' or ''when distributed'' basis. *See* NYSE MKT Rule 501—Equities.

[7] *See* NYSE MKT Rule 103—Equities—Registration and Capital Requirements of DMMs and DMM Units. ''DMM unit'' means any member organization, aggregation unit within a member organization, or division or department within an integrated proprietary aggregation unit of a member organization that (i) has been approved by NYSE Regulation pursuant to section (c) of this Rule 103, (ii) is eligible for allocations under NYSE MKT Rule 103B—Equities as a DMM unit in a security listed or traded on the Exchange, and (iii) has met all registration and qualification requirements for DMM units assigned to such unit. *See* NYSE MKT Rule 98(b)(2)—Equities.

[8] ''DMM rules'' means any rules that govern DMM conduct or trading. *See* NYSE MKT Rule 98(b)(5)—Equities.

obligations and benefits of DMMs in Nasdaq Securities closely track those applicable to DMMs in Exchange-listed equities, subject to certain modifications enumerated in NYSE MKT Rule 509—Equities. As is the case with DMMs in Exchange-listed equities, a DMM unit in Nasdaq Securities has an affirmative obligation to engage in a course of dealings for its own account to assist in the maintenance of a fair and orderly market insofar as reasonably practicable, including maintaining price continuity with reasonable depth and quoting and trading with reference to Exchange-provided Depth Guidelines.[9] In addition, a DMM in Nasdaq Securities is required to facilitate trading when a ''gap'' quote procedure is being used and when a manual block trade is being executed.[10]

The obligations of DMM units registered to trade Nasdaq Securities are, however, slightly different from those that apply to DMMs in Exchange-listed securities. First, the rules that apply to trading in Nasdaq Securities on the Exchange do not provide for opening and closing auctions in Nasdaq Securities, so DMMs in Nasdaq Securities are not responsible for facilitating openings and closings, as DMMs in listed equities are. Second, NYSE MKT Rule 509(a)(1)—Equities states that in lieu of NYSE MKT Rule 104(a)(1)(A)—Equities, with respect to maintaining a continuous two-sided quote with reasonable size, a DMM unit registered in Nasdaq Securities must maintain a quote at the National Best Bid or Offer (''inside'') in each assigned Nasdaq Security an average of at least 10% of the time during the regular business hours of the Exchange for each calendar month for Nasdaq Securities with a consolidated average daily volume (''CADV'') of less than one million shares per calendar month and an average of at least 5% of the time during the regular business hours of the Exchange for each calendar month for Nasdaq Securities with a CADV equal to or greater than one million shares per calendar month. As such, a DMM in a Nasdaq Security is required to meet these quoting requirements on a stock-by-stock basis.

The Exchange proposes to amend NYSE MKT Rule 509(a)(1)—Equities to require that DMM units maintain a bid or offer at the NBBO for a certain percentage of the trading day on a portfolio basis. The percentage required would depend on whether the stock is a ''More Active Security'' or ''Less Active Security'' security, as defined in Rule 103B(II)(B) and (C)—Equities. As proposed, a DMM unit would be required to maintain a bid or offer at the NBBO for at least 15% of the trading day for Nasdaq Securities in which the DMM unit is registered with a CADV of less than one million shares (i.e., Less Active Securities), and at least 10% of the trading day for Nasdaq Securities in which the DMM unit is registered with a CADV equal to or greater than one million shares (i.e., More Active Securities).

The requirements of proposed NYSE MKT Rule 509(a)(1)(A) are modeled on the DMM unit quoting requirements in New York Stock Exchange LLC (''NYSE'') Rule 104(a)(1)(A), which requires that DMM units maintain a bid or offer at the NBBO for a certain percentage of the trading day on a portfolio basis. Specifically, NYSE Rule 104(a)(1)(A) requires that DMM units maintain a bid or offer at the NBBO for at least 15% of the trading day for NYSE-listed securities in which the DMM unit is registered with a CADV of less than one million shares, and at least 10% for securities for NYSE-listed securities in which the DMM unit is registered with a CADV equal to or greater than one million shares.

The Exchange notes that the NYSE requirement for NYSE-listed securities is greater than the DMM unit quoting requirement for Exchange-listed securities. NYSE MKT Rule 104(a)(1)(A)—Equities requires that DMM units maintain a bid or offer at the NBBO for a certain percentage of the trading day for all Exchange-listed securities in which the DMM unit is registered, specifically, at least 10% of the trading day for the Exchange-listed securities in which the DMM unit is registered with a CADV of less than one million shares, and at least 5% for securities in which the DMM unit is registered with a CADV equal to or greater than one million shares.

Accordingly, under the proposed change, DMM units would be required to meet a quoting requirement for Nasdaq Securities that is greater than the quoting requirement for Exchange-listed securities.

The Exchange believes the proposed change is appropriate in light of the low volume of trading of Nasdaq Securities occurring on the Exchange. The Exchange believes that basing the quoting requirements on quoting in the portfolio of securities in which the DMM unit is registered rather than on a security-by security basis will encourage quoting activity in a broader number of Nasdaq Securities, including less active securities. Because, in part, of the difficulty DMM units have in meeting the current stock-by-stock quoting obligation, DMM units have declined to participate in the UTP Pilot Program, and trading in Nasdaq Securities on NYSE MKT is minimal, with only 135 of the approximately 2,600 Nasdaq Securities trading at the Exchange as of May 21, 2013. Specifically, meeting the security-by-security quoting requirement on a daily basis has been sufficiently difficult to discourage DMM units from participating in the UTP program. The Exchange believes that the portfolio approach will give DMM units more flexibility in meeting the quoting requirements, thus encouraging DMM participation in the UTP Pilot Program. The Exchange notes that while there may be more or less quoting in individual securities in the portfolio in any particular trading session, as with the portfolio quoting requirement for NYSE and the Exchange, the Exchange believes that over time, quoting across all of the assigned Nasdaq Securities will even out as the requirement to meet the portfolio requirement would discourage an imbalance in quoting any one security. The Exchange therefore seeks to adopt an obligation that is both meaningful and attainable to encourage increased participation by DMM units in the UTP Pilot Program, which would result in more liquidity providing and quoting in a higher number of Nasdaq Securities trading on the Exchange.

The Exchange also notes that the proposed quoting requirement is higher than the quoting requirement applicable to Exchange-listed securities, and therefore the obligation associated with the quoting requirement for DMMs in Nasdaq Securities would still be greater than the similar obligation for Exchange-listed securities. The Exchange believes that this is appropriate given the Commission's prior finding that the obligations and benefits for DMMs that trade Nasdaq Securities differ from the obligations and benefits for DMMs that trade Exchange-listed securities.[11] The Exchange believes that the proposed change strikes the appropriate balance between setting a meaningful obligation to the market that is tailored to the volume levels of Nasdaq Securities that trade in the UTP Pilot Program while at the same time recognizing that the obligations for DMM units must be meaningful as compared to the benefits they receive.

[9] *See* NYSE MKT Rule 104(a), (f)(ii) and (f)(iii)—Equities.

[10] *See* NYSE MKT Rule 104(a)(5)—Equities.

[11] *See* Securities Exchange Act Release Nos. 62479 (July 9, 2010), 75 FR 41264 (July 15, 2010) (SR–NYSEAmex–2010–31).

Finally, the Exchange notes that using a similar structure for the obligations for listed securities and for Nasdaq Securities would, for the same DMM unit eliminate in large part the additional responsibility and burden for DMM units to design, implement and maintain different technology approaches and programming for their trading and internal compliance applications relating to Nasdaq Securities only.

The Exchange also proposes to delete from NYSE MKT Rule 504(b)(1)(A)—Equities, Nasdaq Security Assignment, the text setting out the DMM quoting requirements of NYSE MKT Rule 509—Equities and to replace the repetition of the text with a cross-reference to NYSE MKT Rule 509—Equities.

The Exchange proposes to implement the rule changes effective [sic] August 1, 2013.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange. In particular, the Exchange believes that its proposal is consistent with: (i) Section 6(b) of the Act,[12] in general, and furthers the objectives of Section 6(b)(5) of the Act,[13] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest; (ii) Section 11A(a)(1) of the Act,[14] in that it seeks to ensure the economically efficient execution of securities transactions and fair competition among brokers and dealers and among exchange markets; and (iii) Section 12(f) of the Act,[15] which governs the trading of securities pursuant to UTP consistent with the maintenance of fair and orderly markets, the protection of investors and the public interest, and the impact of extending the existing markets for such securities.

Specifically, the Exchange believes that the proposed change would remove impediments to and perfect the mechanism of a free and open market and national market system because it would remove an obligation that is virtually impossible for DMM units to meet and replace it with a quoting obligation better tailored to the scope of the UTP Pilot Program and how Nasdaq Securities trade at the Exchange. The Exchange believes that the proposed change would promote fair competition among broker dealers by encouraging more DMM units to quote Nasdaq Securities, thereby increasing the available liquidity in such securities, which would benefit investors and the public.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule changes will impose any burden on competition that are not necessary or appropriate in furtherance of the purposes of the Act. The Exchange believes that the proposed change is pro-competitive because it would remove an overly burdensome obligation that places Exchange DMM units at a disadvantage vis-à-vis market makers on other markets because the Exchange DMM units are unable to meet the quoting obligations, and therefore do not trade Nasdaq Securities at the Exchange. The Exchange further believes that the proposed change will foster competition because it will increase the number of DMM units that would be willing to be registered in Nasdaq Securities, thereby increasing the potential pool of liquidity in Nasdaq Securities in the market.

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

Because the foregoing proposed rule change does not significantly affect the protection of investors or the public interest, does not impose any significant burden on competition, and, by its terms, does not become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act[16] and Rule 19b–4(f)(6) thereunder.[17]

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)[18] 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–NYSEMKT–2013–61 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEMKT–2013–61. 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 Web site (*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 Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official

[12] 15 U.S.C. 78f(b).

[13] 15 U.S.C. 78f(b)(5).

[14] 15 U.S.C. 78k–1(a)(1).

[15] 15 U.S.C. 78l(f).

[16] 15 U.S.C. 78s(b)(3)(A).

[17] 17 CFR 240.19b–4(f)(6). 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.

[18] 15 U.S.C. 78s(b)(2)(B).

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; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEMKT–2013–61 and should be submitted on or before August 5, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[19]

Kevin M. O'Neill,

Deputy Secretary.

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BILLING CODE 8011–01–P

[19] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69947; File No. SR–MIAX–2013–31]

Self-Regulatory Organizations; Miami International Securities Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Adopt a Priority Customer Rebate Program

July 9, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1], and Rule 19b–4 thereunder,[2] notice is hereby given that on June 27, 2013, Miami International Securities Exchange LLC (''MIAX'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange is filing a proposal to adopt a Priority Customer Rebate Program.

The text of the proposed rule change is available on the Exchange's Web site at *http://www.miaxoptions.com/filter/wotitle/rule_filing,* at MIAX's principal office, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to implement a Priority Customer Rebate Program (the ''Program'') for the period beginning July 1, 2013 and ending September 30, 2013.[3] The new Priority Customer Rebate Program is based on the substantially similar fees of another competing options exchange.[4] Under the Program, the Exchange shall credit each Member the per contract amount set forth in the table below resulting from each Priority Customer [5] order transmitted by that Member which is executed on the Exchange in all multiply-listed option classes (excluding mini-options and executions related to contracts that are routed to one or more exchanges in connection with the Options Order Protection and Locked/Crossed Market Plan referenced in Rule 1400), provided the Member meets certain volume thresholds in a month as described below. The volume thresholds are calculated based on the customer average daily volume over the course of the month. Volume will be recorded for and credits will be delivered to the Member Firm that submits the order to the Exchange.

[3] The Exchange notes that at the end of the period, the Program will expire unless the Exchange files another 19b–4 Rule Filing to amend its fees.

[4] *See* Chicago Board Options Exchange, Incorporated (''CBOE'') Fees Schedule, p. 4. *See also* Securities Exchange Act Release Nos. 66054 (December 23, 2011), 76 FR 82332 (December 30, 2011) (SR–CBOE–2011–120); 68887 (February 8, 2013), 78 FR 10647 (February 14, 2013) (SR–CBOE–2013–017).

[5] The term ''Priority Customer'' means a person or entity that (i) is not a broker or dealer in securities, and (ii) does not place more than 390 orders in listed options per day on average during a calendar month for its own beneficial accounts(s). *See* MIAX Rule 100.

Percentage thresholds of national customer volume in multiply-listed options classes listed on MIAX (Monthly)	Per contract credit
0.00%–0.25%	$0.00
Above 0.25%–0.50%	0.10
Above 0.50%–1.00%	0.11
Above 1.00%–2.00%	0.12
Above 2.00%	0.14

The Exchange will aggregate the contracts resulting from Priority Customer orders transmitted and executed electronically on the Exchange from affiliated Members for purposes of the thresholds above, provided there is at least 75% common ownership between the firms as reflected on each firm's Form BD, Schedule A. In the event of a MIAX System outage or other interruption of electronic trading on MIAX, the Exchange will adjust the national customer volume in multiply-listed options for the duration of the outage. A Member may request to receive its credit under the Priority Customer Rebate Program as a separate direct payment.

In addition, the rebate payments will be calculated from the first executed contract at the applicable threshold per contract credit with the rebate payments made at the highest achieved volume tier for each contract traded in that month. For example, if Member Firm XYZ, Inc. (''XYZ'') has enough Priority Customer contracts to achieve 2.5% of the national customer volume in multiply-listed option contracts during the month of July, XYZ will receive a credit of $0.14 for each Priority Customer contract executed in the month of July.

The purpose of the Program is to encourage Members to direct greater Priority Customer trade volume to the Exchange. Increased Priority Customer volume will provide for greater liquidity, which benefits all market participants. The practice of incentivizing increased retail customer order flow in order to attract professional liquidity providers (Market-Makers) is, and has been, commonly practiced in the options markets. As such, marketing fee programs,[6] and customer posting incentive programs,[7] are based on attracting public customer order flow. The Program similarly intends to attract Priority Customer order flow, which will increase liquidity, thereby providing greater trading opportunities and tighter spreads for other market

[6] *See* MIAX Fee Schedule, Section 1(b).

[7] *See* NYSE Arca, Inc. Fees Schedule, page 3 (section titled ''Customer Monthly Posting Credit Tiers and Qualifications for Executions in Penny Pilot Issues'').

participants and causing a corresponding increase in order flow from such other market participants.

The specific volume thresholds of the Program's tiers were set based upon business determinations and an analysis of current volume levels. The volume thresholds are intended to incentivize firms that route some Priority Customer orders to the Exchange to increase the number of orders that are sent to the Exchange to achieve the next threshold and to incent new participants to send Priority Customer orders as well. Increasing the number of orders sent to the Exchange will in turn provide tighter and more liquid markets, and therefore attract more business overall. Similarly, the different credit rates at the different tier levels were based on an analysis of revenue and volume levels and are intended to provide increasing ''rewards'' for increasing the volume of trades sent to the Exchange. The specific amounts of the tiers and rates were set in order to encourage suppliers of Priority Customer order flow to reach for higher tiers.

The Exchange proposes limiting the Program to multiply-listed options classes on MIAX because MIAX does not compete with other exchanges for order flow in the proprietary, singly-listed products.[8] In addition, the Exchange does not trade any singly-listed products at this time, but may develop such products in the future. If at such time the Exchange develops proprietary products, the Exchange anticipates having to devote a lot of resources to develop them, and therefore would need to retain funds collected in order to recoup those expenditures.

The Exchange proposes excluding mini-options and executions related to contracts that are routed to one or more exchanges in connection with the Options Order Protection and Locked/Crossed Market Plan referenced in Exchange Rule 1400 from the Program. The Exchange notes these exclusions are nearly identical to the ones made by CBOE.[9] Mini-options contracts are excluded from the Program because the cost to the Exchange to process quotes, orders and trades in mini-options is the same as for standard options. This, coupled with the lower per-contract transaction fees charged to other market participants, makes it impractical to offer Members a credit for Priority Customer mini-option volume that they transact. Providing rebates to Priority Customer executions that occur on other trading venues would be inconsistent with the proposal. Therefore, routed away volume is excluded from the Program in order to promote the underlying goal of the proposal, which is to increase liquidity and execution volume on the Exchange.

The credits paid out as part of the program will be drawn from the general revenues of the Exchange.[10] The Exchange calculates volume thresholds on a monthly basis. The proposed rule change is to take effect July 1, 2013.

2. Statutory Basis

The Exchange believes that its proposal to amend its fee schedule is consistent with Section 6(b) of the Act [11] in general, and furthers the objectives of Section 6(b)(4) of the Act [12] in particular, in that it is an equitable allocation of reasonable fees and other charges among Exchange members.

The Exchange believes that the proposed Priority Customer Rebate Program is fair, equitable and not unreasonably discriminatory. The Program is reasonably designed because it will incent providers of Priority Customer order flow to send that Priority Customer order flow to the Exchange in order to receive a credit for a limited period in a manner that enables the Exchange to improve its overall competitiveness and strengthen its market quality for all market participants. The proposed rebate program is fair and equitable and not unreasonably discriminatory because it will apply equally to all Priority Customer orders. All similarly situated Priority Customer orders are subject to the same rebate schedule, and access to the Exchange is offered on terms that are not unfairly discriminatory. In addition, the Program is equitable and not unfairly discriminatory because, while only Priority Customer order flow qualifies for the Program, an increase in Priority Customer order flow will bring greater volume and liquidity, which benefit all market participants by providing more trading opportunities and tighter spreads. Similarly, offering increasing credits for executing higher percentages of total national customer volume (increased credit rates at increased volume tiers) is equitable and not unfairly discriminatory because such increased rates and tiers encourage Members to direct increased amounts of Priority Customer contracts to the Exchange. The resulting increased volume and liquidity will benefit those Members who receive the lower tier levels, or do not qualify for the Program at all, by providing more trading opportunities and tighter spreads.

Limiting the Program to multiply-listed options classes listed on MIAX is reasonable because those parties trading heavily in multiply-listed classes will now begin to receive a credit for such trading, and is equitable and not unfairly discriminatory because the Exchange does not trade any singly-listed products at this time. If at such time the Exchange develops proprietary products, the Exchange anticipates having to devote a lot of resources to develop them, and therefore would need to retain funds collected in order to recoup those expenditures.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. The Exchange believes that the proposed change would increase both intermarket and intramarket competition by incenting Members to direct their Priority Customer orders to the Exchange, which will enhance the quality of quoting and increase the volume of contracts traded here. To the extent that there is additional competitive burden on non-Priority Customers, the Exchange believes that this is appropriate because the rebate program should incent Members to direct additional order flow to the Exchange and thus provide additional liquidity that enhances the quality of its markets and increases the volume of contracts traded here. To the extent that this purpose is achieved, all the Exchange's market participants should benefit from the improved market liquidity. Enhanced market quality and increased transaction volume that results from the anticipated increase in order flow directed to the Exchange will benefit all market participants and improve competition on the Exchange. The Exchange notes that it operates in a highly competitive market in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive. In such an environment, the Exchange must continually adjust its

[8] If a multiply-listed options class is not listed on MIAX, then the trading volume in that options class will be omitted from the calculation of national customer volume in multiply-listed options classes.

[9] *See* CBOE Fee Schedule, page 4. CBOE also excludes QCC trades from their rebate program. CBOE excluded QCC trades because a bulk of those trades on CBOE are facilitation orders which are charged at the $0.00 fee rate on their exchange.

[10] Despite providing credits under the Program, the Exchange represents that it will continue to have adequate resources to fund its regulatory program and fulfill its responsibilities as a self-regulatory organization during the limited period that the Program will be in effect.

[11] 15 U.S.C. 78f(b).

[12] 15 U.S.C. 78f(b)(4).

fees to remain competitive with other exchanges and to attract order flow to the Exchange. The Exchange believes that the proposed rule change reflects this competitive environment because it reduces the Exchange's fees in a manner that encourages market participants to direct their customer order flow, to provide liquidity, and to attract additional transaction volume to the Exchange. Given the robust competition for volume among options markets, many of which offer the same products, implementing a volume based customer rebate program to attract order flow like the one being proposed in this filing is consistent with the above-mentioned goals of the Act. This is especially true for the smaller options markets, such as MIAX, which is competing for volume with much larger exchanges that dominate the options trading industry. As a new exchange, MIAX has a nominal percentage of the average daily trading volume in options, so it is unlikely that the customer rebate program could cause any competitive harm to the options market or to market participants. Rather, the customer rebate program is a modest attempt by a small options market to attract order volume away from larger competitors by adopting an innovative pricing strategy. The Exchange notes that if the rebate program resulted in a modest percentage increase in the average daily trading volume in options executing on MIAX, while such percentage would represent a large volume increase for MIAX, it would represent a minimal reduction in volume of its larger competitors in the industry. The Exchange believes that the proposal will help further competition, because market participants will have yet another additional option in determining where to execute orders and post liquidity if they factor the benefits of a customer rebate program into the determination.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act.[13] At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File No. SR–MIAX–2013–31 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File No. SR–MIAX–2013–31. 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 Web site (*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 Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File No. SR–MIAX–2013–31 and should be submitted on or before August 5, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[14]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16817 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

[13] 15 U.S.C. 78s(b)(3)(A)(ii).

[14] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–69951; File No. SR–NSCC–2013–02]

Self-Regulatory Organizations; National Securities Clearing Corporation; Notice of Filing Amendment No. 2 and Order Instituting Proceedings To Determine Whether To Approve or Disapprove a Proposed Rule Change, as Previously Modified by Amendment No. 1, To Institute Supplemental Liquidity Deposits to Its Clearing Fund Designed To Increase Liquidity Resources To Meet Its Liquidity Needs

July 9, 2013.

On March 21, 2013, National Securities Clearing Corporation (''NSCC'') filed with the Securities and Exchange Commission (''Commission'') proposed rule change SR–NSCC–2013–02 (''Proposed Rule Change'') pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Exchange Act'')[1] and Rule 19b–4 thereunder.[2] The Proposed Rule Change was published for comment in the **Federal Register** on

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4. NSCC also filed the proposal contained in the Proposed Rule Change as advance notice SR–NSCC–2013–802 (''Advance Notice''), as modified by Amendment No. 1, pursuant to Section 806(e)(1) of the Payment, Clearing, and Settlement Supervision Act of 2010 (''Clearing Supervision Act'') and Rule 19b–4(n)(1)(i) thereunder. *See* Release No. 34–69451 (Apr. 25, 2013), 78 FR 25496 (May 1, 2013). On May 20, 2013, the Commission extended the period of review of the Advance Notice, as modified by Amendment No. 1. Release No. 34–69605 (May 20, 2013), 78 FR 31616 (May 24, 2013). On June 11, 2013, NSCC filed Amendment No. 2 to the Advance Notice, as previously modified by Amendment No.1. Absent a request by the Commission to NSCC to provide additional information on the Advance Notice, as amended, pursuant to Section 806(e)(1)(D) of the Clearing Supervision Act, *see* 12 U.S.C. 5465(e)(1)(D), the Commission shall have until July 19, 2013 to issue an objection or non-objection to the Advance Notice, as amended. *See* Release No. 34–69605 (May 20, 2013), 78 FR 31616 (May 24, 2013), and *see* 12 U.S.C. 5465(e)(1)(E) and (G). The proposal in the Proposed Rule Change, as amended, and the Advance Notice, as amended, shall not take effect until all regulatory actions required with respect to the proposal are completed.

April 10, 2013.[3] On April 19, 2013, NSCC filed with the Commission Amendment No. 1 to the Proposed Rule Change, which, on May 29, 2013, the Commission published for comment in the **Federal Register** and designated a longer period for Commission action on the Proposed Rule Change, as amended.[4] As of July 9, 2013, the Commission had received fourteen comment letters on the proposal contained in the Proposed Rule Change and its related Advance Notice,[5] including NSCC's response to the comment letters received as of June 10, 2013.[6]

Pursuant to Section 19(b)(1) of the Exchange Act[7] and Rule 19b–4 thereunder,[8] notice is hereby given that on June 11, 2013, NSCC filed with the Commission Amendment No. 2 to the Proposed Rule Change, as previously modified by Amendment No. 1. The Commission is publishing this notice to solicit comments on the Proposed Rule Change, as modified by Amendment No. 2, from interested persons.[9]

Additionally, this order institutes proceedings under Section 19(b)(2)(B) of the Exchange Act[10] to determine whether to approve or disapprove the Proposed Rule Change, as discussed in Section IV, below. The institution of proceedings does not indicate that the Commission has reached any conclusions with respect to any of the issues involved, nor does it mean that the Commission will ultimately disapprove the Proposed Rule Change. Rather, as described in Section III, below, the Commission seeks and encourages interested persons to provide additional comment on the Proposed Rule Change to inform the Commission's analysis of whether to approve or disapprove the Proposed Rule Change.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

The Proposed Rule Change, as modified by Amendment No. 2, is a proposal by NSCC to amend its Rules and Procedures (''Rules'') to provide for a supplemental liquidity funding obligation (''SLD Proposal''), as described below. NSCC filed Amendment No. 2 to the Proposed Rule Change, as previously modified by Amendment No. 1, in order to mitigate potential cash outlay burdens, respond to transparency concerns raised by NSCC members (''Members''), clarify the implementation timeframe, and describe the reports that would be provided to Members so that they can anticipate their supplemental liquidity obligations to NSCC under the SLD Proposal (''Supplemental Liquidity Obligations'').

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NSCC included statements concerning the purpose of and basis for the Proposed Rule Change, as modified by Amendment No. 2, and discussed any comments it received on the Proposed Rule Change, as amended. The text of these statements may be examined at the places specified in Item V below. NSCC has prepared summaries, set forth in sections (A), (B), and (C) immediately below, of the most significant aspects of these statements.[11]

(A) Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Description of Change

Original SLD Proposal

The original proposal contained in the Proposed Rule Change, as modified by Amendment No. 1 (''Original SLD Proposal''), would change the Rules to add a new Rule 4A, in order to establish a supplemental liquidity funding obligation designed to cover the liquidity exposure attributable to those Members and families of affiliated Members (''Affiliated Families'') that regularly incur the largest gross settlement debits over a settlement cycle during both times of normal trading activity (''Regular Activity Periods'') and times of increased trading and settlement activity that arise around quarterly triple options expiration dates (''Quarterly Options Expiration Activity Periods'').

The Supplemental Liquidity Obligation of a Member or Affiliated Family with respect to a Regular Activity Period (''Regular Activity Liquidity Obligation'') or a Quarterly Options Expiration Activity Period (''Special Activity Liquidity Obligation'') would be imposed on the 30 Members or Affiliated Families who generate the largest aggregate liquidity needs over a settlement cycle that would apply in the event of a closeout (i.e., over a period from date of default through the following three settlement days), based upon a historical look-back period.

NSCC states that the calculations for both the Regular Activity Liquidity Obligation and the Special Activity Liquidity Obligation are designed so that NSCC has adequate liquidity resources to enable it to settle transactions, notwithstanding the default of the Member or Affiliated Family presenting the largest liquidity need during Regular Activity Periods, as well as during Quarterly Options Expiration Activity Periods. The Supplemental Liquidity Obligations imposed on Members of Affiliated Families would be apportioned among the Members in that Affiliated Family in proportion to the liquidity risk (or peak exposure) they present to NSCC.

NSCC states that the SLD Proposal is designed to supplement NSCC's liquidity resources and work in tandem with NSCC's committed credit facility (''Credit Facility''), which it maintains as a liquidity resource (in addition to the NSCC Clearing Fund) should a Member or Affiliated Family default. The Regular Activity Liquidity Obligations would be calculated and imposed semi-annually, the first of which would be made to coincide with the annual renewal of the Credit Facility and the second of which would be made six months thereafter. NSCC states that the SLD Proposal seeks to strike a balance between reliance on the Credit Facility to reduce the burden on Members or Affiliated Families for cash outlay, while at the same time obligating those Members or Affiliated Families who expose NSCC to the largest liquidity risks to fund their fair share of the liquidity ''differential.''

NSCC states that the SLD Proposal contains both obligations and incentives. For example, a cash deposit in respect of a Regular Activity Liquidity Obligation (e.g., in the Original SLD Proposal, the obligation of

[3] Release No. 34–69313 (Apr. 4, 2013), 78 FR 21487 (Apr. 10, 2013).

[4] *See* Release No. 34–69620 (May 22, 2013), 78 FR 32292 (May 29, 2013).

[5] *See* Comments Received on File Nos. SR–NSCC–2013–02 (*http://sec.gov/comments/sr-nscc-2013-02/nscc201302.shtml*) and SR–NSCC–2013–802 (*http://sec.gov/comments/sr-nscc-2013-802/nscc2013802.shtml*). Since the proposal contained in the Proposed Rule Change was also filed as an Advance Notice, *see* Release No. 34–69451, *supra* note 2, the Commission is considering all public comments received on the proposal regardless of whether the comments are submitted to the Proposed Rule Change, as amended, or the Advance Notice, as amended.

[6] NSCC also received a comment letter directly prior to filing the Proposed Rule Change and related Advance Notice with the Commission, which NSCC provided to the Commission in Amendment No. 1 to the filings. *See* Exhibit 2 to File No. SR–NSCC–2013–02 (*http://sec.gov/rules/sro/nscc/2013/34-69620-ex2.pdf*).

[7] 15 U.S.C. 78s(b)(1).

[8] 17 CFR 240.19b–4.

[9] Defined terms that are not defined in this notice are defined in Amended Exhibit 5 to the Proposed Rule Change, available at *http://sec.gov/rules/sro/nscc.shtml*, under File No. SR–NSCC–2013–02, Additional Materials.

[10] 15 U.S.C. 78s(b)(2)(B).

[11] The Commission has modified the text of the summaries prepared by NSCC to primarily focus on the Proposed Rule Change.

a Member or Affiliated Family to make a ''Regular Activity Supplemental Deposit'') would be reduced by any liquidity such Members or their affiliates provided as commitments under the Credit Facility. To the extent that NSCC is successful in raising significant amounts of its needed liquidity though the Credit Facility—whether from Members, their affiliates making commitments on their behalf, or non-affiliated lenders—NSCC states that a diversified lender facility serves to mitigate the liquidity risk of NSCC and its membership as a whole, while reducing the cash outlay obligations of the top 30 Members and Affiliated Families.

NSCC states that the cash deposit in respect of a Special Activity Liquidity Obligation (''Special Activity Supplemental Deposit'') was structured in the Original SLD Proposal to address any additional liquidity shortfalls (i.e., over and above NCSS's other available liquidity resources) that arose during the heightened trading activity around the Quarterly Options Expiration Period. As such, these additional Special Activity Supplemental Deposits would be required to be maintained on deposit with NSCC only through the completion of the related settlement cycle and for a few days thereafter.

Both prior to the submission of the Proposed Rule Change, and since, NSCC states that it has engaged in significant outreach to its Members to discuss the SLD Proposal, which outreach, NSCC believes, has been key to the development and evolution of the SLD Proposal over the past 18 months. NSCC is cognizant of the concerns raised by Members who have submitted comments regarding the Proposed Rule Change and related Advance Notice, and, according to NSCC, this Amendment No. 2 seeks to address those concerns.

Proposed Enhancements to the Original SLD Proposal

NSCC is proposing to amend the Original SLD Proposal with enhancements that NSCC believes are collectively designed to mitigate potential cash outlay burdens, as well as respond to transparency concerns raised by Members, by clarifying the implementation timeframe of the proposed change and the reporting that would be provided to Members under this revised SLD Proposal (''Revised SLD Proposal'').

First, NSCC would allow its Members to designate a commercial lender—whether or not affiliated with that Member—to commit as a lender to the Credit Facility as a designee of the Member, subject to satisfaction of reasonable lender criteria.[12] NSCC states that this commitment would reduce the Member's Regular Activity Liquidity Obligation cash requirement by the amount of any such commitment. Therefore, under the Revised SLD Proposal, NSCC states that all Members, whether or not they have affiliated banks, are equally incentivized to seek lenders to maximize the size of the Credit Facility. NSCC states that this change effectively eliminates any perceived discrimination in the Original SLD Proposal between those Members that have bank affiliates and those that do not. This change is reflected in the proposed Rule 4A by the inclusion of a new definition for ''Designated Lender,'' and corresponding adjustments to the calculation formula.

Second, any ''excess'' Credit Facility commitments made by Members directly or through their Designated Lenders (i.e., the amount of any commitment by a Member or its Designated Lender that exceeds the Member's calculated Regular Activity Liquidity Obligation) would be allocated ratably among all Regular Activity Liquidity Providers, which NSCC states would reduce their cash Regular Activity Supplemental Deposit requirements, in the same way that commitments of non-affiliated lenders are applied under the Original SLD Proposal. This change is reflected in adjustments to the calculation formula in Sections 5 and 9 of the proposed Rule 4A.

Third, under the Revised SLD Proposal, the seasonal/peak facility that NSCC believes currently addresses NSCC's liquidity needs over Quarterly Options Expiration Activity Periods would be extended to cover monthly options expiration periods and would be calculated and collected 12 times a year instead of four (''Monthly Options Expiration Activity Period''). NSCC states, based on its review of available historical quantitative information, that the effect of this change would be to reduce the size of the Regular Activity Liquidity Obligations under the Revised SLD Proposal. Additionally, NSCC states that by treating all liquidity obligations derived from Monthly Options Expiration Activity Periods (where there is greater activity fluctuation than during other periods) as Special Activity Liquidity Obligations, the Revised SLD Proposal would provide greater stability and predictability to the size of the Regular Activity Liquidity Obligations. NSCC's analyses based upon historical data estimates that expanding this seasonal/peak facility to cover all Monthly Options Expiration Activity Periods could reduce the size of the aggregate Regular Activity Liquidity Obligations by up to 20 percent. NSCC also states that recalibrating the Special Activity Liquidity Obligations on a monthly basis results in allocating the liquidity burdens among those Members and Affiliated Families more equitably, since only those Members whose monthly options-related activity generate liquidity needs in excess of NSCC's then available liquidity resources would be obligated to fund such additional amounts.[13] NSCC states that this change is reflected in a revised definition of ''Options Expiration Activity Period,'' and clarifications to the calculation formula of the Special Activity Liquidity Obligations, as well as to related definitions to ensure the formula—and the allocation among affected Members—operates as intended.

Fourth, the Revised SLD Proposal includes a new definition for ''Other Qualifying Liquid Resources.'' NSCC states that this new defined term would permit NSCC to take any such additional or alternative liquidity resources that it may obtain in the future into account when calculating Regular Activity Liquidity Obligations and to use them to reduce the amount of cash, if any, that Members would otherwise be obligated to deposit as Regular Activity Supplemental Deposits. This change is reflected both with the inclusion of the new definition of ''Other Qualifying Liquid Resources,'' and with corresponding modifications to the calculation formula.

Fifth, as regards Members' voluntarily prefunding Regular Activity Liquidity Obligations and Special Activity Liquidity Obligations, NSCC would monitor Members' prefunding activity to understand the impact such prefunded amounts have on the amount of its committed liquidity resources. NSCC states that the Revised SLD Proposal provides NSCC with some discretion when including prefunded deposits within its calculated liquidity resources, so as to provide some

[12] NSSC states that such criteria would be designed to cover issues such as credit risk, concentration risk, and lender diversity, so as to ensure the continued robust viability of the line of credit.

[13] NSCC states that since the allocation formula ratably applies the excess amount needed due to activity during Special Activity Periods based upon the affected Member's Special Activity Peak Liquidity Exposure, then to the extent that a Member's Special Activity Peak Liquidity Exposure (as defined) is less than or equal to NSCC's other available resources, that Member's share of the Special Activity Peak Liquidity Need will be zero.

flexibility in the event it becomes too reliant on voluntary prefunding to meet its minimum liquidity needs. NSCC states that this change to the Original SLD Proposal would address any concern that NSCC would not have sufficient liquid resources to effect settlement if prefunding is unavailable when actually needed.

Additional Revisions to the Original SLD Proposal

Reporting. NSCC states that it understands and agrees that Members have to be able to evaluate risks of their membership and be able to plan for their liquidity obligations. NSCC also states that it is critical that Members understand the risks that their own activity presents to NSCC and be prepared to monitor their own activity and alter their behavior if they want to minimize the liquidity risk they present to NSCC. While NSCC states that robust reporting has always been a key element of the Original SLD Proposal, the Revised SLD Proposal clarifies in a new Section 31 of proposed Rule 4A the information that NSCC would provide to Members. Such information would be provided to all Members, not just the top 30 Members and Affiliated Families, at least monthly. NSCC states that these reports would show Members the liquidity exposure they present to NSCC to enable them to monitor their activity and the ''Regular Activity Peak Liquidity Exposure'' that results from their activity. Information provided in these reports would include:

- The Regular Activity Peak Liquidity Exposure of the Member on each Business Day of the preceding month;
- NSCC's largest Regular Activity Peak Liquidity Need for the preceding month;
- in the case of an Unaffiliated Member, for each Business Day of the preceding month, the percentage that the Regular Activity Peak Liquidity Exposure of the Member bears to the aggregate Regular Activity Peak Liquidity Exposures of all Regular Activity Liquidity Providers (the percentage for a Member that is not a Regular Activity Liquidity Provider for that month would be zero); and
- in the case of an Affiliated Family, for each Business Day of the preceding month, the percentage that the aggregate Regular Activity Peak Liquidity Exposures of all Members of that Affiliated Family bears to the aggregate Regular Activity Peak Liquidity Exposures of all Regular Activity Liquidity Providers (Affiliated Families that are not Regular Activity Liquidity Providers for that month would be zero percentage).

Technical Clarifications and Changes. The Revised SLD Proposal includes certain technical changes and clarifications that NSCC states it designed to align notice, payment, and cash return timeframes, and to clarify the operation of the calculation formulas to ensure they operate as intended.

Implementation Timeframe and Funding Notice. While the SLD Proposal would be effective upon the completion of all required regulatory approvals, Members would not be obligated to fund their Regular Activity Liquidity Obligations or Special Activity Liquidity Obligations until the Monthly Options Expiration Activity Period in September 2013. Moreover, Members would be provided with notice of their initial Regular Activity Liquidity Obligations no later than 30 days prior to the date on which that amount must be deposited with NSCC. At that time, NSCC's risk management staff would also provide to affected Members their Special Activity Peak Liquidity Exposure within the look-back period. Specific implementation dates would be provided by NSCC by Important Notice.

NSCC states that its risk management staff would continue to work with Members to help them understand the Revised SLD Proposal and to develop tools that NSCC believes would enable Members to forecast the liquidity exposure they present to NSCC. NSCC states that its risk management staff would also use the reports that would be provided under new Section 31 or proposed Rule 4A to guide ongoing discussions with Members regarding the types of actions that could mitigate those Members' peak liquidity exposure. In addition, under the Revised SLD Proposal (as in the Original SLD Proposal), NSCC states that Members would be able to manage their exposures by making prefund deposits where they project their own activity would increase their liquidity exposure. For example, if a Member that would be a Special Activity Liquidity Provider anticipates that its Special Activity Peak Liquidity Exposure at any time during a particular Options Expiration Activity Period would be greater than the amount calculated by NSCC, then it could make an additional cash deposit to the Clearing Fund (in excess of its Required Deposit) that it designates as a ''Special Activity Prefund Deposit.''

In order to give Members sufficient time to plan for annual Credit Facilities renewals and to line up designated liquidity providers for the Credit Facility, NSCC states that its risk staff would provide Members with an impact analysis of their projected Supplemental Liquidity Obligations beginning on November 31 of each year.[14] NSCC states that the information provided would show the potential impact on affected Members based on different Credit Facility funding levels.

In response to the more general concern regarding refinancing risk and NSCC's reliance on the Credit Facility, NSCC states that it would continue to explore additional financing sources. NSCC states that it would review and evaluate the financing options available to it and the related costs of those options, and would expect to present the findings of that review to the NSCC Board prior to the next renewal of the Credit Facility in May 2014. When sizing and approving the fee and costs structure of the renewal Credit Facility, NSCC states that the NSCC Board would be able to take into account those potential additional financing sources and consider the consequent impact on Members' cash Regular Activity Supplemental Deposit and Special Activity Supplemental Deposit obligations. The items that would be included in this review are:

- analysis of the availability, size, cost, and credit risk necessary to obtain the additional commitments under the Credit Facility likely to reduce the Regular Activity Supplemental Deposit requirements to zero;
- analysis of the availability, size, cost, and credit risk to obtain a new multi-year committed facility to replace the existing Credit Facility;
- an understanding of the aggregate costs, if any, for Members to designate commercial lenders to commit to the Credit Facility as their designees;
- analysis of the availability, size, cost, and potential depth of a capital markets funding among Members and/or third parties as an additional liquidity resource, including the viability of offering the funding to Members or mandating their participation in such funding; and
- a summary of the steps that Members have taken to reduce their NSCC liquidity profile, and whether this should be factored into the historical analysis used to determine NSCC's Regular Activity Period liquidity needs and Members' share of that need.

NSCC states that it would update its Members on the results of this review and the determination of the NSCC Board. NSCC states that it would also update its Members with information regarding future liquidity initiatives designed to increase NSCC's liquidity

[14] NSCC states that given the timing of the calculation look-back periods, information provided in November will necessarily be estimates.

resources and potentially reduce supplemental deposit requirements, including the rationale behind these initiatives, how these initiatives fit within NSCC's liquidity risk tolerance, and the likely impact of the initiatives.

2. Statutory Basis

NSCC states that the Revised SLD Proposal contributes to NSCC's goal of ensuring that NSCC has adequate liquidity resources to meet its settlement obligations, notwithstanding the default of its Members or Affiliated Families that pose the largest aggregate liquidity exposure over the relevant settlement cycle, as required by Commission Rule 17Ad–22(b)(3).[15] As such, NSCC states the Revised SLD Proposal is consistent with the requirements of the Exchange Act, as amended, and the rules and regulations thereunder applicable to NSCC.

(B) Clearing Agency's Statement on Burden on Competition

1. Regulatory Requirements for Proposed Rule Changes

Section 19(b)(2)(C)(i) of the Exchange Act provides that ''[t]he Commission shall approve a proposed rule change of a self-regulatory organization if it finds that such proposed rule change is consistent with the requirements of [the Exchange Act] and the rules and regulations issued under [the Exchange Act] that are applicable to such organizations.'' The requirements of the Exchange Act that are specifically applicable to clearing agencies are set forth in Section 17A relating to a national system for the clearance and settlement of securities transactions. Section 17A(a)(2)(A) of the Exchange Act directs the Commission to facilitate the establishment of the national system, having due regard for inter alia the ''maintenance of fair competition among brokers and dealers, clearing agencies, and transfer agents.'' Section 17A(a)(3)(I) of the Exchange Act provides that a clearing agency shall not be registered unless the Commission determines inter alia that ''[t]he rules of the clearing agency do not impose any burden on competition not necessary or appropriate in furtherance of the purposes of [the Exchange Act].''

Rule 19b–4(a)(i), promulgated by the Commission under Section 19(b) of the Exchange Act, provides that a proposed rule change by a self-regulatory organization (which includes a registered clearing agency) shall be filed on Form 19b–4. The General Instructions for Form 19b–4 prescribe the information to be included in the completed form. With respect to competition, the self-regulatory organization is required to ''[s]tate whether the proposed rule change will have an impact on competition and, if so, (i) state whether the proposed rule change will impose any burden on competition or whether it will relieve any burden on, or otherwise promote, competition and (ii) specify the particular categories of persons and kinds of businesses on which any burden will be imposed and the ways in which the proposed rule change will affect them.'' The self-regulatory organization is further required to explain (i) why any impact on competition is not believed to be a significant burden on competition or (ii) why any burden on competition is necessary or appropriate in furtherance of the Exchange Act.

2. Position of NSCC as Utility for Securities Industry

NSCC is an operating subsidiary of The Depository Trust & Clearing Corporation (''DTCC''), which NSCC states is a user-owned, user-governed holding company for NSCC, two other registered clearing agencies, a derivatives clearing organization joint venture, and a number of other companies that provide a variety of post-trade processing and information services. NSCC states that it and the other registered clearing agencies in the DTCC group provide the critical infrastructure for the clearance and settlement of securities transactions in the United States. These registered clearing agencies operate as utilities for their users, allowing such users to compete against each other (for the benefit of their retail and institutional customers) on the basis of performance and price and not on the basis of any relative advantage with respect to clearing and settlement services.

As a clearinghouse for securities transactions and a central counterparty, NSCC states that it has no reason, interest, or intent to discriminate among its Members—certainly not to give any of its Members a competitive advantage or impose on any of its Members a competitive disadvantage in their operations. NSCC states that although it strives for complete neutrality in its interface with Members, it may be that clearing agency rules of general application to all Members could have a disparate effect on Members with diverse business models and strategies. NSCC states that any such disparate effects arising out of choices made by individual Members in terms of their business models and strategies (including their relative levels of capitalization) should not be seen as due to action by the clearing agency having an impact or imposing a burden on competition.

Although NSCC states that it is always mindful of the effect that its Rules may have on individual Members, NSCC states that it must also be concerned with (i) the interests of its membership as a whole, (ii) its general obligations under Section 17A(b)(3) of the Exchange Act ''to facilitate the prompt and accurate clearance and settlement of securities transactions and derivatives agreements, contracts, and transactions'' and ''to safeguard securities and funds in its custody or control,'' and (iii) the particular requirements of Rule 17Ad-22(b)(3) relating to the financial resources that a clearing agency which is a central counterparty (like NSCC) must maintain to cover the default of the participant family presenting the largest exposure to the clearing agency in extreme but plausible market conditions.

NSCC states that these concerns and the interests of its Members, including their interests relating to issues of competition and the effect of the proposed change on competition among Members and between Members and other financial market participants, can be reconciled. But, NSCC states that individual Members that may be affected by the proposed change—designed to assure that NSCC has the liquidity it needs to safely operate a clearing and settlement business and meet its obligations as a registered clearing agency and central counterparty under the Exchange Act—must also recognize that some accommodation may be required on their part.

3. Modifications to the Proposed Change Address Competition Concerns

In response to comments submitted on the proposed change in the form in which it was originally filed in the Proposed Rule Change, and dialogue with a number of other Members who did not submit comments but otherwise provided their input to NSCC, NSCC states that it has revised the proposed change in a number of respects that bear upon the issue of competition and whether the proposed change would have an impact or impose any burden on competition.

First, the Original SLD Proposal provided that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for the amount of its commitment and the commitment of any affiliate of the Regular Activity

[15] *See* 17 CFR 240.17Ad–22(b)(3).

Liquidity Provider under the Credit Facility. The Revised SLD Proposal provides that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for the amount of its commitment, the commitment of any affiliate, and the commitment of any Designated Lender of the Regular Activity Liquidity Provider under the Credit Facility. As a result, NSCC states that any distinction between Members with bank affiliates and Members without bank affiliates, and any perceived advantage for Members with bank affiliates over Members without bank affiliates, has been eliminated.

Second, the SLD Proposal has been refined to provide that a Regular Activity Liquidity Provider would receive an offset against its Regular Activity Liquidity Obligation for both (i) its pro rata share of the commitments of lenders under the Credit Facility that are not Members or their Designated Lenders and (ii) its pro rata share of the commitments of Members and their Designated Lenders above the amounts of their Regular Activity Liquidity Obligations. As a result of this change, NSCC states that the obligation of Regular Activity Liquidity Providers to provide Regular Activity Supplemental Deposits will be ratably reduced by the amount of such ''excess.''

Third, the Options Expiration Activity Period has been redefined to mean the days around all monthly options expiration dates (12 per year) rather than just triple options expiration dates (four per year). As a result of this change, NSCC states that more periods of increased activity would be excluded by NSCC from the calculation of its Regular Activity Peak Liquidity Need, thereby reducing the Regular Activity Liquidity Obligations of Regular Activity Liquidity Providers.

NSCC states that participation in the Credit Facility is available to financial institutions that have the resources and operational capabilities to be lenders under the Credit Facility, subject to satisfaction of reasonable lender criteria. Although the Credit Facility was renewed on May 14, 2013 for an additional term of 364 days, NSCC states that there are mechanisms in the Credit Facility to increase the commitments of existing lenders and admit new lenders at any time during the term. Accordingly, NSCC states that at the time when the SLD Proposal becomes effective and before the time that any Member may have to satisfy a Regular Activity Liquidity Obligation, such Member would have an opportunity to either join the Credit Facility itself as a lender (if it has the authority to be a lender) or enter into arrangements with a bank to be its Designated Lender—in either case thereby reducing or eliminating the need for it to make a cash Regular Activity Supplemental Deposit to the Clearing Fund.

4. Competition Concerns Raised by Commenters

Bank Affiliates. NSCC states that some commenters raised concerns on competition grounds that the Original SLD Proposal permitted Members and Affiliated Families with bank affiliates to reduce or potentially eliminate their required cash Required Activity Supplemental Deposits by the amounts of the commitments of such bank affiliates under the Credit Facility while Members and Affiliated Families without bank affiliates could not do so. As indicated above, NSCC states that this limitation to bank affiliates has been eliminated from the SLD Proposal. NSCC states that any Member or Affiliated Family could designate a Designated Lender and receive an offset for the commitment of such Designated Lender.

The Top 30 Cut-Off. NSCC states that some commenters raised concerns on competition grounds that Supplemental Liquidity Obligations are only imposed on the 30 largest Members and Affiliated Families rather than on the entire membership. NSCC states that, based on an analysis of Members, NSCC made a business determination that the top 30 Members or Affiliated Families would most appropriately capture the liquidity exposure over and above available NSCC Clearing Fund liquidity. NSCC states that its liquidity analyses show that the liquidity requirements attributable to the top 30 Members and Affiliated Families account for the vast majority of NSCC's liquidity needs. According to NSCC, as of the end of February 2013, the top 30 Members and Affiliated Families represented approximately 85% of the total membership by peak liquidity needs over the prior six-month period. NSCC states that the analyses also show that the remaining membership's peak liquidity demands are covered by the required deposits to the NSCC Clearing Fund. Therefore, NSCC states the SLD Proposal appropriately places the burden of providing liquidity on those Members and Affiliated Families who present the largest liquidity risk. While NSCC does not believe it would be appropriate to require the entire membership to bear the burden of the liquidity needs that are generated by NSCC's largest trading firms, it does note that all Members currently do bear the cost of the Credit Facility as an operating expense that NSCC factors into its overall fee structure, as well as their share of the NSCC Clearing Fund. NSCC states that as a whole, NSCC believes this collective liquidity funding approach represents a fair apportionment of NSCC's aggregate liquidity needs amongst its membership.

Impact on a Sector of the Market. NSCC states that some commenters raised concerns on competition grounds that the SLD Proposal may cause increased concentration of clearing activity by requiring smaller firms to clear through larger financial institutions. NSCC states that implicit in these comments is a concern that smaller, less well capitalized firms have less access to funding than do larger, well capitalized firms. NSCC states, however, that no Member, because of its low capital business model or limited access to funding, should have the right to impose on NSCC (and the rest of the membership) the burden of bearing the risks of that Member's clearing activities. Moreover, NSCC states that the SLD Proposal provides incentives for Members to manage the liquidity risks of their business; by doing so they could reduce the share of their obligation under the SLD Proposal.

NSCC also states that some commenters claim that the risk posed by brokers with business in mostly agency-based transactions was overstated by NSCC in crafting the SLD Proposal because those firms settle transactions on a delivery-versus-payment (''DVP'') basis. NSCC states, however, that agency brokers that execute market transactions that clear at NSCC are obligated, as principals, to settle those transactions at NSCC irrespective of whether their institutional customers complete the institutional delivery DVP side of the transaction (which occurs outside of NSCC). According to NSCC, it, as the central counterparty, remains obligated to complete the other side of the market transaction if the agency broker fails. NSCC states that institutional customers of the agency brokers are not NSCC Members and have no contractual obligation with NSCC to complete those trades if the agency broker fails. Therefore, NSCC states that if an agency broker fails, NSCC (and its other Members) face the risk that the institutional customer will take its own market action, and NSCC will incur the liquidity obligation of completing the market settlement. NSCC states that it must consider this risk in crafting its risk management strategies, and agency brokers are not immune from the risk of failure, as recent events have shown that

they, like other firms, remain subject to market events, as well as technology and other risks.

NSCC states that these comments raise a concern that Members are being asked share the burden of funding the liquidity needs that are dependent on the actions, including trading levels, of other Members, and thus the amounts are not within the contributing Member's control. NSCC states that from a fairness perspective, however, that proportionate share of the affected Member's liquidity burden (whether it be an agency broker or otherwise) would always be less than the Member's own peak liquidity needs, and each Member is in the best position to monitor and manage the liquidity risks presented by its own activity.

5. Impact on Competition

NSCC states that for the reasons stated above, it believes the changes that have been made to the Original SLD Proposal eliminate or substantially ameliorate the impact that the SLD Proposal might have on competition, and that any perceived burden on competition caused by the SLD Proposal is necessary and appropriate in furtherance of the purposes of the Exchange Act.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

While written comments on the Proposed Rule Change, as modified by Amendment No. 2, were not solicited, as noted above, NSCC engaged significant outreach and discussion with affected Members in developing the SLD Proposal.

Written comments on the Proposed Rule Change, as amended, have been filed with the Commission and are available on the Commission's Web site. NSCC states that this Amendment No. 2 addresses some of the issues raised by those comments. NSCC's formal response to the written comments has been submitted separately to the Commission in accordance with the process for submitting comments.

III. Proceedings To Determine Whether To Approve or Disapprove File No. SR–NSCC–2013–02 and Grounds for Disapproval Under Consideration

The Commission is instituting proceedings pursuant to Section 19(b)(2)(B) of the Exchange Act [16] to determine whether the Proposed Rule Change should be approved or disapproved. Institution of such proceedings is appropriate at this time in view of the significant legal and policy issues raised by the Proposed Rule Change. As noted above, institution of proceedings does not indicate that the Commission has reached any conclusions with respect to any of the issues involved. Rather, the Commission seeks and encourages interested persons to provide additional comment on the Proposed Rule Change, as amended, to inform the Commission's analysis of whether to approve or disapprove the Proposed Rule Change, as amended.

Pursuant to Section 19(b)(2)(B) of the Exchange Act,[17] the Commission is providing notice of the grounds for disapproval under consideration. In particular, Section 17A(b)(3)(F) of the Exchange Act requires that the rules of the clearing agency are not designed to permit unfair discrimination among participants in the use of the clearing agency.[18] Here, the Commission believes that it is appropriate to solicit comment on whether Amendment No. 2 adequately addresses the concern raised by some commenters that the Proposed Rule Change could have a discriminatory impact on NSCC's non-bank affiliated Members who would be subject to the SLD Proposal but who do not currently participate in the Credit Facility.[19]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the Proposed Rule Change, as amended, is consistent with the Section 17A [20] or any other provision of the Exchange Act, or the rules and regulations thereunder. The Commission, in its sole discretion, may determine whether any issues relevant to approval or disapproval of the Proposed Rule Change would be facilitated by the opportunity for an oral presentation of views upon such a request.[21]

Interested persons are invited to submit written data, views, and arguments regarding whether the Proposed Rule Change should be approved or disapproved by August 5, 2013. If NSCC chooses to file a rebuttal to any submission, it must file its rebuttal by August 20, 2013. 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 No. SR–NSCC–2013–02 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File No. SR–NSCC–2013–02. 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 Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the Proposed Rule Change, as amended, that are filed with the Commission, and all written communications relating to the Proposed Rule Change, as amended, 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 Web site 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 filings also will be available for inspection and copying at the principal office of NSCC and on NSCC's Web site at *http://dtcc.com/legal/rule_filings/nscc/2013.php.* All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File No. SR–NSCC–2013–02 and should be submitted on or before August 5, 2013. NSCC's rebuttal comments should be submitted by August 20, 2013.

[16] 15 U.S.C. 78s(b)(2)(B).

[17] 15 U.S.C. 78s(b)(2)(B).

[18] *See* 15 U.S.C. 78q–1(b)(3)(F).

[19] *See, e.g.,* comment letter from John C. Nagel, Managing Director and General Counsel, Citadel Securities, to Elizabeth Murphy, Secretary, Commission, dated June 13, 2013, at 7–8 (*http://sec.gov/comments/sr-nscc-2013-02/nscc201302-14.pdf*).

[20] 15 U.S.C. 78q–1.

[21] *See* 17 CFR 201.700(c)(2). Section 19(b)(2) of the Exchange Act, as amended by the Securities Acts Amendments of 1975, Public Law 94–29, 89 Stat. 97 (1975), grants the Commission flexibility to determine what type of proceeding—either oral or notice and opportunity for written comments—is appropriate for consideration of a particular proposal by a self-regulatory organization. *See* Securities Acts Amendments of 1975, Report of the Senate Committee on Banking, Housing and Urban Affairs to Accompany S. 249, S. Rep. No. 75, 94th Cong., 1st Sess. 30 (1975).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–16819 Filed 7–12–13; 8:45 am]

BILLING CODE 8011–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #13647 and #13648]

Oklahoma Disaster #OK–00073

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Oklahoma (FEMA–4117–DR), dated 06/28/2013.

Incident: Severe storms, tornadoes and flooding.

Incident Period: 05/18/2013 through 06/02/2013.

Effective Date: 06/28/2013.

Physical Loan Application Deadline Date: 08/27/2013.

Economic Injury (EIDL) Loan Application Deadline Date: 04/03/2014.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 06/28/2013, Private Non-Profit organizations that provide essential services of governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Atoka, Canadian, Cleveland, Coal, Hughes, Latimer, Lincoln, McClain, Nowata, Okfuskee, Oklahoma, Okmulgee, Pittsburg, Pottawatomie, Pushmataha, Seminole.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations With Credit Available Elsewhere	2.875
Non-Profit Organizations Without Credit Available Elsewhere	2.875
For Economic Injury:	
Non-Profit Organizations Without Credit Available Elsewhere	2.875

The number assigned to this disaster for physical damage is 13645B and for economic injury is 13646B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2013–16828 Filed 7–12–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #13649 and #13650]

South Dakota Disaster #SD–00059

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of South Dakota (FEMA–4125–DR), dated 06/28/2013.

Incident: Severe Storms, Tornado, and Flooding.

Incident Period: 05/24/2013 through 05/31/2013.

Effective Date: 06/28/2013.

Physical Loan Application Deadline Date: 08/27/2013.

Economic Injury (EIDL) Loan Application Deadline Date: 04/03/2014.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 06/28/2013, Private Non-Profit organizations that provide essential services of governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Bennett, Corson, Lawrence, Lincoln, Union, Pine Ridge Indian Reservation Within Bennett County.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations With Credit Available Elsewhere	2.875
Non-Profit Organizations Without Credit Available Elsewhere	2.875
For Economic Injury:	
Non-Profit Organizations Without Credit Available Elsewhere	2.875

The number assigned to this disaster for physical damage is 13649B and for economic injury is 13650B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Joseph P. Loddo,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 2013–16830 Filed 7–12–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #13645 and #13646]

Iowa Disaster #IA–00054

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance only for the State of Iowa (FEMA–4126–DR), dated 07/02/2013.

Incident: Severe storms, tornadoes, and flooding.

Incident Period: 05/19/2013 through 06/14/2013.

Effective Date: 07/02/2013.

Physical Loan Application Deadline Date: 09/03/2013.

Economic Injury (EIDL) Loan Application Deadline Date: 04/02/2014.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/02/2013, private non-profit organizations that provide essential services of governmental nature may file disaster loan applications at the address

[22] 17 CFR 200.30–3(a)(57).

listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Appanoose, Benton, Buchanan, Buena Vista, Butler, Cherokee, Chickasaw, Clay, Clayton, Crawford, Davis, Delaware, Des Moines, Fayette, Floyd, Franklin, Greene, Grundy, Hardin, Henry, Ida, Iowa, Jasper, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Lyon, Mahaska, Marshall, Mitchell, Monona, Monroe, Obrien, Palo Alto, Plymouth, Poweshiek, Sac, Sioux, Story, Tama, Wapello, Webster, Winnebago, Wright.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations With Credit Available Elsewhere	2.875
Non-Profit Organizations Without Credit Available Elsewhere	2.875
For Economic Injury:	
Non-Profit Organizations Without Credit Available Elsewhere	2.875

The number assigned to this disaster for physical damage is 13645B and for economic injury is 13646B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2013–16827 Filed 7–12–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #13651 and #13652]

North Carolina Disaster #NC–00052

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of North Carolina dated 07/09/2013.

Incident: Severe weather, extreme wind and rain.

Incident Period: 06/13/2013.

Effective Date: 07/09/2013.

Physical Loan Application Deadline Date: 09/09/2013.

Economic Injury (EIDL) Loan Application Deadline Date: 04/09/2014.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Stanly.

Contiguous Counties:

North Carolina: Anson, Cabarrus, Davidson, Montgomery, Richmond, Rowan, Union.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners With Credit Available Elsewhere	3.750
Homeowners Without Credit Available Elsewhere	1.875
Businesses With Credit Available Elsewhere	6.000
Businesses Without Credit Available Elsewhere	4.000
Non-Profit Organizations With Credit Available Elsewhere	2.875
Non-Profit Organizations Without Credit Available Elsewhere	2.875
For Economic Injury:	
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Non-Profit Organizations Without Credit Available Elsewhere	2.875

The number assigned to this disaster for physical damage is 13651 B and for economic injury is 13652 0.

The States which received an EIDL Declaration # are North Carolina.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated: July 9, 2013.

Karen G. Mills,

Administrator.

[FR Doc. 2013–16826 Filed 7–12–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #13579 and #13580]

Illinois Disaster Number IL–00041

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 3.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Illinois (FEMA–4116–DR), dated 05/10/2013.

Incident: Severe Storms, Straight-line Winds and Flooding.

Incident Period: 04/16/2013 through 05/05/2013.

Effective Date: 07/03/2013.

Physical Loan Application Deadline Date: 07/09/2013.

EIDL Loan Application Deadline Date: 02/10/2014.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of Illinois, dated 05/10/2013 is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties: (Physical Damage and Economic Injury Loans): Putnam, Warren.

Contiguous Counties: (Economic Injury Loans Only): All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008).

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2013–16829 Filed 7–12–13; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice 8380]

Advisory Committee on International Economic Policy; Notice of Open Meeting

The Advisory Committee on International Economic Policy (ACIEP) will meet from 2:00 p.m. to 4:00 p.m. on Wednesday, July 31, 2013, in Room 1107 of the Harry S. Truman Building at the U.S. Department of State, 2201 C Street NW., Washington, DC. The meeting will be hosted by the Assistant Secretary of State for Economic and Business Affairs, Jose W. Fernandez and Committee Chair Ted Kassinger. The ACIEP serves the U.S. Government in a solely advisory capacity, and provides advice concerning issues and challenges in international economic policy. The

meeting will examine efforts both countries are undertaking to evaluate and strengthen our economic relationship as requested by Presidents Pena Nieto and Obama, including formation of a High Level Economic Dialogue. Subcommittee reports will be provided by the Sanctions Subcommittee, and the Stakeholder Advisory Board for the U.S. National Contact Point for the Organization for Economic Cooperation and Development Guidelines for Multinational Enterprises.

This meeting is open to public participation, though seating is limited. Entry to the building is controlled; to obtain pre-clearance for entry, members of the public planning to attend should provide, by Friday, July 26, their name, professional affiliation, valid government-issued ID number (i.e., U.S. Government ID [agency], U.S. military ID [branch], passport [country], or drivers license [state]), date of birth, and citizenship, to *Ronelle Jackson by fax (202) 647–5936, email (JacksonRS@state.gov), or telephone (202) 647–9204.* All persons wishing to attend the meeting must use the 23rd Street entrance of the State Department. Because of escorting requirements, non-Government attendees should plan to arrive 15 minutes before the meeting begins. Requests for reasonable accommodation should be made to Ronelle Jackson before Friday, July 26. Requests made after that date will be considered, but might not be possible to fulfill.

Personal data is requested pursuant to Public Law 99–399 (Omnibus Diplomatic Security and Antiterrorism Act of 1986), as amended; Public Law 107–56 (USA PATRIOT Act); and Executive Order 13356. The purpose of the collection is to validate the identity of individuals who enter Department facilities. The data will be entered into the Visitor Access Control System (VACS–D) database. Please see the Security Records System of Records Notice (State–36) at *http://www.state.gov/documents/organization/103419.pdf* for additional information.

FOR FURTHER INFORMATION CONTACT: Gregory Maggio, Office of Economic Policy Analysis and Public Diplomacy, Bureau of Economic and Business Affairs, at (202) 647–2231 or *MaggioGFmailto:@state.gov*.

Dated: July 9, 2013.

Laura Kirkconnell,

Director, Office of Economic Policy Analysis and Public Diplomacy.

[FR Doc. 2013–16895 Filed 7–12–13; 8:45 am]

BILLING CODE 4710–07–P

DEPARTMENT OF STATE

[Public Notice 8379]

Privacy Act; System of Records: State-53, Office of Inspector General Investigation Management System

SUMMARY: Notice is hereby given that the Department of State proposes to amend an existing system of records, Office of Inspector General Investigation Management System, State-53, pursuant to the provisions of the Privacy Act of 1974, as amended (5 U.S.C. 552a) and Office of Management and Budget Circular No. A–130, Appendix I.

DATES: This system of records will be effective on August 26, 2013, unless we receive comments that will result in a contrary determination.

ADDRESSES: Any persons interested in commenting on the amended system of records may do so by writing to the Director; Office of Information Programs and Services, A/GIS/IPS; Department of State, SA–2; 515 22nd Street NW., Washington, DC 20522–8001.

FOR FURTHER INFORMATION CONTACT: Director; Office of Information Programs and Services, A/GIS/IPS; Department of State, SA–2; 515 22nd Street NW., Washington, DC 20522–8001.

SUPPLEMENTARY INFORMATION: The Department of State proposes that the current system amend its name from ''Records of the Inspector General and Automated Individual Cross-Reference System'' (previously published at 56 FR 7071) to ''Office of Inspector General Investigation Management System.'' The proposed system will include revisions or additions to the following sections: System location, Categories of individuals, Categories of records, Authority for maintenance of the system, Safeguards, Routine Uses, Purpose, Retrievability, and administrative updates.

The Department's report was filed with the Office of Management and Budget. The amended system description, ''Office of Inspector General Investigation Management System, State-53'' will read as set forth below.

Joyce A. Barr,

Assistant Secretary for Administration, U.S. Department of State.

STATE–53

SYSTEM NAME:

Office of Inspector General Investigation Management System.

SECURITY CLASSIFICATION:

Unclassified.

SYSTEM LOCATIONS:

Department of State, Office of Inspector General (OIG), Office of Investigations, SA–39, 1700 N. Moore St., Arlington, VA 22209 (Hard-copy of files); National Aeronautics and Space Administration Office of Inspector General, Washington, DC 20546–0001 (Electronic copy of files maintained for OIG).

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

In connection with its investigative duties, Office of Inspector General (OIG) maintains records on the following categories of individuals:

(a) Current or former Department of State, Broadcasting Board of Governors (BBG) or U.S. Section of the International Boundary and Water Commission (IBWC) employees;

(b) Individuals (or firms) doing business with the Department of State, Broadcasting Board of Governors (BBG) or U.S. Section of the International Boundary and Water Commission (IBWC), including contractors, grantees or others funded in some way by the Department, BBG or IBWC;

(c) Members of the Foreign Affairs community who come under the direction, coordination and/or supervision of U.S. Chiefs of Mission;

(d) Other individuals whose association with the Department of State, Broadcasting Board of Governors (BBG) or U.S. Section of the International Boundary and Water Commission (IBWC) relates to alleged violations of rules of conduct, the Civil Service merit system or any criminal or civil misconduct affecting the integrity or facilities of these agencies;

(e) Suspects, witnesses, principals, complainants, confidential or non-confidential informants; and

(f) All other individuals closely connected with a matter of investigative interest.

CATEGORIES OF RECORDS IN THE SYSTEM:

Records relating to investigations including reports, preliminary inquiries, complaints, alleged criminal, civil, or administrative misconduct. Categories of records include statements, affidavits, banking and other financial records, medical records, and personnel and other employment-related records obtained during the investigation. These records may contain names, dates of birth, passport numbers, Social Security numbers, account numbers and other personal identifiers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

The Inspector General Act of 1978, as amended (5 U.S.C. Appendix; see 5

U.S.C. Appendix § 4); Inspector General (22 U.S.C. 3929); Inspector General for the Department of State (22 U.S.C. 4861); Abolition and Transfer of Functions (22 U.S.C. 6533); and The Mexican Water Treaty, U.S.-Mex., Feb. 3, 1944, T.S. No. 994 (59 Stat. 1219).

PURPOSE(S):

Office of Inspector General (OIG) maintains this system of records to conduct investigations concerning the programs and operations of the Department of State, Broadcasting Board of Governors (BBG) and U.S. Section of the International Boundary and Water Commission (IBWC) to promote economy, efficiency and effectiveness in the administration of these programs and operations and to prevent and detect fraud, waste and abuse. The records in this system are used in investigating individuals and entities suspected of having committed illegal or unethical acts and/or assisting in related criminal and civil proceedings and administrative actions.

ROUTINE USES OF RECORDS MAINTAINED IN THIS SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

The records contained in Office of Inspector General (OIG) Investigation Management System are collected and maintained in the enforcement of Department of State, Broadcasting Board of Governors (BBG) and U.S. Section of the International Boundary and Water Commission (IBWC) regulations, Federal civil and criminal statutes, Executive Orders and the Code of Federal Regulations. These records may be disclosed as follows to:

(a) Congressional Committees, in furtherance of their respective oversight functions;

(b) Any Federal, state, local, tribal, territorial, foreign or international agency, or other public authority or professional organization that:

(1) Investigates, prosecutes or assists in the investigation or prosecution of an alleged violation; or enforces, implements or assists in enforcement or implementation of any applicable statute, rule, regulation or order;

(2) Maintains civil, criminal or other relevant enforcement records or other pertinent records, such as current professional licenses, in order to obtain information relevant to: an OIG investigation or other preliminary inquiry; a decision concerning the hiring or retention of an employee or other personnel action; the issuance of a security clearance; the establishment of a claim; or the initiation of an administrative, civil or criminal action; a contract award; issuance of a license, grant or other benefit; establishment of a claim; or initiation of an administrative, civil or criminal action;

(c) Consumer reporting agency in order to obtain information relevant to an OIG investigation or other preliminary inquiry;

(d) Any private or public source of information, witness or subject from which information is requested in the course of a legitimate OIG investigation or other preliminary inquiry to the extent necessary to:

(1) Identify an individual;

(2) Inform the source, witness or subject of the nature and purpose of the investigation or preliminary inquiry; or

(3) Identify the information requested;

(e) An attorney or other designated representative of any source of information, witness or subject in the course of a legitimate OIG investigation or other preliminary inquiry;

(f) The Department of Justice (DOJ) on behalf of:

(1) An employee of OIG in his or her individual capacity where DOJ has agreed to represent the employee, or

(2) The United States where OIG determines that litigation is likely to affect the Department of State, the BBG, IBWC or any related components, when any of the above is a party to litigation or has an interest in such litigation, and the use of such records by DOJ is deemed by OIG to be relevant and necessary to the litigation;

(g) A court, grand jury or an administrative or adjudicative body when OIG determines that use of such records is arguably relevant to the proceeding or when the adjudicator of an administrative or adjudicative body determines the records to be relevant to the proceeding;

(h) A member of Congress at the sole discretion of the Inspector General upon a determination of the propriety of such a disclosure and only for such purposes as authorized by the statutory mandate of the Inspector General;

(i) The Department of Justice (DOJ) for the purpose of obtaining its advice;

(j) The Office of Management and Budget (OMB) for the purpose of obtaining its advice;

(k) In response to a subpoena issued by an independent Federal agency having the power to subpoena records of Executive Federal agencies;

(l) A Federal agency responsible for considering suspension or debarment action where the record(s) would be relevant to such action;

(m) An entity or person, public or private, where disclosure of the record is needed to enable the recipient of the record to take action to recover money or property of the Department of State, BBG, and/or IBWC where such recovery will accrue to the benefit of the United States or where disclosure of the record is needed to enable the recipient of the record to take appropriate disciplinary action to maintain the integrity of programs or operations of the Department of State, BBG and/or IBWC;

(n) A Federal, state, local or foreign agency or other public authority to prevent and detect fraud or abuse in benefit programs administered by any agency pursuant to a formal memorandum of understanding (MOU) for use in computer matching programs; to support civil and criminal law enforcement activities of any agency and its components; or to collect debts and overpayments owed to any agency and its components;

(o) A public or professional licensing organization when such record indicates, either by itself or in combination with other information, a violation or potential violation of professional standards or reflects on the moral, educational or professional qualifications of an individual who is licensed or who is seeking to become licensed;

(p) Debt collection contractors for the purpose of collecting delinquent debts as authorized by law.

The Department of State periodically publishes in the **Federal Register** its standard routine uses which apply to all of its Privacy Act systems of records. These notices appear in the form of a Prefatory Statement. These standard routine uses apply to Office of Inspector General Investigation Management System, State-53.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Hard-copy and electronic media.

RETRIEVABILITY:

Name, Social Security number or case number.

SAFEGUARDS:

All Office of Inspector General (OIG) employees, contractors and others authorized to access this system of records have completed thorough background investigations as required. Physical access to OIG where these records are physically maintained is controlled and admission is limited to those individuals possessing a valid, current identification access card or individuals entering with proper escort. All hard copies are maintained in secure file cabinets located in restricted areas, access to which is limited to authorized personnel only.

Access to electronic files is protected by: (1) Cryptographic protocols for communications over a network; (2) a unique user identification (ID) number; (3) a secure ID authentication token specific to each user and possessing its own encryption; and (4) the direct supervision of the system manager. The system manager has the capability of printing access audit trails for electronic media, thereby permitting regular scheduled and ad hoc monitoring of system access. Access privileges are consistent with the established need-to-know, separation-of-duties and supervisory requirements. Inspector General reports of investigation (ROIs) and investigative files and related records are disseminated only to those U.S. government officials and offices with a clear need-to-know concerning the matter being reported. No secondary distribution of ROIs, investigative files or related records is permitted without the express, written permission of the Inspector General. When it is determined that a user no longer needs access, their user account is disabled.

All users are given cyber security awareness training which covers the procedures for handling Sensitive but Unclassified information, including personally identifiable information (PII). Annual refresher training is mandatory. In addition, all Foreign Service and Civil Service employees and those Locally Engaged Staff who handle PII are required to take the Foreign Service Institute distance learning course, PA 459, instructing employees on privacy and security requirements, including the rules of behavior for handling PII and the potential consequences if it is handled improperly. Before being granted access to OIG Investigation Management System, a user must first be granted access to the Department of State computer system.

Remote access to the Department of State network from non-Department owned systems is authorized only to unclassified systems and only through a Department approved access program. Remote access to the network is configured with the Office of Management and Budget Memorandum M–07–16 security requirements which include but are not limited to two-factor authentication and time out function.

RETENTION AND DISPOSAL:

All system records are retired in accordance with published Department disposition schedules as approved by the National Archives and Records Administration (NARA). Investigative records that have been closed are retired to the Federal Records Center three years after their closure, maintained for an additional 10 years, and then destroyed. More specific information on Department of State records disposition schedules may be obtained by writing the Director; Office of Information Programs and Services, A/GIS/IPS; SA–2, Department of State; 515 22nd Street NW., Washington, DC 20522–8100.

SYSTEM MANAGER AND ADDRESS:

Special Agent in Charge of Operations or Designee; Inspector General; Office of Investigations; SA–39, 1700 North Moore Street, Suite 800; Arlington, Virginia 22209.

NOTIFICATION PROCEDURE:

Individuals who have cause to believe that this system might have records pertaining to them and have inquiries about those records should write to the System Manager at the address listed above. At a minimum, the individual must include his or her: name; date and place of birth; current mailing address and zip code; signature; and other information helpful in identifying the record.

RECORD ACCESS AND AMENDMENT PROCEDURES:

Individuals who wish to gain access to records pertaining to themselves should direct those requests, in writing, to the System Manager at the address listed above. The individual must specify the records being requested and must include, at a minimum, his or her name; date and place of birth; current mailing address and zip code; and signature, duly notarized or submitted under penalty of perjury *(See* 22 CFR part 171; 28 U.S.C. 1746). The request should be mailed in an envelope clearly marked ''Privacy Act Request.'' A determination as to exemption(s) shall be made at the time a request for access or amendment is received.

CONTESTING RECORD PROCEDURES:

Individuals who wish to contest information in the system pertaining to themselves should write to the System Manager at the address listed above. The request should clearly and concisely state what information is being contested, the reason for contesting it, and the proposed amendment to the information.

RECORD SOURCE CATEGORIES:

These records contain information obtained from interviews, reviews of records, authorized investigative techniques and other agencies' systems of records.

SYSTEM EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

Pursuant to 5 U.S.C. 552a(j)(2), the records contained within this system of records are exempted from any part of the Privacy Act except subsections (b), (c)(1) and (2), (e)(4)(A) through (F), (e)(6), (7), (9), (10) and (11), and (i).

Pursuant to 5 U.S.C. 552a (k)(1), (k)(2) and (k)(5), the records in this system are exempted from the following provisions of the Privacy Act: subsections (c)(3), (d), (e)(1), (e)(4)(G), (H) and (I) and (f).

See rules published in the **Federal Register,** 22 CFR part 171.

[FR Doc. 2013–16891 Filed 7–12–13; 8:45 am]

BILLING CODE 4710–42–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Notice of Final Federal Agency Actions on the Goethals Bridge Replacement Project in New York and New Jersey

AGENCY: Federal Highway Administration (FHWA), U.S. DOT.

ACTION: Notice of Limitation on Claims for Judicial Review of Actions by FHWA and Other Federal Agencies.

SUMMARY: This notice announces actions taken by the FHWA and other Federal agencies that are final within the meaning of 23 U.S.C. 139(l)(1). The actions relate to the Goethals Bridge Replacement Project located in Staten Island, New York, and Elizabeth, New Jersey. Those actions grant approvals for the project.

DATES: By this notice, the FHWA is advising the public of final agency actions subject to 23 U.S.C. 139(l)(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 December 12, 2013. 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 time period still applies.

FOR FURTHER INFORMATION CONTACT: Jonathan D. McDade, Division Administrator, Federal Highway Administration, Leo W. O'Brien Federal Building, Albany, New York 12207, Telephone (518) 431–4127.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the FHWA and other Federal agencies have taken final agency actions by issuing approvals for the following highway project in the State of New York and New Jersey: Goethals Bridge Replacement Project. The Goethals Bridge provides a direct connection between Staten Island, New York, and Elizabeth, New Jersey. This bridge is part of the Port Authority of New York and New Jersey's (PANYNY)

Interstate Transportation Network and is considered the primary path of travel within the Southern Corridor, connecting the Staten Island Expressway (Interstate 278) and the New Jersey Turnpike (Interstate 95). The Goethals Bridge Replacement Project will consist of a replacement bridge with a new six-lane structure directly and entirely south of the existing structure's alignment. This replacement structure will be built in its entirety, and after completion, the existing bridge would be demolished.

The actions by the Federal agencies, and the laws under which such actions were taken, are described in the United States Coast Guard (USCG) Final Environmental Impact Statement (FEIS) for the project, approved on August 4, 2010, adopted by FHWA in the Record of Decision (ROD) issued on June 13, 2013, and in other documents in the FHWA administrative record. The FEIS, ROD, and other documents in the FHWA administrative record file are available by contacting the FHWA, or the PANYNJ, at the addresses provided above. The FEIS and ROD can be viewed and downloaded from the project Web site at *www.panynj.gov/goethalsbridge.*

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. *General:* National Environmental Policy Act (NEPA) [42 U.S.C. 4321–4351]; Federal-Aid Highway Act [23 U.S.C. 109].

2. *Air:* Clean Air Act, 42 U.S.C. 7401–7671(q).

3. *Land:* Section 4(f) of the Department of Transportation Act of 1966 [49 U.S.C. 303]; Landscaping and Scenic Enhancement (Wildflowers), 23 U.S.C. 319.

4. *Wildlife:* Endangered Species Act [16 U.S.C. 1531–1544 and Section 1536], Marine Mammal Protection Act [16 U.S.C. 1361], Anadromous Fish Conservation Act [16 U.S.C. 757(a)–757(g)], Fish and Wildlife Coordination Act [16 U.S.C. 661–667(d)], Migratory Bird Treaty Act [16 U.S.C. 703–712], Magnuson-Stevenson Fishery Conservation and Management Act of 1976, as amended [16 U.S.C. 1801 et seq.].

5. *Historic and Cultural Resources:* Section 106 of the National Historic Preservation Act of 1966, as amended [16 U.S.C. 470(f) et seq.]; Archeological Resources Protection Act of 1977 [16 U.S.C. 470(aa)–11]; Archeological and Historic Preservation Act [16 U.S.C. 469–469(c)]; Native American Grave Protection and Repatriation Act (NAGPRA) [25 U.S.C. 3001–3013].

6. *Social and Economic:* Civil Rights Act of 1964 [42 U.S.C. 2000(d)–2000(d)(1)]; American Indian Religious Freedom Act [42 U.S.C. 1996]; Farmland Protection Policy Act (FPPA) [7 U.S.C. 4201–4209].

7. *Wetlands and Water Resources:* Coastal Zone Management Act, 16 U.S.C. 1451–1465; Land and Water Conservation Fund (LWCF), 16 U.S.C. 4601–4604; Safe Drinking Water Act (SDWA), 42 U.S.C. 300(f)–300(j)(6); 33 U.S.C. 401–406; Wild and Scenic Rivers Act, 16 U.S.C. 1271–1287; Emergency Wetlands Resources Act, 16 U.S.C. 3921, 3931; TEA–21 Wetlands Mitigation, 23 U.S.C. 103(b)(6)(m), 133(b)(11); Flood Disaster Protection Act, 42 U.S.C. 4001–4128.

8. *Hazardous Materials:* Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), 42 U.S.C. 9601–9675; Superfund Amendments and Reauthorization Act of 1986 (SARA); Resource Conservation and Recovery Act (RCRA), 42 U.S.C. 6901–6992(k).

9. *Executive Orders:* E.O. 11990 Protection of Wetlands; E.O. 11988 Floodplain Management; E.O. 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low Income Populations; E.O. 11593 Protection and Enhancement of Cultural Resources; E.O. 13007 Indian Sacred Sites; E.O. 13287 Preserve America; E.O. 13175 Consultation and Coordination with Indian Tribal Governments; E.O. 11514 Protection and Enhancement of Environmental Quality; E.O. 13112 Invasive Species.

(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: July 3, 2013.

Jonathan D. McDade,

Division Administrator, Albany, NY.

[FR Doc. 2013–16611 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–RY–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2013 0080]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel OFF COURSE; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. 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 August 14, 2013.

ADDRESSES: Comments should refer to docket number MARAD–2013–0080. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Linda Williams, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–0903, Email *Linda.Williams@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel OFF COURSE is:

Intended Commercial Use of Vessel: ''Carrying up to 6 passengers.''

Geographic Region: ''California, Oregon, and Washington.''

The complete application is given in DOT docket MARAD–2013–0080 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 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 given in § 388.4 of MARAD's regulations at 46 CFR Part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

Dated: July 9, 2013.

By Order of the Maritime Administrator.

Julie P. Agarwal,

Secretary, Maritime Administration.

[FR Doc. 2013–16890 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2013–0081]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel COMPASS ROSE; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. 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 August 14, 2013.

ADDRESSES: Comments should refer to docket number MARAD–2013–0081. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Linda Williams, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–0903, Email *Linda.Williams@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel COMPASS ROSE is:

Intended Commercial Use Of Vessel: ''Sailboat charters six passengers or less''.

Geographic Region: ''Maine, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, District of Columbia, Virginia, North Carolina, South Carolina, Georgia, Florida''.

The complete application is given in DOT docket MARAD–2013–0081 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 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 given in § 388.4 of MARAD's regulations at 46 CFR Part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.

Dated: July 8, 2013.

Julie P. Agarwal,

Secretary, Maritime Administration.

[FR Doc. 2013–16892 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2013–0074]

Decision That Certain Nonconforming Motor Vehicles Are Eligible for Importation

AGENCY: National Highway Traffic Safety Administration, DOT.

ACTION: Grant of petitions.

SUMMARY: This document announces decisions by NHTSA that certain motor vehicles not originally manufactured to comply with all applicable Federal Motor Vehicle Safety Standards (FMVSS) are eligible for importation into the United States because they are substantially similar to vehicles originally manufactured for sale in the United States and certified by their manufacturers as complying with the safety standards, and they are capable of being readily altered to conform to the standards or because they have safety features that comply with, or are capable of being altered to comply with, all applicable FMVSS.

DATES: These decisions became effective on the dates specified in Annex A.

FOR FURTHER INFORMATION CONTACT: Coleman Sachs, Office of Vehicle Safety Compliance, NHTSA (202–366–3151).

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. 30141(a)(1)(A), a motor vehicle that was not originally manufactured to conform to all applicable FMVSS shall be refused admission into the United States unless NHTSA has decided that the motor vehicle is substantially similar to a motor vehicle originally manufactured for importation into and/or sale in the United States, certified under 49 U.S.C. 30115, and of the same model year as the model of the motor vehicle to be compared, and is capable of being

readily altered to conform to all applicable FMVSS.

Where there is no substantially similar U.S.-certified motor vehicle, 49 U.S.C. 30141(a)(1)(B) permits a nonconforming motor vehicle to be admitted into the United States if its safety features comply with, or are capable of being altered to comply with, all applicable FMVSS based on destructive test data or such other evidence as NHTSA decides to be adequate.

Petitions for eligibility decisions may be submitted by either manufacturers or importers who have registered with NHTSA pursuant to 49 CFR part 592. As specified in 49 CFR 593.7, NHTSA publishes notice in the **Federal Register** of each petition that it receives, and affords interested persons an opportunity to comment on the petition. At the close of the comment period, NHTSA decides, on the basis of the petition and any comments that it has received, whether the vehicle is eligible for importation. The agency then publishes this decision in the **Federal Register**.

NHTSA received petitions from registered importers to decide whether the vehicles listed in Annex A to this notice are eligible for importation into the United States. To afford an opportunity for public comment, NHTSA published notice of these petitions as specified in Annex A. The reader is referred to those notices for a thorough description of the petitions.

Comments: No substantive comments were received in response to 16 of the 17 petitions identified in Appendix A. In response to the remaining petition, which covers 2004 model year Ford F–150 Crew Cab trucks that were manufactured for the Mexican Market (Docket No NHTSA–2012–0162), the Ford Motor Company stated in pertinent part:

> Vehicles that are designed and manufactured for export to markets outside of the United States are not necessarily tested for compliance to all FMVSS requirements, unless the particular export markets have entirely equivalent safety standards. Therefore, Ford can neither confirm nor deny that a 2004 F–150 Crew Cab manufactured for sale in the Mexican Market would have complied with FMVSS No. 208 at the time it was manufactured.

The petitioner, Mesa Auto Wholesalers, responded in pertinent part:

> We at Mesa auto wholesalers have carefully looked at both a 2004 Ford F–150 that was sold for the American market and the subject vehicle, in our research we discovered that both vehicles were exactly the same and therefore conformed to the standard FMVSS No. 208 both units had factory installed airbags and seatbelts for all seating positions including outward and center seat positions in both the front seat and the rear seat.

NHTSA believes this response fully addresses the comment. The agency also notes that the comment lacks sufficient specificity to provide a basis for the denial of the petition.

NHTSA Decision: Accordingly, on the basis of the foregoing, NHTSA hereby decides that each motor vehicle listed in Annex A to this notice, which was not originally manufactured to comply with all applicable FMVSS, is either substantially similar to a motor vehicle manufactured for importation into and/or sale in the United States, and certified under 49 U.S.C. 30115, as specified in Annex A, and is capable of being readily altered to conform to all applicable FMVSS or has safety features that comply with, or are capable of being altered to comply with, all applicable Federal Motor Vehicle Safety Standards.

Vehicle Eligibility Number For Subject Vehicles: The importer of a vehicle admissible under any final decision must indicate on the form HS–7 accompanying entry the appropriate vehicle eligibility number indicating that the vehicle is eligible for entry. Vehicle eligibility numbers assigned to vehicles admissible under this decision are specified in Annex A.

Authority: 49 U.S.C. 30141(a)(1)(A), (a)(1)(B) and (b)(1); 49 CFR 593.7; delegations of authority at 49 CFR 1.50 and 501.7.

Issued on: July 2, 2013.

Claude H. Harris,

Director, Office of Vehicle Safety Compliance.

Annex A—Nonconforming Motor Vehicles Decided To Be Eligible for Importation

1. Docket No. NHTSA–2013–0032

Nonconforming Vehicles: 2005, 2006 & 2007 BMW 5 Series Passenger Cars Manufactured before September 1, 2006
Substantially Similar U.S. Certified Vehicles: 2005, 2006 & 2007 BMW 5 Series Passenger Cars Manufactured before September 1, 2006
Notice of Petition
Published at: 78 FR 24463 (April 25, 2013)
Vehicle Eligibility Number: VSP–555 (effective date June 7, 2013)

2. Docket No. NHTSA–2013–0031

Nonconforming Vehicles: 1991 Volkswagen Transporter Multipurpose Passenger Vehicles

Substantially Similar U.S. Certified Vehicles: 1991 Volkswagen Transporter Multipurpose Passenger Vehicles
Notice of Petition
Published at: 78 FR 22944 (April 17, 2013)
Vehicle Eligibility Number: VSP–554 (effective date June 7, 2013)

3. Docket No. NHTSA–2013–0022

Nonconforming Vehicles: 2010 BMW Z4 Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2010 BMW Z4 Passenger Cars
Notice of Petition
Published at: 78 FR 20385 (April 4, 2013)
Vehicle Eligibility Number: VSP–553 (effective date May 28, 2013)

4. Docket No. NHTSA–2013–0015

Nonconforming Vehicles: 2012 Porsche GT3 RS Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2012 Porsche GT3 RS Passenger Cars
Notice of Petition
Published at: 78 FR 20386 (April 4, 2013)
Vehicle Eligibility Number: VSP–552 (effective date May 21, 2013)

5. Docket No. NHTSA–2012–0164

Nonconforming Vehicles: 2007 Ford Escape Multipurpose Passenger Vehicles Manufactured for the Mexican Market
Substantially Similar U.S. Certified Vehicles: Ford Escape Multipurpose Passenger Vehicles
Notice of Petition
Published at: 78 FR 20388 (April 4, 2013)
Vehicle Eligibility Number: VSP–551 (effective date May 20, 2013)

6. Docket No. NHTSA–2013–0016

Nonconforming Vehicles: 1992, 1993 & 1994 BMW 3 Series Passenger Cars
Substantially Similar U.S. Certified Vehicles: 1992, 1993 & 1994 BMW 3 Series Passenger Cars
Notice of Petition
Published at: 78 FR 19364 (March 29, 2013)
Vehicle Eligibility Number: VSP–550 (effective date May 6, 2013)

7. Docket No. NHTSA–2013–0012

Nonconforming Vehicles: 2005 Mercedes-Benz G Class (463 chassis) Long-Wheelbase (LWB) Multipurpose Passenger Vehicles
Substantially Similar U.S. Certified Vehicles: 2005 Mercedes-Benz G Class (463 chassis) Long-Wheelbase (LWB) Multipurpose Passenger Vehicles
Notice of Petition
Published at: 78 FR 10686 (February 14, 2013)
Vehicle Eligibility Number: VSP–549 (effective date April 22, 2013)

8. Docket No. NHTSA–2012–0162

Nonconforming Vehicles: 2004 Ford F–150 Crew Cab Trucks Manufactured for the Mexican Market
Substantially Similar U.S. Certified Vehicles: 2004 Ford F–150 Crew Cab Trucks
Notice of Petition
Published at: 78 FR 13754 (February 28, 2013)
Vehicle Eligibility Number: VSP–548 (effective date April 17, 2013)

9. Docket No. NHTSA–2012–0161

Nonconforming Vehicles: 2003 Jeep Wrangler Multipurpose Passenger Vehicles Manufactured for the Mexican Market
Substantially Similar U.S. Certified Vehicles: 2003 Jeep Wrangler Multipurpose

Passenger Vehicles
Notice of Petition
Published at: 78 FR 13755 (February 28, 2013)
Vehicle Eligibility Number: VSP–547 (effective date April 17, 2013)

10. Docket No. NHTSA–2013–0014

Nonconforming Vehicles: 1992 Porsche Carrera (964 Series) Passenger Cars
Substantially Similar U.S. Certified Vehicles: 1992 Porsche Carrera (964 Series) Passenger Cars
Notice of Petition
Published at: 78 FR 10687 (February 14, 2013)
Vehicle Eligibility Number: VSP–546 (effective date March 26, 2013)

11. Docket No. NHTSA–2012–0163

Nonconforming Vehicles: 2005 Ferrari 612 Scaglietti Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2005 Ferrari 612 Scaglietti Passenger Cars
Notice of Petition
Published at: 77 FR 76599 (December 28, 2012)
Vehicle Eligibility Number: VSP–545 (effective date February 12, 2013)

12. Docket No. NHTSA–2012–0151

Nonconforming Vehicles: 2007 Chevrolet Corvette Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2007 Chevrolet Corvette Passenger Cars
Notice of Petition
Published at: 77 FR 69539 (November 19, 2012)
Vehicle Eligibility Number: VSP–544 (effective date January 16, 2013)

13. Docket No. NHTSA–2012–0150

Nonconforming Vehicles: 2009 Porsche Cayenne S Multipurpose Passenger Vehicles
Substantially Similar U.S. Certified Vehicles: 2009 Porsche Cayenne S Multipurpose Passenger Vehicles
Notice of Petition
Published at: 77 FR 67732 (November 13, 2012)
Vehicle Eligibility Number: VSP–543 (effective date January 16, 2013)

14. Docket No. NHTSA–2012–0160

Nonconforming Vehicles: 2009 Porsche 911 (997) Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2009 Porsche 911 (997) passenger cars
Notice of Petition
Published at: 77 FR 70541 (November 26, 2012)
Vehicle Eligibility Number: VSP–542 (effective date January 16, 2013)

15. Docket No. NHTSA–2012–0095

Nonconforming Vehicles: 2005 Chevrolet Suburban Multipurpose Passenger Vehicles
Substantially Similar U.S. Certified Vehicles: 2005 Chevrolet Suburban Multipurpose Passenger Vehicles
Notice of Petition
Published at: 77 FR 46803 (August 6, 2012)
Vehicle Eligibility Number: VSP–541 (effective date November 27, 2012)

16. Docket No. NHTSA–2013–0035

Nonconforming Vehicles: 2011 Thule 3008 BL Boat Trailer
Because there are no substantially similar U.S.-certified version 2011 Thule 3008 BL Boat Trailer the petitioner sought import eligibility under 49 U.S.C. 30141(a)(1)(B).
Notice of Petition:
Published at: 78 FR 24464 (April 25, 2013)
Vehicle Eligibility Number: VCP–52 (effective date June 7, 2013)

17. Docket No. NHTSA–2012–0148

Nonconforming Vehicles: 1991 Mercedes-Benz G Class (463 chassis) Multipurpose Passenger Vehicles
Because there are no substantially similar U.S.-certified version 1991 Mercedes-Benz G Class (463 chassis) Multipurpose Passenger Vehicles the petitioner sought import eligibility under 49 U.S.C. 30141(a)(1)(B).
Notice of Petition
Published at: 77 FR 65444 (October 26, 2012)
Vehicle Eligibility Number: VCP–51 (effective date December 11, 2012)

[FR Doc. 2013–16792 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2012–0145; Notice 1]

BHC Investment Corporation, Receipt of Petition for Decision of Inconsequential Noncompliance

AGENCY: National Highway Traffic Safety Administration, DOT.

ACTION: Receipt of petition.

SUMMARY: BHC Investment Corporation (BHC) [1] has determined that certain ''Choice'' brand reflective warning triangles that BHC distributed to its dealers from June 2011 to August 27, 2012, do not fully comply with paragraph S5.2.3 of Federal Motor Vehicle Safety Standard (FMVSS) No. 125 *Warning Devices.* BHC has filed an appropriate report dated August 30, 2012, pursuant to 49 CFR Part 573, *Defect and Noncompliance Responsibility and Reports.*

Pursuant to 49 U.S.C. 30118(d) and 30120(h) (see implementing rule at 49 CFR part 556), BHC submitted a petition for an exemption from the notification and remedy requirements of 49 U.S.C. Chapter 301 on the basis that this noncompliance is inconsequential to motor vehicle safety.

This notice of receipt of BHC's petition is published under 49 U.S.C. 30118 and 30120 and does not represent any agency decision or other exercise of judgment concerning the merits of the petition.

Equipment Involved: Affected are approximately 13,305 ''Choice'' brand reflective warning triangle kits. Each kit includes three warning devices for a total of 39,915 devices. The affected kits were manufactured by Torch Industrial Company, LTD (TORCH) in its plant located in Fujin, China. The affected kits were imported to and distributed in the United States from June 2011 to August 27, 2012 by BHC.

NHTSA notes that the statutory provisions (49 U.S.C. 30118(d) and 30120(h)) that permit manufacturers to file petitions for a determination of inconsequentiality allow NHTSA to exempt manufacturers only from the duties found in sections 30118 and 30120, respectively, to notify owners, purchasers, and dealers of a defect or noncompliance and to remedy the defect or noncompliance. Therefore, these provisions only apply to the 39,915 [2] warning devices that BHC no longer controlled at the time it determined that the noncompliance existed.

Ruled Text: Paragraph S5.2.3 of FMVSS No. 125 requires in pertinent part:

S5.2.3 Each face of the triangular portion of the warning device shall have an outer border of red reflex reflective material of uniform width and not less than 0.75 and not more than 1.75 inches wide, and an inner border of orange fluorescent material of uniform width and not less than 1.25 and not more than 1.30 inches wide . . .

Summary of BHC's Analyses: BHC explains that the only noncompliance that it has confirmed is that the measurement of the inner orange fluorescent material is only 1.23 inches versus 1.25 inches required by paragraph S5.2.3 of FMVSS No. 125. The other discrepancies alleged in the competitor's notice cannot be verified without supplying samples to an independent testing laboratory and having them tested and confirmed.

[1] BHC Investment Corporation is registered under the laws of the state of Delaware, and as the importer of record for the subject noncompliant equipment is treated as a manufacturer of motor vehicle equipment with respect to the subject petition.

[2] BHC's petition, which was filed under 49 CFR part 556, requests an agency decision to exempt BHC as a motor vehicle equipment manufacturer from the notification and recall responsibilities of 49 CFR part 573 for the affected equipment. However, a decision on this petition cannot relieve vehicle distributors and dealers of the prohibitions on the sale, offer for sale, introduction or delivery for introduction into interstate commerce of the noncompliant motor vehicle equipment under their control after BHC notified them that the subject noncompliance existed.

Therefore BHC decided to suspend sales of the warning triangles produced by TORCH.

BHC stated its belief that the minor discrepancy between the measurements of the orange material and the luminance tests result has an inconsequential effect on motor vehicle safety. The competitor's test results also makes claims regarding whether the Torch triangles meet the FMVSS No. 125 with regard to stability and reflectivity. BHC has not independently verify these allegations.

BHC stated its belief that the subject noncompliance is inconsequential to motor vehicle safety for the following reasons:

1. The triangles are not an integral part of vehicle operation, and are limited to use as a visual warning to passing motorists of a roadside incident.

2. Under FMVSS No. 125, a minimum of 1.25 inches of orange fluorescent material (see page 18 of Industrial Testing Laboratory test report number 120320–05C) must be present. Based on the laboratory testing results and BHC's own measurements, the Choice triangles' reflective material has been measured as 1.23 inches, a difference inconsequential to vehicle safety.

3. The competitor's testing results allege that the reflectivity and stability of the Choice triangles failed to meet NHTSA standards by similarly small margins, which do not present a material safety risk to vehicle operations. Although BHC has not independently verified the competitor's testing results, it has discontinued selling this item.

4. BHC has received no reports from any dealer or end use purchaser of the Choice triangle kits of any failure of these products, accidents, injuries, or other incidents allegedly related to the suspected non-compliance.

5. BHC believes that any recall campaign would be ineffective. BHC is in the process of notifying its approximately 300 dealers of the issue, and has offered to replace any unsold stock with DOT-compliant products. Based on our best information, BHC believes that the retailers of these products generally do not maintain records on end-use purchasers. BHC cannot identify effective point-of-sale or public notice strategies that would effectively notify and remedy the suspected noncompliance.

BHC also, believes that the combination of minor and inconsequential suspected deviations from the DOT standard, the lack of any report of actual failure of the products in the field, and the problems faced in formulating an effective recall program are sufficient to support the granting of this petition. BHC hopes that this application and attached materials fully illustrate the seriousness with which BHC has taken this matter, including the immediate cessation of sales, attempts to verify the suspected deficiencies, and replacement of unsold stock with compliant equipment. BHC believes that such steps are a reasonable and satisfactory step for an importer in this position, and that a recall campaign would produce no marginal benefit in terms of vehicle safety.

In summation, BHC believes that the described noncompliance of its equipment is inconsequential to motor vehicle safety, and that its petition, to exempt from providing recall notification of noncompliance as required by 49 U.S.C. 30118 and remedying the recall noncompliance as required by 49 U.S.C. 30120 should be granted.

Comments: Interested persons are invited to submit written data, views, and arguments on this petition. Comments must refer to the docket and notice number cited at the beginning of this notice and must be submitted by any of the following methods:

a. By mail addressed to: U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.

b. By hand delivery to U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. The Docket Section is open on weekdays from 10 a.m. to 5 p.m. except Federal Holidays.

c. Electronically: by logging onto the Federal Docket Management System (FDMS) Web site at *http://www.regulations.gov/*. Follow the online instructions for submitting comments. Comments may also be faxed to 1–202–493–2251.

Comments must be written in the English language, and be no greater than 15 pages in length, although there is no limit to the length of necessary attachments to the comments. If comments are submitted in hard copy form, please ensure that two copies are provided. If you wish to receive confirmation that your comments were received, please enclose a stamped, self-addressed postcard with the comments. Note that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

Documents submitted to a docket may be viewed by anyone at the address and times given above. The documents may also be viewed on the Internet at *http://www.regulations.gov* by following the online instructions for accessing the dockets. DOT's complete Privacy Act Statement is available for review in the **Federal Register** published on April 11, 2000, (65 FR 19477–78).

The petition, supporting materials, and all comments received before the close of business on the closing date indicated below will be filed and will be considered. All comments and supporting materials received after the closing date will also be filed and will be considered to the extent possible. When the petition is granted or denied, notice of the decision will be published in the **Federal Register** pursuant to the authority indicated below.

Comment Closing Date: August 14, 2013.

Authority: 49 U.S.C. 30118, 30120: delegations of authority at 49 CFR 1.95 and 501.8.

Issued on: July 2, 2013.

Claude H. Harris,

Director, Office of Vehicle Safety Compliance.

[FR Doc. 2013–16793 Filed 7–12–13; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[Docket No. FD 35732]

Sonoma-Marin Area Rail Transit District—Acquisition Exemption—In Marin County, Cal.

AGENCY: Surface Transportation Board, DOT.

ACTION: Notice of Exemption.

SUMMARY: The Board is granting an exemption under 49 U.S.C. 10502 from the prior approval requirements of 49 U.S.C. 10902 for Sonoma-Marin Area Rail Transit District (SMART), a Class III rail carrier, to acquire an approximately 11.25-mile line of railroad in Marin County, Cal., from Golden Gate Bridge, Highway, and Transportation District; County of Marin; and Marin County Transit District.

DATES: The exemption will be effective on August 14, 2013. Petitions to stay must be filed by July 25, 2013. Petitions for reconsideration must be filed by August 5, 2013.

ADDRESSES: An original and 10 copies of all pleadings, referring to Docket No. FD 35732, must be filed with the Surface Transportation Board, 395 E Street SW., Washington, DC 20423–0001. In addition, one copy of each pleading must be served on SMART's

representative: Linda J. Morgan, Nossaman LLP, 1666 K Street NW., Suite 500, Washington, DC 20006.

FOR FURTHER INFORMATION CONTACT: Amy C. Ziehm, (202) 245–0391. [Assistance for the hearing impaired is available through the Federal Information Relay Service (FIRS) at 1–800–877–8339.]

SUPPLEMENTARY INFORMATION: Additional information is contained in the Board's decision. Board decisions and notices are available on our Web site at *www.stb.dot.gov*.

Decided: July 9, 2013.

By the Board, Chairman Elliott, Vice Chairman Begeman, and Commissioner Mulvey.

Derrick Gardner,

Clearance Clerk.

[FR Doc. 2013–16872 Filed 7–12–13; 8:45 am]

BILLING CODE 4915–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0619]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–21), this notice announces that the Veterans Health Administration (VHA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden and includes the actual data collection instrument.

DATES: Comments must be submitted on or before August 14, 2013.

ADDRESSES: Submit written comments on the collection of information through *www.Regulations.gov;* or to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0619'' in any correspondence.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Crystal Rennie, Records Management Service (005R1B), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 632–7492, or email: *crystal.rennie@va.gov*. Please refer to ''OMB Control No. 2900–0619.''

SUPPLEMENTARY INFORMATION:

Title: Inquiry Routing and Information System (IRIS).

OMB Control Number: 2900–0619.

Type of Review: Revision of a currently approved collection.

Abstract: The World Wide Web is a powerful media for the delivery of information and services to veterans, dependents, and active duty personnel worldwide. IRIS allows a customer to submit questions, complaints, compliments, and suggestions directly to the appropriate office at any time and receive an answer more quickly than through standard mail. IRIS does not provide applications to veterans or serve as a conduit for patient data, etc.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on March 26, 2013, at pages 18426–18427.

Affected Public: Individuals or households.

Estimated Annual Burden: 108,000 hours.

Estimated Average Burden per Respondent: 10 minutes.

Frequency of Response: Monthly.

Estimated Number of Respondents: 648,000.

Dated: July 9, 2013.

By direction of the Secretary.

Crystal Rennie,

VA Clearance Officer, U.S. Department of Veterans Affairs.

[FR Doc. 2013–16773 Filed 7–12–13; 8:45 am]

BILLING CODE 8320–01–P

FEDERAL REGISTER

Vol. 78 Monday,

No. 135 July 15, 2013

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Parts 431, 435, 436, *et al.*
Office of the Secretary
45 CFR Parts 155 and 156

Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, 436, 438, 440, 447, and 457

Office of the Secretary

45 CFR Parts 155 and 156

[CMS–2334–F]

RIN 0938–AR04

Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act. This final rule finalizes new Medicaid eligibility provisions; finalizes changes related to electronic Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices and delegation of appeals; modernizes and streamlines existing Medicaid eligibility rules; revises CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amends requirements for benchmark and benchmark-equivalent benefit packages consistent with sections 1937 of the Social Security Act (which we refer to as ''alternative benefit plans'') to ensure that these benefit packages include essential health benefits and meet certain other minimum standards. This rule also implements specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. This rule also updates and simplifies the complex Medicaid premium and cost sharing requirements, to promote the most effective use of services, and to assist states in identifying cost sharing flexibilities. It includes transition policies for 2014 as applicable.

DATES: The effective date for the additions of 42 CFR 435.118, 435.603, 435.911, 435.949, 435.956, 435.1200, 457.315, 457.330 and 457.348; amendments to 42 CFR 431.10, 431.11, 435.110, 435.116, 435.119, 435.907, 435.916, 435.940, 435.945, 435.948, 435.952, 457.340 and 457.350; the removal of 42 CFR 435.953 and 435.955; and the redesignation of 42 CFR 435.911 through 435.914 as 42 CFR 435.912 through 435.915 in CMS–2349 (FR Doc. 2012–6560) published on March 23, 2012, which were to become effective in January 1, 2014 are now effective October 1, 2013.

Other provisions of this final rule that are codified in title 42 of the Code of Federal Regulations are effective January 1, 2014 with the exception of amendments to the following which are effective on October 1, 2013: 42 CFR 431.10, 431.11, 431.201, 431.205, 431.206, 431.211, 431.213, 431.230, 431.231, 431.240, 435.119, 435.603, 435.907, 435.918, 435.1200, 457.110, 457.348, and 457.350; and the addition of 42 CFR 435.1205 and 457.370, which are effective on October 1, 2013.

Regulations in this final rule that are codified in title 45 of Code of Federal Regulations are effective on September 13, 2013.

FOR FURTHER INFORMATION CONTACT:

Sarah deLone, (410) 786–0615, or Stephanie Kaminsky, (410) 786–4653, for provisions related to revisions to eligibility notice and fair hearing appeal processes and additional eligibility changes for Medicaid and CHIP.

Melissa Harris, (410) 786–3397, for provisions related to essential health benefits.

Leigha Basini, (301) 492–4307, for provisions related to Affordable Insurance Exchanges.

SUPPLEMENTARY INFORMATION:

Executive Summary

This final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). This rule reflects new statutory eligibility provisions, implements changes related to Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices, delegation of appeals, and other related administrative procedures with similar procedures used by other health coverage programs authorized under the Affordable Care Act. This final rule also modernizes and streamlines existing rules.

This final rule amends the requirements applicable to Medicaid benefit packages that provide benchmark or benchmark-equivalent coverage, to include requirements to meet new minimum standards, including the provision of essential health benefits, as required by the Affordable Care Act. In an effort to bring consistency and clarity to part 440, we are removing the terms ''benchmark and benchmark-equivalent plan'' where they appear together and are replacing these terms with ''Alternative Benefit Plan'' (ABP).

Beginning in calendar year 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges.'' This final rule: (1) Specifies standards related to authorized representatives, (2) outlines criteria related to the verification of enrollment in and eligibility for minimum essential coverage through an eligible employer-sponsored plan, and (3) further specifies or amends other eligibility and enrollment provisions. This final rule does not address proposed provisions regarding Exchange eligibility appeals, to provide additional time for the careful development of standards that can be effectively implemented, particularly for those regarding coordination with Medicaid and CHIP. Additionally, this final rule does not address proposed provisions regarding the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), certified application counselors in an Exchange and SHOP coordination with individual market Exchanges. We intend to address these provisions in a future issuance. The intent of this final rule is to afford each state substantial discretion in the design and operation of the Exchange established by the state, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

This final rule also updates and simplifies the complex Medicaid premium and cost sharing requirements to promote the most effective use of services and to assist states in identifying cost sharing flexibilities.

Finally, this final rule provides notice that we are considering, for purposes of the initial open enrollment period for enrollment in a Qualified Health Plan through the Exchange, whether various provisions of the Medicaid and CHIP regulations should be effective October 1, 2013, or whether a later effective date is appropriate.

In this final rule, we do not address all of the proposed regulatory changes to 42 CFR parts 431, 435 and 457. We are focusing on those changes that are most

needed to implement the changes made by the Affordable Care Act starting in 2014. We intend to address certain of the other provisions in future rulemaking.

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Acronyms and Terms

Because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

[the] Act Social Security Act
Affordable Care Act The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act (Pub. L. 111–152))
AFDC Aid to Families with Dependent Children
BBA Balanced Budget Act of 1997
BHP Basic Health Program
CHIP Children's Health Insurance Program
CHIPRA Children's Health Insurance Program Reauthorization Act of 2009
CMS Centers for Medicare & Medicaid Services
[the]Code Internal Revenue Code of 1986
DHS Department of Homeland Security
DOL U.S. Department of Labor
DRA Deficit Reduction Act of 2005
EITC Earned Income Tax Credit
EPSDT Early and periodic screening, diagnosis, and treatment
FEHBP Federal Employees Health Benefits Program (5 U.S.C. 8901, *et seq.*)
FFE Federally-facilitated Exchange
FFP Federal financial participation
FMAP Federal medical assistance percentage
FPL Federal poverty level
HCERA Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted March 30, 2010)
HHS [U.S. Department of] Health and Human Services
IHS Indian Health Service
INA Immigration and Nationality Act
IRA Individual Retirement Account
IRC Internal Revenue Code of 1986
IRS Internal Revenue Service
MAGI Modified adjusted gross income
MEC Minimum Essential Coverage
MMEA Medicare & Medicaid Extenders Act of 2010 (Pub. L. 111–309, enacted December 15, 2010)
OMB Office of Management and Budget
OPM U.S. Office of Personnel Management
PHS Act Public Health Service Act
PRA Paperwork Reduction Act of 1995
PRWORA Personal Responsibility and Work Opportunity Reconciliation Act of 1996
QHP Qualified Health Plan
Secretary Secretary of HHS
SEP Special enrollment period
SHOP Small Business Health Options Program
SMD State Medicaid Director
SNAP Supplemental Nutrition Assistance Program
SPA State Plan Amendment
SSA Social Security Administration
SSI Supplemental Security Income
SSN Social Security number
TANF Temporary Assistance for Needy Families

I. Background

A. Medicaid Eligibility Final Rule Part II

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010). These laws are collectively referred to as the Affordable Care Act. In addition, section 205 of the Medicare & Medicaid Extenders Act of 2010 (Pub. L. 111–309, enacted December 15, 2010) (MMEA) and the Middle Class Tax Relief and Job Creation Act of 2012 (Pub. L. 112–96, enacted February 22, 2012) made additional amendments to the Social Security Act (the Act) provisions affected by the Affordable Care Act.

The Affordable Care Act extends and simplifies Medicaid eligibility, and on March 23, 2012, we issued a final rule (referred to as the ''Medicaid Eligibility final rule'') addressing certain key Medicaid and CHIP eligibility, enrollment, and renewal issues.

This final rule provides states with additional flexibility and guidance for delegation of appeals and implementation of electronic notices, and modernizes administrative procedures to further promote coordination across multiple health coverage programs, including enrollment in a qualified health plan

through the Exchange with advance payments of the premium tax credits and cost-sharing reductions, as authorized by the Affordable Care Act, Medicaid and the Children's Health Insurance Program (CHIP). These coverage programs are collectively referred to as ''insurance affordability programs.'' For more information on the legislative overview, please refer to the Medicaid, CHIP, and Exchanges proposed rule (78 FR 4594).

B. Essential Health Benefits in Alternative Benefit Plans

For plan, policy, or coverage years (as applicable) beginning in 2014, most health insurance coverage [1] in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans (now also known as Alternative Benefit Plans (ABPs)), and Basic Health Programs (if applicable) will be required to cover essential health benefits (EHBs), consistent with the definition under section 1302 of the Affordable Care Act and implementing regulations at 45 CFR Parts 147, 155, and 156, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. Under that definition, EHBs include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope of benefits to a typical employer plan, which will constitute minimum coverage in an ABP.

C. Exchanges: Eligibility and Enrollment

1. Legislative Overview

Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange that: (1) Facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers with the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under subtitle D of title I of the Affordable Care Act. Section 1311(d) of the Affordable Care Act describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related requirements. Section 1321(c)(1) directs the Secretary to establish and operate an Exchange within each state that either: (1) does not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operational by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to issue regulations setting standards to implement the statutory requirements related to Exchanges, QHPs, and other standards under title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code of 1986 (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the Affordable Care Act establishes requirements for reducing the cost-sharing obligations of eligible individuals who enroll in a QHP through an Exchange, including special cost-sharing rules for certain Indians.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for enrollment in QHPs through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment under section 5000A of the Code.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other insurance affordability programs.

This final rule supplements and amends provisions originally published as the March 27, 2012 rule titled ''Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers'' (hereafter referred to as ''Exchange Final Rule'') (77 FR 18310) which encompasses key functions of Exchanges related to eligibility and enrollment.

Unless otherwise specified, the provisions in this final rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act.

2. Stakeholder Consultation and Input

HHS has consulted with interested stakeholders on policies related to the eligibility provisions and Exchange functions. HHS held a number of listening sessions with consumers, providers, employers, health plans, and state representatives to gather public input, and released several documents for public review and comment. HHS also released a bulletin that outlined our intended regulatory approach to verifying access to employer-sponsored coverage and sought public comment on the specific approaches.

Finally, HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, consultation with Medicaid directors, and meetings with tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

We considered input from these stakeholder meetings and in response to the bulletin on verifying access to employer-sponsored coverage, as well as comments provided in response to the proposed rule as we developed the policies in this final rule.

3. Structure of the Final Rule

The regulations related to Exchanges and QHPs outlined in this final rule are codified at 45 CFR parts 155 and 156. Part 155 outlines the standards related to eligibility for insurance affordability programs to facilitate a streamlined process for eligibility for enrollment in a QHP through the Exchange and in insurance affordability programs. Part 156 outlines the standards for health insurance issuers for participation in an Exchange. This final rule:

- Revises existing definitions and finalizes new definitions to 45 CFR part 155 subpart A.
- Provides a technical correction to 45 CFR part 155 subpart B.
- Finalizes standards related to authorized representatives under 45 CFR part 155 subpart C.
- Finalizes standards related to eligibility determinations for enrollment in a QHP and for insurance affordability programs under 45 CFR part 155 subpart D.
- Finalizes standards related to enrollment-related transactions, special enrollment periods, and terminations under 45 CFR part 155 subpart E.

[1] For more information on status as a grandfathered health plans under the Affordable Care Act, please see Interim Final Rule, ''Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act.'' Available at *http://cciio.cms.gov/resources/regulations/index.html#gp.*

• Finalizes standards related to termination of coverage under 45 CFR part 156 subpart C.

4. Alignment With Related Rules and Published Information

As noted above, on March 27, 2012, we published the Exchange final rule. This final rule revises and supplements the Exchange final rule, including by finalizing Exchange and Medicaid provisions associated with the eligibility changes under the Affordable Care Act of 2010.

D. Medicaid Premiums and Cost Sharing

Section 1916 of the Act describes long-standing limitations and requirements applicable in states that elect to provide for premiums and other cost sharing under Medicaid. Under section 1916 of the Act, certain individuals are protected from premiums and cost sharing, and cost sharing cannot be imposed on certain services. Permissible cost sharing under section 1916 of the Act is limited to ''nominal'' amounts (except in some circumstances for non-emergency use of a hospital emergency room). Section 1916 of the Act also establishes authority for states to impose premiums on medically needy beneficiaries and specific groups of individuals with family incomes above 150 percent of the federal poverty level (FPL). The Deficit Reduction Act of 2005 (DRA) established a new section 1916A of the Act, which gives states additional flexibility, allowing for alternative premiums and cost sharing beyond what is permitted under section 1916 of the Act for somewhat higher income beneficiaries. Such alternative cost-sharing approaches may be targeted to specific groups of individuals and payment may be required as a condition of providing services. All premiums and cost sharing imposed under sections 1916 and 1916A of the Act cannot exceed 5 percent of a family's income. For more background information on the streamlined and expanded flexibility regarding premiums and cost sharing, please refer to (78 FR 4657 and 78 FR 4658).

We initially implemented the DRA authorities through regulations that mirrored the dual statutory provisions by adding a set of additional regulations on alternative cost sharing under section 1916A of the Act to existing regulations setting forth the framework for cost sharing under section 1916 of the Act. We believe states found this duality confusing and, in this final rule, we have integrated the two statutory authorities for premiums and cost sharing (sections 1916 and 1916A of the Act) into a unified framework.

II. Provisions of the Proposed Rule and Analysis of and Responses to Public Comments

A. Medicaid Eligibility Part II Final Rule

In the January 22, 2013 **Federal Register** (78 FR 4594), we published the proposed rule entitled ''Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing.''

We received a total of 741 timely comments from individuals, state Medicaid and CHIP agencies, advocacy groups, tribes and tribal organizations, policy and research organizations, health care providers, employers, insurers, and health care associations. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding the proposed changes.

In this final rule, we are only addressing some of the provisions of the proposed rule. We are reserving action on other provisions and intend to address those provisions in a subsequent final rule. We discuss below only those public comments associated with provisions addressed in this final rule.

We have revised some of the proposed regulations after careful consideration of the comments received. Some comments were outside the scope of the proposed rule, and therefore, are not addressed in this final rule. In some instances, commenters raised policy or operational issues that will be addressed through forthcoming regulatory and subregulatory guidance to be provided subsequent to this final rule; therefore, some, but not all comments are addressed in the preamble to this final rule.

Brief summaries of the proposed provisions that are being finalized in this rule, a summary of the public comments we received on those provisions (except specific comments on the paperwork burden or the economic impact analysis), and our responses to the comments are as follows. Comments related to the paperwork burden and the impact analyses are addressed in the ''Collection of Information Requirements'' and ''Regulatory Impact Analysis'' sections in this final rule.

The following sections summarize comments about the rule in general, as well as specific comments about certain policies. It should be noted that the summarized comments are structured to explain the provisions being finalized and do not necessarily follow the order of the regulation text:

1. Responses to General Comments

Generally, commenters were supportive of the policies in the proposed rule to continue the process of streamlining Medicaid and CHIP eligibility rules, policies and procedures; to support a consumer friendly approach, and provide increased flexibility for states.

Comment: Several commenters were concerned about the complexity of the proposed rules and the significance of the changes that need to be made to fully implement the provisions of the Affordable Care Act. Many commenters were concerned about the short timeframes for implementation and about states' ability to make needed changes to policy, operations, and information technology systems.

Response: We recognize that the timing of this final rule may result in implementation challenges, especially from a systems perspective. As such, we have evaluated the provisions of the January proposed rule and are finalizing in this rule only those provisions that we believe states are already in the process of implementing or must be finalized to meet statutory deadlines. The remaining provisions of the proposed rule will be addressed at a later date.

We will continue to work with states to support their implementation efforts, ensure successful partnerships between states and the federal government. We will also continue to offer intensive technical assistance and support to states, and facilitate sharing of experience and knowledge across states. Consistent with one commenter's recommendation, we will also utilize other tools, including subregulatory guidance and the State Operations and Technical Assistance (SOTA) initiative to address additional state questions that arise.

2. Appeals—Delegation of Authority To Conduct Medicaid Fair Hearings

We proposed to implement sections 1413 and 2201 of the Affordable Care Act in part through procedures to coordinate Medicaid fair hearings under section 1902(a)(3) of the Act concerning eligibility for populations whose income is determined using modified adjusted gross income (MAGI)-based methodologies of the Act with appeals

of eligibility determinations that are made using MAGI-based methodologies by Exchanges for advance payment of premium tax credits and cost-sharing reductions under section 1411(f) of the Affordable Care Act. Consistent with the requirements to streamline and coordinate eligibility determinations, under section 1943(b)(3) of the Act, as added by section 2201 of the Affordable Care Act, we proposed to provide states with an option to delegate the authority to conduct appeals to an Exchange or Exchange appeals entity. The option is similar to the option states have to delegate Medicaid eligibility determinations to an Exchange under § 431.10. We also proposed changes to existing regulations at part 431 subpart E to support further modernization and streamlining of the Medicaid fair hearing process.

In this final rule, we are finalizing the provisions of our proposed rule related to delegation of authority to conduct Medicaid fair hearings to an Exchange and an Exchange appeals entity at sections §§ 431.10, 431.205(b), 431.206(d) and (e), 431.240 and the proposed rule related to reinstatement of an application at §§ 435.907(h) and 457.340(a). As discussed in section II.A.3. of this final rule (relating to notices), we also are adopting proposed revisions to the current regulations at sections §§ 431.211, 431.213, 431.230, and 431.231, related to modernizing the process of providing notices to applicants and beneficiaries of their fair hearing rights and decisions. In addition to providing substantive comments on the proposed regulations related to coordination of appeals across the Exchange, Medicaid and CHIP, a number of commenters requested delayed implementation of those provisions. To provide states with additional time to consider and effectuate implementation of such coordination, as well as to provide us with additional time to consider the comments received, we are not addressing proposed provisions at §§ 431.200, 431, 201, 431.205(e), 431.206(b), (c)(2), (e) as it relates to accessibility under § 435.905(b), 431.210, 431.220, 431.221, 431.224, 431.232, 431.241, 431.242, or 431.244. Further, we are not addressing the definitions related to appeals proposed in 435.4, nor the provisions related to coordination of appeals in § 435.1200. We expect to address these proposed provisions in a subsequent rulemaking. Until final regulations are released, current rules in part 431, subpart E continue to apply. We note that while we are not finalizing our proposed rules relating to accessibility in the fair hearing process or as it relates appeals and notices at § 431.205(e) and § 431.206(e) at this time, fair hearing processes and notices must continue to be provided in an accessible manner in accordance with relevant federal statutes, including the Americans with Disabilities Act and Title VI of the Civil Rights Act of 1964, as well as any applicable state laws.

We received the following comments regarding the proposed regulations related to delegation of fair hearings and reinstatement of applications in certain circumstances, which we are addressing in this rulemaking:

Comment: Many commenters supported our approach to permit delegation of fair hearings to an Exchange or Exchange appeals entity so that an integrated hearing could be conducted to address Medicaid and Exchange-related eligibility issues together. We also received comments supporting the proposals to streamline and simplify our current fair hearings rules. While not providing specific recommendations, the commenters asked that we consider additional measures to coordinate Medicaid and Exchange eligibility appeals even more effectively. A few commenters requested that the final rule maintain state flexibility for states to retain the Medicaid appeals function within the Medicaid agency.

Several commenters were concerned that our proposed rules require duplicative processes because states must maintain the infrastructure and capacity to hear MAGI-based appeals, even if the state delegates the authority to conduct fair hearings to an Exchange. One commenter requested that we eliminate the requirement at proposed § 431.10(c)(1)(ii) and § 431.205(b)(1)(ii) that an individual be provided an opportunity to request a fair hearing before the Medicaid agency when the state has otherwise delegated authority to conduct the individual's fair hearing to the Exchange, and instead make this provision a state option. The commenter believed that this requirement would undermine the efficiencies achieved through delegation. Another commenter recommended that only one hearing opportunity be made available to individuals, instead of requiring a hearing if determined ineligible for Medicaid and a hearing related to the eligibility for advance payment of premium tax credits and cost-sharing reductions.

Response: We appreciate the support for the proposal to permit states to delegate MAGI-based eligibility appeals to an Exchange or Exchange appeals entity. We note that such delegation is at state option. States are not required to delegate such authority, but may continue to have the Medicaid agency conduct all Medicaid fair hearings.

We understand commenters' concern about duplication of effort in requiring that Medicaid agencies retain an infrastructure independent of the Exchange appeals process to conduct MAGI-based Medicaid eligibility appeals when the state has delegated authority for MAGI-based eligibility appeals to an Exchange. There are two key reasons why the Medicaid agency must maintain its own appeals infrastructure. First, an individual whose application for Medicaid is denied or not acted upon with reasonable promptness has a right under section 1902(a)(3) of the Act to an opportunity for a fair hearing before the Medicaid agency. We do not anticipate that individuals will necessarily prefer to have their appeal heard by the Medicaid agency, but the statute requires that the option be provided in such delegation through our regulations. Second, in a state where the Federally-facilitated Exchange (FFE) is operating, the HHS appeals entity will only conduct appeals related to MAGI-based eligibility determinations made by the FFE. Thus, in states where the FFE is operating, the Medicaid agency will need to conduct all Medicaid fair hearings related to MAGI-based eligibility determinations made by the Medicaid agency. For these reasons, we are finalizing the requirement as proposed.

States have options to streamline the appeals infrastructure and reduce the number of appeals that will come before the Medicaid agency, in addition to the options to delegate Medicaid appeals authority under this final rule as discussed above. In a state that has established a state-based Exchange, the state Medicaid agency may delegate authority to conduct fair hearings of MAGI-based determinations to the state-based Exchange by requesting a waiver under the Intergovernmental Cooperation Act of 1968 (ICA), as long as the state-based Exchange is a state agency and the state can assure sufficient oversight of the delegated fair hearing process. As we noted in the preamble to the proposed rule, when a state has an ICA waiver permitting delegation of fair hearings to another state agency, the state is not required to offer individuals an option to have their hearing conducted by the Medicaid agency.

In states where the FFE is operating, a state Medicaid agency that allows the FFE to make a Medicaid eligibility

determination delegating such authority under § 431.10(c)(1)(i) has appeal delegation options not available to a State that proceeds with the assessment model. If the Medicaid agency authorizes the FFE to make MAGI-based eligibility determinations, the agency may also delegate authority to the HHS appeals entity to conduct fair hearings related to determinations of Medicaid ineligibility made by the FFE, establishing an integrated appeals process with simultaneous appeals related to a determination of advance payments of the premium tax credits or cost-sharing reductions. The Medicaid agency would still need to maintain the ability to conduct fair hearings for eligibility determinations and denials made by the Medicaid agency, as well as when delegations are made under these regulations for individuals who opt out of a coordinated appeal before the Exchange or Exchange appeals entity, and specifically request a hearing before the Medicaid agency. States will also need to continue to conduct fair hearings related to non-MAGI based eligibility determinations, as well as fair hearings related to termination, suspension, or reduction of covered benefits and other adverse determinations.

Finally, with respect to the recommendation that a right to only one hearing be made available, we note that there are two separate statutory authorities for appeals related to Medicaid and enrollment in a QHP and eligibility for APTC and cost sharing reductions, at section 1902(a)(3) of the Act and section 1411(f) of the Affordable Care Act, respectively. While we permit states to integrate these hearings and processes as much as possible, both state Medicaid agencies and the Exchange have distinct responsibilities to provide for such hearings, and we do not have authority to eliminate individuals' statutory rights, or a Medicaid agency's or Exchange's statutory responsibility. We note that we are not addressing in this final rule the proposed requirements relating to coordination of notices. Those proposed rules will be addressed in future rulemaking.

Comment: Several commenters requested clarification of our proposals on delegation of Medicaid appeals to the FFE, a state-based Exchange, or a state with a partnership with the FFE. In addition, commenters sought clarification regarding when an individual's appeals rights are triggered in states which have delegated authority to make Medicaid eligibility determinations to the Exchange versus states in which the Exchange will make only an assessment of potential Medicaid eligibility. A few commenters requested clarification about whether a delegation of authority to conduct Medicaid fair hearings to a state-based Exchange would extend to an appeal to the HHS appeals entity. The commenters were concerned that appeals could not be coordinated at the HHS appeals entity, rendering meaningless any efforts to achieve coordination at the state level.

Response: States may choose to delegate authority to conduct Medicaid fair hearings for MAGI-based eligibility determinations to the Exchange operating in the state regardless of whether the Exchange is the FFE, the state-based Exchange or a partnership between the state and the FFE in accordance with the final rules at § 431.10(c) and (d). There is no difference in the delegation authority under the regulations, as proposed or as finalized, based on the type of Exchange. In accordance with such delegation, the Exchange or Exchange appeals entity may provide a fair hearing on Medicaid issues, but individuals must have the option to have their Medicaid fair hearing heard directly before the single state agency. As discussed below, states with state-based Exchanges that are state governmental agencies also have an additional way to coordinate appeals, beyond delegation under our rules, through a waiver granted under the Intergovernmental Cooperation Act. Under such a waiver, individuals would not have a right to have their Medicaid appeal heard by the single state agency.

In a state that has delegated authority to the Exchange to make Medicaid eligibility determinations based on MAGI, individuals have the right to request a fair hearing when the Exchange has determined the individual ineligible for Medicaid based on MAGI. Thus, the determination of ineligibility by the Exchange will trigger the individual's appeal rights. If the state has delegated authority to the Exchange to conduct fair hearings under these regulations, such an individual found ineligible for Medicaid by the Exchange could request a fair hearing at the Exchange or Exchange appeals entity so that there would be one integrated hearing conducting the Exchange-related and Medicaid appeals at the same time, or the individual may instead request his or her Medicaid issue be heard at the Medicaid agency. If, an individual who is found by the Exchange to be not eligible for Medicaid based on MAGI seeks a determination based on non-MAGI criteria, the individual's electronic account is transferred to the Medicaid agency for a full evaluation by the agency in accordance with § 155.345(b) or (c) of the March 2012 Exchange eligibility final rule. If the Medicaid agency still determines the individual ineligible, he or she would be able to appeal that decision using the Medicaid agency's fair hearing process.

In states in which the Exchange will make an assessment of Medicaid eligibility, and will not make final Medicaid eligibility determinations or denials, an assessment of ineligibility for Medicaid based on MAGI will not trigger Medicaid appeal rights. This is because an assessment is not a final Medicaid eligibility determination. As indicated in § 155.302(b)(4) of the March 2012 Exchange rule, as revised in this rulemaking, applicants assessed by the Exchange as not potentially eligible for Medicaid based on MAGI but as potentially eligible for Medicaid on another basis will be transferred to the Medicaid agency for a full Medicaid determination; for these applicants, Medicaid appeal rights will be triggered when the Medicaid agency makes a final eligibility determination. Under § 155.302(b)(4), applicants assessed as not potentially eligible for Medicaid on any basis will have a choice whether to withdraw their Medicaid application or obtain a full determination by the Medicaid agency. If the applicant withdraws his or her Medicaid application, a final determination or denial of Medicaid will not be made, and therefore no appeal rights arise at that point. (The applicant will have the ability to reinstate their Medicaid application in certain circumstances, discussed more fully below). When an applicant obtains a formal determination by the Medicaid agency, the Medicaid agency's determination will trigger appeal rights, if applicable.

Finally, if a state agency delegates authority to conduct MAGI-based eligibility appeals to an Exchange, including a state-based Exchange, in accordance with § 431.10(c) and (d) of this final rule, such a delegation would extend to any government agency adjudicating an Exchange appeal, including the HHS appeals entity. We note, however, that if a state delegates authority to conduct fair hearings through an ICA waiver to another state agency, including a state-based Exchange or state-based Exchange appeals entity, Medicaid decisions made by that entity could not be appealed to the HHS appeals entity. The ICA waiver is a waiver of single state agency requirements that permits alternative arrangements of state agency functions to another state agency. Once

such an agency has issued a decision after a Medicaid fair hearing, that Medicaid decision would be the final decision of the Medicaid agency and thus no further right of appeal would be available to the individual. If the individual decided to appeal his or her advance payment of premium tax credit, cost-sharing reduction or Exchange eligibility decision to the HHS appeals entity, that entity would need to adhere to the Medicaid appeals entity decision under § 155.302(b)(5), as revised in this final rule, and § 155.345(h) which will prevent inconsistent decisions between the HHS appeals entity and the state-based Exchange or Exchange appeals entity.

Comment: Many commenters requested clarification on the scope of fair hearings that may be delegated from a Medicaid agency to an Exchange or Exchange appeals entity. Commenters specifically requested clarification regarding whether fair hearings of eligibility determinations on bases other than MAGI may be delegated to an Exchange or Exchange appeals entity, and whether findings other than MAGI-based income determinations may be delegated to an Exchange or Exchange appeals entity.

Response: The term ''MAGI-based determinations'' is used to refer to determinations in which financial eligibility is determined using the MAGI-based methods described in § 435.603 of the March 2012 final Medicaid eligibility rule. However, in accordance with § 435.911(c) of the March 2012 final Medicaid eligibility rule, a determination of eligibility based on MAGI also entails a determination that an individual meets the non-financial conditions of eligibility, including state residency and citizenship or satisfactory immigration status, and the denial of eligibility for an individual considered for coverage under a MAGI-based eligibility group may be based on failure to meet any of the financial or non-financial conditions of eligibility. A delegation of fair hearing authority under § 431.10(c)(1)(ii) to an Exchange or Exchange appeals entity regarding a denial of MAGI-based eligibility will need to address any or all of the bases of denial, just as a fair hearing conducted by the Medicaid agency would. We note that we have made some technical modifications to the regulation text at § 431.10(c)(1)(ii) to help clarify this point. As also noted in the preamble to the proposed rule, we remind states that while all appeals for an individual with a MAGI-based eligibility determination may be delegated to an Exchange or Exchange appeals entity under the regulation at § 431.10(c)(1)(ii), the FFE will only accept a delegation of appeals involving determinations rendered by the FFE.

The permissible scope of delegation under § 431.10(c)(1)(ii) to an Exchange or Exchange appeals entity is limited to appeals of MAGI-based eligibility determinations. Appeals related to denials of eligibility for individuals excepted from application of MAGI-based methodologies (for example, eligibility based on disability) may not be delegated under the regulation. As discussed above, states may delegate such appeals to another state agency, including a state-based Exchange, by requesting an ICA waiver.

Comment: One commenter asked whether there is a timeframe under which the individual must request a fair hearing before the Medicaid agency to effectuate the requirement under § 431.10(c)(1)(ii) that the state agency must provide an individual an option to have his or her Medicaid appeal conducted at the Medicaid agency when delegating authority to conduct fair hearings to an Exchange or Exchange appeals entity.

Response: An individual must be provided the opportunity to opt to have his or her Medicaid appeal adjudicated at a hearing conducted at the Medicaid agency, instead of having his or her appeal for both enrollment in a QHP and eligibility for APTC and CSR and eligibility for Medicaid addressed at an integrated hearing at the Exchange or Exchange appeals entity. Section 431.206(d) specifies that the individual must be informed of how to exercise this right. We note that we clarify our proposed regulation at § 431.206(d) to require that individuals must be informed of this option in writing. We are revising the regulation text at § 431.10(c)(1)(ii) to clarify that the request for a hearing before the Medicaid agency would need to be requested *instead* of the Exchange hearing. While we are not specifying a specific timeframe, we would expect that if an individual was opting for a hearing before the Medicaid agency, that request would be made at the time that the individual is requesting a hearing. Thus, we finalize these proposed regulations with these minor modifications.

Comment: Many commenters believed that delegation of fair hearing authority under the regulation should be permitted. Some of the commenters emphasized the need to permit delegation only in the simplest manner reducing burden to the consumer, and without any duplication of appeals processes. A few commenters suggested we permit delegation under the regulation only to an independent state agency employing Administrative Law Judges, and that delegation to any other state agency still require an ICA waiver to ensure transparency and opportunity for stakeholder input. A few commenters asked for clarification of the conditions and process required when requesting an ICA waiver. One commenter opposed delegation of authority to conduct fair hearings to any other state or Exchange entity stating that any delegation is duplicative, as state agencies still will be required to conduct Medicaid MAGI-based hearings.

Response: Under proposed § 431.10(c)(1)(ii), states would be able to delegate authority to conduct MAGI-based fair hearings to an Exchange or Exchange appeals entity, but to delegate Medicaid fair hearings to another state agency, states would need to request an ICA waiver. We sought comment on whether states also should be permitted to delegate authority to conduct fair hearings to another state agency under the regulation.

The purpose of the proposed rule is to promote coordination of appeals and simplification of the appeals process by permitting delegation of Medicaid appeals to the Exchange or Exchange appeals entity. Because coordination between insurance affordability programs is a key goal of the Affordable Care Act, we are finalizing, with minor modifications, the proposed regulations at § 431.10(c)(1)(ii) and at § 431.205(b)(1)(ii) to permit delegation of authority to conduct Medicaid fair hearings for denials of MAGI-based eligibility to the Exchange or Exchange appeals entity, including the FFE, state-based Exchange or HHS or state-based Exchange appeals entity, provided these entities are government agencies or public authorities that maintain personnel standards on a merit basis. After consideration of the comments, we have determined not to extend authority to delegate Medicaid fair hearings to state agencies other than a state-based Exchange or an Exchange appeals entity under the regulations because it is already allowed through an ICA waiver. We note that the main goal and justification for the delegation of fair hearings under the regulation is to achieve coordination across insurance affordability programs, something which would not be served by delegation to another state agency. Furthermore, Medicaid agencies already can delegate conduct of fair hearings to other state agencies through an ICA waiver, and there is nothing additional that states would be able to accomplish

through delegation under the regulation as opposed to an ICA waiver. Indeed, the flexibility available to states under an ICA waiver is greater than that which is available under the regulation since delegation of fair hearings under an ICA waiver does not require that states provide individuals a right to opt for a hearing before the Medicaid agency, nor would the delegation be limited to MAGI-related appeals.

We have and will continue to apply similar conditions to the delegation of fair hearings under an ICA waiver as those we require under § 431.10(c) and (d). As explained in the proposed rule, an ICA waiver may be requested through a straightforward process using a state plan amendment (SPA), and CMS staff is available to provide technical assistance to states in completing that process. We note that our rules relating to hearing officers do not require that hearing officers be Administrative Law Judges or set any particular qualifications for hearing officers other than impartiality. States have flexibility to set such requirements in implementing fair hearings as they see appropriate. Thus, we do not set standards regarding the qualifications of hearing officers for states that delegate authority to conduct fair hearings or specify rules if the state agency employs Administrative Law Judges in this final rule.

Comment: One commenter expressed concern that the proposal to remove § 431.10(e)(2) and (e)(3) weakens the single state agency authority when delegating authority to conduct appeals to another agency. Other commenters supported the removal of those paragraphs because they are inconsistent with the goals of delegation of authority of appeals.

Response: We are finalizing our proposal to remove paragraphs § 431.10(e)(2) and (e)(3) as they are inconsistent with the option to delegate the authority to conduct fair hearings to an Exchange. We believe that the proposed language in § 431.10(e), which we are finalizing without modification, clearly provides that only the Medicaid agency may develop and issue rules and policy related to the Medicaid program.

Comment: Several commenters requested clarification of the kinds of conclusions of law that could be subject to review by the agency under § 431.10(c)(3)(iii). They also asked how the agency review process a state may establish to decisions made by an Exchange or Exchange appeals entity conducting Medicaid fair hearings under this provision relates to the ''trumping rule'' at § 155.302(b)(5), which provides that if an appeals decision rendered by the Exchange or Exchange appeals entity conflicts with a fair hearing decision concerning the same individual rendered by the Medicaid agency, the Exchange must adhere to the Medicaid fair hearing decision. A number of commenters supported the limitation of the agency review process to conclusions of law. One commenter requested that the option be extended to findings of fact. Others recommend that the option be eliminated altogether. These commenters discussed that any review by the state agency of a hearing officer's legal or factual conclusions would violate the due process protections afforded under *Goldberg* v. *Kelly* to have the appeal decided by a neutral arbiter. One commenter suggested that the regulation at § 431.10(c) specify the timeframe in which the Exchange or Exchange appeals entity be required to issue a decision for the state agency to complete its review within the time limits set forth in § 431.244.

Response: We are finalizing this provision as proposed with minor revisions to clarify the scope of the review process. We note the provision at § 431.10(c)(3)(iii) is a state option for Medicaid agencies to establish a process that permits a limited review of the decisions made by the Exchange or Exchange appeals entity to ensure Medicaid fair hearings are made with the proper application of federal and state Medicaid law and regulations, including subregulatory guidance and written interpretive policies. The proposed regulation text is being revised to clarify the scope of what the agency may review would be limited to the legal conclusions made during the fair hearing to ensure that they appropriately apply federal and state Medicaid law and regulations, including subregulatory guidance and written interpretive policies properly and that the review process be conducted by an impartial official who was not directly involved in the initial determination.

By way of example, suppose that the Exchange hearing officer finds that an individual has $800 in wages and $200 in child support income each month and, based on these amounts, concludes that the individual's MAGI-based household income is $1,000 per month. Suppose also that the applicable income standard for the applicable household size for this individual is $900 per month, and that the hearing officer upholds the initial denial of eligibility. The findings of $800 in wages and $200 of child support per month would be factual findings, which the Medicaid agency could not review under the option provided at § 431.10(c)(3)(iii). However, the hearing officer's inclusion of the wages and child support income in total MAGI-based household income involves an application of MAGI-based methodologies, described in § 435.603 of the March 2012 Medicaid eligibility final rule, as implemented by the state, which would be reviewable as a conclusion of law. In this case, the inclusion of wages would be correct, but the inclusion of child support income would be incorrect, and the agency upon finding such an erroneous application of state or federal rules could reverse the hearing officer's decision to conclude that, based on household income of $800, the individual is Medicaid eligible.

Because of the important role that an impartial hearing officer plays in evaluating evidence and weighing credibility in making findings of fact, we are not extending the option at § 431.10(c)(3)(iii) to include agency review of findings of fact. We note that fair hearings conducted under a delegation of authority in accordance with § 431.10(c)(1)(ii) must be conducted in accordance with § 431.10(d)(1), which requires that the delegation agreement between the agency and the Exchange or Exchange appeals entity must set forth the responsibilities of each party to effectuate the provisions of part 431 subpart E of the regulations. Section 431.205(d) provides that the fair hearing process under subpart E must meet the due process standards set forth in *Goldberg* v. *Kelly,* 397 U.S. 254 (1970), which requires that any review process be conducted by an impartial official, and be based solely on the information and evidence in the record. We have made a minor modification to § 431.205(b)(1)(ii) to clarify that the hearing process provided through delegation of authority to conduct a fair hearing to an Exchange or Exchange appeals entity would include the review by the agency of the Exchange or Exchange appeal entity's application of federal and state Medicaid law and regulations, if such review is elected by the state under § 431.10(c)(3)(iii) and conducted by an impartial official who was not directly involved in the initial determination. We note also that the state's election under § 435.10(c)(3)(iii) to conduct this limited review does not create a right for the individual to request or receive a *de novo* hearing before the agency.

The review process that can be established under § 431.10(c)(3)(iii) functions completely independently from the ''trumping rule'' at § 155.302(b)(5) of the Exchange proposed rule. The former comes into

play when an individual's fair hearing has been delegated to, and is heard by, the Exchange or Exchange appeals entity. The ''trumping rule'' at § 155.302(b)(5) as modified by this rulemaking and at § 155.345(h) is invoked when the Medicaid agency has conducted the Medicaid fair hearing relating to the appeal of a denial of Medicaid eligibility and the Exchange or Exchange appeals entity also has conducted a hearing related to an appeal of an award of advance payments of premium tax credits. Similar to the ''trumping rule'' at § 155.302(b)(5) of the March 2012 Exchange final rule relating to initial eligibility determinations, if the Medicaid agency's fair hearing decision conflicts with the Exchange appeals decision, the Exchange must adhere to the Medicaid agency or fair hearing decision for Medicaid eligibility under § 155.302(b)(5) and § 155.345(h).

Finally, we do not believe it is necessary to require in the Medicaid regulations specified timeframes within which an Exchange, in conducting a delegated fair hearing, must transmit a decision to the Medicaid agency. Instead, as part of the agreement required under § 431.10(d), in delegating the fair hearing authority to the Exchange or Exchange appeals entity, the parties will need to stipulate each party's responsibilities to ensure that the time frames established under § 431.244(f) are met.

Comment: One commenter sought clarification of whether the review process of appeal decisions made by the Exchange which the commenter expressed as ''required'' at § 431.10(c)(3)(iii) is considered in the agency's quality assurance Payment Error Rate Measurement (PERM) sampling.

Response: The regulation at § 431.10(c)(3)(iii) does not set a requirement, but provides states an option to establish a review process of appeal decisions as a part of its oversight of the delegation of authority to conduct fair hearings to an Exchange or Exchange appeals entity. We note the agency has other means to oversee its delegation of authority to conduct hearings. Implications for PERM are beyond the scope of this regulation; we intend to issue additional guidance on PERM.

Comment: Many commenters supported the reinstatement of an individual's Medicaid application at § 435.907(h) when the individual had withdrawn his or her application after an assessment of Medicaid ineligibility by the Exchange, appealed the level of APTC and CSR awarded by the Exchange, and the Exchange or Exchange appeals entity reversed the initial assessment and found the individual to be potentially eligible for Medicaid. A few commenters sought clarification regarding the retroactive nature of the reinstatement effective as of the date the individual submitted the application to the Exchange. Another commenter asked how this provision relates to the timeliness requirements for Medicaid agencies to process an application under § 435.912 of the March 2012 Medicaid eligibility final rule. A few commenters raised a concern that if an Exchange appeals entity hearing officer upholds the finding of eligibility for advance payment for premium tax credit, the reinstatement would not take effect. These commenters recommended that the Medicaid application be reinstated whenever an individual files an appeal with the Exchange or Exchange appeals entity to capture a broader set of individuals who may be eligible for Medicaid or CHIP.

Response: We appreciate the support for the provision at § 435.907(h) to reinstate the Medicaid application of an individual who has withdrawn his or her Medicaid application upon initial assessment of Medicaid ineligibility by the Exchange, but who is subsequently assessed as potentially Medicaid eligible following an appeal related to an award of advance payments of the premium tax credits or cost sharing reductions. We are finalizing this provision as proposed, except to clarify that the 45-day or 90-day timeliness standards do not apply to these reinstated applications. By the time the Exchange appeal decision is rendered, 45 or 90 days from the date of application may already have elapsed, making compliance by the Medicaid agency unrealistic. Instead we clarify that the timeliness standards required under § 435.912 of the March 2012 Medicaid eligibility final rule apply based on the date the application is reinstated. However, we note that the 45 and 90 days prescribed in the regulation represent the outer limit for all applications. In the case of a reinstated application which has been the subject of an Exchange appeal, we would expect that the individual's electronic account would be comprehensive, and that considerably less time would be needed for the Medicaid agency to act on the case. We would expect states to take this into account in establishing timeliness standards for prompt determinations on reinstated applications under § 435.911(c) and § 435.912 of the March 2012 Medicaid eligibility final rule. The reinstated application must be made effective retroactive to the date the individual submitted his or her application to the Exchange (not the date the application is reinstated) to protect the effective date of coverage required under § 435.914 of the current regulations (redesignated at § 435.915 in the March 2012 Medicaid eligibility final rule). We also proposed a similar application reinstatement provision for CHIP at § 457.340(a), which we are finalizing as proposed with a minor modification to remove the reference to § 435.909 which was inadvertently inserted in the proposed rule and has no relationship to CHIP. We note that states also will need to develop reasonable timeliness standards for such reinstated applications in accordance with § 457.340(d) of the March 2012 Medicaid eligibility final rule.

We have not modified the proposed regulation text to reinstate the Medicaid or CHIP application of every individual who has withdrawn his or her Medicaid or CHIP application in accordance with § 155.302(b)(4) of the March 2012 Exchange final eligibility rule and who then subsequently appeals the determination of eligibility for advance payments of the premium tax credits or cost-sharing reductions at § 435.907(h) and § 457.340(a). We believe that the interests of individuals filing an Exchange appeal who should have been assessed as potentially Medicaid eligible by the Exchange, but who nonetheless withdrew their Medicaid application following the Exchange's assessment, will be protected through the Exchange appeals process because the Medicaid application for those assessed potentially Medicaid eligible will be reinstated, and their account transferred to the Medicaid agency for a full determination. On the other hand, to reinstate the Medicaid application of every applicant for whom the Exchange appeals processes ultimately confirms the initial assessment of Medicaid ineligibility made by the Exchange—regardless of how high above the Medicaid income standard the individual's income may be—would create confusion for individuals and impose, we believe, unnecessary administrative burden on state Medicaid agencies. We expect to work closely with Exchanges to ensure accurate assessments of Medicaid and CHIP eligibility in accordance with federal regulations.

Comment: One commenter sought clarification of when Medicaid agencies will have to decide whether or not to delegate eligibility determinations or fair hearings to the Exchange, and whether there will be additional

requirements if the agency chooses not to delegate such responsibility.

Response: There is no deadline to elect to delegate eligibility determinations or appeals to an Exchange or Exchange appeals entity. As discussed in section II.A.6. of preamble, the regulation permitting delegation of eligibility and fair hearings goes into effect on October 1, 2013. Once a state decides to delegate authority to conduct eligibility or appeals, it must indicate such an election through the state plan, establish a written agreement with the Exchange or Exchange appeals entity, and otherwise comply with the provisions set forth in the regulation. A state may revoke its delegation at a later time through the same process. Whether or not a state chooses to delegate authority, it must comply with the provisions of § 435.1200, § 457.348 and § 457.350, issued in the March 2012 Medicaid eligibility final rule, to ensure coordination across all insurance affordability programs and a seamless consumer experience. We proposed revisions to these provisions in the January 2013 proposed rule to address the agencies' responsibilities to coordinate notices and appeals, but are not finalizing them in this final rule.

Comment: One commenter questioned whether a state might be able to obtain the enhanced matching funds for systems enhancement at a 90/10 match for enhancement of their appeals systems. Another commenter asked for clarification as to whether federal financial participation (FFP) would be available for appeals delegated to an Exchange.

Response: The enhanced FFP match rate of 90/10 for the design, development, and installation of eligibility systems is available only for components of the Medicaid Management Information System (MMIS), including eligibility and enrollment systems through the end of 2015, subject to meeting the seven conditions and standards outlined in the April 19, 2011 final rule at 74 FR 21950. A 75/25 match rate is available for operations and maintenance of these systems. Appeals systems do not qualify for enhanced funding under these rules. Instead, FFP at a 50/50 rate is available. For more details on 75/25 match rate discussion, see *http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Affordable-Care-Act_-Newest-Version.pdf.* The availability of FFP and responsibility for funding subject to cost allocation rules applies to administration of fair hearings in the same manner as any other context and is not affected by the state's delegation decision.

Comment: A few commenters suggested that we revise § 431.240 to require that hearing officers who adjudicate Medicaid fair hearings abide by specific ethical standards, either the National Association of Hearing Officials' Model Code of Ethics or the National Association of Administrative Law Judiciary's Model Code of Judicial Conduct for State Administrative Law Judges. We did not receive any comments related to our proposed modification of § 431.240 related to access to information.

Response: As discussed above, existing regulation at § 431.240 require hearing officers to be impartial. Additionally, existing regulations at § 431.205 require hearing systems to comport with due process standards of *Goldberg* v. *Kelly,* 397 U.S. 254 (1970). Current regulations do not require hearing officers to belong to a particular profession, and we did not propose to modify this policy in the proposed rule. Therefore, we are not making any changes to § 431.240 in response to this comment. However, as noted above, we are addressing this comment, in part, by including that an impartial decision-maker must be used if a state is electing to establish a review process of legal conclusions made by hearing officers operating under delegated fair hearing authority. We also encourage states to examine this issue further and to ensure that the requirement to utilize impartial hearing officers at § 431.240 are adhered to when conducting fair hearings. We finalize § 431.240(c) without modification.

3. Notices

a. Electronic Notices (§ 435.918)

Current notice regulations require paper-based, written notices. To establish a more timely and effective notification process, proposed § 435.918 would direct states to provide individuals with the option to receive notices through a secure, electronic format in lieu of written notice by regular mail. Consumer safeguards were proposed to ensure that individuals make a conscious choice to receive notices in electronic format, and would be able to opt-in and opt-out of their election. We solicited comments regarding the proposed consumer safeguards. In addition, we requested comments on whether other types of communications, in addition to eligibility notices, should be offered in electronic format. We are finalizing § 431.206(e), to permit beneficiaries to receive notices regarding fair hearings electronically, consistent with proposed § 435.918. We note that we are not addressing in this final rule comments related to accessibility of fair hearing notices. We will consider these comments and this portion of § 431.206(e) when we finalize our rules related to accessibility for individuals who are limited English proficient and individuals with disabilities in a future rulemaking. We also proposed modifications to §§ 431.211, 431.213, 431.230, and 431.231 to update and modernize the language in the regulation to remove the term ''mail'' and instead use ''send,'' to reflect the option for beneficiaries to receive notices electronically, consistent with the consumer protections in proposed § 435.918. We proposed in § 457.110(a)(1) the same consumer option and protections for electronic notices in CHIP, and we are making technical changes in the final rule to better align the provisions. A modification was also proposed to paragraph (a) in § 457.110 regarding the accessibility of information for individuals who are limited English proficient and individuals with disabilities. However, we will finalize this provision in future rulemaking.

We received many comments regarding the requirement to provide individuals with the option to receive notices electronically, the majority of which supported this option as an important part of modernizing the notification process provided that strong consumer protections are in place.

Comment: We received many comments regarding proposed § 435.918(a)(1), which would require the agency to confirm by regular mail the individual's election to receive notices electronically. Some commenters recommended, instead, allowing electronic confirmation for individuals applying on-line. One commenter suggested that in states with a FFE, the FFE should be responsible for issuing all mailed confirmations. Also, several commenters were concerned that the proposed written confirmation actually required individuals to choose receipt of electronic notices twice, and that this would be confusing and burdensome for the agency and these consumers. Many other commenters encouraged CMS to maintain the requirement to confirm an individual's election through regular mail to ensure that individuals have made an informed decision, and to provide them with an opportunity to change their election. One commenter suggested that the mailed confirmation include a list of the types of notices that

the agency will send in electronic format.

Response: Proposed section § 435.918(a)(1), redesignated § 435.918(b)(1) in our final rule, requires the agency to send, via regular mail, written confirmation that an individual has elected to receive electronic notices and that forthcoming notices will be delivered electronically. This communication must also instruct the individual on how to change this election if the individual made the initial choice inadvertently or wishes to change his or her mind. The purpose of the mailed communication is to affirm the individual's choice and allow the individual an early opportunity to opt-out of receiving notices in electronic format. The individual does not have to respond to this written notice to complete his or her election to receive electronic notices; he or she need only respond if he or she wanted to change the initial election. Therefore, there will not be any need for individuals to request electronic notices twice, as some commenters thought. We are clarifying at § 435.918(b)(1) of the final regulation that it is the agency's responsibility to ensure that the individual's election to receive notices electronically is confirmed by regular mail, since the individual will receive all future communication from the Medicaid agency including information on how to establish an electronic account with the state, if he or she has not already done so. If a different arrangement makes more sense in a given state, the Medicaid agency and Exchange can delegate this responsibility to the other agency in the agreement entered into under § 435.1200(b)(3). We are not requiring that this communication specify which types of notices will be delivered in electronic format, but suggest that states take this under consideration as it would enable individuals to better anticipate the type of notices that will be posted to an electronic account. We anticipate, based on one state's experience piloting electronic notices, few individuals will revert back to paper notices. However, given that electronic notification will be a new approach for many individuals, we believe this is an important consumer protection to ensure that individuals make a deliberate choice regarding the format in which they receive information. In future years, when electronic notices are more prevalent, we will revisit whether written confirmation of the individuals choice to receive notices in electronic format is still a relevant consumer protection.

Comment: Several commenters requested that electronic notices be the default method for notice delivery such that if an individual fails to indicate whether he or she prefers an electronic or paper format for notices, notices would automatically be provided electronically. One commenter suggested that electronic notices should be the default for specific populations, such as those individuals determined eligible through an Exchange Web site.

Response: We maintain that electronic notices should be provided only if the individual affirmatively opts for such notices. The default approach makes an assumption that the individual has the technology to regularly retrieve notices posted to his or her electronic account. Even if an individual applies through an Exchange Web site, the individual may not have regular access to technology to enable ongoing retrieval of electronic notices. Consequently, we do not believe this change is appropriate at this time as it could pose a barrier to applicants and beneficiaries with limited access to technology.

Comment: Several commenters recommended that Medicaid and CHIP eligibility notices be provided in both electronic and in paper format until an individual indicates in writing that they no longer wish to receive such notices by regular mail. Some commenters also recommended that all notices regarding adverse actions always be sent in paper format via regular mail to allow for additional protection against delivery error. One commenter recommended that hearing scheduling notices should always be sent via regular mail to ensure adequate hearing slot availability.

Response: We are concerned that requiring agencies to provide dual electronic and paper notices may pose an administrative burden for some states. While we require that agencies provide individuals with a choice to receive notices in electronic format in lieu of paper format, at state option, all notices or a subset of notices, such as those relating to adverse actions, could be provided in dual formats. We appreciate the concern expressed for ensuring consumer protections against delivery error. In § 435.918(a)(4), the agency is required to send an email or other electronic communication alerting the individual that a notice has been posted to his or her account. To guard against delivery error, if the required alert is returned as undeliverable, the agency must send such notice by regular mail within three business days of the date of the failed electronic communication. This requirement has been further clarified by a revision to § 435.918(a)(5). We believe that electronic notices are likely to increase receipt of important eligibility information, as individuals will have greater flexibility to access notices regardless of changes to their postal address.

Comment: We received a few comments that recommended we amend § 435.918 to include specific language noting the importance of ensuring that the notice must be accessible to persons who are limited English proficient and individuals with disabilities.

Response: We agree that all eligibility notices must be accessible to persons who are limited English proficient and individuals with disabilities, and we will be addressing such rules in future rulemaking.

Comment: One commenter requested clarification on what constitutes an ''undeliverable'' communication in § 435.918(a)(5).

Response: ''Non-delivery reports'' are system messages that report the delivery status to the sender. We expect that if the agency receives a non-delivery report, this constitutes an undeliverable communication.

Comment: One commenter requested clarification regarding how to date a paper version of an electronic notice. When an electronic communication is undeliverable, indicating an individual may not be aware of an electronic notice posted to his or her account, § 435.918(a)(5) requires that the agency send a paper version of the electronic notice within three business days. The commenter, noting the ability to send the paper version of the electronic notice within 24 hours, supported maintaining the same date on both notices.

Response: It is important for the date of the paper notice to reflect the date it is sent, not the date of the undelivered electronic notice. We anticipate that while some states may be able to issue a paper version of the electronic notice within 24 hours, other states may take up to the required limit of 3 days. Individuals are given a limited time to take action, such as requesting a date for a hearing, and this is based on the date the notice is sent to the individual.

Comment: One commenter requested clarification as to whether agencies are required to monitor an individual's account to determine if a notice was accessed.

Response: We are not requiring that agencies monitor accounts to determine whether notices are accessed. If the electronic alert is not undeliverable, the agency should assume an individual is able to access his or her notice.

Comment: One commenter recommended that we include a

requirement that allows the agency to limit the number of times an individual can request that an electronic notice be provided in paper format.

Response: We believe that it is an important consumer protection to allow individuals to request notices in a paper format. Some individuals may not have the technology available to readily print notices from an electronic account.

Comment: A number of commenters supported offering additional types of communications through an electronic format. In addition to eligibility notices and information specified in subpart E of part 431, there are other communications that occur between an individual and the Medicaid or CHIP agency. Some of these communications include requests for additional information, annual renewal forms and reminders, premium payment information, and information on covered services.

Response: We do not believe it is necessary to amend § 435.918(a) to include other types of communications. In § 435.918(a), we specify that eligibility notices and information in part 435, and notices and information required under subpart E of part 431, be provided in electronic format. For example, information on covered services must be available electronically in addition to paper format, as required by § 435.905(a). Annual renewal forms must also be offered in electronic format in accordance with § 435.916. We do not think it is appropriate or operationally feasible to require other types of communications to be provided electronically. We encourage states with the capacity to provide additional communications electronically, and with beneficiaries preferring that mode of communication, to do so, as long as in compliance with any existing regulations that govern the type of communication.

Comment: One commenter asked whether proposed § 435.918(b), which asserts that the agency may only provide electronic notices if the individual elected to receive electronic notices and must be permitted to change such election at any time, is duplicative of paragraph § 435.918(a).

Response: We agree with the commenter, and the provision has been amended by removing redundant language in § 435.918(b)(1) and § 435.918(b)(2).

Comment: A number of commenters requested a later effective date for implementing electronic notices.

Response: We recognize that states are at different places in the development of their eligibility and enrollment systems, and that the technology needs to be in place to offer beneficiaries and applicants the option to receive notices electronically. We have amended § 435.918(a) to delay the requirement to provide notices electronically until January 1, 2015, but permit states to implement October 1, 2013 if their systems are ready.

Comment: One commenter suggested that we clarify whether ''send'' in § 431.230 means send by mail or in electronic format consistent with § 435.918.

Response: Under proposed § 431.206(e), all information required under subpart E of part 431 must be provided in electronic format in accordance with § 435.918, if an individual elects to receive such information in electronic format. To further clarify, we have added to § 431.201, that the definition of ''send'' means deliver by mail or in electronic format consistent with § 435.918.

Comment: One commenter requested clarification regarding § 431.231(c)(2), which provides beneficiaries 10 days to request a hearing from receipt of the notice of action. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period. The commenter specifically requested clarification regarding how an individual might show proof that they did not receive an electronic notice within the 5-day time period.

Response: We understand the concern expressed by the commenter, but do not believe that this issue is specific to the receipt of electronic notices, but receipt of notices in general. It is challenging for an individual to provide proof of a negative, however, it is important to provide individuals with the opportunity to demonstrate that they did not receive notices. One example of how an individual might demonstrate that he did not receive an electronic eligibility notice is by providing documentation that he closed the email account on record with the agency. If an individual cannot receive the emailed alert that a notice is posted to the electronic account, the individual is not in receipt of the notice.

Comment: A few commenters requested that we define whether the ''5 days'' § 431.231(c)(2) refers to calendar days or business days.

Response: We are not defining whether the ''5 days'' refers to calendar days or business days, but allow states the flexibility to define this in their operating procedures.

b. Coordinated Notices (§ 435.1200)

For individuals whose electronic account is transferred to the Medicaid agency for a determination of eligibility from another insurance affordability program, § 435.1200(d)(6) of the March 2012 Medicaid eligibility final rule directs that the Medicaid agency notify such other program of its final determination of eligibility or ineligibility only for individuals who have enrolled in the other program pending completion of the agency's final determination. We proposed to redesignate and modify this requirement at § 435.1200(d)(5) to require that the Medicaid agency notify the other program of the final determination of Medicaid eligibility or ineligibility for all individuals whose electronic account was transferred from another insurance affordability program. The same requirement was proposed for CHIP at § 457.348(d)(5). No comments were received regarding these specific provisions. We also proposed a number of other changes to § 435.1200 and § 457.348 relating to coordination of notices and appeals. In this final rule, we are codifying § 435.1200(d)(5) of the proposed rule at paragraph § 435.1200(d)(6). Other proposed changes to § 435.1200 of the March 2012 Medicaid final eligibility rule, including the redesignation of paragraph (d)(6), as appropriate, will be addressed in subsequent rulemaking. We are also finalizing proposed § 457.348(d)(5) as § 457.348(c)(6), but other proposed changes to § 457.348 will be addressed in subsequent rulemaking.

4. Medicaid Enrollment Changes Under the Affordable Care Act Needed To Achieve Coordination With the Exchange

a. Certified Application Counselors (§ 435.908 and § 457.340)

Many state Medicaid and CHIP agencies have a long history of supporting providers and other organizations to assist individuals in applying for and maintaining coverage. Commonly referred to as ''application assisters'' and referred to in this rulemaking as ''certified application counselors,'' these organizations and individuals provide direct assistance to individuals seeking coverage, and can play a key role in promoting enrollment among low-income individuals. The proposed regulations at § 435.908(c) sought to ensure that certified application counselors, whom we expect to continue to play an important role in facilitating enrollment in the expanded coverage options available under the Affordable Care Act, will have

the training and skills necessary to provide reliable, effective assistance to consumers. We proposed basic standards for states to certify application counselors, which we believe are consistent with the practice in many states today. These standards include proposed procedures to ensure that these trained certified application counselors have clear authority to access and protect confidential information about individuals they serve, and with that authority have a special relationship with the Medicaid agency that enables the counselors to track and monitor applications. The proposed regulations at § 435.908(c), as finalized in this rulemaking, are applicable to CHIP, as well under § 457.340(a) of the March 2012 Medicaid eligibility final rule; no revisions are needed or made to § 457.340(a). We received the following comments concerning the proposed certified application counselor provisions:

Comment: We received a few comments expressing support for the proposed requirement that states have a designated web portal for use by certified application counselors that has a secure mechanism for granting rights for only those activities the certified application counselor is certified to perform. Commenters stated that such a portal will increase the proportion of applications that are submitted electronically, thereby providing more applicants with access to electronic verification and real-time eligibility while increasing the state's administrative efficiency. Other commenters also recommended a clarification that states may use the same portal for Navigators and non-Navigator assistance personnel authorized under 45 CFR 155.205(d) and (e) with proper assignment of rights and functionality.

Response: We appreciate the support for the establishment of a designated web portal for use only by properly trained and certified application counselors. However, given the systems challenges states face in preparing for the initial open enrollment period and starting up the new system of insurance affordability programs, we are concerned that requiring such a portal could disrupt well-functioning application counselor programs that exist today. Therefore, while we encourage states to consider such portals as an effective vehicle for administering and overseeing certified application counselor programs, we are removing from the final rule the requirement that such portals be established as proposed at § 435.908(c)(3)(i). Although not required, states may elect to develop these portals to support the work of certified application counselors.

Comment: One commenter requested that we issue guidance on the availability of federal funding to help support grants or payments to certified application counselors—in particular information about how Medicaid administrative claiming can be used to match community-based investments in application assistance.

Response: FFP is available for state expenditures to certify and support certified application counselors, but, since community-based application counselors are not state or local employees, FFP is not available for salaries or other direct costs of certified application counselors.

Comment: Many commenters requested that we require that certified application counselors be trained to provide culturally and linguistically competent services. They believed that it is not sufficient to remind Medicaid and CHIP agencies of their responsibility to ensure access to individuals with limited English proficiency and those living with disabilities, and urged us to provide states with specific guidance and examples of how to fulfill this responsibility. Some commenters recommended that to be certified, application counselors must be trained in providing culturally and linguistically appropriate services. Some commenters recommended that we require training for application counselors include accommodating the health care needs of specific populations, such as children.

Response: Consistent with title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, and other civil rights laws, state Medicaid and CHIP agencies must ensure that their programs are accessible to individuals with limited English proficiency and individuals with disabilities. This responsibility is codified, in part, at § 435.905(b), § 435.907(g), § 435.908(a), and § 457.330 (incorporating by reference the requirements of § 435.907) of the March 2012 Medicaid eligibility final rule, and is also contained in non-Medicaid specific regulations implementing the Americans with Disabilities Act and other civil rights laws. Note that clarifying changes were proposed in the January 2013 proposed rule to the accessibility standard in § 435.905(b); those proposed changes are not addressed in this final rule, but we intend to address them in subsequent rulemaking. State agencies can use certified application counselors as a tool in meeting their responsibilities to make their programs accessible to individuals with limited English proficiency and individuals with disabilities. But, while some organizations providing application assistance to individuals applying for coverage under an insurance affordability program may be subject to civil rights laws independent of the fact that they are serving as a certified application assistor (for example, as a condition of accepting federal funding), we do not believe it appropriate to hold them responsible for meeting the accessibility standards established for state Medicaid and CHIP agencies under our regulations.

Moreover, to require a community organization or provider with a mission to provide targeted assistance to one segment of the population to also be able to provide assistance to all others, would threaten the participation of valuable state partners in maximizing enrollment across the state's entire population.

Comment: Some commenters supported the option provided to states to certify application counselors. These commenters pointed to existing programs in which states work with community organizations to expand enrollment, and that state flexibility to continue current, successful programs is important. Other commenters recommended that certification of application counselors be required for all Medicaid and CHIP agencies. These commenters discussed that there will be organizations providing application assistance in every state, that these organizations need to be trained, and that consumers need to know who is available to provide competent assistance.

Response: We agree that a network of application counselors can be a valuable asset and can support states' outreach and enrollment efforts. We urge all states to consider working with interested organizations and providers in creating an application counselor program. However, we believe states are best able to determine the need for such a program, and we do not believe it is necessary to require that state Medicaid programs create such programs.

Comment: We received a number of comments on certified application counselors and requirements related to conflicts of interest. Some commenters stated that in addition to receiving training on conflict of interests, certified application counselors should be contractually required to serve in the best interests of clients and to disclose any existing relationships with qualified health plans or insurance affordability

programs to consumers. Some commenters recommended that health insurance issuers, their subsidiaries and licensed insurance brokers and agents be explicitly excluded from being certified as certified application counselors given their inherent financial conflict of interest.

Response: We are clarifying the language in § 435.908(c)(1)(iii) to make clear that certified application counselors must adhere to all rules prohibiting conflicts of interest. States may not certify any organization or individual who does not meet this standard, or who may be motivated to act in a manner contrary to best interest of the individual being helped. Thus, any organization that the state finds to have an inherent conflict could not, under the proposed regulation, be certified as an application counselor. We do not believe it necessary or appropriate to identify specific types of organizations as categorically barred from serving as application counselors and are finalizing this regulation as proposed.

Comment: A few commenters requested that we require states to maintain a current list of certified application counselors on the agency Web site, and the list should include any limitations on services that they are certified to provide. Commenters suggested that it will be important for consumers to not only be informed of the functions and responsibilities of certified application assisters, as required in § 435.908(c)(3)(i), but to also know who is certified and whether there are any limitations on the services each certified application counselor is certified to provide.

Response: We encourage states to adopt the practice recommended by the commenter, as an effective mechanism to connect consumers with needed assistance. However, utilization of certified application counselors is at state option, and while we believe such a mechanism will enhance consumers' ability to identify resources available to help with applications we do not think it appropriate to require states to post a current list of counselors on their Web site. We note that such a requirement could deter some states from creating or expanding their application counselor program if they do not have the resources to create and maintain such a list.

Comment: A commenter asked CMS to clarify that states can meet their outstationing requirements under § 435.904 with application counselors at the appropriate locations. They suggested that given the overlap of functions described it would seem inefficient to maintain separate systems of assistance.

Response: States may be able to use certified application counselors to help meet the outstationing requirements set forth in current regulations at § 435.904, under which state Medicaid agencies are required to provide pregnant women and children an opportunity to apply for coverage at designated ''outstation locations.'' Section 435.904(e) requires that, except for outstation locations that are infrequently used by the pregnant women and children targeted under the regulation, the state agency must have staff available at each outstation location. Under paragraph (e)(3) of that section, properly trained provider or contractor staff or volunteers—which could include organizations, staff and volunteers certified as application counselors—may be used in lieu of, or as a supplement to, agency staff to meet this requirement, subject to certain conditions set forth in the regulation.

Comment: Commenters asked for clarification on the overlap of functions and certification requirements between certified application counselors in Medicaid and application counselors as proposed for the Exchange at § 155.225.

Response: Although the exact language of the Exchange application counselor regulation at proposed 45 CFR 155.225 (which is not being finalized in this rulemaking) and that of the Medicaid regulation at § 435.908(c) differ, the policies reflected are consistent. The main substantive difference is that the Exchange regulation at proposed 45 CFR 155.225 would not permit certified application counselors to limit the activities that they agree to perform, but instead would require them to perform all assistance activities identified in the regulation, whereas states can permit Medicaid and CHIP application counselors to elect to limit the activities which they will perform for applicants.

As noted in the preamble to the proposed rule, we remind the commenters that state Medicaid and CHIP agencies and the Exchange are charged under § 435.1200 and § 457.348 of the Medicaid eligibility final rule and proposed § 155.345 of the Exchange rule to enter into agreements with each other to create a seamless and coordinated application and enrollment process across all insurance affordability programs, and the state agencies and the Exchange should consider such coordination in developing their application counselor programs. States could elect, for example, to create a single certification process for all insurance affordability programs, or each program could accept application counselors certified by another program. To the extent to which an application counselor is certified by one program but not the other, the counselor would assist the individual in submitting the single streamlined application for all insurance affordability programs to the entity by which they are certified. It is important to note that regardless of the entity to which the application counselor submits the application, the application will be evaluated for eligibility in QHPs and all insurance affordability programs.

Comment: One commenter requested more information about the development and review of training materials for certified application counselors. This commenter stated that although the regulations provide that any individual providing customer service must be trained in a host of areas related to the insurance affordability programs, no specificity is provided about the development and review of the materials, and they requested clarification on whether states will have the opportunity to review and comment on materials prior to their use. We also received comments that recommended we require certified application counselors to apply for recertification annually or biannually to ensure that they are qualified and up to date on changes in policy and procedures.

Response: Under § 435.908(c)(1)(ii) and (iii), states must ensure that application counselors are properly trained prior to certification, and we expect states will need to develop training and any training materials to be used to satisfy this requirement. We note that materials will be developed by HHS for use by certified application counselors registered with an FFE, including State Partnership Exchanges, and state Medicaid and CHIP agencies may adapt such materials to support their training efforts. FFP is available for costs to the state of conducting training or testing of certified application counselors, including any costs to the state for preparation and assembly of training materials. Being effectively trained in the rules and regulations of the different insurance affordability programs in accordance with § 435.908(c)(1)(ii) necessarily requires keeping abreast of any pertinent changes in those rules, and under these regulations states will need to ensure that application counselors are kept up-to-date. However, there are different ways to accomplish this goal—annual or periodic recertification is one-way, refresher trainings or written communications may be another—and we believe states should have flexibility

in determining the process that best works in each state.

Comment: A few commenters recommended that applicants and enrollees be able to opt to designate their certified application counselor to receive copies of notices, or to access electronic notices in the client account.

Response: As discussed in the preamble of the proposed rule, the certified application counselor program is not designed to provide the level of personal assistance to applicants and beneficiaries that is provided by an authorized representative, discussed in the next section in the preamble. However, there is nothing to prevent an applicant or beneficiary from designating a certified application counselor to also serve as his or her authorized representative, and for such counselor to assume that function, in accordance with § 435.923, as finalized in this rulemaking.

Comment: One commenter suggested that regulations governing application assistance are not necessary. The commenter believed that, absent any evidence that application counselors currently working in states to help individuals apply for Medicaid do not have the training and skills necessary to provide reliable, effective assistance to consumers, or would not meet confidentiality requirements, there is no reason to regulate state practices in this area.

Response: We recognize the successful development of application assistor, or application counselor, programs by many states without the existence of federal regulations, and have aimed to develop regulations that will not disrupt existing, successful programs and practice. However, given the significant changes to the availability of and access to affordable health coverage created under the Affordable Care Act—including the advent of coverage in a QHP through the Exchange, with premium tax credits and cost sharing reductions available to qualifying individuals, the coordinated eligibility and enrollment process required across all insurance affordability programs, and the expansion in use of online applications, with the possibility confidential information being returned to consumers in real time through an electronic interface—we believe that establishment of baseline federal standards, to be applied consistently across states and programs, is important to safeguarding consumer interests and ensuring the integrity of the assistance provided.

b. Authorized Representatives (§ 435.923)

We proposed regulations intended to be consistent with current state policy and practice, regarding the definition, designation, and responsibilities of ''authorized representatives'' to act on behalf of applicants and beneficiaries in applying for and maintaining coverage. Authorized representatives have historically provided valuable support to individuals needing help navigating the application and enrollment process, as well as ongoing communications with the agency, particularly to seniors and individuals with disabilities, and we expect their role to continue. We proposed to define the term ''authorized representative'' as an individual or organization that acts responsibly on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other ongoing communications with the Medicaid or CHIP agency. Under current regulations at § 435.907, retained in the March 2012 Medicaid eligibility final rule, states must accept applications from authorized representatives acting on behalf of an applicant. We received the following comments concerning proposed provisions relating to authorized representatives:

Comment: One commenter requested clarification on whether states may enforce additional requirements not specifically listed in the federal regulations on authorized representatives. An example of this would be state specific regulations governing who may serve as an authorized representative for individuals who are not medically or legally competent.

Response: Under proposed § 435.923(a), legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or power of attorney may serve in place of a written designation from the applicant or beneficiary, signed and submitted in accordance with § 435.923(f). Under the regulation, however, states may not limit authorized representatives to individuals identified in such a legal document or granted authorization under operation of state law or otherwise impose requirements other than those listed in § 435.923 on other individuals whom an applicant or beneficiary wishes to have serve as his or her authorized representative. We have separated the regulation text as proposed at § 435.923(a) at § 435.923(a)(1) and § 435.923(a)(2).

Comment: We received a number of comments regarding who may serve as an authorized representative. One commenter recommended that organizations should not be permitted to be designated as authorized representatives. Another commenter recommended that we allow states to decide whether to permit organizations to be authorized representatives. The commenter suggested that by permitting only individuals to serve as authorized representatives, states will be better able to ensure transparency and accountability of the authorized representative. Another commenter recommended that we add a definition of organization to § 435.923(e) to clarify what types of organizations may act as authorized representatives, for example, only non-profit organizations.

Response: We believe that there are situations in which an individual may need an organization to serve as his or her authorized representative and it is appropriate for an organization to serve in this capacity, such as for individuals residing in a nursing home who do not have family available to assist them. We are finalizing the regulation as proposed in this regard. Protections at proposed § 435.923(e), finalized in this rulemaking, are designed to ensure that organizations serving as an authorized representative adhere to laws and regulations relating to conflicts of interest and act in the best interest of the individual.

Comment: We received a number of comments related to the timeframe for designation of authorized representatives. One commenter recommended that states be given options or flexibility in this area, explaining that states may wish to make the designation of the authorized representative last for 12 months by default, for example, unless the applicant or beneficiary designates otherwise. Another commenter recommended that we add that the authorization is valid until the application is denied or benefits are terminated and the appeal process is completed.

Response: Our regulations clearly state that applicants and beneficiaries are able to change authorized representatives at any time. States may not make a designation automatically expire such that an individual would need to redesignate an authorized representative after a given period of time. However, they are allowed to provide beneficiaries with the opportunity to change their authorized representative at the renewal point. For example, states can indicate that a beneficiary has an authorized

representative and remind the individual that they may keep or change the representative on the renewal document.

Comment: One commenter asked for clarification on whether the scope of the authorization is defined by the beneficiary or applicant, or whether, once invoked, the representative assumes all of the duties named in the regulations, including ''all other matters'' with either agency.

Response: We clarify that the scope of the authorization is defined by the Medicaid applicant or beneficiary.

Comment: We received a number of comments on § 435.923(c), specifically related to the fact that the designation of an authorized representative can only be revoked in writing. Commenters suggested that it would be more appropriate and efficient to allow the designation to be revoked by all of the modalities by which it can be made in the first place.

Response: We agree with the commenter's suggestion and have revised the regulation text accordingly.

Comment: One commenter requested clarification on whether the permissions given the authorized representative may be granted in part, for example in tiers, if an applicant so chooses. The commenter suggested that an applicant may wish to authorize someone to sign his or her application, but not to receive his or her notices, for example.

Response: We are clarifying that the permissions given to the authorized representative may be granted in part. The proposed regulation allows applicants and beneficiaries to designate an individual or organization to act on their behalf and that the scope of authorization is defined by the applicant or beneficiary.

Comment: One commenter asked us to confirm that the definition provided for authorized representatives is the same definition that the Social Security Administration uses.

Response: We clarify that the definition is not the same.

Comment: A few commenters requested additional clarification regarding situations in which an individual is unable to personally elect an authorized representative due to medical incapacity. One commenter agreed that written designation by the individual or legal documentation should be obtained in most instances, but the proposed rule may be overly restrictive in that it could result in unreasonable delay in determining some individuals' eligibility for Medicaid. The commenter recommends that states be given the authority to waive this regulation in instances when obtaining legal documentation to allow individuals or organizations to act as authorized representatives would be difficult. Another commenter suggested that legal documentation of authority to act on behalf of an application or beneficiary under state law, such as court order establishing legal guardianship or a power of attorney, should serve in place of written authorizations by the applicant or beneficiary.

Response: Under section § 435.923(a), legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or power of attorney may serve in place of the applicant or beneficiary's designation. The option to submit such documentation is intended to enable applicants who do not have the capacity to provide a signature to authorize representation.

5. Medicaid Eligibility Requirements and Coverage Options Established by Other Federal Statutes

a. Presumptive Eligibility for Children (§ 435.1102)

We proposed to revise existing regulations to align with the adoption of MAGI-based methodologies.

Comment: One commenter suggested that presumptive eligibility could be better streamlined by using only a gross income standard for eligibility determinations.

Response: Current regulations allow states to use either gross income or to have qualified entities make a closer approximation of the countable family income, which would be used for a regular determination by the state agency, by applying simple disregards. We believe it is appropriate to retain this flexibility for states once MAGI-based methodologies are in place. Therefore, we are codifying the flexibility of states in § 435.1102(a), as proposed, to direct qualified entities to use either gross income or to apply simplified methods, as prescribed by the state, to better approximate MAGI-based household income, as defined in § 435.603 of the March 2012 final rule.

Comment: Many commenters objected to the state option to obtain an attestation of citizenship or satisfactory immigration status, or state residency as part of a presumptive eligibility determination. They suggested that requiring an attestation of immigration status would likely deter some potentially eligible individuals who often need urgent access to health care services from receiving care. Further the commenters suggested that the rules on immigration status are detailed and complex, and qualified entities cannot reasonably be expected to understand or explain them to individuals being asked to attest their status. Some commenters stated that states should have the option to request self-attestation of citizenship.

Response: We clarify that our proposed rule gave states the option to require qualified entities or qualified hospitals to request this information but did not require it. We believe that this option is important in the context of extending the ability to conduct presumptive eligibility determinations to hospitals because it limits the possibility that individuals who are not citizens or qualified immigrants or residents of the state are found eligible on a presumptive basis, receive expensive services, only ultimately to be determined ineligible for Medicaid. Therefore, we are retaining the language as proposed and maintain this provision as a state option.

Comment: One commenter requested that we add current foster care children as a presumptive eligibility group in our final regulation.

Response: We clarify that former foster children are already a population that is eligible to be determined presumptively eligible. We do not currently have the authority to add current foster care children as a presumptive eligibility group, but this is unnecessary because current foster children are automatically eligible for Medicaid and do not need to be determined presumptively eligible.

b. Presumptive Eligibility for Other Individuals (§ 435.1103)

Comment: Some commenters stated that states should have the option to elect how many presumptive eligibility periods should be allowed for each pregnancy. Others supported our proposed rule to permit only one presumptive eligibility period per pregnancy.

Response: We believe that providing pregnant women with one presumptive eligibility period per pregnancy is reasonable in accordance with section 1920 of the Act, under which pregnant women may receive ambulatory prenatal care during a presumptive eligibility period, defined as continuing through the date a full Medicaid determination is made under the State plan, or, if a woman does not submit a regular application through the end of the month following the month during which the presumptive eligibility determination was made. Therefore, we are finalizing the regulation as proposed to provide one presumptive eligibility

period for pregnant women per pregnancy.

c. Presumptive Eligibility Determined by Hospitals (§ 435.1110)

We proposed to add § 435.1110 to implement section 1902(a)(47)(B) of the Act, added by the Affordable Care Act, to give hospitals the option to determine presumptive eligibility for Medicaid. The statute provides hospitals participating in Medicaid with this option whether or not the state has elected to permit qualified entities of the state's selection to make presumptive eligibility determinations for children, pregnant women or other specific populations under other sections of the statute.

We received the following comments concerning the hospital presumptive eligibility provisions:

Comment: We received many comments related to the establishment of standards under proposed § 435.1110(d)(1) for hospitals that opt to make presumptive eligibility determinations. Some commenters encouraged CMS to provide states with maximum flexibility to implement presumptive eligibility standards for hospitals, while other commenters stated that the Secretary should establish federal standards applicable to hospitals making presumptive eligibility determinations in all states. Other commenters supported the flexibility given to state agencies to establish standards, and some stated that states should have even broader authority to establish clear criteria and qualifications which hospitals would have to meet to make presumptive eligibility determinations. Some believe that the Secretary should establish minimum federal standards and qualifications, with the state option to impose additional standards. Commenters generally requested additional guidance to states on how they must work with hospitals that elect to make presumptive eligibility determinations. Finally, some commenters stated that the Secretary should establish federal standards for hospitals that opt to make presumptive eligibility determinations under § 435.1110 of the regulations, related to the proportion of individuals determined presumptively eligible by the hospital that submits a regular application and the percent of such individuals who are ultimately determined eligible by the agency. Commenters suggested that states should use the federal standards to determine which hospitals are capable of making presumptive eligibility determinations.

Response: We are finalizing § 435.1110(d)(1) as proposed. Oversight of qualified entities making presumptive eligibility determinations, including qualified hospitals under § 435.1110, is a state responsibility. Under § 435.1110(d)(1), states may establish state-specific standards for qualified hospitals that conduct presumptive eligibility determinations related to the success of assisting individuals determined presumptively eligible who submit a regular application and/or are approved for eligibility by the agency. We believe this is an area more appropriate for state flexibility, than for imposition of a uniform federal standard for all participating hospitals across all states. Therefore, we are finalizing § 435.1110(d), as proposed. We will monitor implementation and consider whether further guidance is warranted.

Per § 435.1110(d)(2), which we also are finalizing as proposed, state agencies are required to take appropriate correction action for any hospital that does not meet the standards established by the state or which the state otherwise determines is not making, or is not capable or making, presumptive eligibility determinations in accordance with state policies and procedures. In fulfilling their responsibility under § 435.1110(d)(2), states may develop other proficiency standards, training and audits, with which hospitals would need to comply, to be authorized to make presumptive eligibility determinations in the state.

Comment: We received many comments on the populations for which hospitals can make presumptive eligibility determinations. Some commenters stated that hospitals should be allowed to make presumptive eligibility determinations for all of the patient populations they serve. Some commenters recommended that states be given the option to elect and limit the populations that may be determined presumptively eligible by hospitals. Some commenters stated that the preamble did not align with the regulation text relating to this issue in the proposed rule. Many commenters requested additional clarification on the populations for which hospitals may make presumptive eligibility determinations.

Response: We intended to propose that qualified hospitals must be permitted to make presumptive eligibility determinations based on income for all of the populations for which presumptive eligibility may be available in accordance with § 435.1102 and § 435.1103. The specific reference to children, pregnant women, parents and caretaker relatives, and other adults in proposed § 435.1110(c)(1) was not intended to eliminate presumptive eligibility determinations by hospitals for other populations included in § 435.1103 (that is, former foster care recipients or women with breast or cervical cancer or individuals seeking coverage of family planning services). We are revising the regulation text at § 435.1110(c)(1) to clarify that states electing to limit the presumptive eligibility determinations which hospitals can make must permit the hospitals to make presumptive eligibility determinations based on income for all of the populations included in § 435.1102 and § 435.1103. Under § 435.1110(c)(2), which we finalize as proposed in this rulemaking, states may also permit hospitals to make presumptive eligibility determinations for populations for which income is not the only factor of eligibility (for example, for individuals who may be eligible under an eligibility group based on disability, or individuals eligible under a demonstration project approved under section 1115 of the Act).

Comment: A commenter expressed that hospitals wishing to make presumptive eligibility determinations should be required to attend training on policies and procedures established by the states. The commenter suggested that this was important to maximize the likelihood that eligible individuals complete the full Medicaid eligibility process. They supported the proposed rule that states may require hospitals electing to make presumptive eligibility determinations to assist individuals in completing and submitting the full application and understanding any documentation requirements.

Response: In accordance with § 435.1110(a) of the proposed rule, finalized as proposed in this rulemaking, states are required to provide Medicaid during a presumptive eligibility period, to individuals who are determined to be presumptively eligible by a qualified hospital, subject to the same requirements as apply to the State options under §§ 435.1102 and 435.1103 regardless of whether the state otherwise has opted to provide Medicaid during a presumptive eligibility period under either of those sections. While not necessarily requiring establishment of a formal training program, current regulations at § 435.1102(b) require states to provide qualified entities with information on relevant state policies and procedures and how to fulfill their responsibilities in making presumptive eligibility determinations. This requirement is unchanged in this rulemaking and will apply in the case of hospitals electing to

be a qualified hospital under § 435.1110. If a hospital does not follow state policies and procedures, or is not successful in helping individuals to submit regular applications in accordance with standards established by the state, proposed § 435.1110(d)(2) would require states to institute appropriate corrective action, including (but not requiring) termination of the hospital as a qualified hospital. We are revising proposed § 435.1110(d) by adding paragraph (d)(3) to provide that the agency may disqualify a hospital as a qualified hospital only after it has first provided the hospital with additional training or taken other reasonable corrective action measures.

Comment: A few commenters requested that states should be able to receive 100 percent FMAP for any recoupments or disallowances CMS may seek related to an improper eligibility determination by a hospital. One commenter questioned whether a state can make a qualified hospital liable when a presumptive eligibility determination results in a denial for a full Medicaid category.

Response: Under existing regulations, there is no recoupment for Medicaid provided during a presumptive eligibility period resulting from erroneous determinations made by qualified entities. Payment for services is guaranteed during a presumptive eligibility period; without such a guarantee, providers could not rely on the determination. Under this provision, states will not be permitted to recoup money from the hospital (and CMS will not recoup FFP from the state). However, under § 425.1110(d)(2), a state may disqualify a hospital from conducting presumptive eligibility determinations if the state finds that the hospital is not making, or is not capable of making, accurate presumptive eligibility determinations in accordance with applicable state policies and procedures. Such a disqualification is permitted only after the state has provided additional training or taken reasonable corrective action measures to address the issue. Finally, we clarify that states may not make a qualified hospital liable when an individual who was found presumptively eligible by the hospital submits a full application and is subsequently denied Medicaid eligibility.

Comment: Some commenters requested that for individuals determined presumptively eligible by a hospital for the adult group under § 435.119 of the March 2012 Medicaid final eligibility rule, a state should receive 100 percent federal funding for services provided unless and until the individual completes the eligibility process and is determined not ''newly eligible'' or eligible for coverage under the adult group. Commenters suggested that enhanced federal funding is necessary because there will not be sufficient information available to determine whether the presumptively eligible individual should be claimed at 100 percent federal funding or the state's regular FMAP at the time of the initial presumptive eligibility determination.

Response: While we understand the commenters' concerns, there is no basis to provide the 100 percent FMAP during a presumptive eligibility period. The state would receive the increased FMAP provided under the Affordable Care Act only for individuals who the state determines actually (not presumptively) qualify for Medicaid under the adult group and are determined to be ''newly eligible.'' The methodology for such claims is set forth in the final FMAP regulation (78 FR 19918). However, states may retroactively adjust claiming to receive the enhanced matching rate for individuals determined presumptively eligible who subsequently complete a regular application, are determined by the state to be eligible for Medicaid under the adult group and are found to be ''newly eligible.'' Such retroactive adjustment may extend back to the first month of the month in which the regular application was filed or up to 3 months prior to the month of application in accordance with § 435.914 of the regulations (redesignated at § 435.915 in the March 2012 Medicaid final eligibility rule).

Comment: One commenter requested that we confirm that § 435.1110(b)(2) of the proposed rule gives states the option to require that to participate as a qualified hospital, a hospital must assist individuals in completing and submitting the full application and help individuals understand any documentation requirements. The commenter suggested that this function is the same as that of an application counselor and requests clarification on whether a state could also require that a hospital that performs presumptive eligibility determinations must follow regulations in § 435.908 relating to certified application counselors.

Response: Although we are not requiring hospitals that perform presumptive eligibility determinations to also furnish services of certified application counselors, states may impose specific requirements on hospitals to ensure that they fulfill their role in assisting individuals with completing and submitting the full application. At a minimum, states have a responsibility to ensure that an individual determined presumptively eligible by qualified hospitals is informed about how to apply and can obtain an application.

Comment: We received several comments on the viability of presumptive eligibility determinations with the advent of real-time eligibility determinations. One commenter recommended that states should have the latitude to require hospitals to use the state's online application system and determine presumptive eligibility only if a real-time full eligibility determination cannot be made. Another commenter suggested that if eligibility can be determined in real-time, then there is no need for presumptive eligibility, and asked us to clarify whether the state could terminate use of presumptive eligibility without violating the Affordable Care Act's Maintenance of Medicaid Eligibility requirements, as added by section 2001(b) of the Affordable Care Act (codified at sections 1902(a)(74) and 1902(gg) of the Social Security Act (the Act).

Response: We agree that the promise of real-time eligibility determinations makes the role of presumptive eligibility different than it has been in the past. In situations in which the individual files a regular application right away, the presumptive eligibility period would likely be considerably shorter—and eliminated altogether, as a practical matter, if a real-time determination is made. However, even with the most modernized systems, there inevitably will be individuals for whom a real-time eligibility determination will not be possible. There also will be individuals who will not be comfortable with the online application, and will instead opt to use the paper application. In such situations and for such individuals, presumptive eligibility remains a useful tool to facilitate prompt coverage and enrollment in the program. States have flexibility to minimize the length of presumptive eligibility periods by requiring that hospitals and other qualified entities assist individuals in submitting the single streamlined application online. States may not terminate use of presumptive eligibility for pregnant women or individuals with breast or cervical cancer prior to 2014 or for children prior to October 1, 2019 without violating maintenance of effort.

Comment: One commenter requested clarification on how hospital presumptive eligibility will interact with eligibility in breast and cervical cancer groups.

Response: If a state has elected to provide presumptive eligibility for individuals with breast or cervical cancer under § 435.1103(c)(2), it can limit qualified entities under that section to providers which conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP), and if it has done so, the state may limit hospitals which may determine presumptive eligibility for individuals with breast or cervical cancer on that basis to hospitals that conduct screenings under the state's BCCEDP. In states that do not opt to provide presumptive eligibility for individuals with Breast or Cervical Cancer under § 435.1103(c), states similarly may limit hospitals' ability to determine presumptive eligibility for individuals with breast or cervical cancer under § 435.1110 to those that conduct screenings under the state's BCCEDP.

6. Coordinated Medicaid/CHIP Open Enrollment Process (§ 435.1205 and § 457.370)

We proposed to implement section 1943 of the Act and section 1413 of the Affordable Care Act to require that Medicaid and CHIP agencies begin accepting the single streamlined application during the initial open enrollment period to ensure a coordinated transition to new coverage that will become available in Medicaid and through the Exchange in 2014. Our proposed rule seeks to ensure that no matter where applicants submit the single, streamlined application during the initial open enrollment period, they will receive an eligibility determination for all insurance affordability programs and be able to enroll in appropriate coverage for 2014, if eligible, without delay.

Comment: Many commenters supported the proposal in § 435.1205(c)(1) that Medicaid and CHIP agencies to begin accepting the single streamlined application and MAGI determinations from the Exchange and to process MAGI eligibility starting in October 2013. Commenters believe this is necessary to ensure coordination with the Exchange, and to facilitate a seamless transition to the new coverage that will become available in Medicaid and through the Exchanges in 2014. Many commenters acknowledged that the public will be hearing about new coverage options throughout the summer and fall of 2013, and expressed concern that it would result in confusion if, when people went to apply for coverage and were found eligible for Medicaid (or their children eligible for Medicaid or CHIP), they were told to return several months later and submit a new application.

Response: We agree with the commenters that acceptance of the single streamlined application by state Medicaid and CHIP agencies starting in October 2013 is needed to ensure coordination with the Exchange, and in facilitating new coverage that will be available to Medicaid-eligible eligible individuals in January 2014. Therefore, we are finalizing the rule as proposed and confirm that individuals may not be required to return in January to reapply.

Comment: Some commenters expressed concern that it is unreasonable to require states to comply with the prescribed time frames for coordinated enrollment with the Exchange in the proposed rule. They noted that states must make major policy, operations, and systems changes to implement federal requirements, which will impact agency eligibility staff, vendors, clients, and other stakeholders. Pending final and complete federal guidance, it is a significant challenge for states to develop policies, design efficient business processes, build systems and new interfaces, and effectively communicate changes to clients and stakeholders by the proposed federal implementation dates. One commenter noted that its state legacy system cannot process or transfer electronic accounts, which means that the proposed rule has effectively shortened the timeframe to implement its new eligibility system by 3 months. Another commenter noted that Medicaid eligibility systems, policies and staff are not structured to operate in a time-limited open enrollment environment or to apply competing eligibility criteria concurrently, and cannot be changed to do so with only a few months' notice.

Commenters recommended that Medicaid agencies not be required to begin accepting streamlined applications or determinations from the Exchange prior to January 1, 2014. Instead, during the initial open enrollment from October 1, 2013 to December 31, 2013, commenters requested that at state option, individuals may be required to apply separately to the Medicaid agency and to the Exchange and to have their eligibility determined by the corresponding agency. One state suggested, as an alternative, the information exchanged will be limited to only the Medicaid-specific information that is included in the single streamlined application.

Response: We appreciate the operational challenges states face in preparing for implementation of the Affordable Care Act, but we believe that these effective dates are central to the success of open enrollment and we have consistently targeted the October 1 date as we have worked with states to finance and develop their IT systems. We have identified a set of seven critical success factors that states must meet by October 1 in an attempt to prioritize what must be accomplished within this timeframe. We have regularly shared these with states via webinars, on the CALT at *https://calt.cms.gov/sf/go/doc16369?nav=1*, through State Operational Technical Assistance (SOTA) calls and in IT gate reviews. These include the following: (1) Ability to accept application data, (2) MAGI rules engine in eligibility system, (3) MAGI Conversion, (4) Submission of state income thresholds and flexibilities, (5) Connection to Federally Facilitated Exchange (or establishment of State Based Exchange), (6) Connection to Federal Data Services Hub, and (7) Ability to confirm Minimum Essential Coverage.

We recognize the efforts that states are making across a broad range of areas, and have released regulations, information technology (IT) guidance, funding opportunities, business process models and other tools to assist states as they design, develop, implement, and operate new systems. We will continue to help states fully comply with all relevant eligibility and enrollment changes, as well as achieve the necessary degree of interoperability between IT components in the federal and state entities that work together to provide health insurance coverage through Medicaid and CHIP, and Exchanges. We are finalizing the regulation as proposed.

Comment: Several commenters expressed concern that, in the states which are relying on the FFE and will not be ready to implement the single, streamlined application by October 2013, there is a significant risk that people who apply for coverage through the FFE will be told that they are likely eligible for Medicaid or CHIP, and be sent away without any real opportunity to enroll in coverage or complete the application process. These commenters recommended that HHS strengthen this provision by setting forth a specific timeframe and set of procedures that states must follow to ensure that they are ready to implement the single, streamlined application when open enrollment begins in October 2013. Specifically, they recommended modifying the final rule to require states

relying on the FFE to submit information, by September 1, 2013, on whether they intend to: (1) accept the FFE's determinations of Medicaid/CHIP eligibility; or (2) to treat the FFE's finding as an assessment and complete the eligibility determination themselves. In addition, they recommend including a provision to clearly outline that *before* a state can elect the option to treat the FFE's findings as an assessment, the state must demonstrate that it is (or will be by October 2013) capable of acting upon such assessments in full accordance with federal law.

Response: We have a process in place for working with states on implementation, including the adoption of mitigation strategies where necessary. We do not believe that a change in the regulations is needed to effectuate these strategies.

Comment: Many commenters believe that it would be time-consuming and impractical to require states to evaluate all cases for eligibility effective in 2013, but that there is a subset of cases that states should be required to evaluate. Specifically, parents whose MAGI-based income falls very close to the state's current income eligibility threshold for parents should be evaluated based on 2013 eligibility rules. Commenters suggested HHS provide guidance to states on the appropriate MAGI income threshold to use for determining whether an individual appears to be potentially eligibility under 2013 rules and should be assessed for eligibility using those rules. Some commenters also believe that states should be required to inform people when it appears that their children qualify for coverage under 2013 Medicaid and CHIP rules because families are more likely to pursue applications if they believe that their children will be found eligible for coverage. Finally, a few commenters believed states should be given the option to notify a subset of applicants about the process to apply for coverage with an effective date in 2013 (for example, only those applicants who appear to be potentially eligible under 2013 rules based on the available information provided on the single streamlined application).

Some commenters stated that they are already planning for an October 2013 implementation date of MAGI eligibility and requested that states be given this option without need for a waiver. These commenters recommend states have flexibility in handling applications based on 2013 rules for assessing 2014 coverage. States should be allowed to request applicants submit supplemental form that includes additional information to make MAGI determination, or to redirect applicants to new application; or, states should have flexibility to process applications using 2013 rules and determine eligibility based on MAGI proxy when possible.

Response: We recognize the challenge of appropriately evaluating all applications submitted during the open enrollment period under both the MAGI-based rules effective January 1, 2014 and under rule in effect in 2013. However, all applicants must have the opportunity to have their Medicaid eligibility assessed based on existing Medicaid rules for 2013 as well as for prospective enrollment effective January 2014. At a minimum under the regulation at § 435.1205(c)(4)(ii), states must inform individuals who submit the single streamlined application during October–December 2013 that coverage may be available in 2013, but that a different application will need to be completed for consideration of such coverage, and how the individual can obtain and submit such application. Alternatively, under § 435.1205(c)(4)(i), states can use the information on the single streamlined application submitted to make a determination of eligibility effective in 2013, based on 2013 rules, following up with the individual to obtain additional information if needed through additional questions or use of a supplemental form, if needed. States also can pursue a combination of these strategies—using the process outlined in § 435.1205(c)(4)(i) for targeted individuals more likely to be found eligible under 2013 rules (for example, parents and caretaker relatives with MAGI-based income within a threshold margin of the applicable income standard and individuals indicating potential disability on the single streamlined application), while directing those not seen as likely-eligible under the 2013 rules to submit a separate application in accordance § 435.1205(c)(4)(ii).

States may wish to avoid having to operate two sets of rules for children, parents and caretaker relatives, pregnant women and other non-disabled, non-elderly adults that may be eligible for Medicaid enrollment during this period. To address this, we are offering states the opportunity to begin using the new MAGI-based methodology for these populations effective October 1, 2013, to coincide with the start of the open enrollment period. See State Health Official Letter #13–003: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014 at *http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf.*

Comment: One commenter stated that requiring post-eligibility data matching to ensure continued eligibility as of January 1, 2014 for individuals determined not eligible in October-December but eligible in January, creates an enormous burden during a time when new systems are being implemented and states will be experiencing the largest influx of newly eligible individuals into their system. The commenter noted this would create duplication of efforts when an individual who was determined eligible prior to January is already notified of their reporting requirements and states should be allowed to rely on recipients reporting rather than handling the same cases twice in a 3–4 month timeframe.

Response: Post-eligibility data matching is an option for states to ensure continued eligibility as of January 1, 2014 and/or through the first regularly-scheduled renewal. It is not required. The agency also has the option to schedule the first renewal for individuals who apply during the open enrollment period, and determined eligible effective January 1, 2014, to occur anytime between 12 months from the date of application and January 1, 2015. Consistent with § 435.916, beneficiaries are required to report any change in circumstances that may impact their eligibility. In the absence of any reported change that could affect eligibility, no post-eligibility data matching is required.

Comment: One commenter requested that CMS clarify § 435.1205(c)(3)(ii) that this state option [to schedule the first renewal under § 435.916 to occur anytime between 12 months from the date of application and January 1, 2015] authorizes less than annual periods of coverage/eligibility before renewal in instances where renewal date is set before January 1, 2015.

Response: This option does allow for less than 1 year of coverage for a limited time. For example, if someone applies on November 1, 2013, and is determined eligible for coverage to begin January 1, the state may schedule renewal on November 1, 2014. This would result in less than a year of coverage. This one-time option is intended to provide for ease of administration in the renewal of coverage for a large number of individuals whose coverage begins on January 1, 2014 and would otherwise need to be renewed at the same time.

Comment: We sought comments in the proposed rule on which sections of both this rulemaking as well as the March 2012 Medicaid eligibility final regulation need to be effective October 1, 2013 (as opposed to January 1, 2014) to enable states to meet their

responsibilities under § 435.1205 and § 457.370 of this rulemaking. We received no comments in response to this request.

Response: In the absence of any comments regarding this question, we have determined that the following provisions of the March 2012 Medicaid eligibility final rule are effective October 1, 2013 for purposes of effectuating § 435.1205 and § 457.370 of this final regulation during the initial open enrollment period beginning October 1, 2013:

- Sections 435.603, 435.911, 435.1200, 457.315, 457.330 and 457.348;
- Amendments to §§ 431.10, 431.11, 435.110, 435.116, 435.119, 435.907, 435.916, 435.940–435.956, 457.340 and 457.350, and the redesignation of § 435.911 through § 435.914 as § 435.912 through § 435.915.

In addition, the following provisions of this final rule are effective October 1, 2013: §§ 435.918, 435.1205, 457.370, and revisions to §§ 431.10, 431.11, 431.201, 431.205, 431.206, 431.211, 431.213, 431.230, 431.231, 431.240, 435.119, 435.603, 435.907, 435.1200, 457.110(a)(1), 457.348, and 457.350.

Although effective for purposes of codification in the Code of Federal Regulations October 1, 2013 for application during the initial October 1–December 31 open enrollment period, absent a waiver under § 1115 of the Social Security Act approved by the Secretary, financial eligibility based on MAGI-based methodologies codified at § 435.603 and § 457.315 and eligibility for adults under § 435.119 are not effective under the Affordable Care Act until January 1, 2014. Technical revisions to § 435.119 to retain the applicability date of January 1, 2014, even as the effective date of that section is moved to October 1, 2013, are made in this rulemaking. No revisions to § 435.603 or § 457.315 are required, as those sections, as published in the March 2012 Medicaid final eligibility rule, already provide for the January 1 applicability date.

7. Children's Health Insurance Program Changes

a. CHIP Waiting Periods (§ 457.340, § 457.350, § 457.805 and § 457.810)

We proposed revisions to existing regulations regarding prevention of substitution of coverage at § 457.805 to limit the use of CHIP waiting periods to a maximum of 90 days. This policy aligns with section 1201 of the Affordable Care Act, which amended section 2708 of the Public Health Service Act to prohibit waiting periods exceeding 90 days for health plans and health insurance issuers offering group or individual coverage. This standard, though not directly applicable to CHIP, is currently exceeded in roughly half of the states that impose CHIP waiting periods today. We also proposed to require several exemptions to waiting periods, consistent with policies that many states have in place today, such as for individuals working for employers that stopped offering coverage of dependents. We received the following comments on our proposed waiting period policy as described below.

Comment: Many commenters urged CMS to eliminate waiting periods on January 1, 2014, rather than permit states to continue to impose waiting periods of any length of time for children. A few commenters encouraged CMS to retain its current policy of providing states with the discretion to maintain waiting periods and establish their own procedures to minimize displacement of private insurance, and some states expressed their intent to eliminate waiting periods in their CHIP programs in 2014. One commenter suggested that waiting periods be applied only to children with family incomes above 200 percent of the FPL. Commenters' concerns with the proposed 90-day waiting period were related to the administrative burden of waiting periods for state CHIP agencies and Exchanges, potential hindrances to streamlined and coordinated enrollment, disruptions in continuity of care for children and a lack of evidence of substitution.

Response: While we acknowledge the commenters' concerns related to the continuation of waiting periods for children in 2014, we also see a need to permit states flexibility to determine an appropriate substitution prevention strategy, with a full range of options from monitoring to imposition of waiting periods up to 90 days. Some states have already eliminated their CHIP waiting periods and we encourage other states to consider taking this step. Nothing in this final rule precludes a state from doing so. States may also elect to eliminate waiting periods specifically for children at lower income levels and/or identify additional exemptions to the waiting period beyond those required in this rule. Therefore, to maintain states' flexibility in identifying substitution strategies while also limiting the period of time a child may not be eligible for CHIP due to a waiting period, we are finalizing the provisions at § 457.350, § 457.805 and § 457.810 as proposed to permit states to impose a waiting period of no more than 90 days, with certain specified exemptions. We note that this policy is consistent with the 90-day maximum waiting period described in Section 1201 of the Affordable Care Act.

Comment: Many commenters were concerned that the proposed policy for a maximum 90-day waiting period would require states and Exchanges to set up administratively complicated processes to temporarily enroll children in QHPs and to receive APTCs and CSRs while awaiting CHIP eligibility during the waiting period. Several commenters expressed concerns with the administrative complexity of the interactions that must occur between the Exchange and the CHIP agency if a waiting period is in place, including the requirement at § 457.350 for the CHIP agency to send the electronic record back to the Exchange for enrollment in a QHP if the child is determined not eligible for CHIP. These commenters also expressed concern that these potential complications do not align with the streamlined eligibility and enrollment process envisioned by the Affordable Care Act. Many commenters stated that requiring the change to a 90-day maximum waiting period policy would be administratively burdensome and costly to states at a time when information technology systems are already overburdened in preparation for significant eligibility changes in 2014. Some commenters highlighted that it is likely that some state systems will not have the capacity to track children who are locked out of CHIP during a waiting period and others expressed concern as to whether states or the Federal government have the capacity to smoothly implement waiting periods in the manner suggested in the proposed rule without a disruption in coverage for children. Some commenters also indicated that if waiting periods were to exist in 2014, state CHIP agencies would need to both track when these children would become eligible for CHIP and also initiate action to enroll children in the program.

Response: For states that opt to apply a waiting period in 2014, we agree that transitioning a child from one insurance affordability program to another upon the conclusion of a 90-day waiting period may present operational challenges. States must take into consideration their system capabilities and weigh the perceived benefits of opting to have a waiting period against any additional administrative or system requirements needed to effectuate a seamless transition of such children from coverage in the Exchange and APTC to the state's CHIP at the conclusion of the 90-day period. We agree that CHIP agencies will need to track when these children become

eligible for CHIP as required at § 457.350. In addition, we have further clarified at § 457.340(d)(4), that without requiring new applications or information previously provided, CHIP agencies must implement processes to ensure a smooth transition for children from coverage through the Exchange to CHIP at the end of a waiting period, as well as facilitate the enrollment of otherwise CHIP-eligible children who have satisfied the waiting period, but who were not covered in the Exchange. For example, a state could automatically enroll a previously determined CHIP-eligible child at the end of the waiting period without requesting any additional information from the family. Another option would be for a state to suspend applications for all children subject to a waiting period. Once these children have completed the waiting period, the state would then reactivate the application and determine whether the child is eligible for CHIP based on the information previously provided on the application. There is nothing in the above options that precludes a state from checking data sources for updated information or processing a change in circumstances reported by the family.

Comment: Many commenters stressed that waiting periods of any length could negatively impact children's access to continuous and coordinated health coverage. For example, commenters expressed concern that the proposed rule permitting CHIP-eligible children to enroll in qualified health plans (QHPs) in the Exchange during a waiting period, and subsequently enroll in CHIP at the end of a waiting period, will stimulate churning between QHPs and CHIP. These commenters emphasized that disruptions in coverage will impact the health status of children who are left uninsured and/or may have to change plans or providers. Some commenters stated that movement between plans and programs will inhibit the QHPs' ability to measure the quality of care provided to children, and makes it difficult to hold plans accountable for improvements in quality outcomes for children over time.

Response: We acknowledge that the use of waiting periods may create delays in eligibility for CHIP and increase the likelihood of churning between the Exchange and CHIP, which could result in disruptions in coverage that could negatively impact the health status of children. Therefore, this final rule confirms states' ability to eliminate waiting periods to accommodate these concerns. In addition, the final rule codifies the limitation of waiting periods to a maximum of 90 days, to be consistent with waiting periods under section 1201 of the Affordable Care Act. We encourage states to examine the costs and benefits of imposing a waiting period in the context of the Affordable Care Act. To make the transition from Exchange coverage to CHIP as smooth as possible for children, states that do choose to maintain waiting periods will need to meet the requirements at § 457.350(i), including providing notification to the appropriate insurance affordability program (for example, the Exchange) promptly and without undue delay of the date on which the waiting period will end and the child will be eligible to enroll in CHIP. We will provide states with technical assistance in this area.

Comment: Several commenters indicated that while there were initial concerns upon implementation of CHIP in the late 1990s that the incentives for substitution of public coverage for private coverage would be significant, states and researchers have had ample opportunity to examine this issue over the last 15 years. These commenters stated that numerous studies have shown that substitution is difficult to measure, there continues to be much conjecture regarding the degree to which substitution occurs, and that there is no evidence that procedures like waiting periods actually prevent substitution. These commenters also noted that there is evidence that uninsured children, including children in waiting periods, frequently forego medical services due to high out-of-pocket costs.

One state reported that during an almost 15-year period, there has been no evidence that crowd out is a concern, including for children at higher income levels. The commenter reported that the percentage of children in families who dropped their employer sponsored coverage and substituted it for CHIP has been consistently below 2 percent since the inception of CHIP. This commenter recommended that we permit monitoring of crowd out at all income levels rather than continuing to require a substitution strategy, such as a waiting period, for higher income children. Another commenter stated that in their experience in operating CHIP, nearly all families with former employer-sponsored insurance meet at least one of the exemptions to waiting periods included in its CHIP state plan.

Response: We recognize that there is a robust but inconclusive evidence base in the literature calling into question the prevalence of substitution. And, we are therefore, revising our existing regulations to provide states with flexibility to determine how best to operate their CHIP programs. The preamble of the existing regulation (66 FR 2490, January 11, 2001) required that states that provide CHIP coverage to children at or below 200 percent of the Federal poverty level (FPL) must have procedures for monitoring the rate of substitution of coverage, between 200 and 250 percent of the FPL must monitor substitution and identify specific strategies to limit substitution if levels become unacceptable, and for coverage above 250 percent of the FPL states must describe how substitution is monitored and implement specific strategies to prevent substitution. We clarify in this final rule that effective January 1, 2014, monitoring of substitution is a sufficient approach for addressing substitution at all income levels. We expect that if this monitoring demonstrates a high rate of substitution, a state will consider strategies such as improving public outreach about the range of health coverage options that are available in that state.

Comment: Some commenters requested that CMS provide clarity regarding the criteria for specific exemptions (for example, children with special health care needs), and suggested additional types of mandatory exemptions at the Federal level (for example, employees that have employers that have changed health plans or products). Some commenters noted that states have previously implemented many of the proposed required exemptions and that the majority of applicants already qualify for state-identified exemptions to the waiting period.

Response: As noted by some commenters, many of the mandatory exemptions in the proposed rule have previously been instituted by states on a voluntary basis and have been effective. Therefore, we are adopting in our final rule the proposed exemptions at § 457.805. In addition, and as discussed in the preamble of our proposed rule, we are adding an affordability exemption at § 457.805(a)(i) for cases when a child's parent is determined eligible for APTC for enrollment in a QHP through the Exchange because the employer-sponsored insurance (ESI) in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v). We consider this exemption to be essential to preventing families from having to choose between continuing ESI that has been determined to be unaffordable for the parent, and thereby forgoing premium tax credits and cost-sharing reductions for enrollment in an QHP, or dropping the ESI and allowing their child to go without coverage for a period of time to

qualify for CHIP. We note that states continue to have the flexibility to provide additional exemptions beyond those specified in this final rule, but other than the affordability exemption at § 457.805(a)(i), there will be no additional exemptions added in this final rule. We note that we intend to issue further sub-regulatory guidance related to criteria for required waiting period exemptions.

Comment: One commenter requested that CMS delay the effective date of this provision to give states adequate time to make the necessary changes related to its waiting period policy, such as a change in state law and/or budget.

Response: This provision will be effective on January 1, 2014 unless a change in state law is needed for a state to comply with this provision. Specifically, for states with annual legislative sessions, the effective date for the application of the 90-day maximum waiting period and required exemptions must be no later than the first day of the next fiscal year beginning after the close of the first regular session of the 2014 state legislature. For states that have a 2-year legislative session, each year of the session is considered a separate regular session for this purpose.

b. Limiting CHIP Premium Lock-Out Periods (§ 457.570)

We proposed to define a CHIP premium lock-out as a period not exceeding 90 days when, at state option, a CHIP eligible child may not be permitted to reenroll in coverage if they have unpaid premiums or enrollment fees. Following a premium lock-out period, we proposed that the child must be permitted to enroll without regard to past due premiums. We proposed at § 457.570 to permit states to impose premium lock-out periods only for families that have not paid outstanding premiums or enrollment fees, and only up to a 90-day period. We also specified that a premium lock-out period must end once a family has paid the premium or enrollment fee. We also invited comments on any alternative late payment policies to encourage families to make their CHIP premium payments in a timely manner to avoid gaps in coverage. We received the following comments concerning the proposed lock-out period provision.

Comment: The majority of commenters supported the proposed rule requiring reasonable notice of non-payment, limiting the use of lock-outs only for non-payment of premiums (and only as long as the non-payment continues, and subject to a 90-day maximum), and disallowing states from requiring payment of outstanding premiums at the end of the lock-out period before re-enrollment. In particular, commenters strongly supported that the CHIP agency must review the family's circumstances (§ 435.570(b)) to determine if their income has declined, making the child eligible for Medicaid or a lower cost-sharing category. Some commenters also strongly opposed the imposition of lock-out periods for any length of time for a CHIP child, and urged CMS to modify § 457.570 to ban lock-out periods. These commenters indicated that lock-outs are contrary to the goals of a reformed health system, as well as the health of children. Some commenters stressed that a quarter of a year without health insurance can have a significant impact on a child's healthy development, a child should not be subject to penalties for a failure to pay by another family member, and the Affordable Care Act recognizes that children should connect with their medical home eight times in the first year of life alone. One commenter also stated that lock-out periods in CHIP create disruptions in care, burdens on families, unnecessarily increase administrative costs, and that the elimination of lock-out periods is an important consumer protection.

A few commenters asked whether the process of premium collection and debt forgiveness will be aligned with the premium collection regulations for the Exchange.

Response: In response to the support of our proposed rule by the majority of commenters, and comments received by states related to the need to continue to have non-payment of premium policies in place to manage program costs (as described below), we are adopting in our final rule the proposed provisions that authorized states to institute a maximum 90-day lock-out period for non-payment of premiums. Lock-outs are permitted for non-payment of premiums, but only as long as the non-payment continues and subject to a 90-day maximum. We also want to clarify that requirements related to reasonable notice of nonpayment, and review of the family's circumstances to determine if their income has declined (for example, making the child eligible for Medicaid or a lower cost-sharing category), are existing regulatory provisions that we have not modified by this rulemaking.

We appreciate the concerns expressed by some commenters with regard to the potential impact of any lock-out period on children, and for these reasons, we also adopted in the final rule the proposed restriction that lock-out periods may only apply to families who have not paid their premiums, and must end if a family pays its past due premium. We have also maintained the requirement that children must be permitted to enroll in CHIP subsequent to a 90-day lock-out period regardless of whether the family continues to owe past due premiums. In addition, we are also including requirements for non-payment of premium that are intended to align CHIP policies with policies applicable in the Exchange, to the extent possible. In CHIP and for those individuals with APTC in the Exchange, individuals are provided with a premium payment grace period, may be disenrolled for non-payment of premiums, and will not be required to pay past due premiums to reenroll in coverage. Exchange eligible individuals will have a longer grace period (90 days as opposed to 30 days) than CHIP, but will not be permitted to enroll in coverage until the next open enrollment period. Therefore, the amount of time an individual may have to wait before reenrollment in a Qualified Health Plan will vary, depending on when the premiums are missed in relation to the next scheduled open enrollment period, but will be no longer than 90 days for a child in CHIP.

We note that neither CHIP nor the Exchange have explicit rules governing debt forgiveness policies. More information on the Exchange rules related to non-payment of premiums is available at *http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.*

Comment: A few commenters requested clarification on policies governing non-payment of premiums. They requested clarification on policies related to ''forgiving'' past due premiums and enrollment fees, as well as whether a state can continue to try to obtain the outstanding premium amount without affecting eligibility. One commenter indicated that funds should be recoverable using a debt collection process. The same commenter also asked how many cycles of premium forgiveness would be allowed for an individual. Another commenter asked CMS to generally clarify what steps states and health plans would be permitted to take in situations in which a CHIP enrollee re-enrolls after a lock-out period and again does not pay premiums.

Response: We believe that disenrolling a child from coverage and potentially requiring a child to go without coverage up to 90 days (assuming the family has not paid the premium or enrollment fee), is a significant deterrence to prevent a family from establishing a pattern of non-payment of premiums and re-enrollment. Therefore, this rule does not place a limit/cap on the number of times

an individual may be re-enrolled after non-payment of their premiums. Nothing in this rule precludes a state from electing to establish policies for collecting debt from families that have not made their premium payments. Nor does this rule preclude states and health plans from offering incentives to encourage timely payment of premiums.

Comment: Some commenters recommended that states only be permitted to terminate coverage during a continuous eligibility period for failure to pay premiums as proposed at § 457.342(b) after complying with the disenrollment protections at § 457.570. Several commenters stressed that the proposed rule should be strengthened to capture the intent noted in the preamble that ''prohibiting a child from enrollment after the family pays the unpaid premium or enrollment fee is counter to promoting enrollment in and continual coverage.'' Some commenters also recommended that the final rule specify that if a family pays its outstanding premium between the end of their payment grace period and before the end of the lock-out period, the child be reinstated back to the effective end date with no gap in coverage and no loss of 12-month continuous eligibility (if applicable).

Response: We agree that coverage terminations occurring during a continuous eligibility period for failure to pay premiums can be implemented only after complying with the disenrollment protections at § 457.570, and we have modified § 457.342(b) to clarify this requirement. In addition to the preamble language describing that families that pay their premiums or enrollment fees prior to the end of a lock-out period must be re-enrolled in CHIP, we have also specified this requirement at § 457.570(c)(2) under this final rule. Section 2103(e)(3) of the Act describes a statutory premium grace period during which CHIP enrollees may pay their monthly premiums before being disenrolled. This provision requires States to grant individuals enrolled in separate child health programs a 30-day grace period, from the beginning of a new coverage period, to pay any required premium before enrollment may be terminated. The new coverage period begins the month following the last period for which a premium was paid. Aside from these requirements, states have, and will continue to have, flexibility to determine when coverage can be reinstated. As specified in our proposed rule at § 457.342(b), continuous eligibility may be terminated for failure to pay required premiums or enrollment fees.

Comment: Some commenters expressed concerns for potential unintended consequences of the proposed policies. One commenter stated that the proposed rule creates an incentive for individuals who are otherwise able to pay their premium to cycle through CHIP eligibility every other three month period and encourages gaps in access to medical services for children, who may subsequently present to the CHIP with higher acuity levels and higher cost needs. The commenter also stated that the proposed rule increases costs for states and the federal government, and diminishes health outcomes for children. The commenter encouraged CMS to continue to require member accountability in the CHIP program by allowing the collection of outstanding premiums in the presence of a 90-day grace period. Another commenter objected to the proposed rule to limit lock-out periods to 90 days and allow an individual to re-enroll upon payment of past due premiums, regardless of whether the lock-out period has expired. The commenter stated that this approach creates adverse selection, in that families may stop paying their premium when they may not have immediate health care needs, and then again pay their premiums only when they are in need of health care. Additionally, this commenter stated individuals should be required to pay any past due premiums as a condition of retaining eligibility for CHIP, even after a lock-out period has been satisfied. This commenter also stated that the proposed rule discards the plain statutory authority of title XXI that delegates this policy to states. Another commenter noted that CHIP is a ''stepping stone'' between Medicaid and employer-sponsored insurance or Exchange coverage, and that premiums in its current CHIP are minimal in comparison to employer-based coverage and private coverage. The commenter requested that premiums not be waived in states with requirement to repay outstanding premiums and no lock-out period. The commenter stated that waiving premiums does not promote responsibility, intrinsic value, or the effective management of program costs for states.

Response: The goal of allowing coverage for families that make current payments must be balanced with the concern that families will game the system to try to obtain coverage without paying premiums. We agree that there may be situations where families either elect, or are unable to pay their premiums multiple times during a given year. However, we are not aware of any evidence that these situations represent a significant number of cases. And, as stated in our response to the comment above, as long as states adhere to regulations at § 457.570, nothing in this rule precludes a state from continuing to establish policies for collecting debt from families that have not made their premium payments. We also encourage states to continue implementing approaches for simplifying premium payment arrangements and coping with administrative concerns families may have, and we continue to encourage states in this area to minimize the number of families that are disenrolled for non-payment of premiums.

Comment: One commenter stated that if CHIP lock-out periods are allowed in 2014, CMS should prohibit states that use this option from requiring children subject to a lock-out period to reapply for coverage and that a child returning to coverage following a lock-out period should be handled in the same manner as a renewal. The commenter believes that because such children were eligible for CHIP apart from non-payment of premiums or enrollment fees, the state agency should be able to reassess eligibility based on available electronic data sources and families should only be asked for additional information if what has already been provided and currently available electronic data are not sufficient to establish eligibility.

Response: While we encourage states to consider the potential administrative cost savings and reduced burden on families that could result from assigning a pending eligibility status to a child for non-payment of premiums rather than requiring a new application, we will continue to permit states to have the flexibility to make this decision.

Comment: One commenter requested clarification on whether a child can receive APTC or CSR during a premium lock-out period.

Response: We anticipate that this issue will be addressed in further guidance from the Department of Treasury.

Comment: The preamble to our proposed rule specified that a state may not require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once the lock-out period has expired, regardless of the length of the lock-out period. One commenter recommended that this policy also be specified in § 457.570(c)(2).

Response: Section 457.570(c)(2) clearly specifies that ''a state may not require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment

once the State-defined lock out period has expired, regardless of the length of the lock-out period.'' We have not made any modifications to this section.

Comment: Some commenters indicated that providing multiple ways to pay premiums and sending multiple, non-threatening payment due reminders are helpful in encouraging payment. These commenters suggested that CMS consider future sub-regulatory guidance to states to promote best practices in premium payments.

Response: Most CHIPs report efforts to facilitate payment of premiums and enrollment fees, easing the process for families, and the majority of states also send multiple payment due reminders and allow a variety of payment methods (such as allowing families to make payments at multiple locations). We will consider issuing further sub-regulatory guidance in this area.

8. Premium Assistance (§ 435.1015)

We proposed to codify the last sentence of section 1905(a) of the Act that authorizes payment of ''other insurance premiums for medical or any other type of remedial care or the cost thereof'' to support enrollment of individuals eligible for Medicaid in plans in the individual market, including enrollment in QHPs doing business on the Exchange. Premium assistance is one mechanism for facilitating the coordinated system of coverage between Medicaid, CHIP, and the Exchange in 2014. It provides an option for states to assist families who wish to enroll in the same health plan when some family members are eligible for either Medicaid or CHIP while other family members obtain coverage in the Exchange with advance payments of the premium tax credit, and it can provide a way to minimize the extent to which individuals have to change plans when their circumstances change such that their eligibility for an affordable health insurance plan changes. The proposed rule reflected longstanding statutory provisions in light of the new coverage options available in 2014. We received the following comments to proposed premium assistance provisions:

Comment: Many commenters were supportive of states' ability to use premium assistance authority to purchase private insurance coverage for health plans in the individual market, including QHPs doing business on the Exchange. At the same time, however, they emphasized the importance of ensuring that Medicaid and CHIP-eligible individuals receive the full scope of services to which they are guaranteed in Medicaid and CHIP, such as the full range of pediatric services provided in Medicaid and CHIP. Commenters urged CMS to take steps to ensure that states provide families and individuals with all of the information they need regarding the benefits to which they are entitled. They noted that the information states track to ensure cost-effectiveness should also be used to assess whether children and adults are receiving the full package of Medicaid or CHIP services. One commenter suggested that states should be required to ensure that beneficiaries experience a seamless enrollment process and that they have a single insurance card and point of contact for all benefits.

Response: Under all premium assistance arrangements, Medicaid and CHIP-eligible individuals remain Medicaid or CHIP beneficiaries and continue to be entitled to all Medicaid/CHIP benefits and cost sharing protections. Thus, we require at § 435.1015(a)(2) and (a)(3) that the state agency furnish all benefits covered under the state plan that are not available through the individual health plan and also that the individual does not incur any cost sharing in excess of that allowed in Medicaid. We expect states to have mechanisms in place to ensure that beneficiaries understand their available choices of either direct state plan coverage or coverage through premium assistance for an individual health plan, including a QHP in the Exchange, under the premium assistance option, as well as how to access any additional benefits or cost sharing assistance. Therefore, we have revised § 435.1015(b) to include provisions requiring informed choice and information on the process for accessing additional benefits and help with cost sharing, if the individual elects to receive coverage through the premium assistance option. We do not believe, however, that it is appropriate to direct through rulemaking the specific procedures states must employ to provide any necessary ''wraparound'' benefits or cost sharing; under the state plan option, states have the flexibility to determine how best to meet these cost sharing and benefit responsibilities. We have also clarified in § 435.1015(b) that states must require that individuals who have elected to receive premium assistance must obtain covered items and services through the individual health plan to the extent that the insurer is contractually or otherwise responsible to pay for such benefits.

Comment: Some commenters expressed specific concerns about cost sharing policies and urged CMS to consider putting additional beneficiary protections in place specific to premium assistance to ensure that people understand the cost sharing differences between Medicaid and CHIP and QHPs. They recommended that we create requirements for coordination between Medicaid and the QHP issuer to ensure that people do not exceed permissible cost sharing and asked CMS to provide guidance on how to monitor cost sharing.

Response: We expect states to have mechanisms in place to provide benefits that wrap around health plan coverage to the extent that the health plan offers fewer benefits, or has greater cost sharing requirements than in Medicaid or CHIP. These mechanisms will need to be coordinated with the health plan to successfully implement a premium assistance program. As noted above, we are requiring at § 435.1015(b) that states inform individuals how to access additional benefits not provided by the insurer, and also inform individuals how to receive cost sharing assistance. We are not proposing any specific requirements about the way in which such coordination can be effectuated, however, because we believe that states should have flexibility to develop effective coordination procedures consistent with state systems and procedures, including variation in state health care delivery systems.

Comment: Many commenters requested clarification of the cost-effectiveness test for premium assistance. They stressed the importance of a strong cost-effectiveness test to ensure that taxpayer dollars are spent wisely and also that beneficiaries do not lose important benefits and cost sharing protections. They were concerned that the proposed rule could be interpreted to include only the cost of premiums to purchase coverage and not to include in the test the costs associated with paying copayments, deductibles, and other cost sharing requirements. They believe that this should be clarified in the final rule to explicitly include cost sharing. Other commenters stated that this cost-effective analysis should be performed on an annual basis to ensure that the premium assistance program remains cost-effective even if Medicaid and the individual market experience different rates of cost growth.

Response: Consistent with our approach to cost-effectiveness in all premium assistance authorities, we intend for states to consider the cost sharing requirements of the private health plan (and therefore the cost of providing the cost sharing protections) when determining whether premium assistance is a cost-effective option, and we agree that this should be clarified. Therefore, we are revising § 435.1015(a)(4) accordingly. States

implementing premium assistance must describe their cost-effectiveness methodology, and to the extent that such a methodology relies on annual per person costs, we would expect states to be re-running the analysis at least annually, as new cost data is available.

Comment: Many commenters requested additional detail on how the option would be operationalized by state Medicaid agencies, Exchanges, and QHPs. One noted that successful premium assistance programs require robust data sharing, data mining, automated calculations using cost-effective algorithms, and strong relationships with private insurers. Some commenters requested that CMS provide states with a template or other tools to simplify the implementation of premium assistance.

Response: We will continue to provide technical assistance to states on the operational aspects of pursuing this premium assistance approach, relying on the experience states have had over the years implementing premium assistance.

Comment: Some commenters stated that families should have the choice of either premium assistance or direct Medicaid state plan coverage, even when premium assistance is cost-effective for the state, and they supported the proposed rule's provision that states may not require enrollment in premium assistance as a condition of Medicaid eligibility. Other commenters requested that CMS remove the voluntary participation requirement either entirely, or if this requirement is retained, they asked that states be allowed to make participation in premium assistance mandatory for certain Medicaid enrollees, such as adults up to 138 percent of the FPL who would be part of the state's Medicaid expansion population, or for pregnant women with incomes above 133 percent of the FPL.

Response: Consistent with the statute, we are retaining the provision at § 435.1015(b) that states may not require a Medicaid-eligible individual, as a condition of receiving Medicaid benefits, to enroll in a health plan in the individual market through a premium assistance arrangement. Enrollment in individual market coverage is not a statutory condition for eligibility. We are also clarifying in § 435.1015(b) that states must require that individuals who have elected to receive premium assistance must obtain covered items and services through the individual health plan to the extent that the insurer is contractually or otherwise responsible to pay for such benefits. This is consistent with the provision in section 1902(a)(17) of the Act that, in determining the amount of medical assistance, states may consider available resources, and the provision in section 1902(a)(25) of the Act that requires that states ensure that liable third parties pay primary to Medicaid. We address the issue of requiring enrollment in premium assistance for certain populations in the last response in this section.

Comment: Several commenters expressed concern that permitting state Medicaid programs to establish premium assistance programs could affect premiums in the Exchange. Some commenters recommended that CMS revise the proposed § 435.1015(a)(4) to require that premium assistance not increase federal costs and not increase premiums in the individual market.

Response: Medicaid beneficiaries enrolled in a QHP would be included in the individual market single risk pool of the health insurance issuer of the plan in which they are enrolled, just as any other individual obtaining coverage through such plans. § 435.1015(a)(4) requires the cost of premium assistance to be ''comparable'' to the cost of providing direct coverage under the state plan. We do not use a more restrictive word to allow flexibility because the amount, duration, and scope of the QHP coverage, or the nature of the QHP service delivery system, might be different from direct coverage under the state plan.

Comment: Some commenters stated that CMS must take additional steps to ensure that states do not steer family members of Medicaid-eligible individuals into less expensive plans to accommodate a premium assistance model and also to ensure that any enrollees who will be using premium tax credits have sufficient choice in QHPs. The commenters stated that regulations should require states to remain impartial in providing all available information on all QHPs so the family can choose the best plan or plans for the entire family, and also that Navigators, application assisters, and application counselors must be trained on the premium assistance program and provide impartial assistance to families.

Response: As noted above (and at § 435.1015(b)), when a state implements the state plan premium assistance option, the beneficiary's participation must be voluntary. We also expect states to ensure that application assisters and certified application counselors comply with the requirements in § 435.908 of this part and § 457.340 under subpart C of part 457, which include requirements that they be effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP through the Exchange and all insurance affordability programs operated in the state. In addition, the Exchange regulations at 45 CFR 155.210 require that Exchange Navigators provide impartial information and assistance. A Medicaid or CHIP enrollee who is receiving benefits in whole or in part through a premium assistance arrangement with a QHP will not be eligible for a premium tax credit under section 36B of the Internal Revenue Code because such credits are not available to individuals who, for the coverage month, are eligible for minimum essential coverage through Medicaid or CHIP.

Comment: A few commenters questioned whether section 1905(a)(29) of the Act creates the authority for premium assistance in the individual market. Many commenters recommended that CMS eliminate the proposed policy to allow premium assistance for plans in the individual market, or otherwise tightly circumscribe it, citing cost concerns, as well as concerns about the operational complexity and potential consumer confusion for consumers created by the ''wrap'' requirement.

Response: As we stated in the preamble of the proposed rule (78 FR 4624 and 4625), in section 1905(a)(29) of the Act, ''medical assistance'' is defined to include payment of part or all of the cost of ''other insurance premiums for medical or any other type of remedial care or the cost thereof.'' We have interpreted this provision to permit payment of FFP for premiums for health plans for Medicaid-eligible individuals, provided the state determines it cost-effective to do so. CMS has approved state premium assistance programs under this authority prior to the enactment of the Affordable Care Act. The Affordable Care Act provided for new rules regulating the operation of the individual and small group insurance markets, and expanded access to insurance coverage through QHPs participating in the Exchange. This results in new opportunities for states to deliver Medicaid coverage through the purchase of private health insurance in the individual market. Our goal is to work with states to ensure that their premium assistance approaches result in a cost-effective, seamless, and coordinated system of health care for beneficiaries.

Comment: Several commenters recommended delaying implementation of premium assistance until rates are determined for QHPs in the Exchange, and the individual market has settled from the changes it will experience in

2014, and states have experience implementing the Medicaid expansion.

Response: As we noted above, premium assistance is an option available under current law. Some states have already expressed interest in using the premium assistance model to deliver benefits to their Medicaid expansion beneficiaries through QHPs doing business on the Exchange. In addition, beginning in 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage in the Exchange with advance payments of the premium tax credit, and premium assistance provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same plan, even if supported by different payers. It also provides opportunities for continuity of care by increasing the likelihood that individuals could remain in the same health plan when moving back and forth between Medicaid and Exchange coverage due to fluctuations in income or other changes in circumstances. We are not establishing new authority but rather ensuring that the existing authority reflects the new coverage options in the individual and small group markets established by the Affordable Care Act.

Comment: Many commenters supported the retention of the proposed regulation text that makes FFP available for payment of health plan premiums for ''individuals'' eligible for Medicaid. They believe that this language supports the enrollment of Medicaid-eligible individuals in individual market plans, including plans offering family coverage, while not incorporating limiting definitions of ''family'' that would unnecessarily limit the benefits of the rule to individuals in families that do not comprise a taxpayer household. One commenter asked for CMS to clarify the meaning of ''family'' as used in the premium assistance section of the preamble of the proposed rule. The commenter also questioned whether this option is limited to Medicaid and CHIP-eligible individuals who have family members enrolled in an individual health plan, and if so, asked if we proposed to limit this option to members of the same tax household, MAGI assistance group, or to immediate family members.

Response: We have not proposed a definition of ''family'' that is unique to premium assistance. Regulations at § 435.603 of this part (and at § 457.301 and § 457.315 under subpart C of part 457 for CHIP) contain definitions and requirements related to family size, household, and MAGI-based income for the purposes of Medicaid and CHIP eligibility determinations.

The premium assistance option permits Medicaid or CHIP funds to be used to deliver coverage to Medicaid or CHIP-eligible individuals through the purchase of private health insurance, and it is not limited to Medicaid or CHIP-eligible individuals who have family members enrolled in a QHP. In some cases, the Medicaid or CHIP beneficiary could be enrolled in a health plan that provides individual coverage only, while in other situations, the Medicaid or CHIP beneficiary would be enrolled in a health plan that provides family coverage, depending on the categories of family coverage offered in the Exchange.

Comment: Some commenters, who were in favor of the continued authorization of premium assistance programs, stated that states should be allowed to determine how to make the concept work and urged CMS to allow complete state flexibility in designing and implementing benefit structures and cost sharing requirements.

Response: Individuals receiving coverage through premium assistance are Medicaid beneficiaries and are entitled to the full range of protections, including benefits and cost sharing, available under the law. States have flexibility under the state plan option to design how they will effectuate the coverage that is required while meeting applicable statutory and regulatory requirements. To the extent a state needs additional flexibility, the state may wish to explore demonstration options under section 1115 of the Act.

Comment: Several commenters recommended that premium assistance programs might require, or best be operated under, a Medicaid section 1115 demonstration.

Response: States have the flexibility to adopt premium assistance as an option under the state plan if it is voluntary for beneficiaries and adheres to all applicable statutory and regulatory provisions. Enrollment in individual market coverage is not a statutory condition of eligibility. Some states have expressed interest in submitting proposals for section 1115 demonstrations to require enrollment in premium assistance and to allow for consideration of a broader range of factors when cost-effectiveness is assessed. In response to these inquiries, we will consider approving a limited number of premium assistance demonstrations that are determined to further the objectives of the Medicaid program and which will test these new arrangements and inform policy. For states that implement premium assistance through a section 1115 demonstration, which could include mandatory enrollment into premium assistance, we will only consider demonstrations under which states make arrangements with the health plan to provide wraparound benefits and cost sharing assistance. For further information on the section 1115 option, including guidelines for proposals, please refer to Premium Assistance Frequently Asked Questions (FAQs) that CMS issued on March 29, 2013, available at *http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/FAQ-03-29-13-Premium-Assistance.pdf*

9. Changes to Modified Adjusted Gross Income and MAGI Screen

We proposed to implement sections 1902(e)(14) and 1943 of the Act, and section 1413 of the Affordable Care Act as they pertain to the definition of ''modified adjusted gross income'' (MAGI) and ''household income'' in section 36B(d)(2) of the Internal Revenue Code of 1986 (''36B definitions''). We also proposed a modification to previously issued regulations implementing section 1902(e)(14)(I) of the Act. The proposed rule applied the 5 percent disregard established by the Act for purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on MAGI, provided the determination was for the eligibility group with the highest income standard under which the individual could be determined eligible using MAGI-based methodologies. The proposed changes are discussed in more detail in the January 22, 2013 Medicaid Eligibility proposed rule (78 FR 4625 through 4627). We received the following comments concerning the proposed changes to MAGI provisions:

Comment: Some commenters supported the proposal to apply the 5 percent disregard only to the highest income threshold under a MAGI-group available for the individual and the related impact on the number of individuals for whom states will be able to claim the ''newly eligible'' enhanced match rate.

Response: The Affordable Care Act established a 5 percentage point of the FPL disregard ''for the purposes of determining income eligibility'' for individuals whose eligibility is based on MAGI. The objective of the proposal is to balance giving beneficiaries the benefit of the disregard for eligibility purposes, with the intent to give states the opportunity to claim enhanced match for all newly eligible individuals

if the state chooses to extend coverage to the new adult group. We propose doing so by ensuring that the disregard is applied to the income calculation of individuals for whom the disregard matters for a determination of eligibility for Medicaid under MAGI-based rules—that is, those for whom the application of the disregard means the difference between being eligible for Medicaid and being ineligible. These individuals are those whose income is within 5 FPL percentage points of the highest net income standard for which they can obtain Medicaid eligibility under MAGI-based income rules. The disregard would not be applied for a determination of eligibility for a particular eligibility group, but rather for eligibility for Medicaid.

Comment: One commenter questioned whether the proposed policy is consistent with federal law, which the commenter views as entitling all applicants to the 5 percent disregard. The commenter stated that our proposed policy could affect beneficiaries' cost sharing or benefits because it could result in a change in their eligibility groups. Some commenters noted that, for example, some parents could receive ABP coverage instead of the traditional Medicaid benefit package. The commenters noted, however, that this concern should be minimal since newly eligible adults who are medically frail and likely to need additional services covered under the regular Medicaid benefit package would have a choice of benefit package, between what is offered through an ABP that is based on section 1937 requirements, inclusive of EHB's, and ABP coverage that is not subject to section 1937 requirements, and includes the services approved in the state's Medicaid plan. Other commenters cited concerns about pregnant women and categories that offer only limited pregnancy-related services.

Response: The proposal to apply the 5 percent disregard to determine Medicaid eligibility rather than eligibility for a particular category is consistent with section 1902(e)(14)(I) of the Act. It is not necessarily the case that not applying the 5 percent disregard for purposes of determining eligibility category would result in moving individuals into a different eligibility group with different benefit and possibly cost-sharing rules because if the 5 percent disregard were applied as a general disregard, states would set income eligibility standards at levels that would compensate for that impact. For example, if the 5 percent disregard was applied generally, states might set the income eligibility standard for parents at a level 5 percent less than they would otherwise. Moreover, any adverse impact of a shift of beneficiaries from the parent group to the new adult group with coverage through an ABP will be minimized by the medically frail exception to benchmark coverage limitations. For pregnant women with income at the border between full benefits and pregnancy-related benefits, although the absence of the disregard may result in a pregnancy-related benefit package instead of full benefits, our March 2012 rule revised § 435.116(d)(3) to clarify that a State's coverage of pregnancy-related services must be consistent with § 440.210(a)(2) and § 440.250(p), which allows States to provide additional services related to pregnancy to pregnant women (see 77 FR 17149).

Comment: Several commenters recommended that CMS not revise the MAGI disregard rules. They raised concerns that there is too little time for states to make the systems and business process updates required to comply with the October 1, 2013 open enrollment period. They noted that the proposed rule requires more complex programming compared to simply adding 5 percent to all MAGI-based categories and that this policy could impact a state's ability to implement the MAGI requirements timely. In addition, they noted that although the 90/10 matching funds are available to make such systems-related changes, states must still finance 10 percent of the cost of these changes despite experiencing severe budgetary issues.

Response: We understand that many states relied upon the March 2012 final eligibility rule when planning their eligibility system builds for 2014. We appreciate that it may be difficult at this point in time to make programming changes for eligibility systems and have those changes take effect by January 1, 2014. In light of this challenge, we are finalizing our proposal, but we will not take any compliance actions for states whose systems cannot accommodate this eligibility determination requirement. We will approve eligibility determination systems even if as of January 1, 2014, the system applies the 5 percent disregard across the board to all individuals whose eligibility is determined using MAGI-based rules, based on a state's assurance that by January 1, 2015 the state will update the system to apply the disregard only for a determination of eligibility for Medicaid under MAGI-based rules.

Comment: Some commenters requested that states that are not expanding to cover the new adult group—and thus not claiming enhanced FMAP—should have the option to use the new calculation and continue to apply the 5 percent across- the-board disregard. Others requested that all states be given the option to apply the 5 percent disregard only to the highest income threshold under MAGI as proposed in our proposed rule.

Response: We believe that applying the 5 percent FPL disregard to determine eligibility based on overall eligibility rather than eligibility group is the best interpretation of section 1902(e)(14)(I) of the Act. Therefore, we are adopting our proposed policy as final, subject to the flexibility in implementation schedules discussed above.

Comment: One commenter asked whether the 5 percent MAGI income disregard would be applicable to only eligibility for the coverage group or whether it would also be applicable to cost-sharing or premium determinations—within the coverage group.

Response: Under this final rule, the 5 percent disregard under section 1902(e)(14)(I) of the Act applies to income determinations relative to Medicaid eligibility. It does not apply to determine into which eligibility group an individual should be placed. Nor is it intended to be applied to determine income for premium or cost-sharing payments.

Comment: One commenter requested clarification about whether, in a state that implements the eligibility expansion under section 2001 of the Affordable Care Act (that is, adopts the adult group), the state would need to apply the 5 percent disregard to a parent or caretaker relative age 65 or older that was not eligible for the expansion group.

Response: The 5 percent disregard is not applied based on an eligibility group, but based on whether the disregard would affect MAGI-based income eligibility for Medicaid as stated above. In the case of a parent or caretaker relative age 65 or older, the 5 percent disregard would be applied in determining MAGI-based income if the individual would otherwise be ineligible based on income. For example, if the parent/caretaker eligibility standard in a state was 80 percent of FPL and the individual's income before application of the disregard put them over the 80 percent standard, the 5 percent disregard would be applied and the individual would be eligible if the disregard brought their countable income below 80 percent of the FPL.

Comment: Another commenter asked for clarification of whether the 5 percent is only applied when an individual would not be eligible in another group

or if it would apply to all individuals being determined for eligibility in the group. The commenter specifically asked about whether the 5 percent disregard would be applied to keep family coverage in the Transitional Medical Assistance (TMA) group.

Response: TMA is beyond the scope of this rulemaking. TMA will be addressed in future guidance.

Comment: Several commenters questioned whether applying the 5 percent disregard to the MAGI income standards equivalent being produced through the process generally referred to as 'MAGI conversion' creates a double counting of the disregard. Other commenters asked whether states are being required to expand their income levels for pregnant women and children by 5 percent due to application of the disregard.

Response: We considered carefully the requirements in section 1902(e)(14)(A) of the Act in our December 2012 guidance to states on the establishment of converted MAGI-based income standards equivalent to levels used at the enactment of the Affordable Care Act (''MAGI conversion''). See *http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf.* Under this guidance, converted MAGI-based income standards are set without regard to the 5 percent disregard, since the MAGI income conversion requirements in section 1902(e)(14)(A) of the Act are independent of the 5 percent disregard at section 1902(e)(14)(I) of the Act. MAGI-equivalent income standards are established taking into account disregards that are currently in effect but which will no longer be in effect under MAGI. As a result, there is no double-counting of the 5 percent disregard. The 5 percent disregard would apply once when calculating an individual's MAGI-based income if the individual would otherwise be ineligible.

Comment: Several commenters requested clarification regarding how the 5 percent disregard under MAGI applies to applicants under a separate CHIP program. Similarly, commenters asked how the 5 percent disregard is applied to individuals at the boundary between Medicaid and CHIP eligibility.

Response: The 5 percent disregard should be applied to individuals who may be eligible for the highest income standard under the applicable Title of the Act (for example, Title XIX or Title XXI) for which the individual may be determined eligible using MAGI-based methodologies. Therefore, in states that have separate CHIP programs, the income disregard should be applied both for the highest Title XIX eligibility group available to the child, as well as to the separate CHIP program to cover similarly situated children at a higher income standard. The result would be that children with a MAGI in the 5 percent band above the Medicaid income standard at issue would be determined eligible for Medicaid. To clarify, we are modifying the language in the final rule at § 435.603(d)(4) to specify that the 5 percent disregard should be applied to the highest income standard in the applicable Title of the Act under which the individual may be determined eligible using MAGI-based methodologies. We do not believe this will impact the children for whom the state can claim enhanced match, because the state can claim enhanced match for any child whose income is greater than the upper income threshold under Medicaid on March 31, 1997, whether that child is covered under Title XIX or Title XXI.

Comment: One commenter asked whether there is any reason it would not be permissible for a state to program its eligibility system to build in the 5 percent disregard and effectively set the income limit at 5 percent higher than the state's established limit for MAGI related eligibility groups.

Response: Because the disregard is applied at the individual level, increasing the eligibility income standard for a group would not be the best way to program an eligibility system. Furthermore, doing so would be inconsistent with the statutory purpose of developing a uniform income determination methodology applicable in all states, which could be applied by the Exchange as well as the State Medicaid or CHIP agency. Therefore, this would not be permissible. Instead if the eligibility system cascades sequentially through possible eligibility options, it should apply the 5 percent as one last eligibility step, only when the system has returned a determination of ineligibility because the individual is over scale for income.

10. Single State Agency—Delegation of Eligibility Determinations to Exchanges (§ 431.10 and § 431.11)

We proposed to revert to the policy proposed in the Medicaid eligibility proposed rule published on August 17, 2011 (76 FR 51148), that single state Medicaid agencies will be limited to delegating eligibility determinations to Exchanges that are government agencies maintaining personnel standards on a merit basis. We retained many of the provisions strengthening the control and oversight responsibilities of the single state agency including the authority to issue policies, rules and regulations on program matters and to exercise discretion in the administration or supervision of the plan. We also proposed to make changes to § 431.11 regarding state organization. We received the following comments concerning the proposed changes to the single state agency provisions:

Comment: The majority of commenters strongly support the decision to revert to the policy originally proposed in the August 2011 Medicaid eligibility rule that delegation of the authority to determine eligibility for Medicaid is limited to Exchanges that are government agencies maintaining personnel standards on a merit basis. One state specifically commented that it supports this change as it allows states to maintain program integrity. Several other commenters noted that this construct has been a consistent legal interpretation for many decades. Other commenters noted that many state Medicaid employees are trained social workers who have the knowledge and experience to help our country's most vulnerable citizens, ensuring consistency and accessibility to benefits.

Response: We appreciate commenters support for our proposed policy, and therefore, we are adopting in this final rule the policy that delegation of the authority to determine eligibility for Medicaid is limited to Exchanges that are government agencies maintaining personnel standards on a merit basis. This is the policy that we originally proposed in our August 2011 proposed rule and that was re-proposed in the January 2013 proposed rule. We believe that under the best read of the statute, determining Medicaid eligibility is an inherently governmental function that must be performed by governmental agencies.

For purposes of delegation, we are treating a quasi-governmental entity or public authority running an Exchange and employing merit system protection principles as a government agency such that delegation to it would be permitted. Although we were explicit in the proposed regulation at § 431.10(c)(1)(i)(B), § 431.10(c)(2) and § 431.10(c)(3)(i) regarding authority to delegate to public authorities, we are deleting these references to public authorities in the final rule to conform with the Exchange regulation which only explicitly requires at § 155.20 that Exchanges be governmental agencies or non-profit entities established by a state.

Comment: Some commenters wrote that they especially appreciate the recognition that Medicaid agencies would not be parties to contractual

relationships between the Exchange and an entity engaged by the Exchange to determine eligibility, which would make it impossible for the Medicaid agency to provide appropriate oversight. They support maintaining the requirement that the Medicaid agency provide oversight when responsibility for the eligibility determination is delegated to another agency, because monitoring and oversight is necessary regardless of whether the delegation is to a government or non-government agency. They recommended that such oversight should include review of a sample of eligibility decisions made by the Exchange, scrutiny of the ''logic'' used in information technology systems to ensure that Medicaid policy is being applied in an accurate manner, regular observations of the processes used by the Exchange in making eligibility determinations, participation by Medicaid agency staff in training of Exchange staff, and monitoring of complaints and appeals. Many commenters suggested more specific requirements in regulation that should be added to § 431.10(d), specifying the oversight and monitoring required in the agreement between the Medicaid agency and Exchange or Exchange appeals entity include training for the Exchange or Exchange appeals entity, as well as monitoring of the systems being built.

Response: We agree that the single state agency should be required to provide oversight when responsibility for the eligibility determination is delegated to another agency and are finalizing our proposal requiring this. We appreciate the commenter's various suggestions regarding quality control and oversight by the Medicaid agency and believe they are within the ambit of what is intended by § 431.10(c)(3)(ii), requiring the Medicaid agency to exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies to ensure compliance with paragraphs (c)(2) and (c)(3)(i) of this section and institute corrective action as needed. We believe § 431.10(c)(3)(ii) can be exercised in various ways including those suggested by the commenters. We also agree that participation by Medicaid agency staff in training of Exchange staff would be valuable. We believe that the requirements in § 431.10(d) which specify the requirements for the agreement between the Medicaid agency and the Exchange or Exchange appeals entity include the requisite quality control and oversight language.

Comment: Many commenters recommended ways to ensure a coordinated system by engaging non-profits and private contractors in the process of supporting the Medicaid and CHIP eligibility determination, while not allowing them to determine eligibility. Recommendations included providing assistance to consumers with the application and enrollment process as certified application counselors and operating call centers, providing basic information to potential applicants. One commenter suggested that any contract over the amount of $1 million entered into by the State for services which support eligibility determination, such as data-matching or application/eligibility screening, be submitted to the Department of Health and Human Services for review.

Response: We agree that certified application counselors and call center administration are ways to engage non-profits and private contractors in the Medicaid eligibility process while assuring all final eligibility determinations are made by governmental entities. However, we do not believe it necessary to subject state contracts for support services related to eligibility determinations to special oversight rules. We believe that the single state agency's responsibility for determining and/or overseeing eligibility determinations includes oversight of such support functions.

Comment: One commenter noted that, while there is value in continuing the role of public employees in Medicaid eligibility determinations, this decision can be expected to have the inadvertent effect of requiring ''hand offs'' in some states between privatized Exchanges and Medicaid agencies. Specifically, in states operating a privatized Exchange, the Exchange will now be unable to conduct a full Medicaid determination, which means that an individual who applies for coverage via an Exchange and is found likely eligible for Medicaid will be ''bounced'' to the Medicaid agency for a final determination. Families with children, in particular, are likely to be ''bounced'' because they are eligible for Medicaid or CHIP at far higher income levels than adults in all states. As a result the commenter recommended that § 435.1200(d) include a new subpart requiring states to report to HHS and to make publicly available data on the share of applicants who are determined potentially eligible for Medicaid or CHIP by an Exchange who are eventually enrolled. Moreover, they recommended that procedures should be outlined for HHS to evaluate the data and take corrective action if data revealed that significant numbers of people are ''falling through the cracks'' because they must navigate multiple agencies when trying to secure coverage for themselves or their children.

Response: States will be required to establish performance standards in their state plans in accordance with § 435.912. To further this work, earlier this year, we issued a request for information (RFI) regarding performance indicators for Medicaid and CHIP business functions. The RFI explained that CMS intends to begin collecting and reporting on information including data regarding individual (applicant and beneficiary) experience with eligibility and enrollment. One of the indicators proposed under the eligibility and enrollment domain was ''accurate eligibility determinations,'' including a proposed ''accurate transfer rate''. The accurate transfer rate would be measured by the percent of individuals transferred to Medicaid, CHIP, or the Exchange, as applicable, who are determined eligible by that agency. We are currently reviewing the comments received and finalizing our proposal for implementation of performance reporting. For further information about the RFI, see our Web site at *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/RFI-Performance-Indicators-1-24-13.pdf.*

Comment: One commenter requested that we provide public access to agreements between the Medicaid agency and other entities conducting determinations. Some commenters also requested that we require public posting of the agreements on internet Web sites.

Response: We have provided in § 431.10(d) that agreements with federal, state or local entities making eligibility determinations or appeals decisions be available to the Secretary upon request. To the extent that the Secretary requests and obtains a copy of an agreement under § 431.10(d), the public can request a copy of the agreement through the Freedom of Information Act, 5 U.S.C. 552. These agreements may also be obtained at the state level under state freedom of information act laws.

Comment: Some commenters opposed this policy reversal from the previous Medicaid eligibility rule, and noted that, since that rule was issued, several states have relied on it to inform their decisions on establishing a State-Based Exchange, as well as to plan for Exchange and Medicaid systems and operations in future years. They believe these decisions and activities cannot easily be amended or changed in a short timeframe, and this policy change could have a major impact on the work states have completed, as well as their future

plans. They requested that CMS revoke the proposed change.

Response: We appreciate the challenges facing states, which is why we signaled nearly a year ago on May 16, 2012, in guidance titled ''General Guidance on Federally-facilitated Exchanges'' our intent, in light of public comments received on the final Medicaid and Exchange eligibility regulations, to propose further comment regarding ways that States could ensure coordinated systems when engaging non-profits and private contractors in the process of making Medicaid eligibility evaluations, while having government agencies make eligibility determinations. See *http://cciio.cms.gov/resources/files/ffe_guidance_final_version_051612.pdf*. We have also shared our intent to propose revised rules in webinars with states on the eligibility rules and in individual state meetings.

11. Conversion of Federal Minimum Income Standards for Section 1931 of the Act (§ 435.110 and § 435.116)

We proposed to require conversion of the federal minimum income standard for section 1931 of the Act to comport with the new rules regarding modified adjusted gross income (MAGI) that will take effect on January 1, 2014. Sections 1902(e)(14)(A) and (E) of the Act ensure that, in the aggregate, individuals who would have been eligible under Medicaid rules in effect prior to the Affordable Care Act remain eligible once the new MAGI-based methodologies go into effect. Our proposal to direct conversion of the federal minimum standard for section 1931 implements the conversion requirements in the statute more consistently, which is particularly important in light of the Supreme Court's decision in *National Federation of Independent Business* v. *Sebelius,* ____ U.S. ____; 132 S. Ct. 2566; 183 L.Ed. 2d 450 (2012). The proposed changes are discussed in more detail in the January 22, 2013 proposed rule (78 FR 4628 and 4629).

We received no comments on our proposed policy to convert the federal minimum standard for section 1931 of the Act, and therefore, are finalizing our proposal in § 435.110. This policy relates to the coverage levels for parents and caretaker relatives in states that do not implement the eligibility expansion in section 2001 of the Affordable Care Act to provide coverage for the low-income adult group. In addition, because pregnancy benefits for pregnant women under § 435.116(d)(4)(i) are tied to the same May 1, 1988 AFDC income standard for the applicable family size, we are finalizing our proposal in § 435.116 that this income limit should also be converted.

B. Essential Health Benefits in Alternative Benefit Plans

Section 1937 of the Act provides states with the flexibility to amend their Medicaid state plans to provide for the use of benefit packages other than the standard Medicaid state plan benefit package offered in that state, for certain populations defined by the state. These ABPs are based on benchmark or benchmark-equivalent packages. There are four benchmark packages described in section 1937 of the Act:

- The benefit package provided by the Federal Employees Health Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;
- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

Benchmark-equivalent coverage is provided when the aggregate actuarial value of the proposed benefit package is at least actuarially equivalent to the coverage provided by one of the benefit packages described above, for the identified Medicaid population to which it will be offered. Section 1937 of the Act further provides that certain categories of benefits must be provided in any benchmark-equivalent plan, and other categories of benefits must include ''substantial actuarial value'' compared to the benchmark package.

That said, we appreciate that it may be difficult at this point to make changes to the ABP that take effect by January 1, 2014. In light of this challenge, we will partner with states to work as quickly as possible to come into full compliance with these provisions. We do not intend to pursue compliance actions on these issues to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014.

Conforming Changes to Medicaid To Align With Essential Health Benefits

We proposed to implement section 2001(c) of the Affordable Care Act that modifies the benefit provisions of section 1937 of the Act. Specifically, section 2001(c) of the Affordable Care Act added mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage; required the provision of Essential Health Benefits (EHBs) beginning in 2014; and directed that section 1937 benefit plans that include medical/surgical benefits and mental health and/or substance use disorder benefits comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

In addition, we proposed to implement section 1902(k)(1) of the Act, which requires that medical assistance for, the new eligibility adult group for low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act must receive medical assistance provided through an ABP (which must include coverage of EHBs as of the same date).

We also proposed to implement section 1937(a)(2)(B)(viii) of the Act, which provides that individuals in the new mandatory eligibility group for former foster care children under age 26 are exempt from mandatory enrollment in an ABP.

We proposed to implement section 1937(b)(7) of the Act, which provides that medical assistance to individuals described in section 1905(a)(4)(C) of the Act (individuals of child bearing age) through enrollment in an ABP shall include family planning services and supplies.

We proposed to codify in § 440.345(e) the process to determine how often states would need to update ABPs after December 31, 2015.

We also proposed to add a new § 440.347 to incorporate section 2001(c)(5) of the Affordable Care Act.

Furthermore, anti-discrimination provisions found at section 1302(b)(4) of the Affordable Care Act were proposed to be codified § 440.347(e).

1. General Comments

Comment: One commenter stated they support the structure for implementing EHBs as proposed.

Response: CMS appreciates the support.

2. Alignment With Essential Health Benefits Provisions

a. Scope of Alternative Benefit Plans (§ 440.305)

We proposed to add the new adult eligibility group as an eligibility group that must receive benefits consistent with section 1937 of the Act. We also proposed that groups provided ABP coverage under section 1937 of the Act may be identified based on individual characteristics and not by the amount or level of FMAP funding.

Comment: Many commenters commended the addition of language prohibiting states from targeting Medicaid expansion populations solely on the basis of applicable matching rate. In addition, many commenters applauded language proposing to codify the flexibility HHS has given to states to use the Secretary-approved option in section 1937 of the Act to extend comprehensive Medicaid coverage to the newly-eligible expansion population. The commenters further urged CMS to partner with states to ensure that this population's full range of mental health and substance use needs and other health needs will be met.

Response: We thank the commenters for their support.

Comment: One commenter questioned the inclusion of the sentence which states, ''Enrollment in ABPs must be based on the characteristics of the individual rather than the amount or level of federal matching funds.'' The commenter stated this to be an unnecessary statement since eligibility for FMAP is based on eligibility category. It is unclear why enrollment in a benchmark plan would impact FMAP.

Response: People who qualify for eligibility under the new adult eligibility group will be determined to be either newly eligible or already eligible. For Medicaid coverage provided to the newly eligible population, the state will receive 100 percent FMAP in 2014 and for those who are determined to be eligible under December 2009 state rules, the state will receive its otherwise applicable FMAP. We included this language to clarify that states may not design different benefit packages based on the level of FFP they will receive, but rather the benefit package should be designed based on the medical needs of the population being served.

Comment: One commenter believed that the use of ABPs will assist states with expanding coverage in a meaningful way. However, the new adult population may have unique health care needs, including a high incidence of behavioral health and social issues. The commenter believed that the use of the ABPs would be most beneficial if they are used to tailor the scope of services and alignment of benefits to ensure adequate delivery systems for high need populations.

Response: Section 1937 of the Act offers flexibility for states to provide medical assistance by designing different benefit packages plan for different groups of eligible individuals. We agree with the commenter that ABPs can be successfully designed to meet the needs of the new adult population, including those with varying health care needs. As long as each benefit package contains all of the EHBs, much flexibility exists for states to meet the needs of beneficiaries.

Comment: One commenter was concerned that individuals age 50 to 64 may not be provided EHBs that are at least equal to those available to high-income individuals who purchase coverage on the commercial markets.

Response: We understand that there could be some variation in EHBs as defined for the individual market and for Medicaid based on the selection of different benchmark plans to define EHBs. But the flexibility to select different benchmark plans to define EHBs for Medicaid ABPs will allow states to address the unique needs of each circumstance and promote administrative simplicity, while still providing a floor for coverage. As long as that floor is met, Medicaid beneficiaries in the new adult group can also receive benefits from the selected coverage options under section 1937 of the Act or through substitution of benefits.

Comment: One commenter stated it is important that all individuals obtaining Medicaid coverage under the Affordable Care Act receive health coverage appropriate for their needs, including strong coverage for mental health and substance use disorders. The commenter also wrote it is important that traditionally Medicaid eligible populations that may be enrolled in ABPs are guaranteed adequate coverage.

Response: ABP flexibility is an option that states can choose to use in redesigning their current Medicaid benefit program. The requirement that ABPs include EHBs and comply with mental health parity requirements ensures a minimum level of sufficiency of the coverage.

Comment: One commenter requested that HHS require or give states the option to provide EPSDT coverage to 19- and 20-year olds who qualify for the new adult group.

Response: The existing provisions of § 440.345 require states to make available EPSDT services as defined in section 1905(r) of the Act that are medically necessary for those individuals under age 21 who are covered under the State plan. We did not propose to change this requirement. To the extent that any medically necessary EPSDT services are not covered through the ABP plan, states must supplement the ABP plan to ensure access to these services. EPSDT provisions apply to 19- and 20-year olds who qualify for the new adult group.

Comment: One commenter believed that the Affordable Care Act provided an unprecedented opportunity to improve access to somatic and behavioral health treatment for the ''jail-involved'' population. The commenter noted that up to 6 million incarcerated individuals have income below 133 percent which would make them newly eligible for Medicaid under the Affordable Care Act. These individuals could represent up to ⅓ of the newly eligible population, underscoring the importance of considering the particular circumstances of incarcerated individuals in implementation of the Affordable Care Act.

Response: Paragraph (A) following section 1905(a)(29) of the Act and implementing regulations at § 435.1009, specify that Medicaid is prohibited from making payments for care or services for any individual who is an inmate of a public institution, except as an inpatient in a medical institution. We read this prohibition to apply generally to medical assistance, whether provided through the regular coverage plan or through an ABP. Regular coverage or regular Medicaid benefit package is defined as Medicaid state plan services including services defined in section 1905(a), 1915(i), 1915(j) and 1945 authorities. Thus, while we agree with the commenter that incarcerated individuals may be eligible for Medicaid, they would not be entitled to ABP benefits inconsistent with the payment exclusion. We note that this is consistent with the exclusion of incarcerated individuals from eligibility to enroll in coverage through the Exchanges. It is also consistent with the responsibility under the Eighth Amendment of the United States Constitution of governmental entities to provide necessary medical care to individuals who they are holding as inmates, which effectively creates a liable third party for such care.

States should suspend, rather than terminate, the Medicaid eligibility of individuals who are enrolled in Medicaid when entering a public institution, so as to ensure ease of reinstitution of coverage post-release. Additionally, if an individual is not already enrolled in Medicaid, states can enroll eligible individuals prior to their release so that the individual can receive Medicaid covered services in a timely manner upon discharge.

Comment: One commenter believed that the new eligibility category is likely to attract younger and healthier populations than traditional Medicaid. The commenter believed that a percentage of those who are newly eligible will acquire a condition or

disability after they are enrolled in an ABP. The commenter recommended that HHS standardize an effective process for ensuring that beneficiaries whose health status changes have the opportunity to access in a timely manner other ABP or traditional state Medicaid plans which meet their needs. The following standards were suggested: A process for participants to request and receive clinically appropriate benefits not routinely covered by the plan; a process for participants to request and receive coverage for benefits beyond the limits set by the plan where extraordinary circumstances exist; and a process for participants to request and receive coverage of specialty care not routinely coverage by the plan when medically necessary and appropriate.

Response: As noted, states have the flexibility to define different benefit packages to meet the needs of disparate populations. In addition, individuals in the new adult group meeting the exemption criterion found in section 1937 of the Act have the ability to choose between ABP benchmark coverage designed by the state using the rules of section 1937 of the Act including EHBs as a minimum level of coverage, or ABP benchmark coverage defined as the state's approved regular state plan benefit package, which is not subject to the requirements of section 1937 of the Act.

Comment: One commenter supported providing states with flexibility to add state plan benefits and services found in base-benchmark plans to benchmark-equivalent benefits. The commenter also believed it would helpful to clarify that adding such benefits would be possible and appropriate for individuals in the Medicaid expansion group.

Response: We appreciate the commenter's support, and clarify here that individuals in the new adult group can receive benchmark-equivalent coverage or Secretary-approved coverage which can include a broader range of services than in public employee or commercial benchmark coverage options.

Comment: One commenter interpreted the proposed rule to say that individuals who are newly eligible adults—and not deemed medically frail—do not qualify for additional services above and beyond what is required under section 1937 of the Act and the EHB. Based on that interpretation, if a state wanted to provide wrap around services for a particular population, in which some of the newly eligible would fall under, it would not be allowable unless the state created a Secretary-approved plan that incorporates the benefits into the underlying plan. The commenter requested that CMS clarify and/or confirm the interpretation of this provision.

Response: We confirm that the individual's interpretation is correct. Section 1902(k)(1) of the Act provides that individuals in the new adult group receive benchmark or benchmark-equivalent coverage subject to the requirements of section 1937 of the Act (except that individuals who would otherwise be exempt may choose to receive benchmark or benchmark-equivalent coverage that is not limited by section 1937 of the Act, and thus have the option of benchmark or benchmark-equivalent coverage that is equal to the Medicaid benefit package otherwise available). Such coverage can be in the form of Secretary-approved coverage, which may, at state option, include a broader range of services than public employee or commercial benchmark options.

Comment: Many commenters requested CMS clarify that the federal matching rate is based on the individual and not the services provided. A few commenters requested clarification that services provided through the Secretary-approved ABP process for Medicaid expansion individuals will be covered at the enhanced rate and that Medicaid expansion individuals who are exempted into traditional Medicaid coverage will also be covered at the enhanced rate.

Response: We clarify that the enhanced FMAP rate for newly eligible individuals is available for all services they receive. The matching rate is based on the individual, not on the services provided to them.

Comment: One commenter urged HHS to clarify the flexibility that states will have to design multiple ABPs targeting specific populations. The commenter understands this provision will allow states to put in place ABPs for sub-populations within the newly eligible group (that is, people living with chronic viral hepatitis or other chronic conditions) and urges CMS to clarify that this is an appropriate use of the ABP flexibility.

Response: Section 1937 of the Act provides states with significant flexibility to design Medicaid benefit coverage under the State plan. There are many options in selecting an ABP, and states may offer different ABPs to different targeted populations (except that, as discussed elsewhere, targeting cannot be based on the amount or level of federal matching funding). Section 1937 of the Act provides states with the statutory construct to provide an ABP without regard to requirements at sections 1902(a)(1) (related to state-wideness) and 1902(a)(10)(B) (related to comparability) of the Act. This flexibility is provided at § 440.376 and § 440.380, respectively.

Comment: One commenter was unclear why the term ABP is being used. The Affordable Care Act references ABPs specifically for evaluation of the ABPs as required under the Class Independence Advisory Council. Other sections reference alternative benefits or programs specifically under section 1937 of the Act or the establishment of Basic Health Plans. The commenter believed the use of the term is confusing and unnecessary since benchmark plans are not alternative plans or programs as originally identified in the law. Another commenter found § 440.305 confusing as paragraph (a) refers to ''benchmark and benchmark-equivalent'' however paragraph (b) refers to ABP. The commenter suggested revising paragraph (a) by replacing benchmark and benchmark-equivalent with ABP.

Response: The Deficit Reduction Act of 2005 amended the Act by adding a new section 1937 of the Act to provide for the use of benefit packages other than the standard benefit package, namely benchmark and benchmark-equivalent packages. The Affordable Care Act made statutory changes to section 1937 of the Act, one of which is the requirement that section 1937 coverage packages include EHBs. We issued regulations outlining how the precise parameters of EHBs will be established in the non-grandfathered plans in the individual and small group markets and, to some degree, how they will be implemented in section 1937 coverage plans. In that regulation, the term ''base-benchmark'' was used to refer to the base plan used by states to determine EHBs for coverage plans in the non-grandfathered plans in the individual and small group markets. That base-benchmark plan becomes the EHB-benchmark plan after it is supplemented with any missing categories of EHBs. In an effort to prevent confusion between the term ''benchmark'' used for the non-grandfathered plans in the individual and small group markets, and the use of ''benchmark'' by section 1937 coverage plans, we chose from the statutory construct of section 1937 of the Act the term ''Alternative Benefit Plan'' (ABP) to hereafter refer to Medicaid benchmark and benchmark-equivalent plans as ABP.

Comment: One commenter indicated that there was no adult group under section 1902(a)(10)(A)(i)(VIII) of the Act on or before February 8, 2006 so the

exception in subsection (b) does not appear to fit.

Response: Section 6044 of the Deficit Reduction Act of 2005 amended Title XIX by adding a new section 1937 of the Act that allows States to amend their Medicaid State plan to provide for ABPs and limits application of this provision to individuals whose eligibility is based on an eligibility category under section 1905(a) of the Act that could have been covered under the State's plan on or before February 8, 2006. In 2010, section 2001(a)(1) of the Affordable Care Act amended Title XIX to establish a new optional adult eligibility group for low-income adults age 19 to 64. Effective January 1, 2014, States that implement this new eligibility group must provide medical assistance for that group through an ABP. As specified, all provisions of section 1937 of the Act apply to the new adult eligibility group except that those individuals in the new adult group who meet the exemption criteria will have a choice between ABP benchmark benefits as defined by the state under the rules of section 1937 of the Act and ABP benchmark benefits defined as the state's approved Medicaid state plan, without regards to the rules of section 1937 of the Act.

Comment: A few commenters believed the final rule should clarify that an ABP designed for individuals within the new adult eligibility group can align with traditional Medicaid coverage through the process of designing of a Secretary-approved plan.

Response: We understand the importance of this issue, and reiterate guidance here. Secretary-approved coverage, which can include the full regular Medicaid state plan benefit package, is one of the four statutorily specified coverage benchmarks available under section 1937 of the Act. States can choose to use Secretary-approved coverage to significantly align the benefits offered to the new adult eligibility group with the regular state Medicaid package. Like with the other three statutorily specified coverage benchmarks, the Secretary-approved coverage must include EHBs as described in section 1302(b) of the Affordable Care Act and applicable regulations. In all cases, EHBs are first defined as the benefits from the base benchmark plan and supplemented with benefits from other base benchmark plans as necessary. CMS is clarifying in this rule that substitution of benefits as defined at § 156.115(b) is applicable to EHBs in ABPs. We believe that states will appreciate this added flexibility. Substitution of benefits can occur benefit by benefit. The benefits must fit into the same EHB category and the benefits being interchanged must be actuarially equivalent. Benefits do not have to be similar in nature, they must only be in the same EHB category and actuarially equivalent. Furthermore, states may substitute more than one benefit that when combined are actuarially equivalent to a single benefit. States may use their Medicaid state plan benefits for substitution if the state plan benefit is actuarially equivalent and in the same EHB category of benefit that will be replaced.

Comment: Consistent with the provisions of sections 1902(k)(1) and 1903(i)(36) of the Act, the commenter requested that CMS confirm that the coverage for individuals eligible only through section 1902(a)(10)(A)(i)(VIII) of the Act is limited to benchmark or benchmark-equivalent coverage.

Response: That is correct. This still leaves states with significant flexibility to design coverage using the options of benchmark coverage, which includes Secretary-approved coverage, and benchmark equivalent coverage. Section 1937 of the Act must also provide EHBs, which through selection of a base-benchmark plan, supplementation and substitution, will be used to define the EHBs. EHBs are then incorporated with the section 1937 benchmark coverage to lead to a complete benefit package.

Comment: Several commenters stated that the option to offer specialized benefit packages, in the form of more than one ABP, to different target populations creates an administrative burden and confusion for families. The option to offer specialized benefit packages might require more than one design process and public notice; additional actuarial analyses of the different benefit packages for rate setting; an extra process for tracking individuals; and a state's contracted MCOs would have to manages different benefit packages.

Response: The flexibility to provide specialized benefit packages to one or more targeted populations is at the option of the state. Each state will determine whether it is appropriate or administratively feasible to design and offer different benefit packages for different groups of beneficiaries.

Comment: One commenter was concerned with the disparities in coverage that the proposed EHB policy would create. That is, the guidance suggests that the policy only mandatorily applies to the newly eligible category of adults. In states that wish to take up the new expansion option this creates a situation in which the higher income expansion population will receive a more generous benefit package than the existing population would receive.

Response: We understand the commenter's concern, and it is true that the benefit package may be different because of the requirement that ABPs provide EHBs. However, it is not clear that the ABP benefit package provided to the new adult eligibility group will be more generous than the existing Medicaid benefit package. In addition, we remind readers that the EHB requirements apply to all individuals receiving services through an ABP, not just those in the new adult group.

Summary: We did not make any changes to proposed regulation text as a result of comments in this section.

b. Exempt Individuals (Former Foster Care Children) (§ 440.315)

We proposed to implement section 1937(a)(2)(B)(viii) of the Act, added by section 2004 of the Affordable Care Act, as amended by section 10201(a) of the Affordable Care Act, by providing that individuals eligible under section 1902(a)(10)(A)(i)(IX) of the Act will be exempt from mandatory enrollment in an ABP.

Comment: Many commenters commended HHS for confirming that the new former foster care children group is exempt from mandatory enrollment. Many other commenters expressed support for affirming at § 440.315(h) that former foster care children are statutorily exempt from mandatory enrollment in an ABP, and therefore, can access the full Medicaid benefit, including EPSDT services, up to age 21.

Response: We appreciate commenter support. Individuals under age 21 receive EPSDT either through the ABP or as additional coverage that supplements the ABP.

Comment: One commenter wrote that while the proposed rule clarifies that former foster care youth up to age 26 are eligible for full Medicaid benefits, may not be mandated into an ABP, and will have access to full EPSDT services up to age 21, after age 21, former foster care youth will no longer have access to EPSDT benefits and requested clarification as to the meaning of ''full Medicaid benefits.'' According to the commenter, the American Academy of Pediatrics recently reported that children in foster care experience significantly higher rates of medical and mental health challenges, and therefore, believes that youth aging out of foster care require comprehensive health coverage that recognizes their unique needs. Once a youth turns 21 they lose EPSDT coverage but continue to have the same health needs. The commenter

therefore requested that CMS define ''full Medicaid benefits'' to include benefits akin to EPSDT, including dental coverage, mental health services and physical health care.

One commenter stated she appreciates the clarification that former foster care children are exempt from mandatory enrollment in an ABP and that they will receive full Medicaid benefits. However, it is not clear whether this means they can receive EPSDT. The commenter urged CMS to consider mandating, or at a minimum, allowing states to provide EPSDT benefits for this at risk population because in a majority of states oral health is not part of the adult Medicaid benefit package and evidence suggests that roughly 35 percent of children in foster care have significant oral health problems. Making sure oral health issues are addressed as former foster care youth move into adulthood will have a significant impact.

Response: We acknowledge that children in foster care generally experience significantly higher rates of medical and mental health challenges and that these health challenges often continue after aging out of foster care. For this reason, Congress provided statutory protection for an individual who receives aid or assistance under part B of title IV of the Act for children in foster care or an individual for whom adoption or for whom foster care assistance is made available under part E of title IV of the Act, without regard to age, by exempting these individuals from mandatory enrollment in an ABP.

Under the existing provisions of § 440.345, States must make available EPSDT services, as defined in section 1905(r) of the Act, for those individuals under age 21 who are enrolled in an ABP. To the extent that medically necessary EPSDT services are not otherwise covered through the ABP for individuals under 21, states are required to supplement the ABP to ensure access to these services. However, there is no statutory authority to require states to provide EPSDT services beyond age 21. We note that states have the flexibility to design an ABP targeted to former foster care children that provides a more comprehensive array of health coverage than is provided through the regular state plan and to offer voluntary enrollment in such a plan. Through the ABP option, states can provide this population with oral health and other services not otherwise available to adults through State plan coverage.

Summary: We have not changed proposed regulation text as a result of comments received in this section.

c. Benchmark-Equivalent Health Benefits Coverage (Prescription Drugs and Mental Health Benefits) (§ 440.335)

We proposed to implement section 2001(c) of the Affordable Care Act that added mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage.

Comment: Many commenters were supportive of paragraphs (b)(7) and (b)(8) implementing the statutory requirements for benchmark-equivalent coverage to include prescription drugs and mental health benefits. A few commenters commended the broad list of services included in the proposed rule.

Response: We agree that the inclusion of prescription drugs and mental health benefits as defined within ABPs are important and necessary and we appreciate the support of commenters regarding the coverage of the benchmark-equivalent health benefits.

Comment: A few commenters were pleased that HHS listed services that can be vital to people with disabilities and chronic health conditions as allowable in benchmark-equivalent and Secretary-approved coverage.

Response: We acknowledge the special medical needs of individuals with chronic health conditions. The final rule provides a clear path to coverage for chronic disease management under § 440.347.

Comment: A number of commenters requested that CMS clarify paragraph (c)(1). The commenters believed that CMS is suggesting it will use a similar policy for benchmark-equivalent coverage as it does for Secretary-approved coverage and, thus, allow addition of benefits through the benchmark-equivalent coverage process. The commenters believed there is no legal impediment to this approach and supported it. The commenters urged CMS to confirm this interpretation.

Response: We confirm this interpretation. The rule provides states the flexibility to include coverage for benefits beyond the required coverage and allows for states to create benchmark-equivalent coverage that can include benefits not available through the benchmark options.

Comment: Numerous commenters were confused by the language in § 440.335(c)(1) allowing addition of services available in ''2 or more'' benchmark options, as opposed to the language of ''1 or more'' which appears in § 440.330 and in current regulation. The commenters believed this may be a clerical error and recommended the ''1 or more'' language to maximize state flexibility.

Response: A clerical error was made in § 440.335(c)(1). The regulation has been corrected to read, ''. . . for any additional benefits of the type which are covered in 1 or more of the standard benchmark . . .''

Comment: One commenter was concerned that only provision § 440.335(c)(1) was being amended leaving (c)(2) and (c)(3) intact. The commenter believed this will result in conflict with newly added § 440.335(b)(7) and (8) as these provisions provided that four benefits (prescription drugs, mental health, vision and hearing services) must represent 75 percent of the actuarial value and are not required to be covered.

Response: We disagree that the existing provision § 440.335(c)(2) will conflict with § 440.335(b)(7) and (b)(8). The actuarial value of the coverage for prescription drugs, mental health services; vision services; and hearing services must still be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the state.

However, provision § 440.335(c)(3) is in conflict with § 440.335(b)(7) and (b)(8). The state will, by default, meet the conditions of (c)(3) because prescription drugs and mental health services are now required benchmark-equivalent coverage and states will not have an option to provide such coverage as regulation currently allows. States also have the ability to add vision and hearing services through new requirements for additional coverage at § 440.335(c), for individuals not in the new adult group. Individuals in the new adult group can receive these vision and hearing services, at state option, through the use of Secretary-approved coverage. Therefore, we have stricken § 440.335(c)(3) from the final rule.

Summary: As a result of comments received in response to the proposed regulation, CMS has deleted § 440.335(c)(3) from the final rule. Additionally, an error was made in § 440.335(c)(1). The regulation has been corrected to read, ''. . . for any additional benefits of the type which are covered in 1 or more of the standard benchmark coverage packages described in § 440.330(a) through (c) of this part or State plan benefits . . .'' Otherwise, CMS has not made any changes to this section.

d. EPSDT and Other Required Benefits (Family Planning Services and Supplies) (§ 440.345)

We proposed to codify section 2303(c) of the Affordable Care Act by adding

paragraph (b) to § 440.345 to provide that ABP coverage provided to individuals described in section 1905(a)(4)(C) of the Act (individuals of child bearing age), include family planning services and supplies.

Comment: Many commenters thanked CMS for codifying the important provision requiring that ABP coverage provided to individuals of child-bearing age include family planning services and supplies. This will help insure that Medicaid beneficiaries can access essential family planning services and supplies regardless of the type of Medicaid plan in which they are enrolled.

Response: We thank the commenters for their support.

Comment: One commenter requested further clarification as to the specific services and supplies that fall into this category. Clarification was also requested on which services are covered for individuals of child bearing age, including minors who can be considered to be sexually active, who are eligible under the state plan, and who want such services required under section 1905(a)(4)(C) of the Act. Because family planning services are not clearly defined in federal law or regulation, the commenter urged CMS to clarify in this rule that family planning services and supplies include but are not be limited to: examination and treatment by medical professionals; medically appropriate laboratory examinations and tests; counseling services and patient education; medically approved methods; procedures, pharmaceutical supplies; and devices to prevent contraception and infertility services, including sterilization reversal.

Several recommended HHS clarify family planning to specify coverage of section 1905(a)(4)(C) of the Act services and supplies and require states to assure compliance with section 1902(a)(23) of the Act freedom of choice for family planning services and supplies, since it is likely that many states will contract with managed care organizations, some of which may have no Medicaid experience. They believe that explicitly requiring freedom of choice will increase the likelihood that all plans will comply with the freedom of choice requirement.

Response: Family planning services and supplies are described in section 1905(a)(4)(C) of the Act. We have chosen not to use this rule as the vehicle for issuing additional guidance on family planning services, as such guidance would need to have broader implications than this rule provides. In addition, we do not believe it is necessary to address issues relating to beneficiary choice of family planning provider in this provision, since this provision deals only with coverage issues under an ABP, and not with issues such as freedom of choice of provider. That issue is separately addressed in our regulations at § 431.51 and § 441.20.

Comment: One commenter addressed section 2(B)(1) of the preamble, specifically the statement ''Consistent with the current law, states have the flexibility within those statutory and regulatory constructs to adopt prior authorization and other utilization control measures, as well as policies that promote the use of generic drugs.'' The commenter is concerned that the interpretation of this statement could provide too much flexibility for states in the use of utilization control measures, creating a barrier to necessary family planning supplies for Medicaid enrollees, as women need access to the full range of contraceptive methods to utilize the method most effective for them. The commenter requested HHS to issue sub-regulatory guidance that prohibits barriers to the full range of FDA-approved contraceptive methods guaranteed under the Affordable Care Act.

Response: Prior authorization and utilization control measures are common practices used within regular Medicaid, public employee, and commercial insurance products. Benefit packages designed within ABPs also have this flexibility. These approaches should not be used as a barrier to needed services. This proposed rule and final rule added the Affordable Care Act requirement that all ABPs must include coverage of family planning services and supplies. Nothing in the final rule authorizes deviation from the protection of beneficiary free choice of family planning provider, consistent with section 1902(a)(23) of the Act and § 431.51, or an exception to the requirement at § 441.20 that the state plan provide that beneficiaries are protected from coercion or mental pressure and are free to choose the method of family planning to be used.

Comment: One commenter wrote that discrimination in benefit plan design is a persistent practice in the insurance industry and the exclusion of treatment for infertility is one example. Infertility affects an estimated 12 percent of women of child bearing age and infertility treatments are more commonly prescribed for women than for men. Another commenter recommended that the list of required categories of services for benchmark-equivalent coverage incorporate each of the benefits including family planning services and supplies required under EHB as specified in § 440.347(a) for consistency and clarity and to ensure consumer protections.

Response: Coverage of infertility services is generally at the option of the state. However, coverage of infertility services becomes part of the ABP benefit package either: (1) if the state selects a coverage plan under section 1937 of the Act that includes such coverage or chooses to include such coverage as part of a benchmark-equivalent coverage plan; or, (2) if the base-benchmark plan chosen by the State to define EHBs covers infertility treatment in an EHB category, unless the state elects the option set forth in 45 CFR 156.115(b) to substitute actuarially equivalent benefits in defining EHBs. We are reiterating here that CMS is clarifying in this rule that substitution of benefits as defined at 45 CFR 156.115(b) is applicable to EHBs in ABPs. We believe that states will appreciate this added flexibility. Under 45 CFR 156.115(b)(1), substitution of benefits can occur benefit by benefit. The benefits must fit into the same EHB category and the benefits being interchanged must be actuarially equivalent. Furthermore, states may substitute more than one benefit that when combined are actuarially equivalent to a single benefit. States may use their Medicaid state plan benefits for substitution if the state plan benefit is actuarially equivalent and in the same category of benefit that will be replaced. We do believe it is necessary to explicitly list the EHB categories in the regulation text for benchmark-equivalent coverage, as section 1937 of the Act was amended to require both benchmark and benchmark-equivalent coverage to include all EHBs. States will identify substituted benefits in the ABP SPA when submitted to CMS.

Summary: We will not be making changes to proposed regulation text as a result of comments received.

e. EPSDT and Other Required Benefits (Mental Health Parity) (§ 440.345)

Section 2001(c) of the Affordable Care Act directed that benefit plans under section 1937 of the Act that include medical and surgical benefits and mental health and/or substance use disorder benefits comply with MHPAEA and we codified this at § 440.345(c) in the proposed rule.

Comment: Almost all commenters expressed support for the requirement in § 440.345(c) requiring that mental health or substance abuse benefits must be provided by ABPs and must comply with MHPAEA. Many also commended CMS for clarifying that ABPs must include mental health parity as this will

lead to the provision of necessary services to millions of individuals. A number of commenters wrote about how extremely important it is that all individuals gaining Medicaid eligibility under the Affordable Care Act receive coverage appropriate for their needs including strong coverage of mental health and substance use disorders. Many expressed their appreciation for CMS's strong support for this provision. Many stated that they appreciated the proposed rule's explicit recognition of the Affordable Care Act requirement that ABPs must provide the EHBs, including mental health and substance use disorder (MH/SUD) services.

Response: CMS thanks the commenters for their support on the language in the regulation.

Comment: Some commenters asked CMS to provide additional detail on how the requirements of MHPAEA apply to ABPs including details on how to supplement benchmark or benchmark-equivalent coverage to bring it into compliance with parity and how to identify violations in parity compliance. Commenters requested clarification that MHPAEA requires ABPs to offer the same scope of MH/SUD services as medical services, including adequate prescription drug coverage.

Response: On January 16, 2013, CMS released a State Health Official Letter regarding the application of MHPAEA to Medicaid MCOs, CHIP, and ABPs. This guidance specifically states that all Medicaid ABPs (including Secretary-approved coverage) must meet the parity requirements, regardless of whether services are delivered in managed care or non-managed care arrangements. This includes ABPs for individuals in the new low-income Medicaid expansion group, effective January 1, 2014.

Comment: Many commenters wrote that more than just requiring compliance was needed in this final rule because of the documented disparity between coverage of medical surgical benefits and coverage of MH/SUD services in commercial and employer health coverage. With about one quarter of adults suffering from a diagnosed mental health disorder, disparity in services and cost sharing has wide ranging impact. Some stated that studies and literature indicate deficits in employer coverage of mental health benefits and that limits on MH/SUD services were lower than those for medical surgical benefits. Some commenters stated that in clarifying the application of mental health parity CMS should make clear that if psychiatric rehabilitation services are provided, so must psychiatric habilitation be required, and that CMS should assure that a robust package of mental health coverage is part of ABPs. Commenters indicated that supplementation, substitution, parity and other protections are the best approaches for EHBs to meet the complex health needs of the low-income adults who will gain Medicaid eligibility under expansion. The commenters encouraged CMS to do whatever is within its authority to encourage all plans to expand their mental health and substance use disorder treatment to provide better care by providing the full range of MH/SUD services and to ultimately reduce costs and unnecessary loss of productivity and life.

Response: States must offer services in all ten EHB categories, including MH/SUD services, and must provide such MH/SUD services in a manner that complies with the parity requirements of MHPAEA. We do not intend to require or request states to include specific services within EHB categories offered by their ABP. As states determine their ABP service package, states must use all of the EHB services from the base-benchmark plan selected by the state to define EHBs for Medicaid, substituting or supplementing as necessary. We believe this will allay concerns expressed by commenters, as commercial plans must also adhere to mental health parity requirements.

Comment: One commenter wrote that final MHPAEA regulations are not yet released, and therefore, CMS should provide a detailed framework for determining and enforcing parity compliance in this final rule. The commenter recommended that HHS establish a clear process for how states can modify a plan to ensure parity compliance if it is not compliant; clarify that the term ''treatment limitation'' includes both quantitative and non-quantitative treatment limitations and includes limits on scope of service and duration of treatment; require full disclosure of benefit and medical management criteria from states and plans to ensure MHPAEA compliance in ABPs; ensure that ABPs may not apply a financial requirement or treatment limitation, as specified in MHPAEA; include examples of parity violations and detailed information on how to supplement coverage that falls short of the parity requirements; and review all ABPs to ensure compliance with MHPAEA.

Response: The January 16, 2013 CMS State Health Officials Letter provided a framework for States to apply MHPAEA to ABPs. Since the release of this State Health Officials Letter, we have also provided technical assistance to states regarding the application of MHPAEA to ABPs prior to submission of the ABP state plan amendments.

Comment: A commenter requested that we clarify the applicability of mental health parity to Medicaid managed care organizations that provide benchmark or benchmark-equivalent coverage. The commenter wanted to know if states would be required to provide services (for example; rehabilitation, habilitation, substance abuse services, etc.) that are optional services for Medicaid programs if they are not currently covered.

Response: The January 16, 2013 State Health Official Letter specifically states that all Medicaid ABPs (including Secretary-approved coverage) must meet the parity requirements, regardless of whether services are delivered in managed care or non-managed care arrangements. In addition, under § 440.347, ABPs must include MH/SUD services regardless of whether they are currently covered in the state's Medicaid plan.

Comment: One commenter requested that CMS clarify the guidelines concerning ABP benefit substitutions that involve mental health benefits. One wrote that substitutions should not be allowed if they would diminish the value of the mental health coverage provided by the EHB-benchmark plan on which ABP benefits are based. The commenter recommended that this issue be carefully monitored; if possible, CMS should develop an easily applied, objective test to evaluate whether a proposed benefit substitution would reduce the value of mental health coverage compared to the mental health coverage provided by the EHB benchmark plan. Additionally, some commenters stated there still is confusion about how to apply the parity requirements. Commenters encouraged CMS to issue explicit guidance on whether benchmark plans will be evaluated for compliance with parity requirements as necessary before they are approved by CMS as ABPs.

Response: As discussed above and below in the summary, substitution will be allowed according to provisions at 45 CFR 156.115(b) except that states will perform substitution rather than issuers. We will review all ABP state plan amendment requests from states against applicable federal laws and regulations, including MHPAEA.

Comment: Some commenters wrote that because they are not specifically enumerated in MHPAEA, inpatient mental health substance abuse disorder (MH/SUD) services are often not

covered. Many commenters stated that the definition of ''inpatient'' in the Interim Final Rules implementing MHPAEA leaves the definition up to the state and insurance companies. This is important and unfortunate because it allows for avoidance of MHPAEA and invites litigation. A number of commenters stated that HHS can easily rectify this deficiency by explicitly mandating residential coverage as an ''inpatient service which must be offered on par with medical/surgical coverage.'' Some urged CMS to explicitly restate the requirement that all Medicaid ABPs must cover MH/SUD services. A number of comments stated that inpatient services must be defined as including residential services, including Institutions for Mental Diseases (IMDs). HHS can improve the interpretation of relevant definitions by incorporating by reference those definitions as set forth by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders. By offering a federal floor of required services states can take comfort that they have met the mandated requirement. One commenter wrote that IMD restrictions present an access barrier for the expansion population and the Affordable Care Act is clear that ABPs should include the EHB hospitalization and mental health services that are included in commercial coverage that must cover EHB. Another commenter wrote that HHS should prohibit ABPs from including mental health benefits that are subject to higher limitations on amount, scope, and duration than benefits intended for physical/medical conditions, or narrowly specifying that mental health services cannot be a component of other EHB categories, such as the mental health rehabilitation needs that are required following a traumatic medical event.

Response: States must offer services in all ABPs that reflect the ten EHB categories, including MH/SUD services. We do not intend to require states to include specific services within EHB categories offered through an ABP. Nor are we specifically requiring coverage of any particular residential mental health services as part of ''inpatient services,'' provided that the coverage complies with MHPAEA. States may, however, be required to provide residential mental health services that are included in the section 1937 coverage plan that is the basis for the ABP, or that is included in the base-benchmark plan selected by states to define EHBs for Medicaid.

We clarify, however, that the IMD payment exclusion does apply to all medical assistance, even medical assistance furnished through an ABP. This means that FFP is not available for any services, including services provided through an ABP, furnished to an individual under age 65 who resides in an IMD, except for inpatient psychiatric hospital services furnished to individuals under age 21. Finally, we clarify that the requirement that all ABPs comply with MHPAEA includes compliance with MHPAEA requirements regarding treatment limits.

Comment: A commenter wrote that under the traditional Medicaid program, the term ''medical assistance'' does not include care or services for any individual who is a patient in an institution for mental disease, but benchmark coverage does not have an express exclusion of care and services for such individuals. The commenter asserted that for benchmark coverage, which includes coverage for EHBs, exclusion of these same services for patients residing in an IMD would directly conflict with the plain language of the law because section 1937 of the Act provides for no exception for individuals between ages of 21 and 65 residing in an IMD, but does contain an exemption from other provisions of Title XIX (to which the IMD exclusion applies). The commenter states that just as an ABP is exempt from complying with the requirements related to state-wideness and comparability in the Medicaid statute because they conflict with the benchmark authority, so too is the plan exempt from complying with the IMD exclusion which cannot be applied in a consistent manner with the EHB requirements. The commenter also added that, just as application of the IMD exclusion to an ABP would be ''directly contrary'' to a state's ability to offer EHBs, the exclusion is also contrary to any of the benchmark/benchmark-equivalent coverage described in the statute. Another commenter argued the same points and also stated that the IMD exclusion is not consistent with the definition of an ABP to include, among a selection of plans, the health insurance plan offered through the HMO that has the largest insured commercial non-Medicaid enrollment in the state. As such coverage would necessarily be available on par to individuals residing inside and outside of an IMD, the commenter asserted that Congress never intended the IMD exclusion to apply to Medicaid beneficiaries enrolled in an ABP.

Response: We do not agree with the commenters' statements that the IMD exclusion does not apply to medical assistance furnished through an ABP. The IMD exclusion is not a service or benefit exclusion. It is a payment exclusion that applies to all Medicaid services provided to an individual residing in an IMD, not solely a payment exclusion for services provided in or by an IMD. The statute excludes services furnished to residents of an IMD from the term ''medical assistance,'' and we read this exclusion to apply whether medical assistance is furnished through regular coverage or through an ABP. (Above we clarify that we have a parallel reading of the similar payment exclusion for inmates of a public institution.) Thus, we clarify that the IMD payment exclusion applies to coverage offered through ABPs. Benefits furnished through ABPs can be structured so that individuals have inpatient options for mental health treatment outside of IMDs, but to the extent that an individual resides in an IMD, the IMD exclusion would apply. We are not aware of any contrary congressional intent, and this position is consistent with the express statutory exclusion from the definition of medical assistance.

Comment: A few commenters stated that MH/SUD services are sometimes provided in facilities that are considered an institution of mental disease for which FFP is excluded and requested that CMS reconcile the requirement that these services must be provided as an EHB.

Response: For the reasons discussed above, we are clarifying that the IMD payment exclusion does apply to medical assistance furnished through ABPs. We expect that ABPs will ensure that coverage for MH/SUD services is available consistent with MHPAEA and the final regulations that govern EHBs under Medicaid. There may be options for inpatient services other than inpatient services in IMDs that states may wish to consider to meet MHPAEA obligations under ABPs.

Comment: One commenter stated that exclusions for otherwise-covered benefits such as mental health services that treat eating disorders and gender disorders should not be permitted, as these exclusions carve out coverage explicitly on the basis of health condition and are discriminatory.

Response: We will review ABP state plan amendments to ensure their compliance with applicable federal statutes and regulations, including MHPAEA, and EHB anti-discrimination provisions.

Comment: One commenter stated that healthcare providers who provide MH/SUD treatment services were encouraged by the passage of MHPAEA but many states and insurance companies are ''stonewalling'' implementation and inclusion of MH/

SUD treatment as a mandate. EHB requirements will not correct this problem unless HHS rules provide better clarity regarding implementation of parity, in particular inclusion of inpatient services.

Response: MHPAEA does not require the provision of specific MH/SUD services. Rather, it requires these services to be provided in parity with medical/surgical services, when benefit packages include both sets of services. The release of the January 13, 2013 State Health Official Letter has provided initial guidance to states and managed care plans regarding the application of MHPAEA to the Medicaid program. We believe that guidance provides useful information to states regarding their efforts to apply MHPAEA to their Medicaid ABPs. In addition, CMS is reminding commenters that inpatient hospitalization is a required EHB for ABPs.

Comment: One commenter stated that Medicaid regulations should employ the same disorder carve-outs for the expansion population as used for existing populations and remain in compliance with federal parity laws. Further, states should not be required to provide different or additional MH/SUD benefits to the expansion populations than what is furnished to existing beneficiaries.

Response: This regulation does not prohibit states from using their current delivery systems or designing new delivery systems to offer EHBs, including MH/SUD services. States are required to offer MH/SUD services consistent with the process set forth in this regulation regarding the development of ABPs and MHPAEA. Because of the need to select a public employee or commercial plan to define EHBs for Medicaid, there could be differences between the ABP benefit package and the services otherwise offered in the regular Medicaid coverage package.

Comment: Many commenters strongly urged CMS to release final MHPAEA regulations as soon as possible and to include how to apply parity to EHBs and ABPs and to give examples of violations. A commenter stated that without the final rule on MHPAEA, effective compliance will not be possible. Another commenter requested prompt release of additional guidance referenced in the January 13, 2013 State Health Official Letter, concerning any requirements to apply parity principles across multiple managed care delivery systems and urged a flexible approach to measuring parity in carve-out setting in promotion of continuity for existing arrangements and authorities.

Response: A response on the timing of a final MHPAEA regulation is beyond the scope of this regulation.

Comment: One commenter wrote that insurance companies have sought to avoid implementation of MHPAEA and states that do not currently require mental health parity may be concerned that compliance will result in the state incurring the costs associated with the expansion of state mandates. Two commenters stated that there are lingering concerns with some of the parity language in the proposed regulation, which states in § 440.345 that ABPs that provide both medical and surgical benefits, and mental health or substance use disorder benefits, must comply with MHPAEA. CMS should revise this language to make it clearer and more accurate. The commenters asserted that MHPAEA does not apply to coverage under section 1937 of the Act that is delivered in a non-managed care arrangement; rather the Affordable Care Act extended the protections of MHPAEA to this coverage without amending MHPAEA. Specifically, regarding coverage under section 1937 of the Act, the Affordable Care Act requires that ''the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the PHS Act (MHPAEA) in the same manner as such requirements apply to a group health plan'' and the final rule should include similar language.

Response: It is unclear exactly what the commenter is asking, in terms of incurring expenses associated with state benefit requirements. Therefore, we will not be able to respond to this comment at this time. We disagree with the commenters' assertion that mental health parity requirements do not apply to ABPs using non-managed care delivery systems. Parity requirements apply to all ABPs, regardless of the use of managed care.

Comment: One commenter wrote that because of changes in the income eligibility standards we expect Medicaid expansion is more likely to enroll individuals who are working but have no insurance and who need this coverage to access treatment to maintain employment. People with addictions enter treatment at different phases and will use different parts of the continuum, and elimination of any part of the continuum would violate MHPAEA and cost human lives. The commenter urged CMS to adopt the same standards set forth in the proposed rule for the Affordable Care Act standards related to EHB, Actuarial Value, and Accreditation for purposes of Medicaid ABPs. Additionally, the commenter stated that MHPAEA holds out the promise that everyone will be able to get help but strong enforcement of MHPAEA is necessary.

Response: It is unclear exactly what the commenter is asking. Therefore, we will not be able to respond to this comment at this time.

Comment: A commenter wrote that this rule as proposed rule fails to link MHPAEA compliance to adherence to the Interim Final Rule which operationalizes MHPAEA. The previously issued Proposed Rule for Standards Related to Essential Health Benefits, which addressed the design of EHBs for commercial market insurance beneficiaries, made specific reference to the Interim Final Rule effectuating MHPAEA. The proposed rule simply says the EHBs of ABPs must comply with MHPAEA. The commenter questioned whether this lack of direct reference to the existing law mean Medicaid ABPS need not comply with all provisions of the Interim Rule. The commenter strongly urges CMS to clarify whether or not these ABPs must comply with all provisions of the Interim Final Rule and what if any law, in whole, or in part, it will use to assess ABP compliance with MHPAEA.

Response: On January 16, 2013, CMS released a State Health Official Letter regarding the application of MHPAEA to Medicaid MCOs, CHIP, and ABPs. This guidance specifically states that all Medicaid ABPs, including Secretary-approved coverage, must meet the parity requirements, regardless of whether services are delivered in managed care or non-managed care arrangements.

Comment: Several commenters wrote that exclusions of mental health, substance use disorders and behavioral health treatments that fail to meet the parity standards required by MHPAEA are discriminatory. Despite existing parity requirements state implementation and enforcement of MHPAEA has varied widely and patients seeking metal health services are frequently subjected to excessive and inappropriate non-quantitative limitations. Another commenter stated that CMS should identify a standard to determine whether the coverage provided complies with non-discrimination provisions of the Affordable Care Act.

Response: As stated in the January 13th State Health Official Letter, ABPs must comply with MHPAEA.

Comment: One commenter suggested that the goal of Affordable Care Act coverage was to include the 10 EHBs including mental health and substance use disorder services.

Response: We agree with the commenter that one goal of Affordable Care Act coverage was to include coverage of the 10 EHB categories, including mental health and substance use disorder services in ABPs. We support providing a floor of coverage to Medicaid beneficiaries. As mental health parity also applies, this will lead to parity among mental health and substance use services and other medical and surgical services.

Summary: We will not be making changes to proposed regulation text as a result of these comments. However, we are clarifying that the payment exclusion for services provided to individuals residing in an institute of mental disease (IMD) continues to apply to all individuals participating in ABPs. This is important because many commercial products offer coverage of residential services in settings that for Medicaid purposes are considered IMDs, and federal matching funds will not be available for medical assistance for individuals who reside in such settings.

f. EPSDT and Other Required Benefits (ABPs Include EHBs and All Updates and Modifications) (§ 440.345)

We proposed at § 440.345(d) the requirement that ABPs provide EHBs and include all updates and modifications thereafter by the Secretary to the definition of EHBs.

Comment: Several commenters wrote that the revisions make Federally Qualified Health Center (FQHC) requirements within ABPs less clear. The EHBs are the floor of ABP coverage and that the requirement to provide EHBs within ABP does not circumvent existing requirements within section 1937 of the Act, which includes coverage of FQHCs. The commenter stated to identify that the regulation as drafted is confusing as subsections (a) describing the requirement that at least the ten categories of EHBs be included in section 1937 of the Act and (b) describing the requirements to include the benefits covered in one of the state selected benchmark plans and subsection (a) does not indicate that it is a floor. The commenters requested that CMS reiterate or clarify revisions to the regulation to reaffirm this.

Response: There are several benefits specified by section 1937 of the Act that are required in addition to EHBs. We did not change § 440.365, which reflects section 1937(b)(4) of the Act, providing that states must assure access to these services through the benchmark or benchmark-equivalent coverage or otherwise, to rural health clinic services and FQHC services, even if the state does not contract with an FQHC or rural health clinic and that payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act. The inclusion of EHBs within section 1937 of the Act establishes a minimum level for benefits, to which other benefits required as part of section 1937 of the Act are added.

Comment: Many commenters were supportive of the Affordable Care Act's application of EHB requirements to ABPs and providing a floor of benefits. Some commenters also supported inclusion of updates and modifications made thereafter. Some commenters went further to support the inclusion of mental health and substance use disorder benefits as consistent with the MHPAEA.

One commenter generally supported implementing EHBs in ABPs to provide a stable set of core services for people receiving benefits in the ABP, and to help align the rules for patients and providers to ensure continuity of care. This is important for people who will churn between Medicaid, the commercial markets and potentially a state basic health plan.

Response: CMS appreciates the support of commenters.

Comment: A few commenters identified that EHB definitions will affect how individuals maintain access to health care, services and drugs and biologicals that they need.

Response: We agree with these commenters. The new coverage will likely be different from the coverage that beneficiaries receive today. States will have discretion regarding how to define EHBs using the process outlined in this regulation, namely selecting the base-benchmark plan to define EHBs. For Medicaid, we remind readers that EHBs are only the floor for coverage, and states have options for offering coverage that exceeds this floor. States can also add additional coverage for beneficiaries receiving ABPs who are not eligible for the new adult group.

Comment: One commenter suggested that home care services should be included in the Medicaid ABP to the same extent that they are included in the existing regular Medicaid program.

Response: The rules for establishing coverage are different between the regular state Medicaid program and flexibility provided within section 1937 of the Act. States must provide home health services as a mandatory benefit in the regular Medicaid state plan. This is not a minimum requirement for coverage under of section 1937 of the Act and is not required as an element of EHBs.

Comment: One commenter requested clarification that the Affordable Care Act established a floor of coverage using EHBs. Benefits should not be limited solely to EHBs as no ceiling was established. The Affordable Care Act only restricts costs for state mandated benefits from being passed onto the federal government via the EHBs.

Response: Yes, EHBs are considered a minimum level of coverage. ABPs are not limited solely to EHB benefits; ABPs are constructed based on the coverage plan under section 1937 of the Act selected by the state, including EHBs based on the state selected base benchmark plan, supplemented as necessary and subject to substitution of actuarially equivalent benefits as permitted under 45 CFR 156.115(b). The section 1937 coverage plan selected by the state can include a Secretary-approved coverage plan that may include benefits that are not available under other section 1937 coverage options. Furthermore, ABPs are required to cover certain benefits including rural health clinics, FQHCs, and family planning services and supplies. EPSDT services for individuals below age 21 also apply within section 1937 of the Act. MHPAEA also applies to the provision of MH/SUD services.

Comment: One commenter requested that CMS consider adding an EHB requirement for hospitals and pediatricians to conduct risk assessments of all newborns for severe respiratory syncytial virus (RSV) disease.

Response: These services can be covered if states select coverage options that cover such services. Furthermore, children must receive all EPSDT services as part of the ABP, and states may consider such risk assessments to be part of the required EPSDT screening services. For the new adult group, only 19- and 20-year olds will be covered by EPSDT. There are both requirements and flexibility for states in both selecting plans and constructing EHBs and section 1937 coverage options. Please refer to the summary at the end of this section for further discussion of these steps and flexibilities.

Summary: We have not made any changes to regulation text, based on public comments received.

g. EPSDT and Other Required Benefits (Process for Updating EHBs) (§ 440.345)

In § 440.345(e), we proposed that the ABPs that include EHBs will remain effective through December 31, 2015 without a need for updating. We also proposed that we will consult with states and stakeholders and evaluate the

process to determine updates to the ABPs after that date.

Comment: Several commenters offered support of the intent of our proposed policy concerning the updating of ABPs that have been determined to include EHBs as of January 1, 2014. One commenter supported the Department's intent to issue future guidance for updating EHB benefits for 2016 and subsequent years. Similarly, another commenter indicated support of the alignment of the transition period for updating ABPs with the transition period designated for updating EHBs in 45 CFR Part 156.

Response: We appreciate the support.

Comment: A few commenters indicated concern that imposing a requirement to update section 1937 benchmark plans would add significant new workload for states. One commenter believed that there is currently no statutory requirement to make updates to section 1937 plans, and suggested that the Secretary allow for grandfathering of currently offered section 1937 benchmark benefit plans. Many commenters also recommended that HHS reserve some authority to resolve significant problems with the benefits package during this time period by revising the proposed provision to add that states with approved ABPs as of January 1, 2014 do not have to update benefits until December 31, 2015, ''unless the Secretary determines that there are exceptional circumstances to update a plan.'' Several commenters urged the Department to set up a formal mechanism to ensure that adequate data is collected for ABPs in 2014 and 2015 to inform updating benefits in 2016 through a transparent process in which consumers help guide any necessary changes. Similarly, several other commenters urged the Department to consider a more robust stakeholder engagement in all aspects of processes used to assess the current EHB approach and whether to adopt a new approach in 2016.

Response: CMS has been working with states to submit state plan amendments using a standardized template that includes the information needed for approval from CMS. The CMS review process allows for resolution of issues identified within the ABP prior to approval. We aligned the timeframes with CMS policy to allow for implementation efficiencies. As we develop the process, we will take into account balancing potential workload of the state and CMS and the need for information to keep the ABP current with changing commercial market products. It is important for ABPs to stay current with changes in the base-benchmark as well as with public employee or commercial plans that may have been selected as section 1937 coverage options. Commercial plans are usually updated annually. All ABP SPAs are required to have public notice and approved SPAs will be placed on a CMS Web site. We are also updating the Medicaid Statistical Information System (MSIS) to improve the quality, accuracy, and timeliness of data submitted to CMS by states. That said, we appreciate that it may be difficult at this point to make changes to the ABP that take effect by January 1, 2014. In light of this challenge, we will partner with states to work as quickly as possible to come into full compliance with these provisions. We do not intend to pursue compliance actions on these issues to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014.

Comment: One commenter indicated that the applicability of the proposed provision was unclear when applied to states that choose not to expand coverage as of January 1, 2014, but might choose to offer a benchmark benefit plan prior to December 31, 2015.

Response: These provisions apply to all existing and new ABPs that have an effective date of January 1, 2014 or later.

Summary: We will not be making changes to proposed regulation text as a result of comments received.

h. Essential Health Benefits (§ 440.347)

We proposed to add EHBs within section 1937 of the Act and that individuals in the new adult group who meet the criteria for exemption from mandatory enrollment will receive a choice of benchmark coverage defined as the benefit package using section 1937 rules or the state's approved Medicaid state plan that is not subject to the section 1937 rules. We proposed a process for establishing EHBs within an ABP that is consistent with the general provisions for established EHBs in the individual and small group market, but reflects the particular circumstances of Medicaid. In particular, the process reflects the fact that the state establishes coverage rather than an insurance issuer, and that the coverage is consistent with the requirements of section 1937 of the Act. We also proposed that, while EHBs will be defined by the state using a selected base benchmark from the list of those plans that can be chosen to define EHBs in the individual and small group market, the base benchmark plan for defining EHBs for Medicaid can be different than the base benchmark plan chosen for the commercial market. We further proposed that there could be more than one base benchmark plan for defining EHBs for Medicaid ABPs.

Comment: One commenter stated they support the structure for implementing Essential Health Benefits as proposed.

Response: CMS appreciates the support.

Comment: One commenter supported § 440.347, which allows states to have more than one ABP to reflect the health care needs of a targeted population and use a different base benchmark plan for each ABP. A few commenters supported HHS implementing the statutory requirements to at a minimum include EHBs. One commenter supported the general approach to coverage of EHBs. Another commenter supported states having broad flexibility to choose a benchmark plan, including the same options available in the commercial market and the ability to use a different plan from the one that was selected for the state's commercial plans. This commenter also recommended that the state's Medicaid State Plan be considered for Secretary-approved coverage for the ABPs. They requested clarification of the timeframe for approval of Secretary-approved plans.

Response: We appreciate the support of our policy to allow states the flexibility to use different base benchmarks in Medicaid from those used for the non-grandfathered plans in the individual and small group markets.

We confirm that Secretary-approved coverage is part of the ABP template, and can include the full coverage otherwise available under the approved state plan, as long as all requirements of this regulation are met. The entire template is considered a state plan amendment to be completed and submitted by the state to CMS for approval. The timing of action on state plan amendments is addressed in our regulations at § 430.16, which include one 90-day review period, the option for CMS to request additional information, and an additional 90-day review period.

Comment: One commenter requested that HHS clarify that states can design ABPs for subpopulations within the newly eligible group.

Response: We confirm that states can offer different ABPs to subpopulations within the newly eligible group. Under section 1937(a)(1)(A) of the Act, coverage through an ABP can be offered to ''groups specified by the State'' without regard to the comparability or statewideness requirements at section 1902(a)(10)(B) of the Act and § 440.240. (Other requirements, such as civil rights protections, still apply and may affect the nature of the groups that a state may specify.) As a result, states may offer ABPs that are appropriate for the unique

characteristics of subgroups of the new adult group; for example, states may offer different ABPs to individuals in different geographic regions, or to individuals who have particular medical, service or support needs.

Comment: The flexibility for states to select EHBs at § 440.347(b) and (c) to achieve targeting of populations causes more harm than good according to some commenters. The commenters believe that states already have significant flexibility to target ABPs through the Secretary-approved process and the targeting flexibility adds little but creates confusion. CMS would be better served in terms of administrative simplicity, oversight, and consumer understanding if one EHB standard was applicable in the commercial markets and ABPs. These commenters recommend that HHS require states to use the state-selected base benchmark plan that applies for the commercial markets for ABPs as well. Another commenter believes that EHBs should establish a minimum floor of coverage and that all plans should be required to use the state-selected base-benchmark plan that applies for the commercial markets for purposes of section 1937 of the Act as well. This will reduce administrative burden and better align standards between EHB in the commercial markets and in Medicaid.

Response: The flexibility provided at § 440.347(b) and (c) permits states to design different benefit packages that at a minimum include EHBs. Alternatively, one benefit package could be used for multiple populations. States also have the choice to use the same base benchmark in ABPs and the commercial markets, which would result in aligning standards for EHB in coverage under ABPs and the commercial markets. We have adopted policies that would maximize state flexibility while ensuring sufficient coverage for beneficiaries.

Comment: One commenter is seeking clarification of the phrase set forth in § 440.347 ''consistent with the requirements set forth in 45 CFR [part] 156'', particularly if it adds obligations to the requirement to select a benchmark plan that includes benefits in each of the ten EHB categories. A few commenters request clarification of the specific provisions of 45 CFR Part 156 related to EHB that apply.

Response: This regulation is consistent with the EHB requirements under 45 CFR Part 156, but specifically addresses the application of those requirements for purposes of compliance with section 1937 of the Act as amended by section 2001(c) of the Affordable Care Act. The base-benchmark plans for defining EHBs include the same choices in both Medicaid and the non-grandfathered plans in the individual and small group markets. States may choose a different base benchmark plan for Medicaid than for the individual and small group markets. But, recognizing that Medicaid coverage is provided in a different context than coverage in the individual and small group markets, we provide that states may choose a different base benchmark plan for Medicaid than the individual and small group markets, and may choose more than one base benchmark plan for Medicaid. We also provide that states exercise the options available in the individual and small group market to insurance issuers. This regulation identifies those aspects of 45 CFR part 156 that are modified within Medicaid under the section of the preamble entitled ''Modifications in Applying the Provisions of This Proposed Rule to Medicaid.''

Comment: Several commenters suggested that the list of required categories of services for benchmark-equivalent coverage include the EHBs as specified in § 440.347(a) for consistency and clarity as ABP coverage must include at least the EHBs. Another commenter suggested that CMS should pursue parity between Medicaid state plan benefits and the new ABP for newly eligible adults to assist with ''churn'' between Medicaid and the commercial markets.

Response: Section 1302 of the Affordable Care Act establishes EHBs that must be provided as part of benchmark benefit coverage. A benchmark-equivalent benefit package must be actuarially equivalent to the benchmark plan that is chosen. We do not believe it is necessary to specifically add the EHB categories to benchmark-equivalent coverage because we are instead setting out procedures to ensure that coverage includes EHBs that govern both benchmark and benchmark-equivalent coverage.

Comment: Section 440.347(c) allows states to select more than one EHB option for ABPs. A few commenters urged CMS to limit states to choosing a single EHB option for Medicaid to provide a floor of benefits. They asserted that Congress intended consistency among ABPs by applying EHB requirements to them. Some commenters asserted that allowing for selection of multiple options will create unnecessary administrative burdens on state Medicaid programs and this commenter suggests that there should be only one EHB benchmark option for ABPs. But other commenters agreed with our proposed rule that, because ABPs serve a different population than private health plans, the single EHB benchmark does not need to be the same as the one chosen for the state's individual and small group market. Another commenter asked that CMS clarify that states do not have the flexibility to vary amount, duration, and scope of benefits within populations on a plan-by-plan basis as currently allowed, which would only increase complexity. This commenter also requested clarification related to whether the limited authority provided through the DRA and now expanded through this rule can be superseded by section 1115 authority. This commenter also responded that a state may try to combine flexibilities for EHB, ABP, premium assistance, and amount, duration, and scope to shift to a model that has not been adequately explored for unintended consequences.

Response: While it is true that coverage of EHBs will be required for non-grandfathered plans offered in both the individual and small group markets and Medicaid, we think it is important to provide states flexibility to define EHBs as appropriate in each context. In the non-grandfathered plans offered in the individual and small group markets, states have some flexibility to define EHBs through selection of a base benchmark plan. For Medicaid coverage, we believe that additional flexibility will enable states to tailor coverage to the needs of the Medicaid population. While states can, for simplicity, choose one standard to determine EHB in both the individual and group markets and in Medicaid, they are not required to do so. We are permitting states flexibility to choose a single standard or multiple standards for EHB in Medicaid to ensure a full range of coverage options. States must determine whether multiple standards would result in administrative burdens. We are reminding states that the floor of coverage is EHBs defined by the benefits, including limitations on amount, duration, and scope, from the selected base benchmark plan (but states may be required to, or may have options to, cover benefits above that floor consistent with section 1937 of the Act). Please refer to the summary at the end of this section for further discussion of these steps and flexibilities.

Comment: Several commenters recommend that the Department ensure that Secretary-approved coverage is actuarially equivalent to the other benchmark coverage options. These commenters support the clarification that Secretary-approved coverage must provide robust benefits. However, these commenters indicate that it is important

for Secretary-approved coverage to provide the same level of coverage as other benchmark plan options to prevent newly eligible people from receiving lesser coverage.

Response: This rule is not intended to change the assessment of Secretary-approved coverage, except to the extent that it must include EHBs. The standard that we apply for assuring the sufficiency of the benefit package established using Secretary-approved coverage is whether the benefits are appropriate to meet the needs of the population provided that coverage, as outlined in § 440.330(d). EHBs establish a floor of benefits for ABP populations and must be provided with Secretary-approved coverage as with any ABP. Secretary-approved coverage permits states flexibility to design a benefit plan that might differ from the other options available under section 1937 of the Act. As mentioned previously, in all cases a state must first select a base benchmark to define EHBs. The EHBs in the base benchmark plan serve as the minimum floor of coverage that is supplemented for any missing EHBs. Using substitution, states may achieve a benefit package that includes benefits from the regular state plan.

Comment: One commenter believed that extending full Medicaid benefits to the newly-eligible expansion population, supplemented as needed to comply with the EHB, parity, and other protections in the law, is the best approach for meeting the complex health needs of low-income adults who will gain Medicaid eligibility under the expansion. The commenter urged CMS to work with States to ensure that this population's full range of substance use disorders and mental health needs and other health needs will be met. The commenter further suggested that CMS include language in the final rule that explicitly restates the requirement that all Medicaid ABPs must cover mental health services and substance use disorder services for all enrollees.

Response: States have much flexibility, but are not required to use benefits from their regular Medicaid benefit package for the new adult coverage group, as long as EHBs are assured. The statute and regulation direct that mental health parity requirements and EHB requirements, including the provision of mental health and substance use services, be met. In some circumstances, we anticipate that the coverage furnished to the new adult coverage group may include certain benefits, such as certain substance abuse treatment services, that the state has elected not to cover under the state's regular Medicaid benefit package.

Comment: The commenter stated general agreement with the approach that CMS has recommended for the ABP to be offered to certain populations under the expansion of Medicaid. The commenter requested clarification that the state would choose an ABP from four benchmark packages and would compare that choice to the private market EHB, supplementing coverage of the ABP if necessary to ensure that all EHB categories are included.

Response: There are both requirements and flexibility for states in constructing EHBs and section 1937 coverage options. Please refer to the summary at the end of this section for further discussion of these steps and flexibilities.

Comment: One commenter would like to underscore the importance of promoting seamless coverage among low-income individuals. Many of the individuals newly eligible for Medicaid in 2014 are likely to have fluctuations in income, and therefore are likely to ''churn'' between Medicaid and subsidized Exchange insurance coverage. This churn could result in treatment disruptions among patients and create administrative complexity for Exchanges, plans, and providers. Thus, promoting seamless coverage for this population and ensuring coordination of care during coverage transitions will be critical.

Response: We appreciate the circumstances that the commenter identified for individuals that may have fluctuations in income. States have options for minimizing treatment disruptions and CMS will work with states to promote continuity of care.

Comment: One commenter urges CMS to consider revising certain sections of the proposed rule to allow states the greatest opportunity to develop ABPs that are reflective of the population that they serve and ensure the long-term financial sustainability of this category of eligibility. This commenter believes that the proposed regulations create a cumbersome and confusing process and appear to strongly incentivize states to essentially mirror state plan benefits. This commenter wants maximum creativity to define the benefit package that will be provided to the newly eligible population, and encourages CMS to use this opportunity to allow for greater innovation at the state level by allowing design of benefit packages that simply take pieces of both Medicaid and the commercial market while also covering all EHBs. This approach will lead states to compare Medicaid to private and commercial market benefits and potentially add benefits to the Medicaid state plan.

Response: We believe that the regulations offer significant flexibility for states to create benefit packages for all or for different groups of its newly eligible population. Appropriate benefit package design for the population's needs may contribute to long-term financial stability.

Comment: A few commenters were concerned with disparities in coverage as the guidance suggests that the policy only mandatorily applies to the newly eligible category of adults. In states that expand their Medicaid programs to include these new categories of eligibility, they note that a higher income expansion population will receive a more generous package than existing populations. This will create a churn in Medicaid where states will likely have to expand coverage for all adult populations within Medicaid to prevent churn. They assert that this would result in significant financial cost to states to expand benefits to all adults as new benefits for the existing population are ineligible for the enhanced match offered under the Affordable Care Act for the newly eligible expansion population.

Response: The Medicaid statute provides that coverage may be different for those people who receive coverage through an ABP established under section 1937 and those who receive regular Medicaid coverage. People in the new adult group must receive benchmark or benchmark-equivalent benefits, including EHBs. Consistent with the statute, the rules promulgated in this regulation will apply to all ABPs, not just for those people in the new adult group. As long as ABP (including EHB) requirements are met, states have significant flexibility in designing benefit package options that approximate regular state plan benefits.

Comment: Many commenters recommended that ABPs provide appropriate coverage to meet the needs of the population in all ten EHB categories as per the general requirements of § 440.330. These commenters suggest that the lack of a minimum standard in each of the ten categories is a flaw in the Exchange EHB standard that gets further magnified in Medicaid. For women's health, this is particularly important in terms of preventive services, prescription drugs, and maternity care. Several commenters support the EHB requirement as a strong floor for ABPs and indicate that states should have ample flexibility to add to the floor. These commenters also provided recommended regulatory language for § 440.347(a) through (c).

Response: EHBs are a floor to coverage and states have flexibility to

design an ABP that includes coverage above the minimum level of EHBs. Section 1302(b)(2) of the Affordable Care Act directs the Secretary to determine EHBs by reference to benefits typically offered in the group market, which is the same standard that we are applying in Medicaid by requiring that states determine EHBs by selecting a base benchmark from among the regulatory options described in § 156.100. All benefits within the base benchmark that defines EHBs will need to be incorporated into the ABP, supplemented as necessary and subject to substitution of actuarially equivalent benefits as permitted under 45 CFR 156.115(b). But the ABP can include other benefits based on the state choice of coverage option.

For groups other than those in the new adult group, states can also offer additional benefits to supplement the benchmark or benchmark equivalent coverage that includes EHB and other required services. Sections 1902(k)(1) and 1903(i)(26) clarify that individuals in the new adult group receive benchmark or benchmark-equivalent coverage (that includes EHB and other required services and, as we explain below, for individuals who would otherwise be exempt from enrollment in an ABP, the option to receive an ABP that consists of regular Medicaid coverage). We intend to issue an ABP state plan amendment template and corresponding implementation guides for the states to use when submitting ABP state plan amendments.

Comment: One commenter supports requiring coverage of all ten EHBs, as this will go a long way toward ensuring that Medicaid participants have adequate health care coverage. They request that HHS define the scope and services within each of the ten benefit categories to ensure that the covered services are at a minimum the same and provide a level of guaranteed coverage. This is necessary to ensure that there is adequate coverage within categories and balance between categories, and necessary to determine if ABPs are equivalent to the EHB package and comply with Affordable Care Act.

Response: We thank the commenter for the support.

Comment: One commenter indicated that ABPs should include an array of home care services that exist in traditional Medicaid benefit programs to comply with the American with Disabilities Act and Supreme Court Olmstead decision. To the extent that EHBs include institutional care or inpatient settings, a state must offer a choice of ''the least restrictive environment.'' Similarly, states that choose to provide services to individuals enrolled in ABPs that involve care in an institution should be required to include home and community-based care as well.

Response: Section 1902(k)(1) of the Act provides that medical assistance for the new adult eligibility group is limited to benchmark and benchmark-equivalent coverage. Section 1902(k)(1) of the Act also provides an exception to the requirements of section 1937 of the Act for individuals who would be described in the exemptions at section 1937(a)(2) of the Act. This means that individuals in the new adult eligibility group that otherwise meet the exemption criteria are required to be enrolled in benchmark or benchmark-equivalent coverage, but their benchmark or benchmark-equivalent coverage is not limited by the requirements of section 1937 of the Act. Therefore, these individuals must have a choice to receive ABP benefits as defined by the state applying the requirements of section 1937 of the Act using benchmark or benchmark-equivalent coverage (including EHBs and other required coverage) or ABP benefits defined without regard to the requirements of section 1937 of the Act, which consists of regular Medicaid coverage under the state plan. Home care is not a standardized term in Medicaid, so clarification would be needed to determine which Medicaid benefit category is actually applicable.

We agree that states are obligated to comply with the Americans with Disabilities Act and the Olmstead decision.

Comment: One commenter requests that crisis services be included in the mental health and substance abuse services category in the EHB package. This commenter requests that it be offered by qualified health plans and in new Medicaid expansion benefits in each state. These are important services to the safety net and for 24/7 crisis care, suicide prevention and access to emergency health care services, especially in communities where emergency mental health clinics or mobile health services are unavailable.

Response: CMS is not requiring specific services to be included in any of the EHB categories, but all ABPs must include all EHBs defined through the process described in our regulations.

Comment: Several commenters suggest that EHBs should comply with a consistent standard across ABPs as they are concerned that the proposed rule allows for states to select more than one option for establishing EHB to implement multiple ABPs for targeted populations. These commenters also recognize the need for states to target populations to address specific health care needs.

Response: We are providing flexibility for states to select base benchmark plans in Medicaid that are different than the one selected for the individual and small group market, and to select multiple base benchmark plans, to maximize the ability for states to define ABPs that serve the unique needs of Medicaid populations and subpopulations.

Comment: One commenter requested CMS include autism coverage in the EHB package to correct the omission. Lack of coverage can create significant financial burden on families and discourages autism professionals from practice. Families also may decide to not pursue treatment.

Response: States have choices in determining in the benefit package that will be covered in their state within federal guidelines, but all ABPs must provide for coverage of EPSDT services for individuals under the age of 21. We expect that services to treat autism may be covered through a variety of coverage categories and many would be included in a state's ABP either because the services are within the section 1937 coverage option or included as part of EHBs.

Comment: One commenter applauds HHS for including coverage of the full package of EHBs, as it includes coverage of screening and brief counseling for domestic and interpersonal violence, in the Medicaid ABPs.

Response: We thank the commenter for the support. While it is not certain that every ABP will include counseling for domestic and interpersonal violence, such services will be provided if they are part of the EHBs.

Comment: One commenter believes that strong and comprehensive oversight and enforcement of EHBs and nondiscrimination standards at the state and federal level will help ensure consistent coverage of transplant benefits and eliminate discriminatory insurance practices. Therefore, the commenter asserted, ABPs must cover all EHB categories without discrimination for people who have or will acquire health conditions that lead to end stage organ failure. The commenter stated that a wide range of medical services are required during the transplant process and fall under the categories of ambulatory services, hospitalization, chronic disease management, mental health services, rehabilitative services, and prescription drugs. The commenter urged that all of these treatments must be covered under ABPs.

Response: If transplant services are covered as part of the coverage option chosen by the state, or the benefits under the selected base benchmark plan, as supplemented (and subject to permissible substitution of benefits), then they will be covered as part of the ABP.

Comment: According to one commenter, the Affordable Care Act specifies that entities covered under section 340B(a)(4) of the Public Health Services Act, which includes federally recognized Hemophilia Treatment Centers, be designated as essential community providers and that designation requires that qualified health plan networks to include Hemophilia Treatment Centers. This commenter requests that state Medicaid programs be encouraged or required to include essential community providers in their networks.

Response: Coverage through an ABP remains subject to requirements under the state plan to provide for beneficiary free choice of provider, and provider payment rates that are consistent with efficiency, economy, and quality of care and assure sufficient access to services. States have options to limit free choice of provider in some circumstances, for example, managed care service delivery consistent with section 1932 of the Act, or through selective contracting arrangements authorized under a waiver under either section 1915 of the Act or section 1115(a) of the Act. In any of these cases, states must assure sufficient beneficiary access to services.

Comment: Several commenters suggested that the review of EHB, in the private insurance market and Medicaid, consider whether limits in coverage and changes in medical evidence or scientific advancement affect whether enrollees have difficulty accessing services. The EHB should be based on the most recent and reliable clinical evidence available and a process should be developed to inform and shape EHBs based on these factors over time. If not available, there should be an allowance for some physician discretion.

Response: Consistent with the provisions of section 1302(b) of the Affordable Care Act, CMS has in the regulations at 45 CFR part 156 defined EHBs by reference to coverage plans available in the commercial market.

Comment: Several commenters also requested that review of EHBs be disaggregated to include demographic categories. HHS should require states to report enrollees' race, ethnicity, language, sex, and disability status data uniformly, as well as data on other demographic areas such as sexual orientation and gender identity, as described in section 4302 of the Affordable Care Act.

Response: This information does not appear to be related to the review of EHBs. We note, however, that we are developing a Transformed Medicaid Statistical Information System that will include expanded data elements regarding beneficiaries, claims and providers per Affordable Care Act.

Comment: One commenter supports inclusion of all ten EHB to reflect appropriate balance in each category and requested that anesthesia and pain management services be included in the ten categories of benefits covered by the ABPs. This commenter also requested that CRNAs and other non-physician providers who bill for Medicare Part B be included in Medicaid ABPs.

Response: The coverage of particular services will depend upon the coverage option selected by the state, and the EHBs that are determined based on the state-selected base benchmark plan, as supplemented (and subject to substitution of actuarially equivalent benefits) consistent with the process described in 45 CFR part 156. This rule will not affect the ability of states to set provider qualifications for covered services.

Comment: One commenter requested that dollar limits on a specific category of benefits and targeted use of utilization management techniques be prohibited.

Response: Annual dollar limits are prohibited in the public employee or commercial plans that are the basis for coverage options and the base benchmark options according to section 2711 of the Public Health Service Act. Utilization management techniques are common practice for benefit management and will continue to be allowed in Medicaid. We expect that these practices will be non-discriminatory and not impede access to needed, covered services.

Comment: One commenter indicated that HHS should specify in the final rule that to meet the health care needs of diverse segments of the population, an ABP must provide a process for participants to request and receive: clinically appropriate benefits not routinely covered by the plan, especially when the ABP is less costly than the covered benefit; coverage for benefits beyond limits set by the plan; coverage of specialty care not routinely covered by the plan when medically necessary and appropriate.

Response: We are specifying in the final rule that, if an individual in the new adult group meets the criteria for exemption from mandatory enrollment in an ABP that would otherwise be applicable, then the individual would have a choice of an ABP that includes at least the EHBs, and is subject to the requirements of section 1937 of the Act, or benchmark or benchmark-equivalent coverage that is not subject to the requirements of section 1937 of the Act, and thus, includes all regular Medicaid state plan benefits. Other individuals do not have that choice but this rule does not affect their right to appeal denials of coverage through the state's fair hearing system.

Comment: Commenters requested clarification and further guidance on the supplementation process established in both the proposed rule for the EHBs in the commercial market and the proposed rule for EHBs in Medicaid ABPs. Many commenters requested that CMS clarify what benefits would constitute coverage in each category and identify a threshold to trigger supplementation of a benefit category. It appears that a single service could be determined to be sufficient to define an EHB in Medicaid and therefore would not achieve MHPAEA compliance. A few commenters also stated that a single service would not meet non-discrimination requirements in addition to the balance requirement, which requires a much stronger minimum set of benefits in each category. One commenter requested clarification of the Medicaid EHB supplementation process including the extent to which the scope of services in one EHB category must be consistent with services offered other health service categories. Several commenters believe that additional provisions need to be added to ensure that the level of benefits in each EHB category are meaningful and adequate to meet the needs of the population. Several commenters also requested that CMS clarify what benefits would constitute coverage in each category and explain how CMS would enforce the non-discrimination and balance requirements.

Response: Supplementation occurs when a base-benchmark plan does not include items or services within one or more of the categories of EHB. Benefits from the base benchmark that are determined to be EHBs must be included as an EHB, unless substituted by the state. While the rules at § 156.115(b) indicates that the ''issuer'' may substitute benefits, in Medicaid, the state functions as the issuer and we thus provide that the state can exercise the option to substitute benefits. We indicated that requirements at § 156.110 apply unless we specifically modified the approach in Medicaid. Section 156.110(e) that specifies balance requirements also apply to EHBs

established in Medicaid. All benefits within the section 1937 coverage option must also be provided. CMS will conduct a review of all ABP SPAs to determine appropriateness for approval.

There are both requirements and flexibility for states in constructing EHBs and section 1937 coverage options. Please refer to the summary at the end of this section for further discussion of these steps and flexibilities.

Comment: The HHS February 17, 2012 Bulletin allows for substitution of services within the rehabilitative and habilitative benefit, allowing the plan to facilitate substitution of services at the provider level based on patient need not predetermined by the issuer, according to one commenter. The November 20, 2012 Patient Protection and Affordable Care Act; Standards related to Essential Health Benefits, Actuarial Value, and Accreditation proposed rule indicated that the issuer would create a substituted benefit plan, which would leave providers with no choice but to provide services in the benefit package and potentially lead to an individual choosing a plan that does not cover the services that they need.

Response: States, not issuers, define benefits within section 1937 of the Act. Section 156.115(b) outlines the substitution policy that will also be applicable to Medicaid except that, in Medicaid, states have the role of issuers and will indicate the substituted benefits. Substitution requires that benefits be in the same EHB category and that they are actuarially equivalent. This means that a state for example, could substitute a personal care benefit for an in vitro fertilization benefit in the EHB Ambulatory Services category, as long as they were actuarially equivalent. Within the rehabilitative and habilitative services and devices EHB, benefits can be substituted as long as the resulting benefits still provide for coverage of both rehabilitative and habilitative services. We expect that the benefit design will result in clinically appropriate services based on medical necessity. The resulting ABP, which includes EHBs that have been supplemented if necessary, individual benefits that have at state option been substituted, and benefits from the section 1937 coverage option, must be approved by CMS. Once approved, a description of the benefits included in the final ABP should be publicly available so that beneficiaries are knowledgeable of the benefits to which they are entitled. That said, we appreciate that it may be difficult at this point to make changes to the ABP that take effect by January 1, 2014. In light of this challenge, we will partner with states to work as quickly as possible to come into full compliance with these provisions. We do not intend to pursue compliance actions on these issues to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014.

Comment: Many commenters are concerned that there is no requirement regarding adequacy of benefits. These commenters specifically requested that HHS provide a cross-reference to § 440.230(b) and state explicitly that the requirement that every service offered through the Medicaid state plan ''be sufficient in amount, duration, and scope to reasonably achieve its purpose'' also applies to EHBs in the ABPs. A few commenters recommended that the regulations be revised to require states to supplement the benefits in a benchmark plan if any service in the EHB category is not sufficient in amount, duration, or scope to reasonably achieve its purpose.

Response: Under section 1937of the Act, states are authorized to offer ABPs that include benefits derived from public employee or commercial market products, essential health benefits and certain other required benefits. Sufficiency standards applicable to the traditional Medicaid benefit package generally do not apply to ABPs. If Secretary-approved coverage is chosen as the section 1937 coverage option, however, then we would require that the benefit package must ''provide appropriate coverage to meet the needs of the population provided that coverage'' under § 440.330(d). Sufficiency standards at § 440.230 will be applied in our review of proposed Secretary-approved coverage.

Comment: Many commenters requested that CMS reconsider the proposed approach and define comprehensive federal EHBs for section 1937 coverage that all states would be required to use to supplement their chosen benchmark or benchmark-equivalent coverage. They urged that CMS should go further and require states to cover comprehensive benefits in each of the EHB categories and work with states to ensure that minimum coverage is met. One commenter went further to suggest that CMS and HHS adopt a comprehensive, national EHB in 2016, when the trial period for the current approach is complete.

Response: EHBs in Medicaid will generally be defined in the same fashion as they are defined in the individual and small group market, except for certain EHB categories discussed in the proposed rule and this final rule. This approach allows the public employee or commercial market plan selected by the state to define EHBs for Medicaid to set the floor for EHB coverage (with supplementation as needed and substituted as desired). States then have the authority to offer other services (including through Secretary-approved coverage for the new adult group).

Comment: One commenter requested that HHS clarify that the requirement for balance among EHB categories ensures robust coverage in each category and cannot be used to lower other categories if one or more categories lacks robust coverage.

Response: Consistent with the requirements of 45 CFR 156.110, EHB categories must be appropriately balanced to ensure that benefits are not unduly weighted toward any category. Any benefits that are determined to be EHBs from the base benchmark plan must be provided. Section 1937 of the Act also has an ''equal to'' standard that indicates that all benefits from a section 1937 coverage option must be provided. When Secretary-approved coverage is used, benefits must meet Medicaid sufficiency standards as well as the requirement that the benefit package be appropriate to meet the needs of the population.

Comment: Many commenters reiterated concerns regarding the EHB proposed rule and EHB benchmark plan standards. This concern remains for ABPs as the Department does not sufficiently define the scope of coverage in any statutorily required category specifically maternity care. The base benchmark plans may include coverage of maternity services, but the plan documents do not specify which services define maternity coverage or provide details on coverage including limits. The lack of clear definitions further complicates the substitution and supplementation methodology. Several commenters want the Department to establish clear standards for what must be covered as required by sections 1302(b)(1) and 1302(b)(4)(C) of the Affordable Care Act to ensure a comprehensive standard. The adoption of coverage should not result in a discriminatory benchmark.

One commenter expressed concerns related to the ambiguously defined EHB categories and encouraged HHS to definitively confirm the extent to which cost effective, clinically effective nutrition care services such as medical nutrition therapy are included as EHBs within Medicaid benchmark and benchmark-equivalent plans. This commenter requests adequate federal oversight and approval of benchmark plan selection by HHS to reflect the vital and unique role that nutrition plays in

improving and maintaining health for all Americans, but also recognizes the need to define EHBs flexibly. This commenter seeks clarification in the final rule on the metrics and bases upon which HHS will determine whether a benchmark or benchmark-equivalent plan meets the EHBs mandated by Affordable Care Act.

Response: Section 1937 of the Act permits states to offer coverage through an ABP without regard to sufficiency requirements that are applicable to regular state plan benefits, except that we would apply sufficiency standards in our review of proposed Secretary-approved coverage as the section 1937 coverage option. Substitution is allowed in section 1937 of the Act using requirements found at 45 CFR 156.115(b) except that the state will be exercising the option for substitution rather than an individual market issuer.

Comment: Commenters requested that CMS provide clear regulatory guidance to states to ensure that the process for supplementing coverage to meet the additional requirements of Affordable Care Act is clear. This is especially important given that EHBs are not universally covered well by state Medicaid programs such as mental health and substance use services. Furthermore, for states that choose to use benchmark-equivalent coverage, this commenter requests that CMS establish clear limits on states' ability to use benchmark-equivalent coverage to undermine the EHB protections as it appears that under the proposed rule that they can reduce the value of EHBs under the benchmark-equivalent option to anything short of elimination. These commenters request that CMS ensure the comprehensiveness of the benefits for all beneficiaries covered by section 1937 of the Act regardless of the ABP chosen by the state.

Response: Benchmark-equivalent benefit packages must be at least actuarially equivalent to one of the section 1937 benchmark coverage options and must include benefits within certain categories of basic services. In addition, the Affordable Care Act amended section 1937 of the Act to require the provision of EHBs in benchmark equivalent coverage, so we do not believe that use of this section 1937 coverage authority will undermine the EHB protections. The process for supplementation is found at 45 CFR 156.110(b)(1) through (4) and substitution requirements are at § 156.110(b). All benchmark-equivalent coverage packages must adhere to section 1937 requirements, and must not violate the EHB anti-discrimination principles.

Comment: One commenter recommended that HHS specify in the final rule that ABPs must include benefits routinely covered by the benchmark plan, regardless of whether those benefits are listed in the data collection template used to report base benchmark benefits to HHS. Furthermore, all benefits within categories of care that list more than one benefit must be covered. For example, an ABP should be required to cover as three distinct benefits rehabilitative services, habilitative services, and rehabilitative and habilitative devices as opposed to only covering one of them.

Response: We intend to develop a template for states to use to define the ABP in Medicaid that will result in the submission of a state plan amendment. This is a different process than the one used for states to submit the base benchmark benefits for the individual and small group market. A state can select a different base benchmark plan for the individual and small group market than it does for Medicaid purposes. We anticipate issuing further guidance on these operational issues.

Comment: One commenter strongly encourages CMS to provide further guidance on alignment issues during the plan comparison and supplementation process. This commenter encourages CMS to clarify that during supplementation, states must create the most comprehensive benefit package possible, drawing from services covered in either the section 1937 coverage option or the comparison base benchmark plan, which could include drawing across categories if necessary to create a robust set of services that will result in adequate coverage of EHBs.

Response: To clarify, the ABP must include as a floor the EHBs covered by the base benchmark plan selected by the state to define EHBs for Medicaid, supplemented as necessary and subject to substitution of actuarially equivalent benefits as permitted under 45 CFR 156.115(b). Balance requirements of 45 CFR 156.110(e) also apply. In addition, the ABP must include any benefits from the section 1937 coverage option that are not in the base benchmark plan, whether they are EHBs or not. If the section 1937 coverage option that is one of the three public employee or commercial products provides a service in a greater amount, duration, or scope than the EHB provided in the base benchmark plan, the state must utilize that section 1937 standard for that service. If the section 1937 coverage option is Secretary-approved coverage, then the state may choose which benefit to use.

Comment: One commenter requests that HHS specify that appropriate balance of EHB coverage includes coverage of benefits across the care continuum, prohibits substitution between categories of EHB (for example, prohibit coverage of rehab therapy but include drug coverage) and between benefits (cover wheelchairs instead of rehabilitative hospital care to restore a person's ability to walk), cover all EHBs within the settings and by specialists which provide the current standard of care, and protect patients' access to appropriate and medically necessary care as provided by skilled medical professionals.

Response: Substitution of benefits can be achieved when defining the EHBs according to 45 CFR 156.115(b). Benefits must be in the same EHB category and actuarially equivalent. Balance requirements at 45 CFR 156.110(e) apply, as CMS did not indicate that they do not apply in Medicaid. CMS will be reviewing each state plan submission. As with all Medicaid services, states will establish medical necessity criteria for the receipt of ABP services.

Comment: A commenter indicated understanding that benefit substitution among EHB categories would be prohibited for ABPs as it is prohibited for Exchange plans. However, this commenter believes that substitution even within benefit categories could be extremely problematic for children's and pregnant women's access to needed services. Commenters urged HHS to prohibit substitutions or at a minimum give states the flexibility to disallow substitutions. If benefit substitution within categories is retained, this commenter recommends that a more restrictive standard than an actuarial equivalence test on the value of the benefits compared to the EHB benchmark plan be implemented.

Response: Substitution of benefits within EHB categories will be at state option, according to parameters described in 45 CFR 156.115(b). This process will be the same for Exchange plans and ABPs, except that states will be in the role of the health insurance issuer for purposes of substitution.

Comment: Commenters note that in some states the EHB benchmark covers services beyond those included in the Medicaid state plan. They argue that requiring states to supplement coverage to make it comparable to the EHB benchmark is not a workable solution for states, particularly for states that wish to expand in 2014. They further assert that some of the immediate operational challenges include the need to enroll new providers, set reimbursement rates, design claims and

payment rules, and incorporate those rules into systems, and if managed care is used, new capitation rates will need to be designed, which will result in a large administrative burden.

Response: It is true that ABPs under section 1937 of the Act will contain different benefits than those offered in regular Medicaid, based on the coverage options and EHBs that a state elects. These differences are inherent in the statutory design. While EHBs will establish a minimum level of benefits, that level may result in greater or lesser benefits than are available under regular Medicaid. ABPs require that benefits that are based on commercial insurance products include the benefit, the benefit description and limitations on amount, duration, and scope as the minimum standard. States have been working with CMS toward defining EHBs and ABPs and as part of that process states may need to undertake contracting activities and system changes to offer and administer the ABP.

Comment: In the proposed rule concerning EHBs, requirements could be different in different states according to one commenter. Since two of the four benchmarks are tied to what is available to state employees in the state and what is available from the largest HMO in the state, employers may have confusion about the requirements in a particular state. This commenter requests identification of who oversees an employer that has employees with a principle place of employment in multiple states, and wonders whether it would be the Department of Labor.

Response: The standards discussed in this regulation relate to the implementation of EHBs for Medicaid. Employers do not offer Medicaid as part of their offerings to employees and therefore, this question is outside the scope of this regulation.

Comment: One commenter asked if, given the requirement that states must supplement the benchmark package if EHBs are not covered, states would be required to add these benefits to the state plan under the Secretary-approved coverage option that is based on state plan coverage. The commenter asserted that it is unclear if the state must supplement services that are covered in the base-benchmark selection for the Exchange, and that it is unclear if supplementation is only for the benchmark plans provided to newly eligible individuals or if states that are seeking to provide a Secretary-approved benchmark plan to newly eligible individuals will be required to amend the state plan to add the new EHB services not otherwise covered. The commenter also asked whether states would now be required to add services that are not currently covered and categorized as optional, and also wondered if EHB supplementation only applies to benefits for newly eligible people or must the state meet this requirement for all benchmarks offered regardless of population.

Response: States are required as part of the ABP to cover all EHBs. While most of the EHBs are also included under regular Medicaid coverage, there may be exceptions. For example, substance abuse services and habilitative services may not be part of a State's regular Medicaid benefit. The EHB requirement applies to any ABP offered by the state, including those based on Secretary-approved coverage.

Comment: One commenter indicated that the regulatory language fails to specify that states must supplement missing categories. This commenter recommends that the Department clarify that states must follow the process established in 45 CFR part 156 to ensure that any missing categories are supplemented in the final rule. The Department should also ensure that benefit design in ABPs does not result in less comprehensive benefits than the private insurance market, and therefore, ABPs should be required to include benefits at least as robust as those in the state's full EHB package.

Response: EHBs establish a floor of benefits for ABPs offered under section 1937 of the Act and are based on commercial market products, which means at a minimum EHBs will include benefits at least as robust as those in the base benchmark chosen by the state. The supplementation process in section 1937 of the Act will follow 45 CFR 156.110(b).

Comment: Several commenters generally supported the proposed process to designing the Medicaid ABP. However, HHS must establish transparent, minimum standards for states using ''Secretary-approved'' coverage. It will be critical to ensure that the state cannot develop an ABP based on the weakest benefit level available at each step of the process. The commenters expressed concern that the rule offers very little guidance about what the ABP must cover to meet the ten categories of EHBs required by Affordable Care Act and the scope of required coverage. They indicated that this lack of clarity may lead to people in the Medicaid expansion group not receiving the full range of services available to people at higher income levels accessing private market or Exchange coverage in their state. An additional commenter expressed that the youngest and most vulnerable citizens, the birth to three population, need to have access to all necessary high quality, comprehensive physical, developmental, mental health and medical care to ensure positive growth and development.

Response: Current and proposed regulation at § 440.335(d) states that Secretary-approved coverage must be appropriate to meet the needs of the population being served. CMS will review proposed Secretary-approved coverage against that standard. And CMS will apply the sufficiency standards of § 440.230 in evaluating benefits included in Secretary-approved coverage. In addition, all ABPs, including Secretary-approved, must include the full range of EPSDT services for individuals under age 21, which ensures that they will have access to comprehensive screening and necessary medical care.

Comment: Several commenters expressed concern regarding the process proposed by CMS to demonstrate compliance with EHB, saying it is too burdensome and applying the EHB definition that was created for small group health plans for commercial products in the private market needlessly complicates section 1937 of the Act. They asserted that requiring that states begin by using one of the ten commercial benchmark plans as the EHB base is not useful for states that want to use the full Medicaid benefit set under Secretary-approved coverage. They argued that using the full Medicaid benefit set allows all Medicaid clients to receive the same benefit set and states would not have to operationalize a post-eligibility review process to screen people for opting out of the ABP for the traditional state plan. Their position was that, given the number of changes that states must implement in 2014, maintaining a single benefit set reduces administrative burden and confusion for clients and minimizes the number of required system changes. According to one commenter, it is essential that the new adult group have the same benefit set as the full state Medicaid benefit set. Furthermore, the commenter asserted that the mandatory Medicaid benefit set should be an option to serve as the basis for demonstrating EHB compliance under the Secretary-approved option without supplementation. A few commenters recommend that HHS create a second definition of EHB compliance that would be based on the Medicaid mandatory benefit set, limit that definition to the ABP in Medicaid programs, and allow states to use this benefit set as the basis to build a

coverage option for Secretary-approved coverage.

Response: Section 2001(c) inserted new paragraph (b)(5) into section 1937 of the Act. This amendment requires that benchmark and benchmark-equivalent benefit packages must provide EHBs described in section 1302(b) of the Affordable Care Act, beginning January 1, 2014. The same process to define EHBs applies to both commercial plans and Medicaid, with adjustments only to reflect the unique nature of Medicaid. Thus, EHBs must be established within section 1937 using one of the state options for base benchmark plans as set forth in 45 CFR part 156. States may still elect to offer Medicaid state plan benefits in their section 1937 coverage option using Secretary-approved coverage, as long as all requirements of this regulation are met.

Comment: Many commenters indicated that states electing state plan benefits using the Secretary-approved option should not be required to supplement with additional EHB services. Although they acknowledged that section 1937 of the Act requires inclusion of EHBs as defined under section 1302(b) of the Affordably Care Act, they asserted that this does not mandate importation of entire segments of coverage from private plans nor does it require a wholesale matching of these offerings in Medicaid. They asserted that implementing EHBs in section 1937 of the Act in this way is onerous and could result in the relatively less vulnerable, higher income expansion group as compared with Medicaid beneficiaries receiving more generous benefits such as substance use disorder services. They further asserted that Congress certainly could not have intended for the new enrollees to end up receiving more robust coverage than the categorically needy base. They stated that this also creates administrative complexity for states and a situation where incoming beneficiaries who may be disabled must choose between disparate benefit schedules. The commenters believed that the only way to mitigate disparate benefit schedules is for states to expand all benefits for existing and new eligible beneficiaries, something states are not in a fiscal position to do. They further asserted that the Affordable Care Act did not authorize a departure from long standing state discretion under Title XIX to develop appropriately balanced benefits and suggested that, if states must expand all benefits for existing and newly eligible beneficiaries, then states must receive 100 percent FFP for these benefits.

Response: We believe that our response to the question above also responds to this question; the statute requires that all ABPs, even Secretary-approved coverage, include EHBs. There are both requirements and flexibilities for states in constructing EHBs and section 1937 coverage options. The process for defining and including EHBs is the process used under section 1302(b) of the Affordable Care Act, adapted to the unique circumstances of the Medicaid program.

Comment: One commenter indicated that the intersection of § 440.345(d) and § 440.347(a) is confusing, and recommends that CMS clarify in regulation that EHBs form a floor for the ABPs and do not supplant any preexisting requirements under section 1937 of the Act and 42 CFR part 440, subpart C. Regulations would be clearer if § 440.347 were worded as a definition of EHB rather than a restatement of the mandate to include EHB in an ABP and for clarity should simply reference relevant provisions in 45 CFR part 156.

Response: Section 440.345(d) is intended to establish the universe of benefits required within the ABPs. In addition, state must assure access to RHC and FQHC services and transportation to and from medically necessary services as set forth at § 440.365 and § 440.390 respectively. Section 440.347 is intended to specify the categories of EHBs and the process by which those EHBs are established within the ABP. Both sections should be read in conjunction to the other.

Summary: We are adopting the following approach for treatment of individuals in the new adult group who meet the exemption criteria from mandatory enrollment in benchmark or benchmark-equivalent coverage in the final rule. If an individual in the new adult population meets the criteria for exemption, then they have a choice of the ABP based on benchmark or benchmark-equivalent coverage including at least the EHBs, or an ABP with coverage defined as the state's approved Medicaid traditional state plan, which is not subject to any other requirement of section 1937 of the Act, including EHB requirements. We are not making any changes as a result of these comments.

i. Essential Health Benefits (Non-Discrimination Policy) (§ 440.347)

Section 1302(b)(4) of the Affordable Care Act provides that benefit design cannot discriminate and CMS codified this section of the Affordable Care Act at § 440.347(e). Benefit design discrimination policies do not prevent states from using targeting criteria to group people together to receive specific benefit packages.

Comment: One commenter expressed support for the inclusion of the new provision clarifying that individuals cannot be discriminated against based on their ''age, expected length of life, or an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions.'' The commenter seeks age-appropriate care and benefits for children, whether through family or child-only coverage.

Response: We appreciate the support.

Comment: Several commenters indicated that while they understand that section 1937 of the Act allows states the flexibility to amend Medicaid state plans to provide certain populations (as defined by the state) with benefits packages other than those offered in the standard Medicaid state plan, HHS must closely monitor this and ensure there is no discrimination in benefit design for certain populations.

Response: Benefit design should not discriminate against individuals who receive a benefit package under section 1937 of the Act based on age, disability, life expectancy or condition but may include benefits designed to meet the special medical needs of segments of the covered population. Benefit packages designed in section 1937 of the Act include the same oversight as the regular Medicaid state plan. Aside from the EHB anti-discrimination requirements, § 440.230(c) indicates that state Medicaid agencies cannot arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient based solely on diagnosis, type of illness or condition.

Comment: Several commenters expressed support of the requirement that EHB benefit design cannot discriminate on the basis of an individual's age, expected length of life, or an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions. The commenters believe these non-discrimination provisions will require vigorous monitoring and strong enforcement.

Response: We thank the commenters for their support. We expect states to comply with these provisions and implement benefit packages that do not discriminate. ABPs will be subject to the same monitoring process as currently used in the Medicaid state plan.

Comment: Many commenters expressed support for the inclusion of a non-discrimination provision in § 440.347(e). But some commenters pointed out that, while the proposed

rule recognized the importance of non-discriminatory plan design § 440.347(e) fails to state the full range of nondiscrimination protections applicable to the EHB. Many commenters expressed concern that the preamble only references section 1302(b)(4) of the Act and the requirements proposed in § 440.347(e) state only the protections under that statutory provision. Therefore the commenters believe that the requirements in § 440.347(e) reflect an incomplete and insufficient standard. The commenters believe that the protections under section 1557 of the Affordable Care Act also apply, and the final rule must expressly state a comprehensive and consistent nondiscrimination standard, explicitly requiring EHB benefit design to comply with section 1557 of the Affordable Care Act. The commenters recommend the final rule be revised to include the language used in the nondiscrimination standard set out in the proposed EHB rule. The commenters believe that without the additional requirements the benefits of both section 1557 and the Affordable Care Act as a whole in ensuring comprehensive coverage for all individuals will be undermined. Lastly, the commenters also requested the regulation prohibit ABPs from including all of the following:

- Participant cost-sharing designs that are more burdensome on some benefits than others.
- Unreasonable and arbitrary visit and dollar limits on a specific category of benefits, so as to discourage participation by individuals with brain injury.
- Targeted use of utilization management techniques for some benefits, and not to others.
- Defining the benefits in such a way to exclude coverage for those services based upon age, disability, expected length of life, or the willingness or capacity to participate in wellness programs or behavioral incentive programs.

Response: Some of the protections sought by commenters are already contained in laws applicable to state Medicaid programs. Section 430.2, an existing regulation, identifies other regulations applicable to state Medicaid programs including 45 CFR part 80, which requires that programs receiving federal assistance, through the Department of Health and Human Services, include effectuation of Title VI of the Civil Rights Act of 1964 and 45 CFR part 84, which implements Section 504 of the Rehabilitation Act of 1973, prohibiting disability discrimination. In addition, state Medicaid programs are subject to the Age Discrimination Act of 1975. Therefore, these protections are already applicable to Medicaid.

We appreciate commenters pointing out deficiencies in § 440.347(e) and have revised it to align with the regulation implementing EHBs in the Exchanges.

Comment: A few commenters indicated appreciation of CMS's work to revise current Medicaid rules such that they incorporate statutory non-discrimination provisions from section 1302(b)(4). The commenters strongly encourage CMS to also codify all statutory non-discrimination provisions applicable to issuers of QHPs that meet EHB requirements. CMS should specify that § 156.200 and § 156.225 also apply to ABPs. Section 156.200 specifically prohibits discrimination based on factors including but not limited to race, disability, and age. Section 156.225 codifies section 1311(c)(1)(A) of the Affordable Care Act which prohibits marketing practices and benefit designs that result in discrimination against individuals with significant or high cost health care needs. The commenters believe that all Affordable Care Act non-discrimination provisions applicable to QHPs issuers and EHB standards must similarly apply to ABPs in Medicaid to ensure consistency of standards across all forms of all health care coverage.

Response: The requirements in 45 CFR part 156 apply to QHP issuers and not Medicaid managed care plans. However, there are similar protections in place in the regulations governing Medicaid managed care plans. If ABPs are delivered through a Medicaid managed care plan, those protections, including marketing, appeals and grievances, beneficiary information, and non-discrimination based on health status will apply to the Medicaid managed care plans providing ABP benefits. There are similar protections on many of these issues for Medicaid fee for service delivery systems, requiring fair hearing, free choice of provider, and beneficiary information.

We take this opportunity to clarify that States have the flexibility to use managed care to deliver ABP benefits without regard to statewideness and comparability of services. Further, freedom of choice of provider may also be disregarded to the extent the State can demonstrate that freedom of choice would be contrary to the effective and efficient implementation of an ABP.

Comment: Many commenters also recommended § 440.347(e) be amended as follows: EHBs cannot be based on a benefit design or implementation of a benefit design that discriminated on the basis of an individual's race, color, national origin, sex, sexual orientation, gender identity, age expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions. Other commenters recommended § 440.347(e) be amended as follows: (e) EHBs cannot be based on a benefit design or implementation of a benefit design that discriminates on the basis of an individual's age, expected length of life, an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions, race, color, national origin, language, sex, sexual orientation or gender identity.

Response: The suggested change to § 440.347(e) is unnecessary because the protections described are already reflected in existing Medicaid regulations.

Comment: Many commenters expressed concern about the lack of guidance under the proposed rule for monitoring and enforcement of the proposed nondiscrimination provisions, and believe that the final rule must better define how individual states will assess, monitor, and enforce the law's nondiscrimination provisions. Moreover, the commenters do not believe it is sufficient to delegate all monitoring and enforcement to states. The commenters recommend the final rule define how CMS will take enforcement action when states are not ensuring compliance with the nondiscrimination standards established under the Affordable Care Act. The commenters also recommend that CMS develop a clear standard for what constitutes a discriminatory benefit design. This standard must address both individual cases of intentional discrimination and benefit designs that are facially neutral but that have the effect of systematically disadvantaging members of protected classes. Ultimately, this standard must make clear that the determination of whether a coverage limitation or exclusion is discriminatory should turn on the degree to which the benefit design is based on sound standards of clinical appropriateness rather than on arbitrary distinctions between health conditions or personal characteristics. To assist federal and state regulators in rectifying discrimination in benefit design, CMS should follow up on the final rule with sub-regulatory guidance explaining how to evaluate products for impermissible discrimination and providing examples of discriminatory benefit designs such as those listed above. In addition, CMS should require trained evaluators in each state to regularly and transparently review

coverage available through ABPs for discriminatory benefit designs and to ensure identified instances of discrimination are remedied in an expedient manner. Where CMS determines that a state Medicaid agency is not fulfilling its responsibilities in this area, CMS should establish a review procedure to focus on ensuring that all services deemed part of the EHBs are available to all eligible individuals for whom they are medically necessary, without arbitrary discrimination on the basis of any protected personal characteristic.

Response: ABPs are Medicaid state plan amendments and are subject to the same monitoring and oversight that occurs in the Medicaid state plan. Under this process, states review applicable requirements and design their program, including ABPs. The proposed design is submitted to CMS for approval, and CMS reviews the proposal for compliance with federal requirements. If approved, CMS may also review state implementation for compliance with federal requirements. In addition, issues can be raised by beneficiaries through the fair hearing process if services are denied. As with any Medicaid service, we recognize the important role that all stakeholders play in making CMS aware of any perceived ABP noncompliance. We will consider issuing further guidance on this topic.

Comment: One commenter is concerned that the proposed rule does not establish sufficiently robust oversight or enforcement framework to provide states with essential guidance to implement such a program. The regulatory text does not expressly require the Exchanges, states or OPM to monitor plans for compliance with the prohibition on discrimination. This commenter urges CMS to adopt an express requirement in the regulatory text of the rule that the Exchanges, states and OPM monitor for non-discrimination.

Response: Medicaid is a federal and state partnership and as such, states have the first line of responsibility to design and implement their program in compliance with federal requirements, including the non-discrimination requirements. Federal oversight is implemented using the existing state plan process, as well as ongoing monitoring of program operations.

Comment: Several commenters expressed concern that applying the EHB standard to prescription drug coverage in Medicaid would not provide appropriate protections for people with chronic conditions like cancer, diabetes, Parkinson's, HIV/AIDS, schizophrenia, epilepsy, obesity and organ transplant recipients. The commenters believe that focusing on a number of drugs covered, as opposed to ensuring a breadth of drugs are covered, could result in a selection of drugs that meets the minimum requirement but discriminates against potential enrollees.

Response: While we understand the commenters' concerns, the statute permits states a certain amount of flexibility in determining and structuring ABPs that meet the needs of enrollees and are consistent with overall state objectives. We must clarify a statement in the preamble to the proposed rule, indicating that requirements under section 1927 of the Act are applicable to ABPs under section 1937 of the Act. Section 1927 of the Act does not affect the flexibility of states to define ABP benefit packages consistent with a coverage benchmark and including EHBs. The amount, duration, and scope of prescription drug coverage would thus be governed by the requirements of section 1937 of the Act. To the extent that a prescription drug is within the scope of the ABP benefit as a covered outpatient drug, section 1927 of the Act is then applicable. For such covered outpatient drugs, since payment is available under the state plan, all drug rebate obligations under the rebate agreement are required for drug manufacturers under 1927(b) of the Act.

To explain in more detail, the amount, duration, and scope of coverage for an ABP is determined under section 1937 of the Act, which authorizes benchmark or benchmark-equivalent coverage ''notwithstanding any other provision that would be directly contrary.'' But, the drug rebate obligation applies under section 1927 of the Act when payment is made under the Medicaid state plan for covered outpatient drugs as part of the ABP. In addition, to the extent that covered outpatient drugs are within the scope of ABP coverage, the protections and limitations for such coverage under section 1927 of the Act apply. So, for example, to the extent that coverage under an ABP includes a class of covered outpatient drugs, a state could impose limitations on that coverage only consistent with the provisions of section 1927(d) of the Act. In general the requirements for prescription drug coverage under section 1937 of the Act, through the requirement for coverage of EHBs, will mean that ABPs will meet existing section 1927 requirements for Medicaid payment of covered outpatient drugs, which we believe will address the commenters' concerns. We discuss the interaction between the requirements for prescription drug coverage under section 1937 of the Act with the requirements for covered outpatient drugs under section 1927 of the Act in further detail later in this final rule.

Comment: Some of the commenters are concerned that CMS allows states to place limitations on amount, duration, and scope and adopt prior authorization and other utilization control measures, as well as policies that promote the use of generic drugs. The commenters believe that for people living with chronic conditions, use of utilization management techniques can have a detrimental impact and inhibit people from accessing needed treatments. The commenters also believe that these limitations can violate the non-discrimination requirements in the law.

In particular, commenters indicated that it is imperative that non-discrimination protections found in § 440.347 are strictly and clearly applied to the ABP prescription drug benefit. HIV care and treatment standards maintained by Federal agencies recommend a combination of medications for effective management of HIV disease (see *http://www.aidsinfo.nih.gov*). Quantitative limits on the number of drugs covered per month are discriminatory against people with HIV and others whose quality of life and health depend on access to a specific regimen of multiple prescription drugs to treat both HIV and co-occurring conditions as recommended by their medical provider. The application of the non-discrimination provisions should prohibit states from applying quantitative limits on monthly drug coverage for the expansion population, and the commenters urged that this standard also be applied to the traditional Medicaid population. If monthly drug limits are considered, there must be provisions to allow for a timely override process that does not delay immediate and uninterrupted access to the medications when recommended by a medical provider.

Commenters also requested that CMS adopt a more robust standard for evaluating limitations on amount, duration, and scope and prior authorization and utilization control measures that may be discriminatory by design. These evaluations should be specific to the population and based on sound medical evidence regarding the prescription drugs necessary to provide adequate coverage. Restrictions to prescription drug coverage in Medicaid, such as monthly drug limits, could leave some Medicaid beneficiaries with less comprehensive coverage than that offered to individuals covered in the

Exchange because of limitations that are discriminatory based on health care need.

A few commenters also expressed concern that the proposed rule does not discuss the circumstances in which a limitation on drug coverage could violate the non-discrimination requirement. CMS should provide additional guidance about its interpretation of the nondiscrimination rule and its enforcement strategies, particularly for prescription drugs. The commenters believe that this should include oversight functions to actively monitor and test for discriminatory plan design and implementation, and to report such activities to CMS. For instance, the implications of plan substitutions within a category of EHBs or prescription drug cost-sharing designs for high risk enrollees should be considered.

Response: States have considerable flexibility in implementing the provision of Medicaid services through ABPs. While this flexibility permits states in some instances to limit prescription drug coverage based on the coverage offered under other public employee or commercial plans, it also includes the ability to exceed the amount, duration, and scope of prescription drugs covered by those plans, as long as the services provided are consistent with the Medicaid requirements.

The non-discrimination provisions adopted in this final rule at § 440.347 require that states will need to assess whether their ABP benefits, including any limitations placed on the amount, duration and scope of any benefit, discriminate on the basis of the individual's age, expected length of life or any individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions. We will consider whether additional sub-regulatory guidance on these matters is needed.

Comment: One commenter stated that private market carriers argue that exclusions for services or drugs commonly provided for the treatment of conditions such as HIV/AIDS are not discriminatory because they apply to all plan enrollees, regardless of their specific negative effect on people with these conditions.

Response: Under the law, states must assess whether their ABP benefit designs, including service or drug exclusions that are applied to all beneficiaries, discriminate based on an individual's age, expected length of life, or an individual's present or predicted disability, degree of medical dependency, or quality of life or other health condition contrary to the non-discrimination provisions being adopted in this final rule at § 440.347.

Comment: One commenter suggested that in developing an analysis framework to aid in testing for discriminatory plan benefits, CMS must ensure that ABPs refrain from using benefit designs that treat patients in a disparate manner based on age. For example, where FDA approves a drug or biologic for use in patients within a certain population, such as pediatrics, the commenter argued that ABPs should not be permitted to restrict coverage or employ varying utilization techniques for children of different age ranges within that pediatric population. The commenter requested CMS' vigilant oversight to protect children from being subject to age-based discrimination in accessing FDA-approved products.

Response: The non-discrimination provisions adopted in this final rule at § 440.347 require that states will need to assess whether their ABP benefits, including any limitations placed on the amount, duration and scope of any benefit, discriminate on the basis of the individual's age, expected length of life or any individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions. A limitation on medically necessary care provided to pediatric patients would violate the requirement under section 1937 of the Act that ABPs include the full range of medically necessary EPSDT screening and treatment services. Thus, the issue would not be one of benefit design but of compliance in providing a covered benefit.

Comment: A few commenters stated that CMS should adopt similar guidance and review processes as required under Medicare Part D program in the Medicaid EHB final rule. These proven non-discrimination policies and processes have been critically important in assuring that all Medicare beneficiaries—from the healthiest beneficiaries to the most vulnerable beneficiaries with serious and chronic illnesses—can obtain affordable Part D coverage that meets their individual needs. Additionally, CMS' experience assessing Medicare Advantage plans' cost-sharing and benefit designs for discriminatory effects may help point the way.

Response: We appreciate the comments regarding the use of Part D non-discrimination standards and will consider those standards as we evaluate these issues and the need for further guidance.

Comment: Several commenters indicated that meaningful non-discrimination protections will require a thoughtful and thorough review of preferred drug lists (PDLs). They stated that the following approaches could help ensure meaningful access: (1) PDLs should only be permitted to categorize a drug as non-preferred when there are genuine therapeutic alternatives classified as preferred; (2) PDLs should allow for appropriate access to drugs or drug classes needed for adherence to widely accepted treatment guidelines; (3) The most commonly used medications (or therapeutically similar medications) for conditions with high prevalence in the Medicaid population should be categorized as preferred drugs; and (4) Most importantly, medications used by particularly vulnerable Medicaid beneficiaries, such as those living with HIV/AIDS, cancer or serious mental illness, should be largely available as preferred drugs, given the importance of avoiding medical complications and interruptions in therapy for individuals with those conditions.

Response: For covered outpatient drugs, a PDL is permitted under section 1927 of the Act, as long as it is under a prior authorization program that meets the requirements of section 1927(d)(5) of the Act. Furthermore, as we discuss in the cost sharing sections of this final rule, a PDL may also be established for cost sharing purposes.

Comment: Many commenters expressed concern that the regulation did not provide examples of what would be considered discriminatory benefit design. The commenters request CMS identify a clear standard to determine whether the coverage provided complies with the non-discrimination provisions of the Affordable Care Act. Additionally, the commenters believe that CMS should provide examples to States of what would constitute violations, monitor ABP coverage for compliance with the non-discrimination requirements, and enforce these provisions of the law. Many other commenters added that the rule also did not establish a process to bring discriminatory benefit design or practice into compliance. CMS should consider developing more detail in the final regulation defining these protections. This should include a process for bringing a State's chosen benchmark or benchmark-equivalent option into compliance with the law.

Response: States will submit Medicaid state plan amendments for federal approval to implement ABPs and receive FFP. The state will assure in that submission that they will comply with non-discriminatory requirements as set forth in § 440.347(e). If issues are

detected with adherence to these requirements, we will pursue appropriate action with the state to rectify the issues. As always, we appreciate the ongoing input of stakeholders to help inform states and CMS of concerns relating to these matters.

Comment: One commenter indicated that it is unclear how the requirement that EHBs cannot be based on a benefit design or implementation of a benefit design that discriminates on the basis of an individual's age, expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health condition will be evaluated in the context of benchmark plans for specified population. It is unclear whether targeting permitted under other sections such as section 1915(i) of the Act would be permitted. The commenter wondered whether it would preclude the establishment of specialty plans based on diagnosis.

Response: Section 1937 of the Act does allow for a waiver of comparability at § 440.230(c); thus permitting states to identify groups of people, populations, based on certain characteristics such as presence of a chronic condition. States can then design benefit packages that are suitable for the population, but this activity does not permit benefit designs that are inherently discriminatory.

Comment: A few commenters expressed concern that neither earlier rules on EHB nor this proposed rule specifically define ''discrimination'' in the context of discriminatory benefit design. The commenters urge HHS to develop and promulgate a definition of ''discrimination'' that will allow states to evaluate health plans uniformly. The proposed rule delegates entirely to states the task of evaluating EHB for discriminatory design or intent with no further guidance at all. The absence of a definition of discrimination will inevitably lead to a 50-state patchwork of definitions. The commenters strongly believe that the definition of discriminatory benefit design should not vary among states.

Response: Medicaid is a federal and state partnership that allows states to design state-specific programs within broad federal guidelines and, more generally, that allocates responsibilities to both states and the federal government. By identifying states as accountable for determining that benefit design is not discriminatory, we recognize their important role in assuring compliance with this important statutory directive. Such accountability does not negate federal responsibility. As noted, we will consider whether further guidance on discrimination benefit design would be useful.

Comment: One commenter pointed to the Affordable Care Act's provision barring discrimination in EHB as prohibiting disability-based discrimination in making decisions about coverage, reimbursement rates, establishing incentive programs, and designing benefits, and the commenters believe those requirements should apply to Medicaid ABPs. The commenter recommends the Department provide additional guidance concerning applications of the Affordable Care Act EHB non-discrimination mandate to ABPs. The commenter believes the Department should also identify a minimum scope of services that plans must cover to comply with the Affordable Care Act's parity and nondiscrimination requirements and the requirement that EHB take into account the ''needs of diverse segments of the population, including . . . persons with disabilities.''

Response: The United State Supreme Court decision in *Olmstead* v. *L.C.* rendered on June 22, 1999 held that unjustified segregation of people with disabilities constitutes discrimination in violation of Title II of the ADA. Public agencies must provide services to people in the community when services are appropriate, people do not oppose services in the community, and the community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. Medicaid beneficiaries must receive services in the most integrated setting appropriate. We agree with the commenter that benefit design, including rate structures, should not create a pathway to institutionalization or segregation. Setting is not an appropriate targeting criterion, because it is potentially discriminatory as different benefits could be designed based on where individuals live and therefore, it would not be acceptable as a waiver of comparability.

Comment: Many commenters recommend CMS use the following data to determine compliance with the non-discrimination requirements:

- Medical necessity requirements for Medicaid must be evaluated and standardized, and HHS should monitor state implementation of medical necessity to ensure that people living with HIV, chronic disabilities and other chronic and complex conditions have unimpeded access to essential care and treatment.
- Utilization management techniques, exclusions, and service limits must be closely monitored to ensure that plans have not put in place barriers to services or excluded or limited certain items or services solely to deny access to care for people with chronic and complex health conditions. The commenters urge HHS to develop a list of practices that amount to discrimination to help guide monitoring and enforcement activities. For instance, requiring step therapy for HIV treatment without a medical override provision is a discriminatory utilization management technique that should be barred. Similarly, a monthly limit on prescription drugs (for example, several states have monthly limits of three or four prescription drugs) is also per-se discriminatory, as applied to people living with HIV and other chronic conditions.
- Physician network size and composition must be evaluated to ensure that Medicaid managed care plan networks include providers that are able to deliver quality care for people living with HIV and other chronic and complex conditions. A plan network that excludes HIV providers violates network adequacy standards outlined in qualified health plan standards and is a discriminatory plan design practice that forecloses access to EHB services. In addition, patient protections (for example, standing out-of-network referrals) will be necessary to ensure a smooth transition to coverage and to support continuity in care. The commenters strongly urge CMS to require Medicaid managed care plans to contract with Essential Community Providers, including Ryan White medical providers.
- For chronic and complex conditions, where the standard of care is rapidly evolving, reference to clinical guidelines is particularly important to ensure that coverage decisions are based on established medically accepted guidelines.

Response: Thank you for your suggestions. We agree that Medicaid managed care provider networks need to be adequate to provide services to all of their members. It is at state discretion to include (or not) standards for managed care providers in the contracts that the state holds with the managed care organizations in the state. Managed care entities can contract with any provider operating within the scope of their license to provide services.

Comment: A few commenters recommend ongoing procedures for states to monitor and share data on how they are meeting their benefit design and anti-discrimination obligations over time, and make this information transparent and readily available in at

least an aggregate fashion to HHS, the public, and to health advocates.

Response: We appreciate the comments. We are currently redesigning data collection procedures and standards and will consider these comments.

Comment: One commenter is requesting that any coverage under the Affordable Care Act, including Medicaid Programs, adequately cover therapies that cancer patients absolutely must take whether or not there is an actuarial equivalent at a lower cost. Coverage of drugs and services related to cancer care should not create cost barriers to patients through cost-sharing schemes such as burdensome co-pays and co-insurance. To do so would be unfairly discriminatory, and could impact a patient's ability to access their care, particularly low-income patients enrolled in Medicaid. The commenter would like to see strong protections and oversight established to prevent discrimination.

Response: We agree that a patient's ability to pay cost sharing imposed for a service can affect a patient's access to care and that low-income patients are particularly sensitive to such costs. Medicaid cost sharing rules at § 447.52 generally and § 447.53 for drugs apply to ABPs. States design cost sharing for therapies and drugs using those rules, and cost sharing rules may not be implemented in a manner that would be discriminatory. Annual dollar limits on services will not be allowed on benefits in the public employee or commercial plans that are the basis for the base benchmark options used to define EHBs per section 2711 of the Affordable Care Act.

Comment: A few commenters believe that § 440.347(e) sets out a strong non-discrimination requirement. However, the commenters also believe that there will be times when individuals are going to need access to legal advocacy to seek redress from discrimination and enforce these due process protections. The commenters recommend that the states be required to assist individuals to use the due process and appeals processes, this would include: (1) Information and assistance in pursuing complaints and appeals; (2) negotiation and mediation; (3) case advocacy assistance in interpreting relevant law; (4) reporting on patterns of non-compliance by plans as appropriate; and (5) individual case advocacy in administrative hearings and court proceedings relating to program benefits.

Response: We appreciate these suggestions; however, they are outside the scope of this regulation.

Comment: Many commenters representing the Lesbian Gay Bi-Sexual and Transgender (LGBT) community stated that the final rules must also address gaps in enforcement of this prohibition on discriminatory exclusions by providing clear guidance to state Medicaid agencies on implementation of these nondiscrimination standards. Enforcement is a major concern for these commenters in two areas: (i) instances of discrimination against individual enrollees, and (ii) discriminatory benefit design. The former is very important for LGBT enrollees, and they encourage CMS to work with state Medicaid Directors to ensure that robust and transparent appeals procedures are equally available to all individuals who need them. With regard to discriminatory benefits design, they are particularly concerned about enforcement in the context of potential disagreement as to what kinds of benefit limitations and exclusions constitute impermissible discrimination in benefit design.

Response: We appreciate the concerns expressed by these commenters. We intend to work with states on these matters as well as consider ways in which discrimination for LGBT enrollees may be rooted in benefit limitations and exclusions as well as in appeals processes.

Comment: Several commenters stated that the proposed rule requires that a Medicaid benchmark plan's benefit design cannot be discriminatory, and the final regulation must ensure adequate protections against discrimination. The commenters recommend the regulation require the following non-discrimination standards:

- Processes for review of plan benefits design to avoid discrimination caused by unfair utilization management techniques or other plan design elements.
- Requirements for plans to disclose to all prospective and current members all utilization management techniques as well as all limits on services.
- Final authority at the federal level to approve any state non-discrimination review processes to ensure appropriate measures are in place to guarantee that plans are meeting the requirements of this section.
- Federal monitoring programs to ensure appropriate checks are in place to guarantee that plans are meeting federal requirements.

In addition, the commenters urge CMS to clarify that Medicaid cost-sharing limits apply to the managed care organizations participating in the Medicaid program. For more details on non-discrimination standards, the commenters refer CMS to its proposed regulatory language for a comprehensive set of patient protections.

Response: In Medicaid, utilization management processes are at state discretion. States have flexibility to design and implement the Medicaid program in the state according to state policies and procedures. States will assure in the state plan amendment submission that anti-discrimination practices at § 440.347(e) are met. We clarify here that Medicaid cost sharing parameters apply to services provided in a managed care delivery system. Furthermore, we have oversight responsibility of state programs to insure that federal rules and requirements are being followed.

Comment: One commenter pointed out that § 440.347 deals exclusively with patient non-discrimination. The commenter indicated that there is also provider discrimination within health plans, where sometimes entire classes of healthcare professionals are excluded from providing services under the benefit solely based on their licensure or certification. The commenter believes such discrimination can limit or deny patient choice and access to a range of beneficial, safe and cost-efficient healthcare professionals, impairing competition, patient access to care, and optimal healthcare delivery. The commenter recommends the rule require ABPs offering EHBs to align payment systems to adhere to existing state provider non-discrimination laws as applicable, and to the federal provider non-discrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706, ''Non-Discrimination in Health Care'', 42 U.S.C. 300gg–5) slated to take effect January 1, 2014.

Response: We require that all providers are operating within the scope of their licensure or certification when providing services to Medicaid beneficiaries.

Summary: We appreciate the comments and suggestions and may consider further guidance. No change in the substance of the regulatory text is needed. However, CMS made grammatical changes to the regulation text at § 440.347(e) as a result of comments received in this section.

3. Modifications in Applying the Provisions of This Final Rule to Medicaid

We proposed in the implementation of section 1937 of the Act and the provisions in the Affordable Care Act relating to EHBs, a process in Medicaid

for designing ABPs. The Affordable Care Act modified section 1937 of the Act to implement two standards for minimum coverage provision; not only must EHBs, as defined by the Secretary, be provided, but all requirements of section 1937 of the Act continue to apply. Furthermore, we outlined expectations for specific EHBs as they are implemented in Medicaid including: habilitative services; pediatric or and vision services; prescription drugs; preventive services as an EHB; and the fact that all other Title XIX provisions apply.

a. Essential Health Benefits (Rehabilitative and Habilitative Services and Devices) (§ 440.347)

The proposed rule requested comment on an approach for defining habilitative services in Medicaid and we reserved regulatory text to do so. We received varied comments, and are adopting in this final rule the requirement that services covered by the base benchmark are the floor of EHB coverage, substituted as desired by the state. Under 45 CFR 156.110(f), if no habilitative services and devices are included in the base benchmark, states have the option to determine generally the required EHB services that are in the category of habilitative services and devices. If the state has done so, the base benchmark, and coverage under the ABP, must reflect that determination. If the state has not made a general determination of the habilitative services that are required for this EHB category, the state must exercise the option set forth in 45 CFR 156.115(a)(5) to determine EHB for the specific ABP. Under that option, habilitative services and devices must be included as EHBs either in an amount, duration, and scope no more restrictive in terms of treatment and benefit limitations than rehabilitative services and devices, or otherwise to an extent determined by the state and reported to HHS. In other words, if the base benchmark does not include habilitative services and devices, ABP coverage must, at a minimum, be based on the general state determination of habilitative services and devices that are included in EHBs, or on a Medicaid-specific determination for the particular ABP.

While we are not prescribing a specific definition of habilitative services and devices for purposes of ABP coverage of EHB, we clarify here that states may choose to adopt service definitions similar to those issued by the National Association of Insurance Commissioners (NAIC), as follows: rehabilitative services and devices are defined as services and devices provided to assist a person to prevent deterioration and regain or maintain a skill or function acquired and then lost or impaired due to illness, injury or disabling conditions. The NAIC also defines habilitative services and devices as services and devices provided for a person to prevent deterioration or attain or maintain a skill or function never learned or acquired due to a disabling condition. CMS will consider the need for future guidance, once experience is gained in implementing these EHB services and devices. We also note that while there is a definition of habilitative services under existing sections 1915(c) and 1915(i) of the Act, this definition is not necessarily applicable and may in fact not be appropriate for the population covered under ABPs.

Comment: A number of commenters believed that by requiring coverage of habilitative services in the ten mandatory EHB categories, Congress clearly indicated its intent to meet the health needs of individuals with functional limitations following illness, injury, disability or due to a chronic condition. The commenters recommended that HHS develop an objective minimum national standard for habilitative services based on ''appropriate coverage to meet the needs of the population,'' and allow states flexibility to add to this minimum for purposes of innovation.

A few commenters recommended HHS better define this category of services including providing clarity as to how plan definitions and scope of coverage will be assessed to ensure compliance with non-discrimination provisions. A number of commenters requested HHS cover habilitation at parity with rehabilitation, with some comments suggesting this standard also require habilitative services under Medicaid to be at least as generously defined as in the private market.

Many commenters requested that HHS require coverage of habilitative devices without arbitrary restrictions and caps that limit the effectiveness of the benefit.

Several commenters recommended HHS include a set of habilitative services specifying the minimum type of services to be provided and specify that these services are a floor.

Many commenters recommended that habilitation be covered separate and distinct from rehabilitation. For example, the plan cannot substitute rehabilitation for habilitation or apply only a single visit limit to both benefits. Each benefit must have separate and distinct limits which are applied based on medical necessity, not an arbitrary cap.

One commenter requested that HHS recognize that habilitative services are similar in type and scope to rehabilitative services (for example, physical therapy, occupational therapy, speech-language pathology). One commenter believed that habilitation should be covered in the same setting and include the same type of providers and specialists as covered in the rehabilitation benefit.

A number of commenters believed that setting clear, comprehensive, and uniform standards for habilitative services will prevent non-aligned localized definitions that could create serious problems across programs and states. A few commenters requested formal guidance on what the minimal expectation is for habilitative services.

A few commenters believed that when states adopt the habilitative benefit for ABP, HHS require that they do not impose financial requirements, quantitative treatment limitations, or financial limitations that are more restrictive than the predominant requirements or limitations that apply to all other benefit categories.

Response: We believe the provision of habilitative services is in addition to rehabilitative services and devices as an EHB. As EHBs are based on commercial market products, we are interpreting rehabilitative services as an EHB to more closely align with commercial market definitions, rather than the broader definition of rehabilitation in Medicaid. We therefore, are establishing that the commercial market definition of EHBs is the floor of coverage, subject to substitution flexibilities. If the commercial market coverage is not adequate, states, not issuers, define the benefit. At state discretion, as indicated above, states may offer coverage of habilitative services and devices that is no more restrictive in terms of amount, duration, and scope than rehabilitative services and devices. We expect that the services will be clinically appropriate to meet the needs of individuals based on medical necessity. We have added this flexibility for states to define a minimum standard of coverage if the commercial market benefits are not adequate. We are suggesting, but not requiring, definitions of rehabilitative and habilitative services and devices, as indicated above, and will consider needs for future guidance. We are reiterating that the benefit flexibility under an ABP allows states considerable latitude to define the benefit package for each population and there may be services that are covered in some settings but not in other settings, or that are covered when furnished by some practitioners but not others. This is

flexibility that exists currently in the commercial marketplace, and is extended to state Medicaid programs under section 1937 of the Act.

Comment: One commenter recommended that the coverage and medical necessity determinations for habilitative services and devices should be based on clinical judgment of the effectiveness of the therapy, service, or device to address the deficit. In addition, HHS should make clear that such benefits are to cover maintenance of function not just improvements, to assure that individuals in need have access to care that prevents deterioration of their conditions.

One commenter requested that HHS inform states that habilitative services need to be medically necessary and plans must be clear on how they define and determine medical necessity.

Response: States may require that all services covered under Medicaid be medically necessary. Determining the specific coverage of habilitative services and devices will be done by the state, based on services found in the base benchmark plan selected by the state to define EHBs for Medicaid, and substituted as desired. If a base benchmark plan does not include habilitative services, consistent with 45 CFR 156.110(f) and 156.115(f), States will determine which services are included as EHB in the habilitative services and devices category. We agree with the commenter that habilitative services, generally speaking, cover acquisition and maintenance of skills, while rehabilitative services cover restoration of previously acquired skills, but we are not setting forth a specific definition of these terms at this time.

Comment: One commenter recommended that HHS look to state Medicaid programs as a guide for defining what habilitation services should be covered under the EHB. A number of commenters requested that HHS require states and plans to adopt the definition of habilitative services put forth by the NAIC, which was included in the Department's proposed rule defining medical and insurance terminology. Many commenters recommend that if the NAIC definition is not used, an alternate definition to consider is provided in Medicaid law under section 1915(c)(5)(A) of the Act.

Response: We appreciate these suggestions and find the definitions of rehabilitative services and devices and habilitative services and devices extremely useful. Habilitative services and devices as described in the base benchmark plan is the floor of coverage, subject to substitution flexibility. If a base benchmark plan does not include habilitative services, consistent with 45 CFR 156.110(f) and 156.115(f), States will determine which services are included as EHB in the habilitative services and devices category. States may choose to offer habilitative services and devices in no more restrictive in terms of amount, duration, and scope of treatment than is applied for rehabilitative services and devices.

Comment: One commenter requested the state-defined habilitative benefit definition, as applied to section 1937 ABP in Medicaid, should not be extended to QHPs on the Exchange. This commenter indicated that in many states, Medicaid takes an expansive view of habilitative services, and there is a risk that if applied to the commercial market, this could raise costs on QHPs in the Exchange. States should have the option to either separately define habilitative services for Medicaid or apply the state-defined habilitative definition for the Exchange to the Medicaid programs, but not apply a broad Medicaid habilitative service definition to QHPs in the Exchange.

Response: This regulation is focused on the parameters of the habilitative services and devices that are EHBs for purposes of section 1937 ABPs under the Medicaid program and, this regulation does not apply to QHPs.

Comment: Many commenters recommended that states should be allowed to define habilitative services for their Medicaid program.

Response: We are adopting the position in this final rule that states will have the ability to define habilitative services and devices. If the base benchmark plan selected by the state to define EHBs, does not include habilitative services and devices, states will define the habilitative services and devices that will be regarded as this EHB category and must be covered in the ABP. In so doing, states can choose to offer habilitative services and devices that are at a minimum no more restrictive in terms of amount, duration, and scope than rehabilitative services and devices.

Comment: One commenter requested that HHS continue to allow states and issuers the flexibility to define habilitative services for the individual and small group markets as proposed in the EHB proposed rule and not be required to follow Medicaid definitions.

Response: We reiterate that this regulation applies only to the Medicaid program, and has no bearing on the provision of habilitative services in the individual and small group markets.

Comment: One commenter requested HHS clarify that states will be deemed to cover habilitation if they provide ABP enrollees with such services through a section 1915(c) waiver program.

Response: The new adult eligibility group is not eligible for enrollment in section 1915(c) waivers. However, states may also add section 1915(i) services to the ABP using Secretary-approved coverage, which may include some habilitative services and devices. But we do not see a reason to ''deem'' compliance with the habilitative services and devices EHB requirements just because a state may include some habilitative services and devices in those ways. The state must still determine habilitative services and devices that are EHBs in accordance with this regulation.

Comment: A few commenters recommended that if HHS does not use a national standard for Medicaid habilitative service benefits, then states should be required to base their definitions on documented and evidence-based criteria, such as those endorsed by a relevant national academy of providers or national disease group; and states should not automatically be allowed to use their Exchange habilitative services definitions unless it independently meets the criteria stated above.

Response: We expect that states will consider the efficacy of services, evidence-based criteria, and the needs of the populations being served as they are designing habilitative services, based on the services found in the base benchmark selected by the state to define EHBs for Medicaid, and supplemented and substituted as necessary and desired.

Comment: Many commenters recommended that the state-defined habilitative services for Exchanges should not apply to Medicaid. Instead, some commenters indicated that states should be required to define habilitative services through a public process that establishes minimum standards for coverage, while taking into account unique circumstances of the Medicaid population, including the impact of a restrictive definition on access to critical services in early intervention and special education. One commenter believed that states should have the option to offer parity.

Response: In terms of complying with EHB requirements, the same basic framework applies to both ABPs and plans in the individual and small group markets. But that basic framework includes considerable flexibility that states can exercise in the Medicaid context. While states will ultimately determine coverage of habilitative services we encourage states to do so in recognition of the unique needs of the

Medicaid population. As states work to identify coverable habilitative services, they are expected to consider input from the public in making the decisions. ABPs are subject to public notice requirements in § 440.386.

Comment: One commenter requested that the final rule ensure that the state's Medicaid definition of habilitation is at least as generous as the definition used for Exchange plans.

Response: While we believe that the procedures we are adopting to determine habilitative services included in EHB for Medicaid will generally be at least as generous as the parallel procedures for the individual and group market, we are not requiring that result. We believe that the procedures for Medicaid will lead to appropriate coverage for Medicaid beneficiaries while recognizing the state's role in designing Medicaid coverage.

Comment: Many commenters recommended against HHS allowing any of the potential flexibility, authorized in the Exchange, for issuers to define the habilitative benefit. Commenters were concerned that issuers would limit the range of services too narrowly.

Response: States will retain flexibility to design services covered within the rehabilitative and habilitative services and devices EHB consistent with the procedures set forth in this final regulation.

Comment: A few commenters recommended HHS require states to establish the same definition of habilitative services for ABP, QHPs, and Exchange, due to the significant amount of churn associated with the population being served. One commenter believed that habilitative services should have a common definition, but that definition should not necessarily determine what is covered by the Exchange or Medicaid. Those habilitative services that are to be covered should be separately established by the Exchange and by Medicaid, since this is a question of affordability and comprehensiveness.

Response: We recognize the possibility for churn between Medicaid and the individual and small group markets. We believe the flexibility reflected in this regulation provides the basis for continuity between the commercial market and Medicaid. We are also allowing states to use provider qualifications from the commercial market plans to help minimize the possibility for provider changes if a person's plan changes.

Comment: One commenter indicated that currently under Medicaid, habilitation services are defined in statute and provided as an alternative to institutional services such as nursing home care. As noted in the regulation, employers do not cover the service consistent with Medicaid requirements. As a result, if parity is required without consideration of the scope of habilitation services offered, the result could be states exceeding the EHB standard. States should be provided the flexibility to define and provide coverage of habilitation services.

Response: Habilitative services and devices are coverable services under the section 1915(c) waiver program and the waiver program does provide a suggested definition. Section 1915(i) also allows coverage of habilitative services and devices where states define the service. We are giving states flexibility to define habilitative services and devices within the standards finalized in this regulation. In addition, states may offer either habilitative or rehabilitative services in excess of these standards.

Comment: Numerous commenters believed that states should not be allowed to define habilitative services through parity with rehabilitative services since the two service sets have totally distinct purposes and impact different sets of individuals. They asserted that parity is a poor standard because there is no certainty that the rehabilitative services level is itself adequate to begin with.

Response: We appreciate the commenters' concerns. We are establishing that the state may determine the ABP-covered benefit beyond the benefits included in the base benchmark plan,. To the extent that the base benchmark has no habilitative services, the state may elect to include as the EHB category habilitative services and devices coverage that is no more restrictive in amount, duration, and scope than the coverage of rehabilitative services and devices. We acknowledge that this standard does not guarantee provision of any particular habilitative or rehabilitative service. This will be in large part determined by the services offered in the plan selected by the state to define EHBs for Medicaid.

Comment: One commenter requested HHS, at a minimum, afford flexibility to issuers allowing them to either provide parity by covering habilitative services in the same manner as rehabilitative services or report the services it decides to cover to HHS.

Response: The procedures we have adopted recognize that states have the role that issuers have in the individual and small group market. Federal Medicaid works directly with state governments and not issuers. Therefore, we believe that having states define the habilitative services benefit instead of issuers, using the procedures finalized here, is the most appropriate approach.

Comment: One commenter believed that habilitative services complement rehabilitative services and are integral to ensuring that the beneficiary receives comprehensive care that restores him/her to maximum functional levels. This commenter stated that both substitution among and parity between these services could be problematic if the beneficiary's medical condition requires significantly more rehabilitative services than habilitative services and vice versa.

Response: States may implement utilization management processes that allow for individuals who need additional services beyond the limits established in the ABP to receive such services based on medical necessity. States could substitute rehabilitative services for rehabilitative services and habilitative services for habilitative services.

Comment: A number of commenters recommended that HHS remove the requirement that state Medicaid programs cover habilitative services, as this is not a separate mandated category of EHB services. Instead, a Section 1937 plan that covers either rehabilitative or habilitative services should be deemed to cover items and services within the general EHB category for rehabilitative-habilitative services.

Alternatively, a few commenters recommended that HHS clarify that ABPs must cover all of the benefits within categories of care that list more than one benefit, as is the case for rehabilitative and habilitative services and devices. In particular, a plan should not be considered to meet the requirement of covering all EHBs unless it covers, as three distinct benefits, rehabilitative services, habilitative services, and rehabilitative and habilitative devices, as opposed to covering only one of the many benefits included in this category.

Response: Habilitative services are listed as a required benefit category of EHB at section 1302(b)(1)(G) of the Affordable Care Act. It is part of a category of EHBs, but is distinct from rehabilitative services and devices. Both rehabilitative and habilitative services and devices must be offered in all ABPs.

Comment: A number of commenters supported access to habilitative services and devices including autism services, durable medical equipment, orthotics, prosthetics, low vision aides, hearing aids, augmentative communication devices that aid in speech and hearing, and other assistive technology and supplies that are often critical to ensure

individuals are able to function independently in the community.

Response: We appreciate the comment and agree that these types of services could assist people with living in the community. We are not requiring any specific services to be offered within this EHB category.

Comment: A number of commenters requested that HHS require coverage of services without age restrictions. They indicated that a pediatric-only habilitative benefit is inadequate, especially as the new eligibility category is for adults only.

Response: EHBs including rehabilitative and habilitative services and devices apply to all individuals who receive a benefit package in ABPs, regardless of age. For the new adult group, only individuals who are ages 19 and 20 will qualify for EPSDT services.

Comment: A few commenters requested HHS prohibit the exclusion of specific conditions or diagnoses from accessing the benefit.

Response: ABPs allow for comparability to be waived, which results in allowing for targeting of individuals to specific benefit packages. However, all individuals in the new adult group and other individuals the state either mandates or offers voluntary enrollment into an ABP must receive all EHBs, including habilitative and rehabilitative services and devices.

Comment: A few commenters recommended that states should define habilitation using EPSDT criteria.

Response: Section 1905(a) of the Act does not include a service category for ''habilitation services'' so it is not useful to look to EPSDT coverage for guidance and EPSDT criteria do not apply under law to adults. For children, however, the EPSDT benefit must provide eligible individuals with any medically necessary service that is coverable under a section 1905(a) service category. Consistent with the law, these regulations extend the EPSDT benefit, which also includes children covered in an ABP. Therefore, children in an ABP should receive any covered section 1905(a) benefits that they require based on medical necessity.

Comment: A few commenters requested that HHS cover habilitation services, which maintain an individual's functional status, as defined by the HHS Summary of Benefits and Coverage regulations.

Response: The HHS Summary of Benefits and Coverage regulations apply to private insurance markets, which do not include Medicaid.

Comment: A few commenters cautioned against restricting services in EHB plans without allowing for an exception process.

Response: States do have the flexibility to allow for exception processes for utilization management of the benefit; such exceptions must be based on medical need.

Comment: One commenter recommended that the habilitative benefit cover the full array of health and ancillary service needs of children with special health care needs. The commenter believed that this is especially important for children aging out of foster care, as these children are at greater risk of having a chronic condition requiring habilitative services.

A few commenters indicated that it is inappropriate for any one service to satisfy the requirement for a benchmark plan covering habilitative services. For example, providing only Applied Behavioral Analysis to children under the benchmark plan is inadequate to satisfy the full requirement of coverage of habilitative services. These commenters requested that the benchmark plan utilized be as comprehensive in its coverage as feasible. One commenter recommended defining habilitation and contrasting it with rehabilitation to help clarify the distinction between the two benefits.

Response: We remind readers that states must not only comply with the standards finalized in this regulation, but must also include all habilitative services covered in the public employee or commercial plan selected by the state to define EHBs for Medicaid, supplemented and substituted as necessary and permitted.

Comment: One commenter believed there should be no exclusion for services that may be educationally-relevant, as is the current policy in Medicaid.

Response: Payment for Medicaid services must be for services that are medical or remedial in nature as specified by the particular authority from which the service is derived.

Comment: One commenter requested HHS provide states a description of maintenance programs and clarify at what point services are no longer covered.

Response: The level at which services no longer have clinical value is determined by the state through medical necessity criteria.

Comments: One commenter requested that HHS clarify the clinical settings in which habilitative services may be covered and ensure that there is a prohibition against ''school'' exclusions.

Response: Settings in which services are furnished are largely determined by the providers authorized by the state to deliver services. Practitioners within schools can become Medicaid providers if they meet the provider qualifications as established by the state. In ABPs, states may use provider qualifications for the benefit as defined for the commercial market, Medicaid provider qualification rules for the benefit, or a combination of both.

Comment: A few commenters requested information related to the cost of adding habilitative services.

Response: Habilitative services are not included in the benefit package typically included in the Medicaid state plan, and our limited experience does not allow for extrapolation for a nationally required service. States will initially receive 100 percent FMAP starting January 1, 2014 to cover the cost of providing services to individuals who are considered newly eligible in the new adult group, and that funding will decline to 90 percent FMAP in 2020. For individuals who are considered not newly eligible in the new adult group and those who are not in the new adult group, FMAP will be provided at the state's regular FMAP rate.

Comment: Many commenters recommended that HHS prohibit the use of cost-sharing requirements or utilization management tools which target the habilitation benefit and are not applied to other EHB benefits.

Response: We are not accepting this comment because states have the flexibility to impose cost sharing consistent with the exemptions and beneficiary protections set forth in sections 1916 and 1916A of the Act, which we address separately in this final rule. There is no exemption under those provisions for habilitation services. In determining how to exercise the flexibility to impose cost sharing, however, we recognize that states must consider their obligations under the Americans with Disabilities Act and must not implement a discriminatory benefit design.

Comment: A few commenters were disappointed that HHS has chosen not to provide states any guidance regarding the habilitation benefit in ABP.

Response: In the proposed rule, we solicited public comments on the EHB requirements for rehabilitative and habilitative services, including devices. We received considerable numbers of comments, and considered those comments carefully. We weighed concerns about burden and cost of expansive coverage against the benefits of wider access for beneficiaries to needed care. We also considered the treatment of these benefits in the commercial market. Based on this consideration, we are issuing in this

final regulation the policy for coverage of rehabilitative and habilitative services, including devices. We hope that these policies provide the guidance requested by commenters.

Comment: Many commenters requested HHS stipulate in the final regulation an ongoing process for data collection and evaluation related to ABP and Exchange coverage of habilitative services and devices. If this data were compared to the model definition of habilitation, that would give parameters for determining the adequacy of coverage for the first year of ABP and exchange operation.

Response: CMS collects data from states in a variety of ways. The data will be available to help states, CMS and others determine what services are actually being provided, and it will help to inform us for future coverage decisions.

Comment: One commenter indicated that states should be able to include as Medicaid state plan services any habilitative services included in either its Exchange EHB benchmark or ABP.

Response: Habilitative services are only required in the Medicaid program for individuals in an ABP. Many states cover habilitative services under their section 1915(c) waivers. States interested offering habilitative services in other contexts should initiate conversations with CMS.

Comment: One commenter believed the habilitative benefit proposed to be defined in the November 20, 2012 EHB proposed regulation is wholly inadequate and urged HHS to pursue promulgation of a strong, uniform definition of habilitative services for ABPs, as well as those offered through the Exchange.

Response: The scope of this regulation is related to the definition of habilitation services as EHBs for purposes of Medicaid ABPs under section 1937 of the Act. This regulation does not extend to the definition of habilitation services as EHBs for purposes of the individual and small group markets.

Comment: One commenter recommended that HHS have the authority to amend state defined coverage of habilitative services should evidence show that they provide insufficient coverage for users.

Response: We anticipate that states will provide appropriate coverage of this service but section 1937 of the Act gives states a certain amount of flexibility to define ABPs that include the minimum coverage defined as EHBs.

Comment: One commenter believed that by requiring section 1937 plans to cover habilitative services, CMS is creating a disconnect between the scope of services offered under the state plan and section 1937 coverage, in essence making the section 1937 plans more generous than current Medicaid state plans (which goes against congressional intent).

Response: The Affordable Care Act established habilitative services as part of the EHB category ''Rehabilitative and Habilitative Services and Devices.'' EHBs are required to be offered as part of ABPs and are not required in other Medicaid state plan benefits for adults. ABP benefit packages will be different from those defined as the Medicaid state plan.

Comment: One commenter believed that requiring habilitative coverage does little to ensure that appropriate services are available to individuals, as those requiring habilitative services are likely to be considered ''medically frail'', exempting them from mandatory enrollment in the benchmark package.

Response: Individuals in the new adult group who meet the criteria to otherwise be determined to be exempt for medical frailty, will have a choice between ABP coverage that is defined in accordance with the requirements of section 1937 of the Act, including the EHB requirements, or ABP coverage that is defined as the coverage available under the state's approved Medicaid state plan. People who are not in the new adult group and are eligible for voluntary enrollment may be given a choice by the state between the benefit package defined using the ABP or the state's approved Medicaid state plan. An individual who has such an election may obtain needed habilitation services if the state has elected to provide such coverage under the state plan under section 1915(i) of the Act. If not, such individuals who need habilitative services may wish to voluntarily enroll in an ABP defined under section 1937 of the Act, if the EHB benefit package, inclusive of habilitative services, meets their needs.

Summary: We solicited public comments related to this provision in the proposed rule. We clarify in regulation text that the state will define rehabilitative and habilitative services. Services covered by the base benchmark are the floor of EHB coverage, substituted as desired by the state. Under 45 CFR 156.110(f), if no habilitative services and devices are included in the base benchmark, states have the option to determine generally the required EHB services that are in the category of habilitative services and devices. If the state has done so, the base benchmark, and coverage under the ABP, must reflect that determination. If the state has not made a general determination of the habilitative services that are required as this EHB category, the state must exercise the option set forth in 45 CFR 156.115(a)(5) to determine EHB for the specific ABP. Under that option, habilitative services and devices must be included as EHBs either in an amount, duration, and scope no more restrictive in terms of treatment and benefit limitations than rehabilitative services and devices, or otherwise to an extent determined by the state and reported to HHS. In other words, if the base benchmark does not include habilitative services and devices, ABP coverage must, at a minimum, be based on the general state determination of habilitative services and devices that are included in EHBs, or on a Medicaid-specific determination for the particular ABP.

b. Pediatric Oral and Vision and EPSDT Services

For Medicaid, medically necessary services, including pediatric oral and vision services, must be provided to eligible individuals under the age of 21 according to requirements of the EPSDT benefit. We clarified in the proposed rule that any limitations relating to pediatric services that may apply in the individual or small group market does not apply to Medicaid. In this final rule, we made no change from the proposed rule.

Comment: Several commenters expressed appreciation for and support of the clarifying language in the preamble that confirmed that medically necessary services provided to eligible beneficiaries under the age of 21 must be provided under the EPSDT program, and that any limitation relating to pediatric services based on benchmarks would not apply to Medicaid for children enrolled in ABPs.

One commenter added that the EPSDT benefit ensures that Medicaid eligible children have access to a complete range of medically necessary services, concluding that this will prove especially important for children with chronic conditions.

A separate commenter believed that the pediatric services category for benchmark plans for all populations must include a comprehensive pediatric services benefit modeled after EPSDT.

Response: We generally agree with these commenters, that the EPSDT benefit is important in offering increased access and a comprehensive range of medically necessary services for children under the age of 21. For children enrolled in Medicaid, all medically necessary services in general, including pediatric oral and vision

services, are covered under the Medicaid EPSDT benefit, which applies to every section 1937 ABP. As a result, EHB supplementation for pediatric services is not necessary in Medicaid.

When assuring access to EPSDT services, a state has the option to offer medically necessary services to eligible children through either benchmark and benchmark-equivalent plan benefits without limitation or, alternatively, a state may meet the ESPDT requirement by providing services in combination with an eligible individual's benchmark or benchmark-equivalent plan as additional benefits. The state Medicaid program must assure that eligible individuals enrolled in ABP coverage receive EPSDT services that can be accessed in the most beneficial and seamless manner for the population being served.

Comment: One commenter believed that subjecting ABP benefit categories to EPSDT requirement, such as preliminary screening, would water down ABP benefit packages and serve as an artificial barrier to care that children need. The commenter believed that a robust pediatric vision services benefit, as envisioned by Congress in the Affordable Care Act, based on coverage typical in the commercial market, should not be interrupted by imposing a harmful screening requirement.

Response: We disagree. The commenter may have a misunderstanding of the EPSDT screening requirements. States are required to adopt EPSDT screenings (that is, preventive visits) for well-child, vision, hearing, and dental services. States may also adopt a national periodicity schedule such as Bright Futures (the Guidelines for health of the American Academy of Pediatrics). Services are provided based on these periodicity schedules and at other intervals as determined medically necessary. The inclusion of screening requirements as part of the EPSDT mandate should not in any way ''water down'' benefits provided under ABPs to individuals under the age of 21. It should serve to ensure that children receive the necessary screenings and any additional services and treatments according to appropriate standards of care.

Summary: No changes were made. CMS clarified in regulation text that EPSDT applies to pediatric services including oral and vision care as a result of comments received in this section.

c. Essential Health Benefits (Prescription Drugs) (§ 440.347)

In the proposed rule, we proposed to add a new paragraph (b)(7) to include benchmark-equivalent health benefits coverage for prescription drugs. We also indicated in the preamble that section 1927 of the Act requirements for covered outpatient drugs also apply to such prescription drug benefits as an EHB. As we previously discussed, we are clarifying in this final rule that this statement may have been over-inclusive, since section 1927 requirements do not apply to ABPs to the extent that they conflict with the flexibility under section 1937 of the Act for states to define the amount, duration, and scope of the benefit for covered outpatient drugs. We received the following comments:

Comment: A few commenters expressed support of paragraph (b)(7) of § 440.335, which implements the statutory requirements for benchmark equivalent coverage of prescription drugs.

Response: We appreciate the commenters' support for the coverage of prescription drugs as required under section 1937 of the Act.

Comment: A few commenters indicated that in the current Medicaid program, states limit the number of drugs and include other utilization control measures that are harmful to patients and deny them the therapies that meet their health needs as prescribed by their physician. Some state Medicaid programs limit patients to two to four brand name drugs per month. Such limitations clearly do not meet patients' needs and the commenter urges CMS not to allow states to adopt them for the expansion population. Patients should be able to access the medications that they need as prescribed by their physicians. If they are not able to access appropriate medications, patients may become ill, impacting healthcare spending in the long run.

The commenters further seek clarification on what is being proposed in the rule's recommendation regarding prescription drug limits. While the rule proposes that the ABP has to meet the benefits in the state-selected EHB for the private market, the rule separately appears to replace the ABPs EHB drug benefit category with that described in section 1927 of the Act. In the final rule, the commenters ask for clarification on this matter and specifically on whether the ABP drug benefit is trumped by what is outlined in section 1927 of the Act, including with respect to any limitations. Furthermore, they are greatly concerned by the seemingly open ended ability of states to impose limits, and recommend that quantity limitations not apply to the ABP.

Another commenter states that CMS' final rule must clearly specify all the drug access protections that apply to Medicaid ABPs. The commenter believes that these protections are essential in the Medicaid context because Medicaid beneficiaries represent a vulnerable population that tends to have lower health status and fewer resources to obtain needed care.

Response: States have considerable flexibility in designing benefit packages for ABPs, including in the process of ensuring coverage of EHBs. While this flexibility permits states in some instances to limit prescription drug coverage based on the coverage offered under other public employee or commercial plans, it also includes the ability to exceed the amount, duration, and scope of prescription drugs covered under those plans. We also clarify that nothing in the commercial market implementation of EHBs, including prescription drugs, directly prohibits the utilization of monthly quantity limits. In developing ABPs, states must include prescription drug coverage to at least reflect the EHB-benchmark plan standards, including the requirement to have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered. We believe these requirements will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

Comment: A few commenters stated that they support the rules governing coverage of prescription drugs under Medicaid (section 1927 of the Act) applying to the ABP requiring coverage of nearly all of the drugs produced by manufacturers who participate in the Medicaid drug rebate program. The breadth of coverage offered by the Medicaid drug benefit is important to meet the medication needs of people with HIV who rely on a complex and unique drug regimen to treat HIV infection and manage serious co-occurring conditions, such as heart disease, serious mental illnesses and hepatitis B or C. However, they have serious concerns regarding the flexibility afforded to states to apply quantitative limits on drug coverage, particularly given that these limits are not common practice in the private insurance market. Allowing these types of limits in ABPs threatens access to lifesaving care and treatment and undermines the letter and spirit of the Affordable Care Act's EHB requirements for newly eligible Medicaid beneficiaries. It will also have the effect of undermining the adequacy of prescription drug coverage for those

with chronic health needs. The commenters recommend that HHS apply the section 1927 requirement for the range of covered medications, but prohibit additional authority for quantitative limits or other limits except as legally applicable based on the underlying ABP and EHB benchmarks. The commenters further recommend that § 440.347 be amended to read: ''(e)Prescription drugs. Prescription drugs will be offered at a minimum in accordance with the requirements of section 1927 of the Act and implementing regulations.''

Response: While drug rebate obligations under section 1927(b) of the Act are applicable to payment for covered outpatient drugs covered through an ABP, the amount, duration and scope of coverage for an ABP is determined under section 1937 of the Act, which authorizes benchmark or benchmark-equivalent coverage ''notwithstanding any other provisions that would be directly contrary.'' This being the case, we do not have the authority to require states, when establishing its benefits under its ABP, to meet the coverage requirements of section 1927 of the Act. Doing so would be directly contrary to flexibility with respect to the amount, duration, and scope of coverage provided under section 1937 of the Act. As for the commenters' concerns with the limits provided under section 1927 of the Act as they apply to the Medicaid population, especially on disease specific or chronic care populations, we note that states have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of prescription drugs covered under ABPs. We also clarify that nothing in the commercial market implementation of EHBs, including prescription drugs, prohibits the utilization of monthly quantity limits.

Comment: One commenter stated that in 2014, the Affordable Care Act requires that ABPs cover at ''least essential health benefits, as described in section 1302(b) of Affordable Care Act''. The commenter continues that while CMS proposes that the EHB requirements described in its November 2012 EHB proposed rule apply to ABPs, the Medicaid EHB proposed rule does not spell out the minimum prescription drug coverage requirements that will govern ABPs.

The commenter requests CMS clarify that Medicaid ABPs must cover at least the same number of drugs in a particular United States Pharmacopeia (USP) class that the state-selected benchmark plan pertinent to the ABP covers, consistent with the ''Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation'' proposed rule. The commenter also requests that CMS consider identifying classes of drugs in which broad access to different drugs within the class is essential to assure that vulnerable patients have prompt access to the right medicine for a serious illness, and bolster the drug coverage requirements for those drug classes accordingly.

Response: As indicated above, states have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of prescription drug coverage under an ABP. In developing ABPs, states must include prescription drug coverage consistent with the EHB-benchmark plan standards. These standards are set forth at 45 CFR 156.122 and include the requirement that health plans have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. We believe such requirements will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

Comment: One commenter is concerned with the adequacy of the EHB prescription drug benefit, which will apply to Medicaid beneficiaries enrolled in ABPs effective January 1, 2014. Medicaid beneficiaries in ABPs including those low-income adults who are newly eligible for Medicaid under Affordable Care Act are entitled to coverage for EHB. The proposed rule codifies this requirement and incorporates the definitions and standards that were specified for EHB coverage in the individual and small group market in the EHB proposed rule that CMS published on November 26, 2012, including CMS' proposed formulary standard for the prescription drug benefit. While the final rule states that USP will be used at least through ''the years 2014 and 2015 during the transitional EHB policy'' and thus it applies to the Medicaid ABPs during that time, the commenter urges CMS reconsider the use of the USP system as it is currently structured after 2015 given that many significant concerns remain. The commenter lists the following concerns regarding the EHB prescription drug benefit:

- The inadequacy of the USP to represent the full range of categories and classes of drugs needed by the populations covered by the EHB, including Medicaid beneficiaries enrolled in ABPs, because the USP was created as a classification system to be used by Medicare Part D plans;
- The need to incorporate specific protections for vulnerable populations to ensure appropriate access to vital medications;
- The need to expand the USP categories and classes and include more detail to adequately represent the drugs needed by enrollees in plans subject to EHB;
- The inability of USP categories and classes to capture all medical benefit drugs, including physician-administered drugs, and the need for CMS to specify that plans must offer robust coverage of drugs that are included as part of a comprehensive medical benefit, including a wider range of therapies, and should not rely on the USP categories and classes when determining coverage for physician-administered therapies;
- A requirement that new therapies be reviewed and added to plan formularies within 90 to 180 days through a process that mirrors the review process performed by independent Pharmacy and Therapeutic Committees in Medicare Part D to support timely access to new and innovative medications;
- A requirement for specific appeals and exceptions procedures to ensure that patients have access to needed treatments, and the application of these procedures also apply to drugs that are covered as part of a comprehensive medical benefit; and,
- The need for CMS to provide specific guidance about Medicaid ABPs regarding acceptable and unacceptable utilization management techniques, without which there is a real risk that plans could apply utilization management tools in a way that discriminates against individuals with more significant health care needs.

Response: We appreciate the comments submitted regarding the application of the EHB requirements to ABPs, including the commenter's concerns with the use of the USP classification system. As stated above, states have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of coverage under an ABP. We also clarify that nothing in the commercial market implementation of EHBs, including prescription drugs, prohibits the use of utilization management tools. In developing ABPs, states must include prescription drug coverage to reflect the EHB-benchmark plan standards, including the requirements at section 45 CFR 156.122. We believe these requirements will result in coverage that

is similar to the coverage otherwise required under regular state plan coverage.

Comment: A few commenters indicated that the preamble to the proposed rule says that all drugs of the companies that participate in the drug rebate program should be included in the ABP; however that language is not included in the language of the proposed regulation. The commenters recommended that the regulatory language be amended to correct that omission. Additionally, commenters agreed with HHS' legal conclusion, stated at 78 FR 4631, that section 1927 of the Act applies to ABPs and believe that this is a critical protection requiring coverage of a range of drugs necessary to meet the needs of the Medicaid population. The commenter recommends that HHS' explicitly state this requirement in the regulation.

Response: As noted earlier, we must clarify a statement in the preamble to the proposed rule, indicating that coverage requirements under section 1927 of the Act are applicable to ABPs under section 1937 of the Act. While drug rebate obligations under the rebate agreement are required for drug manufacturers under section 1927(b) of the Act, the amount, duration and scope of drug coverage under an ABP is determined under section 1937 of the Act. The drug rebate obligation applies because payment is made under the Medicaid state plan for covered outpatient drugs as part of the ABP. The amount, duration, and scope of coverage for an ABP are determined under section 1937 of the Act, which authorizes benchmark or benchmark-equivalent coverage ''notwithstanding any other provision that would be directly contrary.'' That said, to the extent that covered outpatient drugs are within the scope of coverage, the non-coverage provisions under section 1927(d) of the Act would apply. For example, states will continue to be permitted to apply certain permissible restrictions such as prior authorization. However, when establishing such programs, states must continue to adhere to the requirements that states must respond within 24 hours for pre-authorization requests, except for excluded drugs listed at section 1927(d)(2) of the Act, and that at least a 72-hour supply of a covered outpatient prescription drug must be dispensed in an emergency situation. Further, we are revising § 440.345 to add a new paragraph (f) that states that when states pay for covered outpatient drugs under their ABP's prescription drug coverage, they must comply with the requirements of section 1927 of the Act.

Comment: A few commenters believed that ABPs are required by statute to include all outpatient drugs in the Medicaid drug rebate program, as well as meet the requirements for prescription drugs as proposed in the EHB proposed rule for the commercial market. These commenters also believe that in the absence of prescription drug coverage in a particular category or class, the ABP benefit must include at least one drug. They also recommend that the final rule clarify that prescription drug coverage within ABPs must provide the greater of the statutorily required coverage described in section 1927 of the Act, or the required EHB coverage described in the proposed rule issued November 26, 2012. Another commenter recommended that CMS require each ABP's coverage of prescription drugs to be consistent with the state's EHB standard.

Response: As indicated above, states have considerable flexibility in implementing the provision of Medicaid services through ABPs. In developing ABPs, states must include prescription drug coverage to reflect the EHB-benchmark plan standards at section 45 CFR 156.122 for prescription drug coverage. We believe these requirements will result in coverage that is similar to the coverage otherwise required under regular state plan coverage.

Comment: A few commenters indicated that the regulatory text is correct at part 440, but the preamble is not, in that the rebate statute section 1927 of the Act does not apply to ABPs. They reasoned that the benefits under section 1937 of the Act are mandatory benefits, and they explicitly refer to the prescription drugs of the essential health benefits and not to the covered outpatient drugs of the voluntary Medicaid benefit to which section 1927 of the Act applies. Thus, the EHB's prescription drug coverage, which requires the greater of one drug in a class or the number of drugs in the class in the benchmark plan, should apply to ABPs. If it is determined that section 1927 of the Act applies, then all the requirements and protections of section 1927 of the Act should apply to ABPs.

A commenter stated that the rebate statute applies exclusively to covered outpatient drugs; it requires manufacturers to pay rebates on covered outpatient drugs (when they are paid for under a state Medicaid plan); and it limits the restrictions that states can place on access to covered outpatient drugs. The statute defines a ''covered outpatient drug'' in terms of what is included in the definition and what is excluded. This commenter believes the term ''covered outpatient drug'' is a well understood term of art meaning those drugs to which the Medicaid rebate statute applies. If Congress had intended the Medicaid rebate statute to apply to Medicaid ABPs, then Congress would have stated this explicitly and described the drugs covered under an ABP as ''covered outpatient drugs.'' When Congress decided to apply the rebate statute to Medicaid managed care organizations, Congress made its decision clear and took the steps necessary to make its decision workable. For example, Congress explicitly revised the rebate statute to provide that covered outpatient drugs for which payment was made under the state Medicaid plan includes ''such drugs as dispensed to individuals enrolled with a Medicaid managed care organization if the organization is responsible for coverage of such drugs,'' among other changes.

By contrast, the commenters assert that Congress took an entirely different approach with Medicaid ABPs. Unlike in the Medicaid MCO case, Congress never mentioned Medicaid rebates in the statutory provision authorizing ABPs, never mentioned ABPs in the Medicaid rebate statute, never established any mechanism for ABPs to report drug utilization data to states and for states to include this data in manufacturers' rebate invoices, and never provided that state payments to ABPs would be premised on the understanding that states would collect Medicaid rebates.

Similarly, the commenters indicate that section 1937 of the Act makes no mention of covered outpatient drugs. Instead, the drug-related provisions in section 1937 of the Act provide only that (1) benchmark-equivalent coverage must include ''prescriptions drugs'' (among other basic services required in benchmark-equivalent plans) and (2) starting in 2014, all ABPs must provide ''at least essential health benefits as described in section 1302(b) of Affordable Care Act, which benefits include prescription drugs.'' Thus in both of the statutory provisions referencing ABPs' drug coverage, Congress omitted the term denoting those drugs that are subject to the Medicaid rebate statute and instead incorporated different terms with no connection to the rebate statute. And Congress' decision to omit ''covered outpatient drug'' terminology is consistent with its decisions: (1) not to require to authorize reporting of ABP drug utilization data to states and manufacturers; and (2) not to address any implications of state rebate collection on ABP payments. Congress'

decision not to apply the rebate statute also is consistent with the purpose of section 1937 of the Act, which is to give State Medicaid programs more flexibility and allow them to operate more like commercial payers.

Another commenter stated that the prescription drug benefit to be provided to Medicaid beneficiaries under section 1937 of the Act is not the same benefit as the ''prescribed drugs'' provided under a State plan under section 1905(a)(12) of the Act. Indeed, the coverage for prescription drugs made available to the Medicaid expansion population is derived from a different statutory authority than the traditional Medicaid option to provide coverage for ''prescribed drugs.'' The benefit under section 1905(a)(12) of the Act is optional for a State, while the prescription drug provided by an ABP is mandatory in accord with EHB requirements established by Affordable Care Act. Therefore, the commenter contends, and urges CMS to clarify in the final rule, that there is no statutory basis to apply section 1927 of the Act to these ABPs.

In short, the commenters believe the statutory evidence demonstrates that Congress decided not to apply the Medicaid rebate statute to ABPs. When a word or phrase has become a term of art with a specialized meaning, that specialized meaning governs. Likewise, when Congress uses a term of art in one statutory provision but omits it in another (like section 1937 of the Act), then Congress intends a different meaning; ''where Congress includes particular language in one section of a statute but omits it in another . . ., it is generally presumed that Congress acts intentionally and purposefully in disparate inclusion or exclusion.'' Accordingly, applying the rebate statute to ABPs would be directly contrary to section 1937 of the Act and thus prohibited.

Response: Drug rebate obligations are required for drug manufacturers under 1927(b) of the Act when payment occurs for covered outpatient drugs covered through an ABP. However, the amount, duration, and scope of drug coverage under an ABP are determined under section 1937 of the Act. That is, the drug rebate obligation applies because payment is made under the Medicaid state plan for covered outpatient drugs provided as part of the ABP prescription drug benefit. The amount, duration, and scope of coverage for an ABP are determined under section 1937 of the Act, which authorizes benchmark or benchmark-equivalent coverage ''notwithstanding any other provision that would be directly contrary.'' That said, to the extent that covered outpatient drugs are within the scope of coverage, the non-coverage provisions of section 1927 of the Act would apply.

Comment: A commenter indicated that they anticipate that requiring ABPs to satisfy the requirements of both section 1927 of the Act and the EHB formulary standard may present significant practical challenges for the ABPs. The proposed rule does not explain how these two sets of requirements will fit together or whether and when the requirements of section 1927 of the Act will take precedence over the EHB formulary standard. For example, section 1927 of the Act requires manufacturers and the Secretary to enter into an agreement under which manufacturers must pay rebates to state Medicaid agencies for utilization of the manufacturer's covered outpatient drugs, in return for the state coverage of such drugs, which may be restricted only within the set confines of section 1927(d) of the Act. The proposed EHB prescription drug benefit, by contrast, requires coverage of at least the greater of (1) one drug in every USP category and class; or (2) the same number of drugs in each category and class as the EHB benchmark plan.

Response: As we stated earlier, there is no authority to require states to meet requirements of section 1927 of the Act related to the amount, duration and scope of covered outpatient drugs under an ABP. States have some discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of coverage under an ABP. In developing ABPs, states must include prescription drug coverage to reflect the standards used to define EHBs for Medicaid. As stated earlier, we believe these requirements at 45 CFR 156.122 will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

Comment: A few commenters indicated that to the extent that CMS nonetheless decides to apply section 1927 to ABPs, it is of the utmost importance that CMS apply and stringently enforce both the coverage and access requirements of that section. CMS should explicitly indicate that the section 1927 safeguards on coverage and exclusions apply, in addition to the prescription drug benefit requirements of the EHB proposed rule. Any requirements for payment of rebates under section 1927 of the Act without adherence to the coverage and exclusion limitations violates the intent and spirit of that section.

Another commenter indicated that the Medicaid rebate statute requires states that provide payment for drugs to cover all ''covered outpatient drugs'' of manufacturers that sign a Medicaid rebate agreement, subject to certain limitations on coverage that the statute describes very specifically. The rebate statute explicitly lists the limited circumstances in which a State Medicaid program may exclude or otherwise restrict coverage of a drug manufactured by a company with a Medicaid rebate agreement.

Response: While drug rebate obligations under the rebate agreement with drug manufacturers under section 1927(b) of the Act are applicable to covered outpatient drugs covered through an ABP, the amount, duration, and scope of drug coverage under an ABP are determined under section 1937 of the Act alone. The drug rebate obligation applies when payment is made for covered outpatient drugs in accordance under the Medicaid state plan, including a state's ABP. The amount, duration, and scope of coverage for an ABP is determined under section 1937 of the Act, which authorizes benchmark or benchmark-equivalent coverage ''notwithstanding any other provision that would be directly contrary.''

Comment: One commenter recommended that the prescription drug benefit under ABPs should include all over-the-counter and prescription medications approved by the FDA to treat tobacco cessation. The commenter continues that tobacco cessation medications are currently on the list of ''drugs subject to restriction'' in section 1927(d) of the Act, and therefore, states are allowed to exclude coverage of these drugs.

Response: Effective January 1, 2014, section 1927(d) of the Act requires states to provide coverage of non-prescription and prescription covered outpatient drugs used to treat tobacco cessation for all Medicaid beneficiaries. Notwithstanding that requirement, we note that there is no authority to require states to meet requirements of section 1927 of the Act related to the amount, duration, and scope of covered outpatient drugs under an ABP. States have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of coverage under an ABP. In developing ABPs, states must include prescription drug coverage to reflect the standards for defining EHBs in Medicaid. As stated earlier, we believe these requirements at 45 CFR 156.122 will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

Comment: A few commenters indicated that the agency says that the states have the flexibility to ''adopt prior authorization and other utilization control measures, as well as policies that promote use of generic drugs.'' The commenters believe there is potential for conflict between the prescription drug coverage of an ABP supplemented by the states' essential health benefit standard, and a drug benefit that is consistent with the State's Medicaid program. The commenter urged clarification of the coverage standard accompanied by protections to ensure that patients can appeal utilization controls that might prevent them from receiving necessary medications.

One commenter recommended that CMS monitor the implementation of traditional Medicaid and ABP PDLs and utilization management techniques, and act to stop burdensome limitations that reduce access to care and could impact patient health because of limited access to needed drugs. The commenter also recommends requiring that decisions regarding PDLs take into account evidence-based clinical practice guidelines, and not just of drugs; and that CMS require that states only be permitted to classify a drug as non-preferred when there are genuine therapeutic alternatives classified as preferred.

Response: Prescription drug coverage under an ABP is still subject to the provisions related to drug rebates, as well as the non-coverage provisions under section 1927(d) of the Act. Therefore, states will continue to be permitted to apply certain permissible restrictions such as prior authorization. However, when establishing such programs, states must continue to adhere to the requirements that states must respond within 24 hours for pre-authorization requests, except for excluded drugs listed at section 1927(d)(2) of the Act, and that at least a 72-hour supply of a covered outpatient prescription drug must be dispensed in an emergency situation.

Furthermore, a state Medicaid agency's Pharmacy and Therapeutics (P&T) Committee typically makes decisions on inclusion of preferred drugs in a therapeutic class when establishing a state's PDL. Specifically, the P&T Committee reviews evidence-based information, along with review of comparative clinical trials to make such decisions regarding a state's PDL. A PDL is permitted under section 1927 of the Act, as long as it is under a prior authorization program that meets the requirements of section 1927(d)(5) of the Act.

Comment: One commenter recommends that individuals have access to the full range of available clotting factors without limitation through restrictive drug formularies, which negatively impacts patient care. Patients and physicians should make the choice of which therapy is appropriate. The commenter also noted that hemophilia patients should have access to a range of specialty pharmacy providers. Several commenters recommend that CMS require states to implement beneficiary protections consistent with Medicare Part D, including consideration of specific drugs, tiering, and utilization management strategies used in each formulary.

Response: As we stated earlier, there is no authority to require states to meet requirements of section 1927 of the Act related to the amount, duration and scope of covered outpatient drugs under an ABP. States have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of coverage under an ABP. In developing ABPs, states must include prescription drug coverage to reflect the standards for defining EHBs in Medicaid. As we have noted in prior responses, we believe these requirements will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

Comment: One commenter stated that section 2001(c) of Affordable Care Act modified the benefit provisions of section 1937 of the Act. Among other things, section 2001(c) of the Affordable Care Act added mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark equivalent coverage; and directed that ABPs that include medical/surgical benefits and mental health and/or substance use disorder benefits comply with the Mental Health Parity and Addiction Equity Act of 2008.

This being the case, the commenter encourages CMS to clarify and strengthen the guidance on drug formularies in the current parity regulations which make it difficult to determine whether a formulary satisfies the law's parity standards.

Response: While we appreciate the commenter's concern, the Interim Final Regulation regarding the Mental Health Parity and Addiction Equity Act of 2008 is not the subject of this final rule.

Comment: One commenter suggested that CMS provide guidance to states on medication assisted treatment of substance abuse disorder. Specifically, states should be required to cover Methadone, Buprenorphine, Vivitrol, etc., in the EHB and that where needed states should expand the formulary to include all FDA approved medications for the treatment of substance use disorders.

Response: CMS is not providing guidance regarding specific services offered in each of the ten essential health benefits in this final rule.

Comment: One commenter requests that CMS encourage state Medicaid programs to utilize the 340B drug purchasing program provided by hemophilia treatment centers or HTCs so that individuals with hemophilia can receive their pharmacy services from their HTC. HTCs with 340B programs integrate clinical and pharmacy services to provide comprehensive high-quality care to patients and closely monitor drug utilization, allowing for more immediate changes in treatment and better management of treatment costs. Patients benefit from lower cost prescriptions that reduce out-of-pocket spending and accumulation of costs towards caps on health insurance expenditures and ongoing education and support to ensure that they appropriately assess their treatment needs. Medicaid programs will benefit from better management of overall treatment costs through close monitoring of bleeds and factor use to reduce complications.

Response: We appreciate the comments regarding the 340B program and coverage of drugs for hemophilia; however, the State's utilization of the 340B drug purchasing program is outside the scope of this rule.

Comment: CMS should establish clear requirements to assure that utilization data for populations eligible to receive Medicaid rebates is maintained separately from data from other lines of business. That is, the final regulation must provide clear rules to assure that plans maintain data on prescription drug claims appropriately and do not mix data from populations eligible for Medicaid rebates with data for other enrollees not eligible for Medicaid rebates. Because many plans may offer products in the exchanges as well as participate in Medicaid managed care (under either section 1903(m) of the Act, as well as Medicaid ABPs) the potential for confusion is high and clear rules are needed to assure that utilization for rebate-eligible patients is maintained separately from data for other lines of business.

Response: If the state administers its ABP via a Medicaid MCO, the state will need to ensure the MCO distinguishes these claims from its other lines of business for the purpose of claiming

Medicaid rebates consistent with the current requirement for such claims under section 1927 of the Act. CMS expects to issue subregulatory guidance on collecting manufacturer rebates for ABPs. Manufacturers are not required under section 1927 of the Act to pay rebates absent a Medicaid payment for the drugs, which would not be present in the case of drugs dispensed to Medicaid beneficiaries that are enrolled in qualified health plans where the only Medicaid payment was premium assistance for the beneficiary.

Summary: Based upon the comments requesting clarification as to whether or not section 1927 of the Act applies to prescription drug coverage provided under a state's ABP, we will be adding paragraph (f) to § 440.345 to require that when states pay for covered outpatient drugs under their ABP's prescription drug coverage, states must comply with the requirements under section 1927 of the Act.

4. All Other Title XIX Provisions Apply

We clarified in the proposed rule that all other Title XIX of the Act provisions apply unless, as spelled out in section 1937 of the Act, a state can satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement ABPs under section 1937 of the Act.

Comment: We received one comment requesting that CMS elaborate on what is meant by the preamble language that all other provisions under title XIX of the Act apply, and whether states are required to cover the current mandatory Medicaid benefits, and ensure non-emergency transportation, when using an ABP for the new adult expansion group.

Response: The Medicaid benchmark and benchmark-equivalent coverage was first authorized by the DRA, which included language stating that ''notwithstanding any other provision of title XIX'' states can offer medical assistance to certain Medicaid beneficiaries through benchmark or benchmark-equivalent benefit packages. As a result of CHIPRA changes to the DRA, CMS regulations were revised to implement this change in law. CHIPRA language provides clearly that a state's benchmark or benchmark-equivalent programs may vary only from statutory requirements explicitly waived in section 1937 of the Act (statewideness and comparability), unless states can demonstrate that other provisions not identified in section 1937 of the Act would be directly contrary to their ability to implement ABP. As such, in the proposed rule, we offered clarifying language in the preamble to reiterate that this current policy continues to apply. Due to statutory requirements, states may not disregard any provisions of title XIX and are therefore required to assure that all populations receiving ABPs, including the new adult expansion group, have access to transportation necessary to obtain Medicaid covered services.

Summary: No changes will be made to the proposed regulation as a result of comments received in this section.

5. Preventive Services as an EHB

The EHB Final rule specified that, to provide EHB, a plan must provide coverage of preventive services. This requires plans to cover a broad range of preventive services including ''A'' or ''B'' services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices recommended vaccines; preventive care and screening of infants, children and adults recommend by HRSA's Bright Futures program, and additional preventive services for women recommended by the Institute of Medicine. We proposed that Title XIX premium and cost sharing provisions apply to preventive services for adults, but not for children.

Comment: Many commenters commended HHS for including in ABPs the full range of preventive services required in the EHB, including all of the services specified in section 2713 of the PHS Act. The commenters believed this is a critical provision for vulnerable populations and will help achieve the Affordable Care Act objective of shifting health care emphasis from expensive interventions to cost-effective prevention. The commenters requested that HHS explicitly state this requirement (currently in the preamble at 78 FR 4631) in the regulation itself.

Response: The language in the preamble to the proposed rule, originating in section 2713 of the PHS Act, was included as a reference to the requirement to cover preventive services as part of providing EHB, which has been implemented by regulation codified at 45 CFR 147.130. We do not believe this requires further clarification in this final rule.

Comment: A number of commenters asked CMS to clarify its preamble language, ''Title XIX premium and cost sharing provisions apply to preventive services.'' Specifically, CMS should clarify whether it intends this to apply to the ABPs for the new expansion population and/or to current state Medicaid plan services.

Response: We agree that this issue needs to be clarified, particularly in light of the issuance of the final rules implementing EHB requirements for the individual and small group markets. In the final regulations issued February 25, 2013 at 78 FR 12835, the provision of EHB was defined at 45 CFR 156.115(a)(4) to ''include preventive health services described in [45 CFR] § 147.130''. That cross referenced provision describes the requirement for coverage of preventive services without cost sharing. As explained in the preamble to the proposed regulations, at 77 FR 70644, 70651 (Nov. 26, 2012), the intent was to include in the EHB coverage obligation the prohibition on cost sharing for preventive health services. Thus, while Medicaid cost sharing provisions at sections 1916 and 1916A of the Act apply generally to preventive services provided in ABPs, cost sharing may not be applied to preventive services that are within the definition of EHBs (described in 45 CFR 147.130). An ABP may include preventive services beyond the floor of coverage required as EHBs, and cost sharing may be applied to such preventive services at state option to the extent permissible under sections 1916 and 1916A of the Act.

Comment: One commenter requested clarification on whether the full range of United States Preventive Services Task Force (USPSTF) ''A'' and ''B'' services is specific to benchmark benefits offered to individuals that are newly eligible.

Response: These services, along with IOM-recommended women's preventive services, ACIP-recommended vaccines, and HRSA's Bright Futures recommendations, comprise the preventive services EHB category that will be provided to all individuals in an ABP, including those in the new adult group. In addition, coverage of USPSTF ''A'' and ''B'' preventive services under section 4106 of the Affordable Care Act applies, at state option, to preventive services furnished under the regular state plan. States implementing the preventive services EHB in their ABP without cost sharing will be eligible for the additional 1 percentage point of FMAP (for newly eligible individuals, this increased FMAP will be available once Federal reimbursement of services drops below 100 percent).

Comment: A few commenters were concerned that other preventive screenings recommended by the CDC are not included in the proposed rule. The commenters recommended the inclusion of all CDC hepatitis B and C screening recommendations as required components of Medicaid's ABPs.

Response: CMS recognizes the importance of CDC recommendations related to preventive services. The proposed rule was not meant to be an

exhaustive list of all recommendations made by government agencies such as the USPSTF. States have the option to adopt CDC recommendations as long as they are in line with EHB preventive service statutory and regulatory guidance.

Comment: A few commenters requested that HHS clearly define which tobacco cessation treatments are required to be covered as a preventive service under EHB. The commenters believed this definition should be comprehensive, and include—and require—all tobacco cessation medications approved by the FDA as well as individual, group and phone counseling. The commenters believed it should be based on and reference the most recent version of the Public Health Service Guideline Treating Tobacco Use and Dependence, to ensure that when and if the guideline is updated the benefit will be revised as appropriate.

Response: We appreciate the commenter's recommendations. Tobacco cessation programs are important preventive services. However, states have been given latitude on how to furnish this service within the bounds of statute, regulation, and sub-regulatory guidance. Tobacco cessation for pregnant women is defined in section 4107 of Affordable Care Act and is located at section 1905(a)(4)(D) of the Act. We also issued a letter to State Medicaid Directors dated June 24, 2011 that clarified policy related to this provision. The only tobacco cessation services required to be furnished in the EHB package are those recommended by the entities designated in section 2713 of the Public Health Service Act.

Comment: Many commenters requested greater definition of the preventive services that states are required to cover to meet the EHB requirement. The commenters found it difficult to determine what preventive health services are covered and what the scope and limits of the coverage may be.

Response: The definition of preventive services as an EHB includes a broad range of preventive services including: ''A'' or ''B'' services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by Institute of Medicine (IOM). Further definition was not provided as these standards were established by experts in the field of prevention.

Comment: A few commenters requested that HHS provide the following guidance:

- Clarify in the language of the final rule that Medicaid ABP must cover all section 2713 services.
- Clarify that section 2713 coverage requirements apply even where there is overlap with EHB categories.
- Create standards to ensure that section 2713 preventive service coverage offers meaningful incentives to providers.
- Encourage states to align traditional Medicaid coverage with the section 2713 preventive services requirement.

Response: We appreciate the commenters' request to include further descriptions within the final rule. The rule, as written, requires states to provide a robust set of preventive services that align with § 147.130. The Affordable Care Act established § 4106 effective January 1, 2013 within regular Medicaid coverage, which includes a subset of the services implemented in § 2713 of the Public Health Service Act (PHSA). A State Medicaid Director Letter on § 4106 was released on February 1, 2013 (*http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-002.pdf*).

Comment: One commenter requested clarification regarding the interval after which a preventive service rated with an A or B by the USPSTF must be included in EHBs for Medicaid plans. The commenter encouraged HHS to establish an interval of no later than the 1-year minimum specified in section 2713(b)(1) of the Public Health Service Act, irrespective of any other timetable HHS choose for updating the EHBs more broadly over time.

Response: Section 2713(b)(1) and (2) of the Public Health Service Act set forth the interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year for which of the requirements described in subsection (a) is effective for the service described in such recommendation or guideline. We believe that such an interval is appropriate for applicable preventive services included in the ABP.

Comment: One commenter requested specificity around the process by which USPSTF recommendations will be incorporated into EHBs over time and the process for determining the frequency and intensity of USPSTF-recommended behavioral interventions.

Response: A broad range of preventive services including all ''A'' or ''B'' services recommended by the United States Preventive Services Task Force must be incorporated in the EHB and are required to be implemented according to the effective date of the submitted SPA. If states want an effective date of January 1, 2014 for the entire ABP including these preventive services, then a SPA will need to be submitted by the end of the first calendar quarter of 2014. States are expected to keep abreast of changes to the USPSTF-recommended services to ensure provision of a current array of services.

Comment: One commenter indicated that, to the extent that HHS does not specify the number of covered visits to registered dietician specialists for medical nutrition therapy, national practice guidelines should determine appropriate coverage.

Response: We encourage states to consult and rely on national practice guidelines, as they design their benefit packages.

Comment: One commenter requested that while HHS may be reluctant to explicitly require coverage of obesity treatment, HHS should clarify whether management of obesity and metabolic disorders are chronic disease management services and are therefore covered services under the ''Preventive and Wellness Services and Chronic Disease Management'' category of the EHB package. One commenter believed that beneficiaries affected by severe obesity should have access to bariatric surgery with comprehensive pre- and post-surgery nutrition evaluation and counseling to ensure the efficacy and cost effectiveness of the bariatric surgery benefit over the long term.

Response: ''A'' or ''B'' services recommended by the United States Preventive Services Task Force must be incorporated in the EHB. Current USPSTF guidelines provide for the screening and counseling for obesity in both children and adults. Aside from the services specified at section 2713 of the Public Health Service Act, we are not mandating the provision of specific services through the EHB package. We agree that bariatric surgery, complete with appropriate counseling, can be a valuable service, and it will covered in the ABP if it is included in EHB definitions of the public employee or commercial plan selected by the state to define EHBs for Medicaid, supplemented and substituted as necessary and permitted. States may also choose to add this service to their ABP.

Comment: One commenter asked HHS to clarify whether a state that chooses to use its current state plan as the ABP would need to add services to the state plan for ABP recipients if not all preventive services are included. The

commenter also asked whether states would need to amend the state plan and provide these services for all Medicaid recipients of the state plan services.

Response: The regular state plan does not need to be amended to reflect the breadth and depth of required preventive service coverage in an ABP. States will have to comply with the definition of preventive services for the EHB category within the ABP. States using Secretary-approved coverage to implement a benefit package similar to their Medicaid state plan would need to ensure provision of all EHB preventive services through the ABP, even if such services are not available under the state plan. A state plan amendment will be required to implement an ABP for the new adult group and for any other categorically needy eligibility groups that a state may wish to enroll in an ABP.

Comment: A number of commenters recommended that HHS apply the PHS Act 2713 cost-sharing prohibition for preventive services under section 2713 of the PHS Act to the same preventive services covered by ABPs. The commenters believed these protections are essential to provide meaningful coverage to vulnerable population and avoid the unfair outcome of greater cost-sharing for poorer individuals. The commenters believed cost sharing on preventive services should be prohibited based on the authority of section 2713 of the PHS Act. One commenter believed that cost-sharing for preventive services is prohibited under the definition of EHB in regulations at 45 CFR 156.115, which state that the EHB include ''preventive health services described in [45 CFR] § 147.30.'' The commenter explained that this section lists the services included in the definition of preventive health services and states that insurers ''may not impose any cost-sharing requirements (such as copayment, coinsurance, or deductible) for those items or services.'' The commenter believed the definition of preventive services in the EHB is unique in that it incorporated a prohibition on cost-sharing in the definition of the benefit. The commenter believed that by requiring EHB in ABPs, Congress intended to carry that prohibition on cost-sharing into Medicaid's ABPs. A number of commenters believed that prohibiting cost sharing for preventive services is consistent with the provision giving states a percentage point increase in their FMAP under section 4106 of the Affordable Care Act.

Response: We appreciate the concerns commenters raised regarding cost sharing for preventive services and we are adopting their suggested policies in light of the provisions of the recently issued EHB regulations for the individual and group markets at 45 CFR 156.115(a)(4). As stated above, states may not impose cost sharing for preventive services included in ABPs that are within the scope of EHBs, as defined at 45 CFR 147.130, but may impose cost sharing consistent with sections 1916 and 1916A of the Act on preventive services that go beyond that scope. This is because the definition of preventive services for purposes of the EHBs precludes cost sharing, and Medicaid ABPs must include EHBs. We clarify that the broader prohibitions on cost sharing for preventive services at section 2713 of the PHS Act apply only to group health plans and health insurance issuers providing group or individual health insurance coverage, and do not apply to Medicaid. For preventive health services beyond the scope of EHBs, we note that cost sharing is not allowed for preventive services provided to children under sections 1916 and 1916A(b)(ii) of the Act. We agree with commenters that this preclusion of cost sharing for preventive service EHBs is consistent with the policies set forth in section 4106 of the Affordable Care Act, which added section 1905(b)(5) to the Act, giving states an increase in the federal medical assistance percentage for preventive services if the state did not impose cost sharing on such services.

Comment: A number of commenters believe that cost sharing should not be applied to the EPSDT population.

Response: While we discuss cost sharing issues at greater length in discussing the streamlined cost sharing regulations being issued in this final rule, for EPSDT for individuals enrolled in ABPs, we note that sections 1916 and 1916A(b)(ii) of the Act preclude cost sharing for individuals under age 18 who are mandatorily eligible, and preclude cost sharing for preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income. Section 1916(b)(2)(a) of the Act further states that cost sharing cannot be imposed under the plan for services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over). These provisions also apply to ABPs.

Summary: No changes will be made to the proposed regulation as a result of comments received in this section.

6. Other Changes To Simplify, Modernize, and Clarify Medicaid Benchmark Requirements and Coverage Requirements

We proposed to make certain changes to the regulations to promote simplification and clarification where needed, and provide some additional flexibilities to states regarding benefit options. We received the following comments:

a. Diagnostic, Screening, Preventive, and Rehabilitative Services (Preventive Services) (§ 440.130)

We proposed to conform our regulatory definition of preventive services at § 440.130(c) with the statute relating to the issue of who can be providers of preventive services. Our current regulation states that preventive services must be provided by a physician or other licensed practitioner. This is not in alignment with the statutory provision at section 1905(a)(13) of the Act that defines ''services . . . recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under state law.'' We proposed to change the rule to make clear that physicians or other licensed practitioners may recommend these services. In our proposed rule, we inadvertently used punctuation that would have had the effect of eliminating the other three prongs of the preventive services definition, and we are restoring those prongs in this final rule.

Comment: Many commenters commended HHS for conforming the regulatory definition relating to who can provide preventive services at section 1905(a)(13) of the Act that defines ''services . . . recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under State law.'' Many commenters believed this change will improve access to preventive services, expand access to evidence based practices, and provide greater partnership between providers and advocates. The commenters urged CMS to preserve this important provision in the final rule.

Response: We agree that the amended regulatory definition of who can provide preventive services will result in improved access to preventive services and facilitate partnership between providers and advocates. This provision has been codified in the final rule.

Comment: A number of commenters believed that the amended regulatory definition will be especially important to low-income people who disproportionately access care through

community-based and support services and may experience significant stigma and lower trust levels with other providers.

One commenter believed current Medicaid regulations surrounding § 440.130(c) have significantly limited the available care and treatment for Medicaid and CHIP-enrolled children who suffer from chronic diseases.

Response: The amended definition may result in greater access for individuals who suffer from chronic disease as the pool of providers could increase significantly.

Comment: A few commenters commended HHS for making reference to this regulatory change in a February 1, 2013 letter to State Medicaid Director. The letter stated that if the proposed regulatory change is finalized, then preventive services recommended by USPSTF or ACIP, and provided by practitioners other than physicians or other licensed practitioners, are eligible for the 1 percentage point FMAP increase established under the Affordable Care Act.

Response: We attempt to provide as much notice as possible related to rule making and appreciate the commenter's support.

Comment: One commenter believed the proposed language, ''(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law'', was overly broad.

Response: The regulation is consistent with statutory language in section 1905(a)(13) of the Act. The final rule increases the number of providers able to furnish services. We are not changing regulation text at § 440.130(c)(1) through (c)(3).

Comment: One commenter believed that the proposed new definition in the rule represents a far broader view of the term ''preventive services'' than Congress contemplated in Affordable Care Act. For purposes of describing what services are included in EHB, ''preventive services'' are already extensively described at § 147.130. The proposed revision in the definition of ''preventive services'' at § 440.130 would not primarily affect the scope of preventive services required to be offered as EHB in the state benchmark plans. Rather, the amendment would greatly expand the scope of the preventive services benefit that may be offered as an optional service under standard state MA plans.

Response: This change is not based on an interpretation of ''preventive services'' as it is used in the Affordable Care Act for purposes of EHB, but an interpretation of the coverage of preventive services under regular Medicaid under section 1905(a)(13) of the Act. This regulatory change will primarily impact the provision of preventive services under the regular state Medicaid plan. Section 4106 of the Affordable Care Act, 'Improving Access to Preventive Services for Eligible Adults in Medicaid,' broadens the section 1905(a)(13) preventive services benefit by providing a 1 percentage point FMAP increase on clinical preventive services that are assigned a grade of A or B by the USPSTF.

Comment: A number of commenters believed the new definition could have a significant fiscal impact on states' Medicaid programs because, as a part of EPSDT, the expanded scope of services must be offered to recipients under age of 21.

Response: While we acknowledge that this change will result in additional providers being authorized to provide preventive services, it accurately reflects the statutory language for the preventive services benefit. In addition, broadening the scope of providers who can provide preventive services in the Medicaid program may reduce, rather than increase, program expenditures by making available services in the most efficient and effective settings. Providing broader access to these types of providers and benefits may assist individuals with improved health.

Comment: A number of commenters requested clarification on preventive services. The commenters believed that the definition provided (§ 440.130) is broad and will be difficult for states to operationalize without more detail. The commenters requested a more precise definition that includes the current procedural terminology codes for each preventive service and that HHS work with states to develop preventive definitions. Without such guidance states and the federal government could end up inappropriately paying for air conditioners, ineffective weight loss programs, or similar services which are simply not appropriate.

Response: States still have the ability to restrict preventive services to direct patient care that is medically necessary and is for the purpose of preventing disease, disability and other health conditions or their progression, prolonging life and promoting physical and mental health and efficiency. The commenters may have been confused because we inadvertently proposed to eliminate these other prongs of the preventive services definition, which we preserve in this final rule. States also have some options in determining coverage of preventive services, and can specify the options, and specific billing codes, for covered preventive services using the state plan amendment process.

Comment: One commenter urged HHS to retain the current regulatory definition which established that the allowable providers of preventive services are physicians or other licensed practitioners. The commenter disagreed that the provider requirements for preventive services under the Affordable Care Act should be aligned with Medicaid provider requirements for the optional benefit category as established under section 1905(a)(13) of the Act. The commenter stated that the benefits are distinctly different and have different purposes, particularly for children up to the age 21.

Response: We disagree with this position. Both section 1905(a)(13) of the Act and Affordable Care Act provide for a more robust set of preventive services than the current regulations, in allowing a broader pool of providers to deliver such services. In making this change in the final rule, we are aligning our regulation with the statutory coverage provision. States will continue to have some flexibility to determine the scope of covered preventive services in their state by submitting a SPA to do so.

Comment: Many commenters were concerned that this broad language would allow for unlimited services as recommended by health care providers and other providers of the healing arts. These commenters requested that this be clarified to impose reasonable limits on services.

Response: Under existing rules, states can establish limitations on amount, duration, and scope, on the optional preventive services provided the resulting benefit is sufficient to meet the purpose of the benefit. CMS reviews each state plan amendment submitted by states to determine the sufficiency of the benefit.

Comment: One commenter recommended closer integration of community prevention and lifestyle changes into the Medicare and Medicaid programs, as an important opportunity to both effectively and often less expensively treat and prevent chronic disease, such as heart disease and diabetes.

Response: We agree that greater coordination between Medicare and Medicaid will provide efficiencies and health outcomes for individuals with chronic disease as well as other conditions. Medicaid continues to build closer and more integrated community preventive services with Medicare.

Comment: One commenter believed that Registered Dieticians should be designated as the recognized providers

of nutrition services, including medical nutrition therapy and nutrition counseling because of RD's demonstrated competency and effectiveness. This commenter stated that nutrition counseling is medically necessary for chronic disease states in which dietary adjustment has a therapeutic role, when it is prescribed by a physician and furnished by qualified provider.

Response: We believe that Registered Dieticians have an important role in furnishing nutrition services. All preventive services should be furnished by qualified providers within their scope of practice.

Comment: One commenter urged HHS to clarify that § 440.130 of the proposed regulation does not dictate who can provide preventive services; it merely dictates what providers can recommend them, consistent with the totality of the statute.

Response: The proposed regulation does not dictate who can provide preventive services; it defines who can recommend such services. States will have discretion to determine which providers will provide the service using the state plan amendment process.

Summary: No changes to the proposed regulation will be made as a result of comments received in this section.

b. Public Notice (§ 440.386)

The proposed rule added a new provision to allow states greater flexibility when required to publish public notice associated with an ABP state plan amendment (SPA). We proposed modifying the public notice requirement for ABPs to require that such notice be given prior to implementing a SPA when the new ABP provides individuals with a benefit package equal to or enhanced beyond the state's approved state plan, or adds additional services to an existing ABP. We proposed the requirement to publish public notice no less than two weeks prior to submitting a SPA that establishes an ABP that provides coverage that is less than the coverage by a state's approved state plan or includes cost sharing of any type. Based on public comment, we are negating what we proposed, as we do not believe that 2 weeks is a sufficient time period. We will be reverting back to our existing policy of requiring the states to provide ''a reasonable opportunity to comment'' on all ABP SPAs prior to their submission to CMS.

Comment: Many commenters supported requiring states to give public notice before implementation of a SPA that established an ABP. The commenters also commended HHS for requiring states to provide public notice regarding how they must comply with the requirement that children have access to EPSDT.

Many commenters believed that the proposed public notice requirements at § 440.386 are problematic and HHS should not use them as a model for all SPAs. Some commenters believed proposed § 440.386 repeats the language of § 440.305(d) requiring a ''reasonable opportunity'' for public comment, but then limits the public comment period to just two weeks for certain ABPs which the state Medicaid agency determines provide less coverage or higher cost sharing than existing benchmark plans, and other commenters believed that two weeks is an inadequate amount of time for meaningful stakeholder consideration and input.

Many commenters believed HHS should require an advance notice and comment period of no less than 30 days as this aligns with other comment periods (such as the state comment period for section 1115 waivers) and is particularly important because of the time and effort required to conduct the benefit-by-benefit comparisons between non-aligned Medicaid state plans, ABP proposals and EHBs which will be necessary to provide meaningful input.

Response: We have considered all of the comments concerning the requirement for public notice and agree with the commenters that two weeks is not sufficient to allow for a meaningful timeframe in which public comments can be solicited and considered. We are therefore revising § 440.386 to revert to our existing ABP public notice policy currently found at § 440.305(d). We would also like to clarify that the public notice requirements at § 440.386 are applicable only to section 1937 ABPs.

Comment: A number of commenters requested HHS require a mandatory 15-day period (sometimes referred to as a ''cool down'' period) for states to review comments received and incorporate suggestions into the final ABP submission.

A few commenters believed that § 440.386 creates a two tiered process whereby the state's own evaluation of an ABP determines whether it is subject to public notice and comment. The commenters believed this kind of agency determination defeats the very purpose of transparency and stakeholder input.

Many commenters believed that there is no compliance provision to help ensure meaningful participation by the public, unlike the reporting requirement of § 431.412(viii) for section 1115 demonstrations. The commenters requested that any SPAs, including those establishing ABPs, should be subject to the same transparency and public input procedures and reporting requirement modeled upon those governing section 1115 demonstrations to help ensure meaningful participation by the public, and that HHS understands the issues raised at the state level when making the SPA approval decision.

Response: In revising § 440.386 to revert to our existing policy, we believe that we have provided a minimum floor that allows sufficient time for stakeholder feedback and state review.

Comment: Numerous commenters requested that at a minimum, SPAs that materially change a state Medicaid program should be subject to increased transparency and stakeholder input requirements.

Response: States will be required to follow existing public notice requirements, which requires that the state must have provided the public with advance notice of the State plan amendment and reasonable opportunity to comment prior to the submission of the SPA.

Comment: A few commenters recommended that states should be required to provide detailed information on the ABP options under consideration.

Response: The state is required to provide information regarding the ABP through the public notice process.

Comment: A number of commenters requested that HHS include specific requirements for adequate public posting of the proposal, including that it be posted on an internet Web site, as well as a clear description of the process and timeline for comment submission.

Response: We believe that states should have the flexibility to determine how best to provide public notice to the populations in their state.

Comment: One commenter believed that notice and stakeholder engagement requirements should explicitly include HIV/AIDS programs within health departments.

Response: We believe that all stakeholder groups, including HIV/AIDS, will be served by the public notice policy.

Comment: One commenter noted that there were a number of different sources of information for public notice (including 59 FR 49249 (September 27, 1994); § 447.205; and new transparency requirements for waiver and waiver renewals (see State Health Official (SHO) Letter #12–001)) and HHS could achieve efficiencies by streamlining notice requirements.

Response: While there are various methods for providing public notice across programs, we believe that each serves its own purpose for that program. The public notice regulations under § 440.386 provide the most efficient and effective policy for ABPs.

Comment: One commenter proposed that HHS further define ''substantial'', which triggers the ''notice and comment'' requirement. The commenter requested that HHS adopt a universal definition of ''substantial'' so that there is no confusion of the word's meaning.

Response: ''Substantial'' is used in the ABP public notice requirements. It means that eligibility, enrollment, benefits, cost sharing, payment methodologies, or delivery systems have changed significantly to affect beneficiaries.

Comment: One commenter believed that requiring public notice for a SPA when an ABP provides a benefit package equal to or enhanced beyond a state's approved state plan was puzzling. The commenter believed it added yet another public notice requirement with questionable return, particularly when this occurs prior to implementation. The commenter agreed that prior public notice should be required when providing a lesser benefit package than the approved State Plan, adding cost sharing or reducing benefits.

Response: We believe, for the purpose of transparency, ABPs should be disseminated to the public. We believe it is important that all beneficiaries are made aware of changes being made to ABPs.

Comment: One commenter requested that when a SPA is submitted providing less coverage the public should have at least 30 days to submit comments and the agency should provide a summary of the comments it receives and how the comments were addressed when it submits the SPA to CMS for approval.

Response: Based on comments related to this section of the regulation, we will be continuing with the existing ABP public notice requirements. Requiring the state to provide a summary of the comments it receives and how the comments were addressed when it submits the SPA to CMS for approval could be too onerous to operationalize depending on the magnitude of comments received. CMS reserves the right to request, when appropriate, specific information on public comments.

Comment: A few commenters requested that HHS publically release all ABPs selected and allow an opportunity for public comment to ensure plan adequacy.

Response: All approved SPAs are public documents. If the commenter would like to comment on a particular SPA they may contact their specific state.

Comment: Many commenters recommended HHS amend § 430.12 by adding new paragraph (d) or deleting § 440.386 (a) and (b) and replacing them with language that would require a 30 day public comment period and a 15 day review period for the state and outlined the detail to be included in the public notice. These commenters also included requirements for publication of public notice and information to be included in the SPA.

Response: We appreciate the commenters' thorough language recommendations. However, we believe that the current public notice policy sufficiently balances the need for transparency while preventing the impediment of the approval of SPAs in a timely manner.

Comment: One commenter requested that HHS monitor the public information on Medicaid programs and State-Based Exchange, provide and consider issuing guidance on how to communicate benefit packages to enrollees and plan members in a clear and effective way, incorporating low literacy-level principles. The commenter suggested that HHS should consider requiring states to undergo a public stakeholder review process for these materials.

Response: We thank the commenter for these recommendations and will take them under further review however they are beyond the scope of this regulation.

Comment: One commenter requested that HHS require all state plan amendments be made public and subject to comment.

Response: While we agree it is a good practice for states to place SPAs online; requiring states to do so is beyond the scope of this regulation.

Comment: One commenter asked if HHS was going to require additional public notice requirements on anything that is related to cost-sharing.

Response: Cost sharing of any type requires public notice per § 440.386.

Comment: One commenter believed there was a technical error made in the Part 440-services. The commenter noted that the general provisions section § 440.305 to § 440.386 is not mentioned in the description of the changes to either § 440.305 or § 440.386.

Response: CMS will take this opportunity to delete § 440.305(d) as a new § 440.386 has been added for public notice.

Summary: CMS will delete § 440.305(d), which was the section describing public notice requirements, as a new § 440.386 has been added for public notice. We have reverted to our existing public notice requirements based on public comment on this section of the rule.

c. Exempt Individuals (Modifying Definition of Medically Frail) (§ 440.315)

The proposed rule updated the definition of the ''medically frail'' category of individuals exempted from mandatory enrollment, and solicited comment about whether to add SUD to the definition. The final rule adds individuals with chronic SUDs to the definition of ''medically frail'', based on the overwhelming support in public comments.

Comment: Many commenters strongly supported CMS's definition of exempt individuals and clarification of medically frail. In supporting the definition of medically, many commenters also thanked the Secretary for including in the definition of medically frail, individuals with serious or disabling mental illness, (including children with serious emotional disturbances), and individuals with physical, intellectual or developmental disabilities that significantly impair their ability to perform one or more activities of daily living; many commenters agreed that individuals with a disability determination based on Social Security criteria should be exempted from mandatory enrollment in an ABP.

One commenter stated that medically frail are an identifiable population with unique care and cost characteristics and this definition provides an opportunity for these individuals through practices that may not be included in the products offered through state exchanges.

Response: We are pleased with the overwhelming support for the clarified definition of ''medically frail'' displayed in the majority of comments.

Comment: Many of the commenters urged CMS to include individuals with substance use disorders in the definition of medically frail because individuals with substance use disorders (SUD) have similar health needs as those with the other complex conditions included in the definition, and ABP coverage may be less likely to provide needed services and supports typically provided by Medicaid.

Many commenters also pointed out that individuals with SUD cannot be considered disabled under Social Security law if SUD is a contributing

factor material to the determination that the individual is disabled, regardless of the severity of the SUD. Particular concern was raised about benchmark coverage in states that may choose the weakest available benchmark plan option in an effort to limit perceived financial risk for the state, or to avoid political risk. Concern was also raised that beneficiaries living in states offering fewer benefits ''suffer'' from placement in clinically inappropriate levels of care resulting in poor outcomes and higher federal costs.

One commenter wrote that SUD should be included in the definition of medically frail because scientific research indicates that addiction is a chronic brain disorder with intrinsic behavioral and social components, similar to other forms of mental illness.

In supporting clarification of the definition of medically frail, a commenter wrote that the definition should include all those with disabling conditions because the reference plans that may serve as the model for benefits in ABPs are employer-sponsored insurance plans and may not be adequate to serve the needs of those who are too medically frail to work.

Another commenter wrote that it supported clarifying the definition of medically frail by including all those with disabling conditions. Medicaid should provide more comprehensive benefits for individuals and this language will allow it to do so since employer sponsored plans often inadequately cover substance use disorders, therefore the commenter supports adding SUD to the definition of medically frail.

Alternatively, a few commenters recommended that CMS not require that individuals with SUD be considered exempt from mandatory ABP enrollment. This commenter wrote that because states must design their ABPs to include a comprehensive array of mental and behavioral health services, inclusive of substance use treatment at parity with physical health services, it seems unnecessary and overly prescriptive to mandate the exemption of individuals with SUDs.

Response: Since publication, in 2010, of the Final Rule: State Flexibility for Medicaid Benefit Packages, numerous stakeholders have raised concern that individuals with SUD may not be appropriate for enrollment in an ABP because ABPs may not provide the same level of care provided by the standard Medicaid State plan. Individuals with a substance use disorder may have chronic health conditions and need an expanded array of behavioral health and possibly long term services and supports.

Considering the overwhelming support for including SUD in the definition of medically frail, we have modified § 440.315(f) to include as medically frail, individuals with chronic SUD. While we recognize that substance use is among the EHBs, we believe that individuals with this condition could be medically frail and should have the choice to elect voluntary enrollment in an ABP or receive full state plan benefits (for individuals in the new adult group, through an ABP that consists of full state plan benefits).

Comment: One commenter wrote that while the definition of ''medically frail'' appropriately clarifies that individuals with serious mental illnesses and children with serious emotional disturbances are included among ''individuals with disabling mental disorders'' it inappropriately excludes people with psychiatric disabilities from another listed group—''individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.'' People with psychiatric disabilities should continue to be included in that group. Particularly due to the lack of clarity about what may count as a ''serious mental illness,'' it is important to ensure that people with mental illness have the same opportunity as people with other disabilities to qualify for exemption on the grounds that their disability significantly impairs their ability to perform one or more daily living activities.

Response: We acknowledge that individuals with serious mental illness tend to have significant co-morbid conditions that are going to require a different array of mental health and medical services, and long term services and supports that may not be available through an ABP. However, we do not believe it is necessary to explicitly specify that individuals with psychiatric disorders also qualify for ''medically frail'' due to deficiencies in activities of daily living. Individuals only need to meet one criterion within this definition to qualify for the exemption to mandatory enrollment. Section 440.315(f) provides states with a minimum standard for identifying individuals who are medically frail and states have the flexibility to expand this definition.

Comment: A commenter wrote that the term medically frail should be replaced with individuals with disabilities.

Response: We are retaining the term medically frail in our regulations because that term is specified in section 1937 of the Act and we believe it would be confusing to use a different term for the exemption.

Comment: One commenter stated that CMS should avoid defining any new categories of medically frail as the concept of medically frail as outlined in the proposed rule is incomplete and unworkable, and more time and thought needs to be put into this before moving forward with final rules. The commenter believes there are both operational and implementation challenges to the new concept of medically frail contained in the proposed rule and since there is no clear definition of medically frail, or guidance on how a state would go about making that determination, if the rules were implemented as written, the likely result would be a significant disruption of the eligibility process and a large number of appeals.

Response: Section 440.315 provides states with a minimum standard for exempting specified categories of individuals from mandatory enrollment in an ABP. We do not expect these exemptions to mandatory enrollment to be disruptive to the eligibility process as eligibility determination occurs first as a separate process. States will not need to determine whether a beneficiary qualifies as medically frail upfront but will need to have a process for identifying individuals who cannot be mandatorily enrolled into an ABP.

Comment: We received many comments requesting that CMS provide further clarification regarding the operationalization and coverage implications of the proposed revision to the definition of medically frail, as well as clarifying how the revised definition will impact implementation.

One commenter indicated that states have limited experience with ABP coverage under section 1937 of the Act, and it is unclear how exemption from mandatory enrollment in an ABP for individuals defined as medically frail (and other categories of exempt individuals) would be operationalized on a broader scale. Further, it may be operationally challenging to identify the range of individuals included in the proposed definition as medically frail, prior to eligibility determination and plan enrollment, particularly for individuals with SUDs.

Several commenters requested CMS to provide clear, objective standards for defining medically frail, such as the criteria used to determine eligibility for Supplemental Security Income. One comment also expressed concern that

any approach to identifying individuals who could be exempt from mandatory enrollment in an ABP not stigmatize individuals or create unintended barriers to seeking treatment. Several commenters wrote that the definition of medically frail is vague and will be difficult for states to operationalize. Another wrote that the impact of the medically frail definition will be significantly mitigated if CMS clarifies that a state's existing Medicaid benefit package will be deemed to meet the ABP standards under the Secretary-approved coverage option.

One commenter expressed concern that the definition of medically frail is so broad that there could be confusion, inconsistency, and costly implications to having such a broad set of individuals eligible for exemption and recommended that CMS should clearly and carefully define the set of individuals who would be exempt and not include individuals with chemical dependency in the definition.

A number of commenters encouraged HHS to develop a systemic plan for how the medically frail that are enrolled into an ABP, based on the streamlined application collecting minimal information about disability or function, will be identified for exemption and stated HHS must develop requirements and supports for states to identify exemption eligibility.

Several commenters expressed concern that the process of ensuring that all exempt individuals are identified and enrolled in the benefit plan that best service their health care needs (either an ABP or traditional Medicaid) will be very burdensome or difficult for states and asked that CMS provide further guidance on how this can be accomplished. Several of these commenters stated that ABPs are not well aligned with traditional Medicaid and urged CMS to provide further guidance to states on methods and strategies for identifying exempted individuals through the streamlined application process and enrolling them in the appropriate coverage.

Another commenter envisioned situations where it may be beneficial for a medically frail individual to have access to an ABP rather than traditional Medicaid and urged CMS to design processes that ensure that individuals have the ability to make an informed choice about their Medicaid benefit options.

Another commenter voiced concern that the proposed rule does not require a process to ensure that individuals are appropriately identified as potentially exempt when they apply for coverage. This commenter pointed out that individuals with serious mental illnesses and disabilities may not realize that they may qualify as exempt if they do not receive clear notification concerning (1) The possibility that they may be exempt, (2) the process for determining whether they are exempt, and (3) how to opt out of enrollment in an ABP if they are exempt. The final rule should require this type of notice and process.

Response: CMS acknowledges that many states will not have prior experience with implementation of an ABP, or with identifying individuals who are exempt from mandatory enrollment or who meet the criteria for exemption. We anticipate that for existing eligible individuals the state, if it chooses, will be able to screen beneficiaries it intends to enroll to identify exempt individuals by eligibility category and through the use of historic medical encounter data.

For newly enrolled individuals, who are eligible based on income rather than disability, the state will not initially have information concerning their current health status or historic encounter data. Therefore, the enrollment process could be important to identifying if an individual meets the criteria of the statutory exemptions. One appropriate screening option includes beneficiaries identifying themselves as meeting the exemption criteria. We encourage states to implement a process to screen for exempt individuals using this minimum standard for identifying individuals who are medically frail. Proposed regulations that were not finalized as part of this rule at § 435.917(b) and (c) set forth the information that must be provided to an individual regarding benefits and services and provide that the information must be sufficient to enable the individual to make an informed choice. Sample beneficiary notices will be provided to the states by CMS, incorporating questions posed to beneficiaries to aide in the self-identification process. While the individual is being provided with this information through options counseling, the individual could be initially enrolled in benchmark or benchmark-equivalent coverage that is subject to section 1937 requirements.

Comment: One commenter wrote that the phrase ''disabling mental disorders'' relies on non-measurable terms. The commenter believes that specific disorders, including SUDs, should be added if they meet a defined disability test. CMS should provide states with the flexibility to define medically frail or provide states with general guidelines that an individual would have to meet to qualify and allow states to set defined criteria.

Response: To ensure appropriate service protection for individuals with disabilities and special medical needs, we have included a basic definition of medically frail that we anticipate will ensure that vulnerable individuals with special medical needs are not mandatorily enrolled in an ABP that may not provide appropriate medical treatment for their individual medical condition. Section 440.315(f) provides states with a minimum standard for defining medically frail populations.

Comment: Several commenters stated that the underlying goal of the exemption from mandatory enrollment of vulnerable populations is to protect access to needed services. There may be instances where amount, duration and scope limitations are more restrictive under the Medicaid state plan rather than under the ABP, highlighting the need for beneficiaries to receive easily understandable information that allows them to compare coverage options.

Response: CMS thanks the commenters' for acknowledging the underlying purpose for exempting certain populations from mandatory enrollment in an ABP and concurs with this comment. Beneficiaries need to make individualized determinations of the benefit package (either the ABP or the regular state plan) that best meets their needs.

Comment: Several commenters requested CMS provide further guidance on the enrollment and selection process for medically frail beneficiaries as this will be critical for those who qualify to be able to select the benefit plan that best meets their health care needs. The commenter wants to assure that, depending on the circumstances, medically frail individuals will not be forced into a plan that provides fewer benefits than the traditional Medicaid plan or the ABP.

Response: The purpose of the criteria for the exempt categories is to assure that individuals with special medical needs will be enrolled in a coverage plan that best provides necessary services. The design and implementation of a process to determine medical frailty will likely be specific to each state. However, states will have to follow proposed regulations that were not finalized as part of this rule at § 435.917(b) and (c) in that sufficient information must be provided to an individual about benefits and services to enable the individual to make an informed choice.

Comment: One commenter requested that CMS allow states to define the

exempt medically frail population using objective measurable criteria.

Response: Section 440.315 provides states with a minimum set of criteria for exempting specified categories of individuals from mandatory enrollment in an ABP or for individuals in the new adult group, a choice between benchmark coverage that is either coverage defined in the ABP or benchmark coverage that is the state's regular approved Medicaid state plan.

Comment: One commenter recommended that the definition of ''medically frail'' include individuals that meet the Medicaid Health Home eligibility requirements in section 2703 of the Affordable Care Act.

Response: We believe that many enrollees in health homes, as they are individuals with chronic conditions that are serious and complex, will be covered by the existing definition of medically frail. But not all health home enrollees have that level of medical need, and we have determined that the suggested revision would not serve the limited purposes of the exemption.

Comment: One commenter requested that the definition of medically frail include all people with disabilities, because this definition is one of the most essential provisions among all of the proposed rules, and because persons with disabilities would be imperiled as a result of mandatory enrollment in an ABP modeled after a commercial plan.

One commenter stated that inclusion of individuals with SSI appears to broaden the definition of medically fragile for which there is currently no standard definition and historically states have been able to define. As a result, determinations for SSI will likely differ as other considerations are included in the determination.

Response: In defining medically frail, § 440.315 (f) covers a wide range of populations that will be determined to be eligible for voluntary enrollment, or in the case of individuals determined eligible for the new adult group, eligible to choose to receive benchmark benefits as defined in the ABP or benchmark benefits that are the state's approved Medicaid state plan, assuring that these individuals will receive care that is appropriate to their medical needs. As proposed, § 440.315(f) specifically includes individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, and individuals with a disability determination, based on Social Security criteria, or in states that apply more restrictive criteria than the Supplemental Security Income (SSI) program, as the state plan criteria. Sufficient information must be provided to an individual about benefits and services to enable the individual to make an informed choice according to proposed regulations that were not finalized as part of this rule at § 435.917(b) and (c).

Section 440.315(f) provides states with a minimum standard for identifying individuals who are medically frail and states have the flexibility to expand this definition.

Comment: One commenter wrote that, by including in the final rule such a broad description of medically frail, CMS could substantially increase the number of individuals who would be exempt from mandatory enrollment in section 1937 benefit plans. The commenter asserted that this would allow the states less flexibility in creating plans to best meet the needs of these individuals. The commenter wrote that this is particularly true if individuals with SUDs were to be included in the definition and strongly recommended not including people with SUD in the medically frail category as mental health and SUD services are required benefits under the EHB benefits package. The commenter also questioned the reasoning behind including people with SUD in the definition of medically frail.

Response: We do not agree that the definition of medically frail is too expansive and will unduly limit state flexibility. Nor do we think that inclusion of individuals with SUDs will be problematic. We recognize that a broader definition of medically frail individuals will mean that such individuals will only elect to enroll in an ABP if the benefits are designed to meet their needs at least as well as regular state plan coverage.

Comment: One commenter wrote that if newly eligible individuals meet the criteria for exemption and are exempt from section 1937 of the Act, the Federal government needs to clarify if the enhanced funding for this group would be available for all services provided to those individuals.

Response: Yes, enhanced FMAP is available for all services provided to a newly eligible individual, whether that person chooses the ABP based on a benchmark or benchmark equivalent package that includes the EHBs in compliance with section 1937 of the Act, or chooses an ABP equal to the state's approved regular state plan.

Comment: A number of commenters expressed concern how individuals who are exempt will be identified and requested further guidance on enrollment and selection process for medically frail so that those exempt can select the plan that best meets their needs. Several commenters recommended adding a requirement that the notice provided to individuals who have been found eligible for the expansion group include detailed information regarding how one can qualify for an exemption and the services and supports that would be available to a person who is exempt from mandatory enrollment in an ABP, and should include information regarding how to request and receive an exemption. A commenter suggested that this requirement should be added to § 435.917. Another stated that those who may be exempt will need clear, consumer friendly information and decision support to help them understand their choices.

Another commenter voiced concern that the proposed rule does not require a process to ensure that individuals are appropriately identified as potentially exempt when they apply for coverage. Individuals with serious mental illnesses and disabilities may not realize that they may qualify as exempt if they do not receive clear notification concerning (1) The possibility that they may be exempt, (2) the process for determining whether they are exempt, and (3) how to opt out of enrollment in an ABP if they are exempt. The final rule should require this type of notice and process.

A commenter expressed concern that the proposed rule does not issue requirements outlining the process states should use to identify people who are exempt and this is particularly pertinent given the ongoing confusion about whether or not states will be able to claim enhanced federal match for Medicaid expansions individuals who are exempt from ABP enrollment. The commenter fears states will incur high administrative costs managing different federal match rates for different Medicaid expansion individuals, creating an incentive to develop processes that implicitly or explicitly discourage exempt individuals from taking advantage of their right to enroll in traditional Medicaid.

One commenter voiced concern that including in the definition of medically frail individuals with disabling mental disorders, individuals with serious and complex medical conditions, individuals with physical and intellectual or developmental disabilities that significantly impair

their ability to perform one or more activities of daily living, or individuals with a disability determination based on Social Security criteria does not appear to be couched entirely within SSA disability criteria and that some individuals with substance use disorders who are not otherwise considered ''disabled'' under Medicaid may be viewed as medically frail and exempt for ABP. Therefore, individuals with SUDs would be included in a higher-level, comprehensive Medicaid benefit package, thereby increasing costs to the state without the benefit of the higher federal match under the Medicaid expansion to newly eligible adults.

Response: We intend that, as amended, § 440.315 may expand the number of individuals who will qualify as exempt beyond the scope of those who are otherwise considered disabled to include other individuals whose medical needs mean that they are medically frail. We also agree that exempt individuals will need clear, consumer friendly information and decision support to help them understand their choices. For Medicaid beneficiaries who are not in the new adult group, existing requirements at § 440.320 requires the state to provide each individual considering voluntary enrollment in an ABP a comparison of the ABP option versus the State plan option before the individual chooses to enroll. The comparison must also include information on the cost-sharing obligations of beneficiaries. CMS has proposed requirements that were not finalized as part of this rule at § 435.917(b) and (c) that an individual must receive information based on eligibility regarding benefits and services that are available to them. Information must be sufficient for the individual to make an informed choice. Proposed regulations that were not finalized as part of this rule at § 435.917(b) and (c) will apply to all Medicaid beneficiaries including adults in the new eligibility group. Individuals in the new adult group who otherwise meet criteria for exemption from mandatory enrollment may be enrolled in benchmark or benchmark-equivalent coverage subject to section 1937 requirements during the options counseling period to insure coverage during this time.

Comment: Several commenters stated that CMS should further clarify which medical conditions are considered ''serious and complex'' and urged CMS to specify that chronic conditions such as HIV/AIDS and viral hepatitis, which may have co-morbidities, are serious and complex and individuals with serious and complex conditions should be exempted from mandatory enrollment in an ABP. Many commenters strongly recommended that HHS also include in the definition of medically frail or special medical needs, individuals with chronic health conditions because individuals with chronic illness should not be forced into an ABP package that will not meet their predictable needs, as this may lead to higher long term costs associated with poorly managed chronic conditions.

One commenter indicated it was assumed that chronic kidney disease and end stage renal disease were considered to be chronic diseases and another commenter indicated that individuals with Cystic Fibrosis fall squarely within the medically frail definition.

Another commenter wrote that it was assumed that long term cancer survivors managing complex treatment or a complicated set of late and long-term effects would fit the description of complex medical conditions and therefore could choose the most appropriate benefit plan.

Some commenters also stated that being forced into a health plan that does not meet the needs of a person with chronic illness may lead to higher long-term costs associated with poorly managed chronic conditions.

One of the commenters urged CMS to specifically include in the definition of medically frail individuals with chronic viral hepatitis.

Response: The exemption categories established by statute and the proposed clarification in § 440.315 are intended to provide states with a minimum standard for exempting vulnerable populations. We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions. It would not be possible for CMS to include an exhaustive list of conditions that should qualify as medically frail, but we believe that the criteria as currently drafted is broad enough to include individuals for whom a choice of service package is most appropriate.

Comment: Several commenters suggested that benchmark exempt populations are vulnerable and best serviced by traditional Medicaid.

Response: We expect the exemptions process or the process designed for individuals in the new adult group will provide these individuals with an informed choice of the benefit package that best meets their needs.

Comment: A commenter wrote that the current exemption definition would create the need for a new frailty determination process for all newly eligible adults for states that implement an ABP that is different from the standard benefit. This is a concern for one state as it becomes an administration burden for the consumer and the state system with considerable fiscal implications and proposes a common benefit for adult populations in Medicaid that would avoid the frailty determination and exemption process.

Response: We acknowledge the writer's concerns, and are not requiring any specific processes for implementing the exemptions criteria for the new adult group. We provided a minimum standard for identification of individuals who are medically frail and proposed regulations that were not finalized as part of this rule at § 435.917(b) and (c) regarding benefits option counseling should be followed. Individuals may receive benchmark or benchmark-equivalent coverage subject to 1937 requirements during the options counseling period to insure coverage during this time.

Comment: Two commenters wrote that some states have Medicaid and other public health care programs that have developed special initiatives designed to meet the needs of enrollees who have substance use disorders. They indicated that these initiatives may include provision of care management series, discouraging drug-seeking behavior by requiring care to be provide by a specified doctor and hospital, etc. The commenters asserted that exempting these individuals from mandatory ABP enrollment would make it far more difficult for Medicaid Programs to meet these individuals' health care needs. While the writers agree with the characterization of a substance use disorder as ''medically frail'', and thereby exempting them from mandatory enrollment in an ABP, it would make it more difficult for Medicaid Programs to meet these individuals' care needs.

Response: We appreciate the commenters' concern but do not agree that exempting individuals with chronic SUD from mandatory ABP enrollment would make it more difficult for Medicaid programs to meet the individuals' health care needs. Section 1937 of the Act provides states with the flexibility to redesign current Medicaid benefit coverage to provide unique programs for targeted populations and encourages states to be creative in the design of its coverage packages. The exemption of individuals with chronic SUD is not an impediment to providing quality care that meets the specific needs of this population. Conversely, the flexibility provided by ABPs

encourages states to design comprehensive benefit packages that would encourage voluntary enrollment.

Comment: One commenter wrote that states should be able to employ traditional Medicaid disability assessments in evaluating medically frail exemption and limit receipt of long term care services and supports to those undergoing asset testing. To ensure long term stability and a fiscally sound expansion, the commenter requested sufficient flexibility to limit receipt of non-EHB services including long term care services, to the non-expansion population via state plan amendment or section 1915(c) waiver and recommended revision to the medically frail exemption to align with the disability assessments already in use within Medicaid.

Response: We disagree with this commenter. We believe the current construct of the medically frail exemption category is in keeping with legislative construct

Comment: A commenter wrote that the proposed revision to the definition of medically frail seems to run against the Affordable Care Act's benefit design for the expansion population, that is, coverage tied to section 1937 of the Act and incorporation of an EHB standard from the individual and small group markets, which excludes coverage from long-term care and supports. The commenter asserted that Affordable Care Act congressional goals to contain the costs of the Medicaid expansion may be jeopardized if states are faced with widespread eligibility for long term care services without the traditional program integrity tools used to filter such services based on objective need. The commenter further asserted that existing ABP rules already exempt a broad range of vulnerable individuals as compared to traditional disability assessment and that within what is likely to be a large exempted class, these beneficiaries will access benefits otherwise excluded from the EHB standard, namely institutional or long term care through the state plan, at sizable cost to states and the federal government. Of particular concern to the commenter is the application of personal care services to a large exempt segment of the new adult group and these long-term care benefits would be accessed in the streamlined MAGI enrollment where asset evaluation would be prohibited.

Response: The Affordable Care Act did not change the categories of individuals exempted from mandatory enrollment, and added the provision at section 1902(k)(1) of the Act, which contemplates that individuals who meet the conditions for exemption would receive ABP coverage that is not subject to the requirements of section 1937 of the Act. There is nothing in the Affordable Care Act that would preclude us from clarifying and amplifying the term ''medically frail'' to include populations that have high medical needs resulting from disabling mental disorders, substance use disorders, serious and complex medical conditions, or disabilities. We are clarifying in this final rule that the exemptions to benchmark or benchmark-equivalent coverage do not directly apply to the new adult population, but if an individual in the new adult population meets the criteria for exemption, then that individual has a choice of an ABP based on benchmark or benchmark-equivalent coverage including EHBs, or an ABP defined as the state's approved Medicaid regular state plan, which is not subject to EHB requirements. Please see more detailed response above for additional information related to this provision.

Summary: We changed the proposed regulation language at § 440.315(f) by adding ''chronic substance use disorders'' to the definition of the medically frail exemption category.

d. Benchmark Health Benefits Coverage (Adding Benefits to Secretary-Approved Coverage) (§ 440.330)

In the proposed rule, we amended § 440.330(d) by broadening the benefits available as Secretary-approved coverage from section 1905(a) benefits to benefits of the type that are available under 1 or more of the standard benchmark coverage packages or state plan benefits described in sections 1905(a), 1915(i), 1915(j), 1915(k) or 1945 of the Act, or any other Medicaid state plan benefits enacted under Title XIX, or benefits available under base benchmark plans described in § 156.100.

e. Secretary-Approved Health Benefits Coverage and § 440.330(d) and State Plan Requirements for Providing Additional Services (Adding Benefits to Additional Coverage) (§ 440.335)

Comment: Many commenters offered general support for the flexibility allowed in the proposed rule to include a broader range of selected benefits through a Secretary-approved coverage package.

Some commenters noted that the ability of states to select coverage corresponding to their full traditional Medicaid benefit as their ABP, which would be presented under the Secretary-approved coverage option, offers a clear distinction between the section 1937 benchmark options and the EHB benchmark options set forth in 45 CFR part 156.

Many commenters believed that the proposed language correctly offered states the option to use the Secretary-approved option in section 1937 of the Act to extend comprehensive Medicaid coverage to the new adult expansion group and that extending full Medicaid benefits to this population, supplemented as needed to comply with the EHBs, mental health parity and other protections in the law, is the best approach for meeting the complex health needs of the low-income adults who will gain Medicaid eligibility under the expansion.

Response: The proposed provisions for defining Secretary-approved coverage sought to balance statutory requirements for establishing a minimum coverage standard through ABP with the flexibility that states may need when considering the appropriate range of ABP coverage relative to the medical needs of the population being served. States may also substitute benefits using the state's approved Medicaid state plan benefits as long as the benefits are in the same EHB category and they are actuarially equivalent. We appreciate the commenters' support.

Comment: Some commenters were not clear on which state plan benefits may be included and, thus, urged HHS to clarify that state plan benefits enacted under Title XIX are available for inclusion through the Secretary-approved process irrespective of whether they have otherwise been implemented in a particular state Medicaid program. As an example, those commenters noted that a state that may conceivably want to design a Medicaid benchmark targeting vulnerable populations, such as individuals with dementia, and include a particularly relevant home support service that is not an otherwise available service in the state's Medicaid program.

Response: We wish to clarify for commenters that any benefits described in sections 1905(a), 1915(i), 1915(j), 1915(j) or 1945 of the Act, and any benefits included in a selected benchmark coverage option may be included in an ABP whether or not those benefits are offered through a particular Medicaid program.

Comment: Many commenters requested that, in addition to the provisions that Secretary-approved coverage must meet the needs of the target population, HHS revise language to require that the final Secretary-approved benefits package be at least actuarially equivalent to one of the first

three benchmark options, indicating that this would ensure that states use the Secretary-approved option to provide a benefit that is innovative and comprehensive, and not solely to provide a benefit that is lesser.

Many of the same commenters recommend amending § 440.330(d) to read as follows: Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage, and is at least actuarially equivalent to one of the benchmark options in paragraphs (a), (b), or (c). Secretarial coverage may include benefits of the type that are available under 1 or more of the standard benchmark coverage packages defined in § 440.330(a) through (c) of this chapter, State plan benefits described in sections 1905(a), 1915(i), 1915(j), 1915(k), and 1945 of the Act (whether actually covered in the state plan or not), any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in § 156.100.

Response: For commenters requesting that we require an actuarial equivalence study for Secretary-approved coverage against one of the three benchmark options at § 440.330(a) through (c), the statute defines Secretary-approved coverage as one of the minimum standards for benchmark coverage, and as such, the benchmark options in § 440.330(a) through (d) should serve as a reference for states considering the benchmark-equivalent coverage option offered in other regulatory provisions at § 440.335. Section 1937 of the Act does not expressly mandate an actuarial study of Secretary-approved coverage Therefore, we are adopting § 440.330(d) as proposed, and we believe that our clarification here will serve to clarify that a state plan benefit need not be offered through the regular state Medicaid program for its inclusion in benchmark coverage, or benchmark-equivalent coverage.

Comment: Many commenters indicated support of the intent to revise § 440.335(c)(1) to similarly align policy for benchmark-equivalent coverage as it does for Secretary-approved coverage and, thus, allow addition of benefits through the benchmark-equivalent coverage process. Commenters believed that there are no legal impediments to this approach and urged HHS to finalize the revision.

Similarly, other commenters commended the Secretary for continuing to allow states the option for coverage of additional benefits in excess of the minimum required coverage for benchmark-equivalent plans and for revising the language to include home and community-based services available under state plan options among these potential additional benefits.

Many other commenters applauded HHS's inclusion of various options for LTSS and care coordination support. Commenters generally offered strong support and commended the decision to enable states the flexibility necessary to align ABPs with state-plan options for home and community-based services, self-directed personal assistance services and attendant services, and other state Medicaid plan benefits described in section 1915(i), (j), (k) and section 1945 of the Act.

One commenter indicated that the flexibility to offer such services may provide states further opportunity to offer home and community-based services to particular populations since the proposed rule retains the section 1937 waiver of comparability that allows states to choose target populations for receipt of specialized benefit packages. The commenter offered an example of a state that could design benefit packages that help support community living, including employment for persons with disabilities.

One commenter was concerned that states may not take advantage of this flexibility, and suggested that CMS consider issuing additional guidance to states regarding the ability to cover services critical to chronic care management for the new adult eligibility group, such as the new health home benefit.

Similarly, another commenter requested that CMS clarify how authorities at sections 1915(i) and 1945 will be used given that individuals that would most likely benefit from these authorities will be exempt from enrollment:

Response: CMS is providing states with additional options to craft benefit packages that most appropriately meet the needs of the population being served. Benefits that can now be included as Secretary-approved coverage may in fact assist people who do not yet qualify as medically frail. For instance, if someone needs assistance with medication administration, they may not yet meet the definition of medically frail, but they may benefit significantly from the service and in fact avoid progression toward that exemption group or meeting the associated criteria. We are in support of melding regular medical/surgical benefits with home- and community-based services that support people living the community and potentially avoiding or delaying hospitalization or institutionalization.

Comment: One commenter indicated recognition that section 1915(i) of the Act has proven to be a particularly critical tool available to states to expand home and community based services and supports to cover a broad array of services that enable individuals with mental illnesses to succeed in their own homes.

Response: We are in agreement with the commenter that section 1915(i) of the Act can serve as a critical tool available to states to expand an array of services that enable individuals with chronic condition to succeed independently. For this reason, we will finalize regulations to include section 1915(i) of the Act as a viable state plan option that states may consider for inclusion when selecting an ABP.

Comment: A few commenters requested clarification from CMS that states may include section 1915(c) of the Act and other waiver-based services in their ABPs. Commenters stated concern that states may need flexibility to include additional services, such as personal care and other services that enable Medicaid beneficiaries to remain in their homes to their ABPs because section 1915(c) of the Act was not referenced in § 440.360.

Similarly, many state Medicaid agencies stated that the regulatory sections should expressly specify that states may provide ABP enrollees with access to section 1915(c) programs. The commenters indicated belief that section 1915(c) services are ''state plan benefits enacted under Title XIX'' given that section 1915(c) is found in Title XIX and offers services that a state plan may include as ''medical assistance under such a plan.'' The commenters also requested that CMS confirm their reading of §§ 440.330, 440.360, allowing states the option to provide enrollees with section 1915(c) waiver services either as part of Secretary-approved ABP or as ''additional services'' available to non-expansion enrollees.

Response: Section 1915(c) of the Act is not a state plan benefit, and therefore, is not consistent with our general principle that Secretary-approved or additional coverage consists of coverage under one of the benchmark coverage options or regular state plan benefits. Because the same services provided under section 1915(c) of the Act may be provided under section 1915(i) of the Act, which can be offered in an ABP, we do not see any reason to add section 1915(c) benefits as an exception to this general principle.

Summary: No changes to the proposed regulation were made as a result of these comments.

f. Benchmark-Equivalent Health Benefits Coverage and § 440.360 State Plan Requirements for Providing Additional Services (Adding Benefits to Additional Coverage) (§ 440.335)

In the proposed rule, we amended § 440.335(c) and § 440.360 by broadening the benefits available as additional coverage from section 1905(a) benefits to benefits of the type that are available under 1 or more of the standard benchmark coverage packages or state plan benefits described in sections 1905(a), 1915(i), 1915(j), 1915(k) or 1945 of the Act, or any other Medicaid state plan benefits enacted under Title XIX, or benefits available under base benchmark plans described in § 156.100.

Comment: Many commenters believed that the proposed rule would prohibit states from providing wrap-around or other additional benefits to newly-eligible adults, but would allow states to provide additional benefits for other populations in ABPs.

Many commenters shared the belief that the Affordable Care Act does not appear to prohibit states from providing additional services to the newly-eligible populations and that CMS should allow states flexibility to provide additional services to the newly eligible population without having to go through the additional process required for Secretary-approved coverage. Those commenters believed that if CMS determines that the law prohibits states from providing additional benefits to the newly-eligible population, it should allow states the ability to simply add these benefits using a streamlined process under the Secretary-approved option or through another mechanism.

Several commenters urged CMS to clarify through the final rule that states may provide additional benefits to ABPs for those eligible through section 1902(a)(10)(A)(i)(VIII) of the Act through the Secretary-approved coverage option, so as to not implicate the restriction on additional coverage for the new adult group contained through § 440.360. Those commenters believed that the proposed language is misleading and could be interpreted that the expansion population is not able to receive additional benefits in any circumstances, noting that the intent of the proposed rule is that the expansion group is limited to benchmark ABP coverage.

A number of commenters requested that CMS allow states the flexibility to provide additional benefits beyond what is minimally required in the benchmark to any or all populations in ABPs, including the expansion population.

Similarly, another commenter urged CMS to allow states to be as expansive as they want to be in offering health care services to all beneficiaries of ABPs, including the newly eligible Medicaid expansion population, beyond what is minimally required within each state's ABP.

Other commenters noted that states may identify deficiencies and gaps in the commercial benchmark plan options that fall outside parity, non-discrimination, EHB and other requirements. In this situation, commenters believed that a state should be able to add benefits easily for its expansion population and CMS should provide states with all available flexibility to do so.

Response: Section 1902(k)(1) of the Act is very clear that individuals eligible through the new adult expansion group are limited to benchmark or benchmark-equivalent coverage. In addition, there is a payment exclusion under section 1903(i)(26) of the Act for FFP in any additional coverage. ''Additional services'' authorized under section 1937 fall outside benchmark and benchmark-equivalent coverage. But we are addressing this concern by allowing states increased flexibility under this final rule to include broader benefits and services that are appropriate for the population being covered and that are similar to the benefit types listed in § 440.360, through Secretary-approved coverage or benchmark-equivalent coverage.

Comment: Many commenters indicated strong support for HHS' proposed policy and commended the Department for clarifying the authority for states to provide a wide range of benefits in developing Secretary-approved coverage. In continuing, those commenters noted that many consumer stakeholders have misunderstood the allowance for inclusion of benefits under Secretary-approved coverage due to the general prohibition on adding services to Medicaid benchmarks and requested that the Department clarify that benefits can be added, but only through the Secretary-approved process.

Other commenters urged CMS to consolidate these sections and clarify that, despite the prohibition on adding services to Medicaid benchmarks, states have the flexibility to offer additional and richer benefits to all those enrolled in ABPs, including the expansion group, by choosing the Secretary-approved coverage option. Those commenters also requested clarification that the federal match otherwise available for these populations is available for the additional benefits when they are approved by the Secretary.

Similarly, other commenters requested that CMS clarify and confirm that the interpretation of this provision within the proposed rule is that if a state wanted to provide wrap-around services for a particular population that some of the ''newly eligible'' population may fall under, it does not appear that would be allowed unless the state creates a Secretary-approved plan that incorporates the benefits into the underlying plan itself.

One commenter indicated that it would be helpful for CMS to clarify that adding additional benefits is possible for individuals in the newly eligible group, and that the prohibition on additional coverage for the expansion group at § 440.360 only applies to benefits that have not been included in the benchmark package selected by the state. The commenter also suggested that both benchmark-equivalent coverage and Secretary-approved coverage provide the state flexibility to include benefits that can be covered through a Medicaid state plan or a base benchmark option available to the state.

Response: We reassert the statutory construct that does not allow the new adult group to received ''additional'' services. However, the broadening of Secretary-approved coverage to include the same options for services accomplishes the goal of allowing individuals in the new adult group access to that same robust benefit package. We reiterate that services provided under an ABP do not have to be offered under the regular state plan.

Comment: Several commenters recognized that the Secretary's clarification that additional benefits may include those available under base benchmark plans (described in § 156.100), in additional to standard benchmark coverage packages or standard state plan benefits. Those commenters were concerned about flexibility for states to model ABPs after any base benchmark, noting that not every base benchmark plan option may provide appropriate benefit levels for the Medicaid population.

One commenter familiar with the needs of underserved and poor populations with chronic conditions was appreciative that the EHB rules builds upon protections already offered through existing rules that allow states to enroll certain populations in Medicaid benchmark plans, and grants states significant flexibility through regulations at § 440.360 to develop a more comprehensive benefits package

that will better meet the needs of people with HIV and others with chronic conditions.

Response: As mentioned in previous responses, we believe the statute requires states to balance the appropriateness of the ABP package when considering the population being covered. Therefore, we believe our regulations encourage states to consider other options if their analysis reveals that the base benchmark options elected do not provide an appropriate level of benefits relative to the population being covered.

Comment: A few commenters wished to emphasize that section 1937 of the Act requires states to provide FQHC services to beneficiaries who receive ABP coverage in the same manner as CMS previously stated and conveyed in the agency's April 30, 2010 final rule. The commenters emphasized that for situations where no FQHCs are available to section 1902(a)(10)(A)(i)(VII) of the Act enrollees under their managed care plan, then the state must provide the beneficiary enrolled in ABP coverage with FQHC services on a per-visit basis as required by section 1902(bb) of the Act. Alternatively, if a managed care entity is able to provide FQHC services to any beneficiary receiving ABP coverage, payments for such services must be made on a cost-related prospective payment system basis, with state supplemental payments provided where the PPS payment would exceed the amount provided under the managed care contract.

Commenters indicated concern that because § 440.360 is silent on states' obligation to provide FQHC and RHC services as part of benchmark or benchmark-equivalent coverage, the proposed regulation fails to distinguish clearly between required and ''additional benefits'' for the section 1937 package and that the omission of FQHC services from the list creates the impression that these services are not a required benefit within section 1937 coverage.

Several commenters recommended that CMS clarify the FQHC services requirement by: (a) Consolidating § 440.365 into § 440.345; or (b) independently reference § 440.365 in § 440.360 by having the first sentence of regulatory provision § 440.360 read, ''In addition to the requirements of § 440.345 and § 440.365.''

Response: We agree with the commenters that regulations at § 440.365 continue to require that the state must provide that individuals enrolled in an ABP have access, through that coverage or otherwise, to rural health clinic services and FQHC services. Such required services are required as part of § 440.365 and a state must assure to CMS that they are providing these services, which is different than adding additional services described at § 440.360. FQHCs are considered Essential Community Providers in the commercial market, and we anticipate these entities playing a critical role in Medicaid ABPs as well. When these providers are part of the ABP provider network, reimbursement to them must adhere to statutory requirements.

Summary: Minor grammatical edits to the proposed regulation were made as a result of these comments.

g. Other Comments Received

We received various other comments that did not relate specifically to provisions proposed in the proposed rule.

Comment: One commenter stated that to realize the opportunity presented by the Affordable Care Act, it is essential that individuals who are admitted to jail and are eligible for Medicaid be enrolled in Medicaid either during incarceration or immediately upon release to the community. By law federal Medicaid matching funds are not available for the costs of needed items and services for individuals who are enrolled in Medicaid while they are inmates, unless they are admitted to a medical institution for treatment during the period of incarceration. Nonetheless, the suspension of benefits does not affect the Medicaid eligibility of inmates or their ability to enroll in the program if eligible.

Response: Paragraph (A) following section 1905(a)(29) of the Act and implementing regulations at § 435.1009, exclude from the definition of medical assistance care or services for any individual who is an inmate of a public institution, except as an inpatient in a medical institution. We read this exclusion to apply generally to medical assistance, whether provided through the regular coverage plan or through an ABP. Thus, while we agree with the commenter that incarcerated individuals may be eligible for Medicaid, they would not be entitled to benefits inconsistent with the exclusion. We note that this is consistent with the exclusion of incarcerated individuals from eligibility to enroll in coverage through the Exchange. It is also consistent with the responsibility under the Eighth Amendment of the United States Constitution of governmental entities to provide necessary medical care to individuals who they are holding as inmates, which effectively creates a liable third party for such care.

Individuals who are enrolled in Medicaid when entering a public institution should have their eligibility suspended, rather than terminated, as they remain eligible. This also ensures ease of reinstitution of coverage post-release. Additionally, if an individual is not already enrolled in Medicaid, states are encouraged to enroll eligible individuals prior to their release so that the individual can receive Medicaid covered services in a timely manner upon discharge.

Comment: A commenter requested additional guidance as to what type of information CMS will need to approve an ABP state plan amendment and how CMS will determine if mental health parity has been met.

Response: We will be issuing a template for states to use to submit ABPs as a state plan amendment. At this time, mental health parity will be determined to be met with an assurance by the state. We will be developing more specific policy related to this topic in the near future.

Comment: One commenter requested CMS clarify what Medicaid category the EHBs are applicable. The commenter wondered whether EHBs only apply to the expansion population and ABPs or does it also apply to individuals who are currently eligible for Medicaid. The commenter questioned whether, for example, current Medicaid benefits would need to be adjusted to include habilitative services.

Response: EHBs apply only to section 1937 of the Act and were not extended into regular Medicaid. Therefore, regular Medicaid state plan benefits will not include the EHBs.

Summary: No changes to the proposed regulation were made as a result of these comments.

7. Summary

ABPs are intended to offer states flexibility in designing benefit packages for the Medicaid population that are benchmarked to public employee or commercial plans. To ensure coverage of the kinds of services that will also be assured for those purchasing coverage in the individual and small group market, the law also requires that ABPs cover the ten EHBs specified by law.

Recognizing that states face challenges in administering both their state plan benefits and ABPs, we have sought to provide as much flexibility in aligning those packages as possible. That said, we appreciate that it may be difficult at this point to make changes to the ABP that take effect by January 1, 2014. In light of this challenge, we will partner with states to work as quickly as possible to come into full compliance

with these provisions. We do not intend to pursue compliance actions on these issues to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014. To establish its base benchmark for EHBs for Medicaid, the state can select the same or a different plan than the base benchmark used for the Exchanges. Once having selected the base benchmark plan for EHBs, the state maps the benefits to EHB categories, and then can engage in supplementation and/or substitution:

- Through supplementation at 45 CFR 156.110, the state must add EHBs to a base benchmark plan that is missing a required category of EHBs. States can supply the missing EHBs from other base benchmark plans.
- Through substitution at 45 CFR 156.115(b), the state can replace one or more of the benefits within each category of EHB, as long as it maps appropriately to the category and the services are actuarially equivalent to the services that are being substituted. State Medicaid programs can use this process to substitute Medicaid state plan benefits for public employee or commercial plan benefits, for example, as long as applicable requirements are met. States must provide notification to CMS that they have engaged in substitution and have an actuarial certification and analysis available for inspection.

States must assure, as they evaluate their base benchmark for EHBs and take these steps that they also properly account for special Medicaid considerations discussed in this rule. When states pay for covered outpatient drugs under the ABP prescription drug benefit, they must comply with the requirements under section 1927 of the Act. Habilitative services and devices are defined by what is in the state selected base benchmark plan, substituted as desired. If not defined in the base benchmark, the state will define the benefit. For example, states may offer coverage of habilitative services and devices that is no more restrictive in terms of amount, duration, and scope than the rehabilitative services and devices covered under the applicable benchmark plan. We expect that the services will be clinically appropriate to meet the needs of individuals based on medical necessity. Pediatric oral and vision care must follow requirements of the EPSDT benefit.

The final base benchmark plan for EHBs for Medicaid, after completion of these steps, provides the floor for Medicaid coverage to individuals in the ABP.

States also select a section 1937 coverage option. If the section 1937 coverage option and the plan initially selected as the base benchmark for EHBs are the same, the state will meet all requirements by specifying as the final ABP the final base benchmark, as supplemented and subject to permissible substitution, and further supplemented to the extent necessary to ensure coverage required under section 1937 of the Act, including EPSDT services, family planning services, and FQHC and RHC services.

If the section 1937 coverage option and the selected base benchmark plan are different (including when the state elects Secretary approved coverage option or benchmark equivalent coverage), states have to take the following steps to construct their final ABP:

- If any other benefits are available in the section 1937 coverage option, add that benefit.
- For any benefits in common from the section 1937 public employee or commercial market plan options, but with one having more robust qualities related to amount, duration, or scope, the benefit with the more robust coverage.
- For any benefits in common from the section 1937 Secretary-approved coverage option, but with one having more robust qualities related to amount, duration, or scope, determine whether to apply the benefit with the more robust coverage.

Alternatively, a state can first determine their ultimate goal in creating their benefit package (for example, wanting to create an ABP that mirrors the state's regular Medicaid state plan benefit package as much as possible), and develop their ABP starting first with the selection of their 1937 coverage option. This would entail comparing the state plan benefit package with the base benchmark benefit package, supplementing the state plan benefit with EHBs as necessary, and applying permissible substitution of benefits consistent with 45 CFR 156.115(b) to better align with state plan benefits.

C. Exchanges: Eligibility and Enrollment

Throughout this proposed rule, we proposed technical corrections to regulation sections in part 155 to replace references to section 36B of the Code with the corresponding sections to the Department of Treasury's final rule, Health Insurance Premium Tax Credit (26 CFR 1.36B–0 et seq.), published in the May 23, 2012 **Federal Register** (77 FR 30377). We are finalizing these technical corrections as proposed.

1. Definitions (§ 155.20)

In § 155.20, we proposed technical corrections to the definitions of ''advance payments of the premium tax credit'' and ''application filer,'' and added a definition of ''catastrophic plan'' by referencing the appropriate statutory provision within the Affordable Care Act. We did not receive specific comments on these technical corrections, and are thus finalizing them as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.20 of the proposed rule with a technical correction to the definition of advance payments of the premium tax credit, which we clarify refers to the payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations.

2. Approval of a State Exchange (§ 155.105)

In § 155.105, we proposed a technical correction to replace the reference to section 36B of the Code to the applicable Treasury regulation. We did not receive specific comments on this section, and are thus finalizing the provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.105 of the proposed rule without modification.

3. Functions of an Exchange (§ 155.200)

In § 155.200, we proposed to clarify that the Exchange must also perform the minimum functions described in subpart F concerning appeals. The only comments we received supported this clarification.

Summary of Regulatory Changes

We intend to finalize the clarification to paragraph (a) at a future date when subpart F is finalized, and so thus maintain the previous language from the Exchange final rule.

4. Authorized Representatives (§ 155.227)

We proposed to add § 155.227, establishing minimum requirements for the designation of authorized representatives who may act on an applicant's or enrollee's behalf in the individual and small group markets. We noted in the preamble that the proposed rule for authorized representatives for Exchanges closely tracks the proposed rule for authorized representatives for Medicaid.

In paragraph (a), we proposed that the Exchange must permit applicants and enrollees in the individual and small

group markets to designate an individual person or organization to act on that applicant or enrollee's behalf. We also proposed that an applicant or enrollee may have such a representative through operation of state law, subject to applicable privacy and security requirements. We also proposed that the Exchange must not restrict the option to designate an authorized representative to only certain groups of applicants or enrollees. We noted that the Exchange should ensure that the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by the Exchange, and that authorized representatives should adhere to applicable authentication and data security standards. Additionally, we proposed that the Exchange should ensure that the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in this section, to the same extent as the person he or she represents.

In paragraph (b), we proposed the situations when the Exchange must permit an applicant or enrollee to designate an authorized representative. We also proposed that the single, streamlined application described in § 155.405 will provide applicants the opportunity to designate an authorized representative and will collect the information necessary for such representative to enter into any associated agreements with the Exchange as part of the application process. We noted that applicants and enrollees who do not designate an authorized representative on their applications will subsequently be able to do so through electronic, paper formats, and other modalities, as described in § 155.405(c)(2). We also noted that legal documentation of authority to act on behalf of an applicant or enrollee under state law, such as a court order establishing legal guardianship or a power of attorney, may serve in the place of the applicant or enrollee's designation.

In paragraph (c), we proposed that the Exchange must permit an applicant or enrollee to authorize a representative to—(1) Sign the application on the individual's behalf; (2) submit an update or respond to a redetermination for the individual; (3) receive copies of the individual's notices and other communications from the Exchange; and (4) act on behalf of the individual in all other matters with the Exchange.

In paragraph (d), we proposed that the Exchange must permit an applicant or enrollee to change or withdraw an authorization at any time. We also noted the authorized representative also may withdraw his or her representation by notifying the Exchange and the applicant or enrollee.

In paragraph (e), we proposed that an authorized representative acting as either a staff member or volunteer of an organization and the organization itself must sign an agreement meeting the requirements proposed in regards to Exchange certified application counselors. We noted that while the protections afforded by such an agreement are important when an authorized representative is a member or volunteer of an organization, we believe that they are not logical in cases where an authorized representative is not acting on behalf of an organization. We sought comments on applying the protections in paragraph (e) to authorized representatives more broadly.

In paragraph (f), we proposed that the Exchange require authorized representatives to comply with any applicable state and federal laws concerning conflicts of interest and confidentiality of information.

In paragraph (g), we proposed that the designation of an authorized representative must be in writing, including a signature, or through another legally binding format, and be accepted through all of the modalities described in § 155.405(c) of this part.

We received the following comments concerning the proposed authorized representative provisions.

Comment: Several commenters recommended that the Exchange be required to make clear the powers and duties authorized representatives may have with respect to the Exchange, as well as all other requirements of § 155.227, in a manner that is easily understandable by both the authorized representative and applicant or enrollee.

Response: In the final rule, we added a provision to paragraph (a) specifying that the Exchange must provide information regarding the powers and duties that an authorized representative may have with respect to Exchange activities to both the applicant or enrollee and the authorized representative.

Comment: Several commenters suggested that an authorized representative should have an affirmative duty to notify the Exchange and the applicant or enrollee on whose behalf he or she is acting of any revocation or material change in the authorized representative's legal authority to act on behalf of the applicant or enrollee. These commenters also suggested that such a material change or revocation should result in revocation of the authorized representative's authority to act on behalf of the consumer for Exchange purposes.

Response: We have clarified in § 155.227(d)(2) of the final rule that an authorized representative must notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

Comment: Several commenters asked HHS to clarify which legal documentation may serve in the place of an affirmative representation to designate an authorized representative. Other commenters recommended clarifying that a power of attorney may be used for such a purpose only if it authorizes the holder to act in the types of activities permitted under § 155.227(c). One commenter recommended that legal documentation to act as an authorized representative be required, as opposed to optional, to protect vulnerable applicants or enrollees. Another commenter recommended adding language that authorizes the Exchange to dictate the form or manner of the authorization. A few commenters also expressed concerns about the proposed requirement that the designation of an authorized representative be in writing including a signature or other legally binding format.

Response: In paragraph (a)(2), we outline the form and manner of how an applicant or enrollee may designate another person as his or her authorized representative, specifying that this designation should be in a legally binding format. We also provide examples of legal documentation that could be used to designate an authorized representative in lieu of a signed document, including, but not limited to, a court order establishing legal guardianship or a power of attorney. While we do not require that legal documentation be provided before the Exchange may recognize an individual as an authorized representative, we anticipate that Exchanges will have procedures in place to ensure that applicants and enrollees have control over whom they designate as an authorized representative. For example, Exchanges have flexibility to require that the designation should occur through a signed agreement or legally binding document. In general, an Exchange could accept any document that is valid for designating an authorized

representative in the state, and that permits the holder to perform the activities specified in § 155.227(c), in place of an affirmative representation to designate an authorized representative. We emphasize that to be used in this manner, documentation has to give the authority needed to be an authorized representative for the activities specified in § 155.227(c).

Comment: A few commenters inquired about the relationship between an authorized representative designated through the Exchange and a QHP issuer, and recommended that an applicant or enrollee be required to complete a separate authorization form to designate a representative to act on his or her behalf in interactions with the QHP issuer. Commenters expressed an understanding that QHP issuers would be responsible for developing and executing the authorized representative forms that govern interactions between the enrollee and the issuer.

Response: Subject to applicable law, we believe that the authorized representative designated by an applicant or enrollee through the Exchange process should also be able to serve in the same capacity with the QHP issuer, and that streamlining this process is important to minimize the burden on applicants or enrollees who need authorized representation. Therefore, we would urge QHP issuers to allow an Exchange authorized representative to serve in the same capacity with the QHP issuer. We note that the companion guide [2] that will be used by all Exchanges for sending enrollment data to QHP issuers has fields that may accommodate this information.

Comment: Some commenters suggested that HHS develop some conflict of interest standards to ensure that consumers are protected when interacting with entities that may benefit from becoming an authorized representative. Other commenters suggested banning all organizations from becoming authorized representatives, because some entities may benefit from becoming an authorized representative.

Response: We appreciate the comments and plan to monitor organizations acting as authorized representatives over time to determine whether more specificity is needed. Additionally, § 155.227(e) of the final rule clarifies that authorized representatives must comply with applicable state and federal laws regarding conflicts of interest.

Comment: Several commenters recommended that an applicant or enrollee should be able to authorize their representative to engage in fewer than all of the activities described in the proposed rule.

Response: In the final rule, we maintain language specifying that an Exchange must allow applicants and enrollees to authorize a representative to perform the full range of activities listed in the rule. We also add language to § 155.227(c) clarifying that the Exchange may (but need not) permit consumers to authorize fewer than all of the listed activities, so long as the Exchange is able to track the specific permissions for each authorized representative. We note that for plan years beginning before January 1, 2015, the FFE will not have the operational capacity to support the authorization of representatives to perform less than the full range of activities listed in the rule.

Comment: Several commenters urged that the provision in proposed § 155.227(d) that the applicant or enrollee notify both the Exchange and the representative that the representative is no longer authorized to act on his or her behalf be removed. Other commenters suggested that the applicant or enrollee should notify only the Exchange.

Response: In the final rule, we clarify that the responsibility for notifying a representative whose authorization has been discontinued by an applicant or enrollee falls only on the Exchange.

Comment: One commenter expressed support for a policy that would permit the Exchange to terminate a designation after a given period of time to be determined by the Exchange. This commenter noted that this aligns with the 5-year limit on authorizations from enrollees to allow Exchanges to request tax information for conducting annual redeterminations in accordance with § 155.335(k).

Response: In the final rule, we have added a provision specifying that authorized representatives will notify the Exchange if they are no longer authorized to act in that capacity. As long as a person has the authority to act as an authorized representative, there is no need to terminate or reauthorize that relationship after a set amount of time. An applicant or enrollee may also modify the authorization at any time.

Comment: A commenter suggested that compliance agreements for authorized representatives should be available directly from HHS, instead of Exchanges, for entities such as multi-employer plans that are subject to federal regulation under ERISA, the Code, and the Taft-Hartley Act, but not to state insurance regulation. The commenter noted that the relationships between plans and plan participants and beneficiaries established under the Taft-Hartley Act should continue to be recognized in regulations implementing the Affordable Care Act.

Response: We expect that authorized representatives will be used primarily by applicants and enrollees who are unable to represent themselves or who are seriously challenged in representing themselves in their relationship with the Exchange. Accordingly, authorized representatives' agreements are between an applicant or enrollee and his or her authorized representative regarding representation before the Exchange.

Comment: One commenter sought clarification on whether staff or volunteers of organizations must be trained and certified as Exchange certified application counselors under proposed § 155.225(b) to serve as authorized representatives.

Response: The rule does not require authorized representatives to be trained and certified as certified application counselors. The role of an authorized representative is distinct from the role of a certified application counselor. Specifically, certified application counselors, for which standards will be finalized in a future regulation, provide guidance and assistance to applicants and enrollees who will interact with the Exchange on their own behalf, while authorized representatives are commonly used by applicants or enrollees who are unable to represent themselves, and have the legal authority to actually sign for an applicant or enrollee and make other decisions on his or her behalf.

Comment: Several commenters suggested that requiring organizations to enter into agreements and follow a set of standards as proposed in § 155.227(e) will lead to disruptions in the availability of assistance and lead to real harm to persons who need assistance. Other commenters expressed concerns that every authorized representative would have to be certified.

Response: In light of the commenters' concerns, and the protections for consumers that already apply to all Exchange authorized representatives, we have not finalized the proposed requirement that organizations and staff and volunteers of organizations sign a separate agreement. We recognize that authorized representatives are given significant authority, and accordingly, we need to ensure that the privacy and security of applicants' and enrollees' personal data are protected. We note

[2] Standard Companion Guide Transaction Information, (March 22, 2013). Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf.*

that all authorized representatives, not just organizations and those working for organizations, will be subject to the privacy and security standards established and implemented by the Exchange consistent with 45 CFR 155.260 through agreements, as is required by 45 CFR 155.260(b)(2). This will be further clarified in subregulatory guidance. Since all authorized representatives will be subject to privacy and security standards, in this final rule, we removed the requirement for organizations and staff and volunteers of organizations to sign a separate agreement.

We have also not finalized the provision in the proposed rule that would have subjected authorized representatives who are staff and volunteers of organizations, and their organizations, to the proposed standards for Exchange certified application counselors. This proposal was motivated in large part by a concern that staff and volunteers of such organizations might be likely to have conflicts of interest. This concern, however, is addressed by § 155.227(e), which clarifies that authorized representatives must comply with applicable state and federal laws regarding conflicts of interest.

Comment: One commenter suggested requiring legal documentation when an applicant or enrollee changes or withdraws his or her authorization.

Response: Applicants and enrollees will not always have legal documents to substantiate discontinuing an authorization. When an applicant or enrollee appoints a new authorized representative, including to replace an existing authorized representative, he or she should follow the same process as an applicant or enrollee who appoints an authorized representative for the first time.

Comment: Another commenter recommended that an enrollee should not be able to designate an authorized representative if he or she failed to do so during the application process.

Response: We see no need to limit an applicant or enrollee's ability to designate an authorized representative solely to the application process, particularly as some enrollees may develop a need for an authorized representative after submitting an application, choosing a plan, and maintaining coverage for many years.

Comment: Several commenters sought clarification about whether an applicant or enrollee who applies through the Exchange with the assistance of an authorized representative and is subsequently transferred to the state Medicaid agency would need to redesignate his or her authorized representative.

Response: If the application is transferred to the state Medicaid agency, the authorized representative designation would be transferred as well.

Comment: One commenter inquired about whether the Exchange will be deemed liable for any breaches of confidentiality that are beyond the control of the Exchange. A commenter also requested that HHS modify language to make it clear that it is the legal duty of the authorized representative to maintain confidentiality in daily practice.

Response: We appreciate this comment and recognize that this issue applies more broadly. There are potentially some instances in which a person that provides application assistance, including an authorized representative, could negligently disclose an applicant's or enrollee's information under circumstances that the Exchange could not have prevented. We note that authorized representatives will need to comply with the same privacy and security standards that the Exchange adopts consistent with § 155.260, or with more stringent standards, pursuant to § 155.260(b). Additionally, paragraph (e) of the final rule requires authorized representatives to comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.227 of the proposed rule, with a few modifications. For clarity and consistency with the terminology defined in § 155.20, and to make it clear that we intend authorized representatives to provide assistance both in the SHOP Exchanges and in the individual market Exchanges, we replaced the terms ''individual'' and/or ''employee'' with the terms ''applicant'' and/or ''enrollee'' to describe the people helped by authorized representatives. To further indicate that we intend authorized representatives to provide assistance both in the SHOP and in the individual market Exchanges, we clarify in § 155.227(a) that an applicant or enrollee can designate an authorized representative in the individual or small group market Exchange and have added ''subpart H'' to the regulation text to account for the functions that an authorized representative may perform in a SHOP. To avoid confusion with the defined term ''qualified individual,'' we use the term ''person'' instead of ''individual'' in the final rule when describing individual persons acting as an authorized representative.

We added paragraph (a)(5) to specify that the Exchange must provide information about the powers and duties of an authorized representative both to the applicant or enrollee and to the authorized representative. We redesignated proposed paragraphs (c)(1) through (c)(4) as (c)(1)(i) through (c)(1)(iv), and added a new paragraph (c)(2), which allows an Exchange to permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (c)(1) of this section, provided that the Exchange tracks the specific permissions of each authorized representative. Additionally, we removed paragraph (d)(1), and redesignated proposed paragraphs (d)(2) and (d)(3) as paragraphs (d)(1) and (d)(2). We modified the language in redesignated paragraph (d)(1) to explain that the Exchange, not the applicant or enrollee, will notify the authorized representative when an applicant or enrollee notifies the Exchange that he or she is no longer represented by his or her previously authorized representative. We further modified redesignated paragraph (d)(2) to clarify that an authorized representative will notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee. We also deleted paragraph (e) and redesignated paragraphs (f) and (g) as (e) and (f), respectively. We also made the following technical corrections. We made a technical correction in paragraph (a)(1) to specify that authorized representatives are permitted to assist individuals apply for eligibility determinations or redeterminations for exemptions from the shared responsibility payment under subpart G of this part. We made technical corrections in paragraphs (a)(2) and (g) to clarify that the designation of an authorized representative must be in a written document signed by the applicant or enrollee instead of saying it must be in writing, including a signature. We also added the word ''must'' to paragraphs (a)(3), (a)(4), and (f) to clarify that the activities described in those paragraphs are required Exchange functions. We made a technical correction in paragraph (d) to move the words ''the applicant or enrollee notifies'' to the paragraph they modify. Finally, we made a technical correction in paragraph (f), to clarify what is meant by legally binding format

by adding ''as described in § 155.227(a)(2).''

5. General Standards for Exchange Notices (§ 155.230)

In § 155.230, we proposed to make a technical correction in paragraph (a) to clarify that the general standards for notices apply to all notices sent by the Exchange to individuals or employers.

We also proposed to revise paragraph (a) by redesignating paragraph (a)(1) as paragraph (a)(4) and redesignating paragraph (a)(2) as paragraph (a)(5). We proposed to revise redesignated (a)(2) to change ''; and'' to ''.'' We proposed to add new paragraph (a)(1) to indicate that any notice required to be sent by the Exchange to individuals or employers must be written and include an explanation of the action that is reflected in the notice, including the effective date of the action, and we proposed to add new paragraph (a)(2) to require the notice to include any factual findings relevant to the action. We proposed to revise paragraph (a)(3) to clarify that the notice must include the citation to, or identification of, the relevant regulations that support the action. We note that the contents of notices are subject to privacy and security provisions in § 155.260, including the limitations on disclosure of information.

Furthermore, we proposed to add paragraph (d) to allow the Exchange to provide notices either through standard mail, or if an individual or employer elects, electronically, provided that standards for use of electronic notices are met as set forth in § 435.918, which contains a parallel provision. We did not propose that the standards specifically described under proposed paragraph (d) would apply to the SHOP, and sought comment regarding this issue. We received the following comments concerning the proposed provisions for standards for Exchange notices:

Comment: Several commenters supported our proposal to clarify that the general standards for notices under § 155.230 apply to notices sent by the Exchange to both individuals and employers, and they supported the changes and additions proposed under paragraph (a). Many commenters indicated that the Exchange should be required to include contact information for both customer service and consumer assistance resources in notices, and commenters indicated that HHS should make copies of the applicable statute or regulation available upon request by consumers. One commenter stated the notice needs to include a clear explanation of any next steps and the timeframe by which action needs to be taken, while another commenter emphasized that notices should contain information about where individualized and unbiased counseling is available for the individual. Lastly, a few commenters suggested that we add ''laws or regulations'' to § 155.230(a)(3).

Response: In response to comments received, we clarify that while the standards under § 155.230 generally do apply to notices sent by the individual market Exchange to both individuals and employers, HHS does not expect that the Exchange will have the information necessary to provide an employer with a choice to receive the notice specified in § 155.310(h) regarding eligibility for advance payments of the premium tax credit electronically, as we do not expect that individuals will provide email information for employers on the application. Accordingly, we expect that notices sent from the Exchange to employers will likely be provided by standard mail, at least in the early years of program implementation. We will continue to work with employers regarding how best to implement notices from the Exchange to employers in an efficient manner.

We intend to consider the suggestions regarding notice content in the development of model notices, and encourage Exchanges to do the same in developing notices they will use. We expect that notices will include clear information about next steps and timeframe by which action needs to be taken. We acknowledge the value of including contact information for both customer service and consumer assistance resources in notices. We recognize that including a list of all available consumer assistance resources will make the notice longer, and so note that this is an area in which Exchanges have flexibility. We also note that applicable federal regulations are and will remain available through public Web sites.

Comment: Several commenters reinforced their support for the use of plain language to help notify enrollees of their rights and to properly explain health coverage options that may be available to consumers. One commenter recommended the notice include clear information about how to get help if the individual does not understand the notice, as well as clear information that an individual does not have to take the premium tax credit in advance.

Response: All notices specified under 45 CFR parts 155 and 156 are required to meet the accessibility standards described under § 155.205(c), which specify that information must be provided in plain language and in a manner accessible to limited English proficient individuals. We expect Exchanges to make consumers aware of the reconciliation process applicable to advance payments of the premium tax credit as a part of the initial Exchange educational materials, as well as at the time that an individual selects a QHP. HHS is working with states to identify all key messages that should be communicated to individuals through notices and other Exchange processes, and will take these comments into consideration for implementation.

Comment: Commenters generally expressed support for the electronic notice standards proposed under § 155.230(d), while some expressed concerns or suggestions related to the proposed standards. Commenters raised a variety of concerns about how consumers who elect to receive electronic notices may not actually receive them, including as a result of not checking email regularly. One commenter urged that Exchanges should be required to change the enrollee's delivery method for notices if the Exchange finds that electronic notices are not being opened. One commenter suggested that written notifications should cease only after clear and unambiguous expression from an enrollee that they no longer wish to receive paper notifications, and that the Exchange should be required to track whether electronic notices are delivered and opened by an enrollee. Another commenter recommended that individuals be allowed to decide which notices they receive electronically or by mail. One commenter suggested that electronic notices should be in addition to, rather than replace, mailed paper notices. Lastly, one commenter recommended modifying the notice provision so that if an individual elects to receive electronic notices, the Exchange also always would send a mailed notice in addition to the electronic notice when the Exchange is taking an adverse action or when the consumer is required to take an additional action to maintain his or her eligibility for enrollment in a QHP, advance payments of the premium tax credit, or cost-sharing reductions.

Response: We do not expect that the Exchange will track and monitor when an individual opens emails and electronic notices. As described in the electronic notice standards under § 435.918, which are incorporated by reference under § 155.230(d), applicants will receive paper notices by mail until they affirmatively elect to receive electronic notices. We expect Exchanges to remain consistent in their overall

approach to distributing notices, as required under § 155.230(d). Individuals will be able to control how they receive notices. Additionally, under § 435.918(b)(6), an individual will be able to request any notice posted in the individual's electronic account to be sent through regular mail. Furthermore, nothing precludes the Exchange from providing an individual with the choice to receive some types of notices electronically and others through regular mail (for example, notices concerning adverse actions). Accordingly, we are finalizing this provision as proposed, with one modification to allow the individual market Exchange to choose to delay the implementation of the process described in 42 CFR 435.918(b)(1) regarding sending a mailed confirmation of the choice to receive electronic notices, given the time available for implementation.

Comment: Some commenters supported the exclusion of the SHOP Exchange from the electronic notice standards under § 155.230(d), while others expressed support for the SHOP being able to send all notices electronically. Many commenters urged that employers in the SHOP should have a choice regarding to how they receive notices, and some expressed concern about employers not having a choice. One commenter recommended that the SHOP be allowed to choose between offering both written and electronic notices, to allow qualified employers and employees to select which method they prefer; or to only offer paper notices. The commenter noted that allowing states to adopt an electronic-only approach for notice delivery might be problematic for some employers. Another commenter indicated that the proposed rule is not clear about what the default format would be for notices sent by the SHOP.

Response: Based on the comments received and because we believe it is important for employers to be able to choose how they receive notices, we are modifying the proposed rule to allow an employer or employee in any SHOP to elect to receive electronic notices, provided that the standards for electronic notices in § 435.918(b)(2), (b)(3), (b)(4), and (b)(5) are met for the employer or employee. Accordingly, the SHOP must: (1) Permit the employer or employee to change such election, at any time, and inform the employer or employee of this right; (2) Post notices to the employer or employee's electronic account within one business day of notice generation; (3) Send an email or other electronic communication alerting the employer or employee when a notice has been posted; and (4) If an electronic communication is undeliverable, send the notice by regular mail within three business days of the date of the failed electronic communication.

Comment: Several commenters asked for clarification regarding how electronic notice standards apply to QHP issuers, and they suggested that QHP issuers also be allowed to offer enrollees the option of receiving electronic notices. Some commenters recommended that the Exchange adopt electronic notice standards for QHP issuers similar to those applicable to the individual market Exchange. One commenter recommended that the single, streamlined application include an option for applicants to elect to receive notices from the QHP issuer electronically, in addition to the election to receive notices from the Exchange electronically. One commenter requested that a provision be added permitting managed care organizations to provide electronic notices.

Response: The provisions related to electronic notice standards under part 155 of the proposed rule apply to the individual market and SHOP Exchange. We acknowledge the importance of QHP issuers being able to send, and enrollees being able to choose to receive, electronic notices, and we clarify that nothing in this regulation precludes QHP issuers from offering their enrollees the option to receive notices electronically. We understand that most QHP issuers already make electronic notices available as an option to their current enrollees, and we are supportive of QHP issuers continuing to make this option available to enrollees when they are participating in the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.230 of the proposed rule with a few modifications. We renumber proposed paragraph (d) as paragraph (d)(1) and modify it to specify the electronic notice standards for an individual market Exchange, while also adding paragraph (d)(2) to establish the electronic notice standards for a SHOP. We also add language to allow the individual market Exchange to choose to delay the implementation of the process described in 42 CFR 435.918(b)(1) regarding sending a mailed confirmation of the choice to receive electronic notices. We provide in paragraph (d)(2) that an employer or employee in any SHOP may elect to receive electronic notices, provided that the requirements for electronic notices in § 435.918(b)(2), (b)(3), (b)(4), and (b)(5) are met for the employer or employee.

6. Definitions and General Standards for Eligibility Determinations (§ 155.300)

In § 155.300, we proposed technical corrections in paragraph (a) to the definitions of ''minimum value,'' ''modified adjusted gross income,'' and ''qualifying coverage in an eligible employer-sponsored plan,'' and also removed the definition of ''adoption taxpayer identification number.'' We are finalizing the technical corrections as proposed, with an additional technical correction to specify the appropriate definition of minimum value.

Comment: Several commenters recommended that HHS should not cross-reference in § 155.300 to the affordability standard for eligible employer-sponsored coverage in the Department of the Treasury's premium tax credit regulation, 26 CFR 1.36B–0 *et seq.,* as the Department of the Treasury regulation is based on individual rather than family coverage.

Response: The Department of the Treasury maintains the legal authority to interpret and implement the eligibility standards for the premium tax credit, including those related to affordability and minimum value of coverage in an eligible employer-sponsored plan, because those are based on provisions of the Code. The proposed technical corrections do not revise the policy regarding the Exchange's determination of the affordability of eligible employer-sponsored coverage, but simply update the cross-reference to align with the Department of the Treasury's implementing regulation. As such, we are finalizing the technical corrections as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.300 of the proposed rule with a technical correction to specify the appropriate definition of minimum value.

7. Options for Conducting Eligibility Determinations (§ 155.302(a) and (b), and (d))

In § 155.302, we promulgated provisions as interim final with request for comments in the Exchange final rule (77 FR 18310, at 18451–52). We proposed to modify some of the provisions in § 155.302 in the proposed rule (78 FR 4594, 4635).

In paragraph (a) of the interim final rule, we provided that the Exchange may fulfill its minimum functions under this subpart by either executing all eligibility functions, directly or through contracting arrangements described in

§ 155.110(a), or through a combination of this approach and one or both of the approaches identified in paragraphs (b) and (c), which apply when other entities make eligibility determinations for insurance affordability programs. We proposed a revision to the interim final rule in paragraph (a)(1) to specify that Medicaid and CHIP eligibility determinations made by the Exchange may only be made by a government agency that maintains personnel standards on a merit basis.

In paragraph (b) of the interim final rule, we provided that the Exchange may conduct an assessment of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP, provided that the Exchange make such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with Medicaid and CHIP regulations, without regard to how such standards are implemented by the state Medicaid and CHIP agencies.

In paragraph (b)(2) of the interim final rule, we provided that notices and other activities that must be conducted in connection with an eligibility determination for Medicaid or CHIP would be conducted by the Exchange consistent with the standards identified in this subpart or by the applicable state Medicaid or state CHIP agency consistent with applicable law.

In paragraph (b)(3) of the interim final rule, we provided that if the Exchange assesses an applicant potentially eligible for Medicaid or CHIP, the Exchange would transmit such the applicant's information to the State Medicaid or CHIP agency for a formal determination of eligibility for such insurance affordability program. We explained in the preamble to the interim final rule that the Exchange would consider the applicant ineligible for Medicaid or CHIP for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions until the state Medicaid or CHIP agency notified the Exchange that the applicant was eligible for Medicaid or CHIP.

In paragraph (b)(4) of the interim final rule, we proposed that if the Exchange assesses an applicant not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, and notify the applicant and provide him or her with the opportunity to withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid and CHIP from the applicable state agencies. To the extent that an applicant withdraws his or her application for Medicaid and CHIP, the applicant would not receive a formal approval or denial for Medicaid and CHIP.

We proposed a revision to the interim final rule in paragraph (b)(4)(i)(A) to specify that, if an applicant who is not assessed as potentially eligible for Medicaid or CHIP by the Exchange withdraws his or her application for Medicaid or CHIP, and then appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and is found potentially eligible for Medicaid or CHIP, the Medicaid or CHIP application is not considered withdrawn. The purpose of this revision is to reinstate the Medicaid and CHIP application date, which is used in determining the effective date of coverage under Medicaid and CHIP.

We provided in paragraph (b)(4)(i)(B) that the Exchange must notify and provide an applicant who is assessed as not potentially eligible for Medicaid and CHIP with the opportunity to request a full determination of eligibility for Medicaid and CHIP by the applicable state Medicaid and CHIP agencies. For an applicant who requests a full Medicaid and CHIP determination, we provided that the Exchange must transmit all information provided as part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the state Medicaid and CHIP agency. We provided that the Exchange must consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the state Medicaid or CHIP agency notifies the Exchange that the applicant has been determined eligible for Medicaid or CHIP.

We provided in paragraph (b)(5) that, under an assessment model discussed above, the Exchange must adhere to the eligibility determination for Medicaid or CHIP made by the Medicaid or CHIP agency. We provided in paragraph (b)(6) that the Exchange and the applicable state Medicaid and CHIP agencies must enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP, which requirement complements the standards in § 435.1200(d). In accordance with these standards, when the Exchange performs an assessment and transmitted it to the state Medicaid or CHIP agency, and the Exchange is providing advance payments of premium tax credits pending an eligibility determination for Medicaid and CHIP, the Exchange will receive a notification of the final determination of eligibility for Medicaid and CHIP made by the receiving agency. This approach helps avoid duplicative requests for information from applicants and verification of information.

We proposed a revision to the interim final rule in paragraph (b)(5) to specify that the Exchange also will adhere to the appeals decision for Medicaid or CHIP eligibility determinations made by the state Medicaid or CHIP agency or appeals entity for such agency.

In paragraph (d) of the interim final rule, we provided the standards to which the Exchange must adhere when assessments of eligibility for Medicaid and CHIP based on MAGI and eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) and (c); such standards include that all eligibility processes are streamlined and coordinated across applicable agencies, that such arrangement does not increase administrative costs and burden on applicants, enrollees, beneficiaries, or application filers, or increase delay, and that applicable requirements under part 155 and section 6103 of the Code are met.

Comment: Several commenters raised concerns regarding § 155.302(a) as promulgated in the interim final rule, as they believed it could permit non-public agencies to conduct eligibility determinations for Medicaid and CHIP, which they worried would have a negative impact on consumer assistance, timeliness, accuracy, and the potential for conflicts of interest. Some commenters wanted to ensure that agreements between state Medicaid agencies and private entities related to the eligibility determination process would be relayed to HHS for appropriate review. Several commenters recommended clear language to specify that a private Exchange is not permitted to make final determinations regarding an applicant's eligibility for Medicaid and CHIP. One commenter wanted HHS to strengthen the conflict of interest language and specify that the Exchange may not contract out eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions due to such determinations being inherently governmental.

Response: We appreciate these comments regarding the interim final rule, as well as comments received

regarding the proposed revisions to paragraph (a)(1) of the interim final rule that would specify that any contracting arrangement for eligibility determinations for Medicaid and CHIP is subject to the standards in 42 CFR 431.10(c)(2). In response to these comments, we are finalizing § 155.302(a) with the proposed revision to paragraph (a)(1), with a minor clarification to specify that the reference to 42 CFR 431.10(c)(2) is specific to contracting arrangements for eligibility determinations for Medicaid and CHIP. Specifically, this means that an Exchange contractor may make eligibility determinations for Medicaid and CHIP if it is a government agency or public authority that maintains personnel standards on a merit basis. We note that 42 CFR 431.10(d) specifies that agreements regarding the delegation of eligibility determinations by state Medicaid agencies must be available to the Secretary, upon request. Exchanges are permitted to contract eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions in accordance with § 155.110(a).

Comment: Many commenters expressed concerns about the potential bifurcation of the eligibility process under § 155.302(b) for Medicaid, CHIP, and advance payments of the premium tax credit and cost-sharing reductions in terms of its impact on various stakeholders. Commenters urged that HHS maintain the ''no wrong door'' approach envisioned by the Affordable Care Act to ensure that an individual is appropriately screened for all relevant insurance affordability programs. As such, some commenters requested that by 2016, HHS revisit the decision to allow states to implement eligibility systems in the manner as described in the interim final rule, while also evaluating whether more Exchanges move from making assessments to determinations during the intervening time period. Commenters recommended that, if HHS retains this provision, HHS should specify that states must demonstrate they have the capacity to manage electronic accounts and applicant information in so as not to increase the burden on individuals and families by requesting duplicate information or increase the administrative costs for state Medicaid and CHIP agencies related to file transfers or unnecessarily duplicative verification processes. Some commenters wanted HHS to require the Exchange to notify the transferring program that it had received the electronic account and report its final eligibility determination, to protect applicants. Furthermore, commenters urged HHS to establish a process for monitoring and enforcing the standards, as well as educating the public, regarding the division of eligibility responsibilities between the Exchange and relevant Medicaid and CHIP agencies. Commenters stated that if such monitoring uncovers noncompliance with performance standards or other requirements, HHS should require the Exchanges and state Medicaid and CHIP agencies to submit corrective action plans.

Response: We appreciate the suggestions from commenters, and note that many of these recommendations are already included in the interim final rule. We intend to monitor the efficiency of how states implement assessment or determination models to determine whether to propose revisions in future years. We believe that the existing language in § 155.302(b) is augmented by § 155.345(g) and 42 CFR 435.1200, which specify that the Exchange and the state Medicaid and CHIP agencies must have the capacity to manage electronic accounts, and also that the Exchange will notify the transferring Medicaid or CHIP agency regarding the receipt of an electronic account as well as of its final eligibility determination. Accordingly, we do not modify this provision further to address these comments. Although we do not establish a formal process for monitoring and taking enforcement action for noncompliance with these standards in the regulation text, HHS will continue to evaluate the need for such processes during the implementation of these regulations.

Comment: Several commenters suggested that states should adopt procedures that would allow Exchanges to assess eligibility for Medicaid based on factors other than MAGI, and potentially also allowing the Exchange to assess eligibility for other programs, including the Supplemental Nutritional Assistance Program. Some commenters urged HHS to require Exchanges to develop appropriate screening standards to identify vulnerable populations that might be eligible for certain programs on a basis other than MAGI.

Response: This comment is outside the scope of § 155.302(b) of the interim final rule, as this provision only concerns the use of MAGI determinations, while § 155.345(b) concerns the duties of the Exchange for Medicaid eligibility based on factors other than MAGI. We note that Exchanges are not precluded from entering into agreements with Medicaid and CHIP agencies to make eligibility determinations for Medicaid based on factors other than MAGI.

Comment: Some commenters requested that HHS provide greater specificity throughout § 155.302(b) to indicate that contracting agreements, verifications rules and standards, notices, and other activities discussed must adhere to the specific standards of §§ 155.302(d) and 155.345(g), and 42 CFR part 431, subpart E.

Response: As noted earlier, § 155.302(b) only applies in place of the standards elsewhere in subpart D that specify that the Exchange will make eligibility determinations for Medicaid and CHIP based on MAGI, rather than assessments; it does not conflict with standards provided elsewhere in subpart D that address other components of the eligibility process that are unaffected by whether the Exchange is making assessments or determinations of eligibility for Medicaid and CHIP. As such, Exchanges are still guided by other provisions in subpart D, such as § 155.345(g). Provisions in 42 CFR part 431 concern standards for Medicaid agencies, which continue to apply to Medicaid agencies in accordance with that part notwithstanding the role of the Exchange for Medicaid eligibility. Finally, § 155.302(a)(2) already specifically states that use of the option in § 155.302(b) is subject to § 155.302(d), so we do not believe that it is necessary to add further references to § 155.302(d).

Comment: Some commenters supported the increased level of flexibility for the Exchange to make assessments of eligibility for Medicaid and CHIP based on MAGI, rather than determinations. However, these commenters expressed concerns about relying on applicants who are not assessed as potentially eligible for Medicaid or CHIP based on MAGI to self-identify as potentially eligible based on non-MAGI standards or proactively request a full determination from the state Medicaid and CHIP agencies, as opposed to placing greater burden on the Exchange to take additional steps to proactively identify applicants who might be Medicaid eligible based on non-MAGI standards. One commenter also asked HHS to clarify that in cases where an Exchange conducts an assessment of Medicaid eligibility; the assessment must include an assessment of Medicaid eligibility on bases other than MAGI. These commenters suggested that HHS encourage states to utilize a process whereby individuals who enroll in a QHP, but are subsequently determined eligible for Medicaid, are able to transition into the same carrier's Medicaid product if the

QHP also operates a Medicaid health plan.

Response: We appreciate the concerns regarding how to create a streamlined process that is minimally burdensome on individuals and families, and results in accurate eligibility determinations. Under § 155.345(b) and (c), the Exchange will evaluate applications for applicants who are not eligible for Medicaid based on MAGI for possible Medicaid eligibility based on factors other than MAGI, and must provide an opportunity for applicants and enrollees to request a full determination of Medicaid eligibility based on factors other than MAGI. If the Exchange evaluates an applicant as potentially eligible for Medicaid based on factors other than MAGI, or the applicant or enrollee requests a full determination of Medicaid eligibility, § 155.345(d) specifies that the Exchange will transmit the applicant's information to the state Medicaid agency for a full determination. The Exchange has the same responsibilities regarding eligibility for Medicaid based on factors other than MAGI under the assessment and the determination models, which we believe is appropriate because the single, streamlined application that will be used by the Exchange does not request all the information necessary to conduct a full determination of Medicaid eligibility based on factors other than MAGI. Rather, it includes an opportunity for an application filer to indicate that an applicant has limitations in daily activities or lives in a medical facility or nursing home, which are factors that are considered in determining eligibility for Medicaid based on factors other than MAGI. If answered affirmatively, the Exchange will trigger a referral to the applicable state Medicaid agency such that the state Medicaid agency can determine the applicant's eligibility for Medicaid, including based on factors other than MAGI. Further, we note that the assessment of eligibility for Medicaid based on MAGI is designed to be a robust evaluation, and we expect that the number of applicants who will receive an assessment that is inconsistent with the final determination will be limited. We note that while comments related to HHS encouraging a process to help individuals transition between QHPs and Medicaid products of the same carrier is outside the scope of this regulation, Exchanges maintain the flexibility to pursue such an option.

Comment: Some commenters noted the need for high levels of coordination between the Exchange and state Medicaid and CHIP agencies. A few commenters also wanted HHS to provide guidance with a view toward minimizing the situations in which an individual will enroll in a QHP through the Exchange pending the outcome of a Medicaid or CHIP eligibility determination and then be subsequently determined eligible for Medicaid or CHIP.

Response: We agree that a high degree of coordination is needed to manage an assessment model, and believe that the language in § 155.302(b) and (d), as well as § 155.345, prescribes an appropriate set of standards. We recognize the challenges that may occur related to individuals who enroll in a QHP pending the outcome of a Medicaid or CHIP eligibility determination, but we believe that these are outweighed by the benefits associated with providing eligible individuals with health coverage pending the completion of an eligibility determination for Medicaid or CHIP, and we note that enrolling in a QHP through the Exchange during such a period is the individual's choice. With that, we expect that as states implement their Exchanges and as eligibility systems for the Exchange, Medicaid, and CHIP mature, the need for multiple entities to take part in processing an application will lessen, and the time needed to complete the entire eligibility process will also decrease, which will reduce the need for interim coverage.

Comment: One commenter worried that the remainder of subpart D concerning the eligibility process was not updated to reflect § 155.302(b).

Response: We note that § 155.302(b) provides that the Exchange may conduct an assessment of MAGI-based eligibility for Medicaid and CHIP, rather than a determination of eligibility for Medicaid and CHIP, in accordance with the specified standards, ''[n]otwithstanding the requirements of this subpart[.]'' In view of this language, we did not update other provisions in subpart D to reflect § 155.302(b). We note that § 155.302(b) does not supersede other provisions, such as those in § 155.345, that set additional standards for Exchanges in coordinating with Medicaid and CHIP agencies.

Comment: Some commenters worried that the Exchange assessment provision would allow the Exchange the assess eligibility without applying Medicaid rules and procedures. Commenters recommended that, under an assessment model, the Exchange should provide presumptive eligibility for Medicaid, which they believed was particularly important for children and pregnant women, while the application is transferred to the Medicaid and CHIP agencies and a determination is made. One commenter suggested HHS develop a universal model for tracking children as they move from one coverage type to another, which Exchanges should be required to implement.

Response: Section 155.302(b)(1) specifies that an assessment will be made based on, ''the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented by the State Medicaid and CHIP agencies.'' We maintain this language in this final rule, which ensures that the Exchange will use standard Medicaid rules and procedures in making an eligibility assessment. We appreciate the commenter's recommendations related to presumptive eligibility, but note that HHS' approach in establishing an assessment model was premised on having the Medicaid or CHIP agency make all eligibility determinations that result in the provision of benefits under Medicaid or CHIP. Accordingly, we do not specify that the Exchange will make presumptive determinations under an assessment model. HHS will continue to work with Exchanges and Medicaid and CHIP agencies to ensure that vulnerable populations, such as children and pregnant women, receive the correct eligibility determinations for insurance affordability programs in a timely fashion.

Comment: Some commenters recommended that the interim final rule be amended to eliminate or strictly limit differences between the procedures used by Exchanges in assessing eligibility for Medicaid and CHIP, and those used by state Medicaid and CHIP agencies in determining eligibility, with HHS permitting Federally-facilitated Exchanges and State Partnership Exchanges to have slightly more flexibility for differences than State-based Exchanges.

Response: We agree that the differences between the procedures used by Exchanges and their partner Medicaid and CHIP agencies in conducting eligibility determinations should be limited, and believe that § 155.302(b)(1) already accomplishes this to a significant extent. We reiterate that an assessment under § 155.302(b) will be robust and will involve the execution of detailed MAGI-based eligibility rules and verification procedures. Further, we believe that there is little reason for the use of an assessment model in a state that operates a state-based Exchange, given the availability of shared information technology services and the status of the

state-based Exchange as a state, rather than a federal, entity. We intend to continue to work closely with states to ensure that systems and processes are appropriately integrated, with the goal of reducing administrative costs, burden on consumers, and the time needed to complete the eligibility process.

Comment: Several commenters recommended that HHS set a specific timeliness standard regarding the electronic transmission of the application along with all relevant information collected from either the application or available electronic data sources from the Exchange to the state Medicaid or CHIP agency to ensure that eligibility determinations are provided without undue delay. Some commenters requested that HHS specify that an Exchange must complete an eligibility determination in no more than 30 days (with up to 60 days for evaluations based on factors other than MAGI under § 155.345(b)) and complete the transfer of an individual's electronic file, where required, within one business day; some commenters also urged greater alignment between Exchange and Medicaid timeliness and other performance standards.

Response: In § 155.302(b)(3) and (b)(4)(ii)(A), we specify that information will be transferred promptly, and without undue delay. Further, in § 155.310(e)(1), we specify that the Exchange will make an eligibility determination promptly, and without undue delay. We believe that this is an appropriate approach to initial timeliness standards, given the fact that this is an entirely new program, and we intend to work closely with states to monitor and improve the timeliness of all aspects of the eligibility and enrollment process. Further, we note that we agree with the commenter's suggestion regarding the alignment of performance standards, and intend to issue future guidance on this topic.

Comment: Several commenters suggested that HHS modify § 155.302(b)(6) related to the standards for agreements entered into between the Exchange and state Medicaid and CHIP agencies to provide greater specificity regarding eligibility determinations, transfer procedures, notice and appeals processes, and consumer assistance. Additionally, these commenters asked that the agreements be made readily available to the public in addition to HHS, while also providing a period for public review and comments on the agreements prior to their approval by HHS.

Response: We finalize § 155.302(b)(6) from the interim final rule with a clarification that, like the agreements specified in § 155.345(a), the agreement under § 155.302(b)(6) will be made available to HHS upon request. To the extent that the Secretary requests and obtains a copy of an agreement under § 155.302(b)(6), the public can request the agreement through the Freedom of Information Act, 5 U.S.C. 552. The public may also obtain copies of these agreements under applicable state freedom of information laws. We believe that there are ample opportunities for public input for Exchange operations, particularly given that the standards that will govern the content of these agreements are specified in this regulation. We also note again that § 155.302(b) does not supersede other provisions, such as those in § 155.345, that set additional standards for Exchanges in coordinating with Medicaid and CHIP agencies.

Comment: One commenter wanted to ensure that HHS would review and approve all state Medicaid verification plans.

Response: This comment is outside of the scope of this regulation. We note, however, that as described in 42 CFR 435.945(j), state Medicaid verification plans must be available to the Secretary of HHS upon request, thereby enabling appropriate oversight of verification standards.

Comment: One commenter sought clarification as to whether an Exchange could choose to perform neither an assessment nor a determination for Medicaid and CHIP.

Response: We clarify that the Exchange must make either determinations or assessments for Medicaid and CHIP based on MAGI for applications that include a request for an eligibility determination for insurance affordability programs. However, we note that the Exchange is permitted to contract with an eligible contracting entity, including the state Medicaid agency, to conduct eligibility determinations for Medicaid and CHIP, consistent with § 155.302(a).

Comment: Several commenters recommended that an applicant who appears to be eligible for Medicaid based on factors other than MAGI be flagged by the Exchange early in the process, and if the Exchange does not assess such an applicant as potentially eligible for Medicaid or CHIP based on MAGI, the applicant should not have to request a full eligibility determination from the state agency under § 155.302(b)(4)(i)(B) to receive an eligibility determination for Medicaid based on factors other than MAGI.

Response: As noted above, § 155.302(b) does not supersede § 155.345(b), which specifies that the Exchange will assess information provided on an application by an applicant who is not eligible for Medicaid based on MAGI to determine whether he or she is potentially eligible for Medicaid based on factors other than MAGI. We clarify that this provision applies in an Exchange that is implementing the option under § 155.302(b), such that if the Exchange does not assess an applicant as potentially eligible for Medicaid based on MAGI, it will then examine the application to determine whether to transfer the applicant to the state Medicaid agency for consideration of Medicaid eligibility based on other factors.

Comment: Commenters recommended that the provision at § 155.302(b)(4)(i)(A), allowing an individual the opportunity to withdraw his or her Medicaid and CHIP application, be eliminated or modified to allow only individuals above a certain income threshold to withdraw their Medicaid and CHIP applications. Others commenters were concerned that language notifying an individual of his or her opportunity to withdraw would be confusing and lead to individuals being dissuaded from pursuing a Medicaid or CHIP eligibility determination.

Response: When an applicant requests an eligibility determination for insurance affordability programs, the single, streamlined application is an application for Medicaid and CHIP (as well as for eligibility for enrollment in a QHP through the Exchange, and related insurance affordability programs), so it needs to end in either a final determination of eligibility for Medicaid or CHIP (approval or denial), or a withdrawal of the application as it relates to Medicaid and CHIP. When a state Medicaid or CHIP agency elects to have the Exchange make assessments of Medicaid or CHIP eligibility, rather than determinations, the Exchange is unable to provide a final determination of Medicaid or CHIP eligibility, including a denial of Medicaid or CHIP eligibility. Accordingly, withdrawal allows the assessment model to function such that an applicant does not require a formal, final denial of Medicaid and CHIP from the state Medicaid or CHIP agency to gain eligibility for advance payments of the premium tax credit and cost-sharing reductions, if otherwise eligible. This approach provides significant efficiencies for consumers by not requiring multiple eligibility determinations, as well as for Exchanges and Medicaid and CHIP agencies. Given that the proposed approach preserves the application date for purposes of

Medicaid and CHIP in the event of an appeal, we note that the only implication of withdrawing an application in this context is that the applicant can no longer request a determination from the state Medicaid or CHIP agency based on the withdrawn application, and would instead need to submit another application to be considered for those programs (other than on appeal).

We acknowledge commenters' concerns regarding the potential for confusion when an applicant is given the opportunity to withdraw his or her Medicaid and CHIP application. To reduce the potential for consumer confusion and administrative burden on the consumer and the Exchange associated with this requirement, we offer the following option in implementing this provision. Upon notifying an applicant that the Exchange has assessed him or her as not potentially eligible for Medicaid or CHIP, the Exchange will provide an opportunity for the applicant to request a determination of Medicaid or CHIP eligibility from the state Medicaid or CHIP agency. Rather than expressly asking the applicant if he or she wants to withdraw the application for purposes of Medicaid or CHIP eligibility (instead of requesting a determination from the state agencies), the Exchange may consider the application withdrawn for purposes of Medicaid and CHIP eligibility if the applicant does not affirmatively request a determination from the state Medicaid or CHIP agency within a time period specified in the notice to the applicant, provided that the notice that communicates the opportunity to request a determination from the state Medicaid or CHIP agency and the time limit for doing so also specifies that the Exchange will take this approach to withdrawal. This will allow an appropriate disposition for each application, as it relates to Medicaid and CHIP, and will help alleviate any confusion associated with the opportunity to expressly withdraw an application, without creating any adverse impacts for consumers.

Comment: A few commenters requested language that explicitly preserves the date of application when an applicant withdraws his or her Medicaid or CHIP application.

Response: Provisions related to preserving the date of the Medicaid or CHIP application are contained in this final rule at 42 CFR 435.907(h).

Comment: Commenters supported the inclusion of language that requires the application to not be considered withdrawn if, upon appeal, the applicant is found potentially eligible for Medicaid or CHIP. A few commenters requested that any subsequent review finding potential eligibility for Medicaid or CHIP be sufficient to nullify the withdrawal.

Response: We are finalizing proposed language requiring the application to not be considered withdrawn if, upon appeal, the applicant is found potentially eligible for Medicaid or CHIP. The additional suggestions to amend this provision would expand the scope of the provision beyond its intended scope. Further, it would be impossible to administer the commenters' suggestion to nullify a withdrawal when any future review finds potential eligibility for Medicaid or CHIP eligibility, beyond the parameters established in this rule, since subsequent eligibility determinations and redeterminations will not necessarily be connected to the withdrawn application.

Comment: Commenters supported the additional proposed language in § 155.302(b)(5) requiring the Exchange to adhere to State Medicaid or CHIP agency appeals decisions.

Response: We are finalizing the proposed language with a modification such that the Exchange appeals entity, in addition to the Exchange, will adhere to the eligibility determination or appeals decision for Medicaid or CHIP made by the Medicaid or CHIP agency, or the appeals entity for such agency.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.302(a) with one clarification that any contracting arrangement for eligibility determinations for Medicaid and CHIP is subject to the standards in § 431.10(c)(2). We are finalizing the provision proposed in § 155.302(b)(5) with a slight technical modification to add ''Exchange appeals entity.'' We are finalizing § 155.302(b)(6) of the interim final rule issued at 77 FR 18310, 18451–52 with a modification to specify that the agreement under § 155.302(b)(6) must be made available to HHS upon request. We are finalizing the provisions proposed in paragraph (d) of the proposed rule without modification. We are otherwise finalizing the other provisions of the interim final rule with the exception of § 155.302(c), which we are not finalizing at this time. We are leaving the text of § 155.302(c) as an interim final rule as published at 77 FR 18310, 18451–52.

8. Eligibility Standards (§ 155.305)

In § 155.305, we proposed to add paragraph (a)(3)(v) regarding residency standards for eligibility for enrollment in a QHP when an individual attests to being temporarily absent from the service area of the Exchange but intends to return to the service area of the Exchange and otherwise meets the residency standards, unless another Exchange verifies that the individual meets the residency standard in that Exchange. We also proposed technical corrections within paragraph (f) to replace the references to section 36B of the Code to the application Treasury regulations.

We proposed to amend paragraph (f)(3) to clarify the availability of advance payments of the premium tax credit and cost-sharing reductions to applicants enrolled in a QHP, that is not a catastrophic plan, through the Exchange. We did not receive specific comments on this amendment, and we are thus finalizing the provision as proposed.

We also proposed to add paragraph (h) to codify the eligibility standards for enrollment through the Exchange in a QHP that is a catastrophic plan, which are based on age or having in effect a certificate of exemption from the shared responsibility payment under section 5000A of the Code in specific categories. We proposed that all Exchanges must conduct eligibility determinations for a QHP that is a catastrophic plan within the Exchange.

Comment: Commenters generally offered support for the provision at § 155.305(a)(3)(v) specifying that the Exchange not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if he or she meets the residency standards described in paragraph (a)(3) but for a temporary absence from the service area of the Exchange. A few commenters recommended deleting the phrase that allowed the Exchange to deny or terminate eligibility if another Exchange verifies that the individual meets the residency standard of such Exchange; others suggested rephrasing the provision to allow an individual to maintain residency in the Exchange service area unless he or she is enrolled in another Exchange. Commenters recommending revisions disagreed with how this language would limit an applicant's ability to establish residency, under the rules described in § 155.305(a)(3), in more than one Exchange.

Response: We are finalizing the provision without the proposed clause ''unless another Exchange verifies that the individual meets the residency standard of such Exchange.'' As commenters pointed out, under some circumstances, certain individuals may

establish residency for purposes of Exchange enrollment in multiple Exchange service areas simultaneously (for example, under § 155.305(a)(3)(iv)(B), if a parent expects to claim a child who lives in another state on the parent's tax return, the child may enroll in a QHP through the Exchange either in the child's state of residence, or the parent's state of residence). Accordingly, while generally, applicants will establish residency in the Exchange service area in which they intend to reside, since there are exceptions to this general principle, this clause limiting residency to one Exchange service area is unnecessary.

Comment: In response to the provision proposed at § 155.305(a)(3)(v), some commenters expressed concern about operational challenges specific to providing and coordinating coverage while individuals are temporarily residing outside the Exchange service area. A few commenters asked that we further define the term ''temporary'' to ensure that the term is used consistently across Exchanges, and to help reduce consumer confusion and administrative inefficiencies.

Response: We acknowledge that coordinating care for applicants while they are temporarily absent from the service area of the Exchange through which they enroll in a QHP may present challenges for QHP issuers. However, we believe this challenge is outweighed by the importance of maintaining continuity of coverage while an individual is temporarily absent from a particular Exchange service area. Additionally, in paragraph (a)(3)(v), we specify that ''temporarily absent'' means the applicant must intend to return to the Exchange service area when the purpose of the absence has been accomplished, so we do not believe that further definition is required in regulation. To ensure that applicants understand the implications of applying for coverage through a particular Exchange, we encourage Exchanges to notify applicants that they may want to apply for coverage through the Exchange where they meet the residency requirements and wish to most frequently access benefits.

Furthermore, this provision should not be construed to impose any additional requirements on QHP issuers related to maintaining networks outside the Exchange service area or coordinating care for applicants temporarily absent from the Exchange service area.

Comment: Commenters were divided regarding the Exchange's role in determining eligibility for catastrophic plans inside and outside the Exchange, as some expressed support for what they interpreted as HHS limiting enrollment for catastrophic coverage to enrollment through the Exchange in QHPs that are catastrophic plans and urged flexibility for an Exchange to decide not to conduct eligibility determinations for catastrophic plans, while other commenters requested that the Exchange conduct eligibility determinations for QHPs that are catastrophic plans for enrollment both through and not through the Exchange. Commenters also urged HHS to clarify that an applicant still must be determined eligible for a QHP to enroll in a catastrophic plan through the Exchange. Commenters wanted to ensure that the Exchange would provide clear information to applicants considering purchasing different QHPs, including by describing the significance of enrolling in a catastrophic plan for applicants who are also determined eligible for advance payments of the premium tax credit.

Response: We note that paragraph (h) only concerns eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. The Exchange will not be conducting eligibility determinations for enrollment outside the Exchange, including in a catastrophic plan. In finalizing this provision, we are modifying the provision from its proposed form to clarify that an individual must be determined eligible for enrollment in a QHP through the Exchange in accordance with § 155.305(a) in addition to meeting the specific eligibility standards for enrollment in a catastrophic QHP through the Exchange. We believe that maintaining the provision specifying that the Exchange will determine eligibility for a QHP that is a catastrophic plan through the Exchange preserves flexibility for young adults and people for whom coverage would otherwise be unaffordable to have access to health coverage, and thus confirm that Exchanges will conduct determinations of eligibility for enrollment in a QHP that is a catastrophic plan through the Exchange. We expect that Exchanges will fully inform qualified individuals regarding the implications of enrolling in a QHP that is a catastrophic plan through the Exchange as they consider various health coverage options, particularly as it affects their eligibility for insurance affordability programs.

Comment: Some commenters wanted us to clarify that Exchanges would grant certificates of exemption to all applicants eligible for enrollment in a catastrophic plan, which applicants could use to enroll in catastrophic plans outside the Exchange (at least temporarily), and suggested that issuers of catastrophic plans outside the Exchange should be permitted to rely solely on an attestation by the applicant that he or she is eligible to enroll in a catastrophic plan.

Response: This provision does not concern catastrophic plans offered outside of the Exchange. As discussed in the Market Reforms final rule at 78 FR 13423, the statutory provisions related to eligibility for catastrophic plans apply to such coverage offered both inside and outside an Exchange. We maintain that approach and clarify that nothing in this proposal modifies the Market Reforms final rule related to the eligibility standards for a catastrophic plan. Similarly, the eligibility standards for catastrophic plans generally are specified at § 156.155(a)(5), which provides that a catastrophic plan can only cover an individual who has either not attained the age of 30 prior to the first day of the plan or policy year, or has received a certificate of exemption in specified categories. While we specify that the Exchange will only conduct determinations of eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan, in HHS' Exemptions and Miscellaneous Minimum Essential Coverage proposed rule, at 78 FR 7368, we propose that the Exchange will determine eligibility for exemptions from the shared responsibility payment, and will provide a notice and an exemption certificate number to any individual determined eligible for such an exemption. If that provision is finalized as proposed, an issuer of a catastrophic plan offered outside the Exchange could request a copy of this notice from an applicant to validate his or her eligibility for enrollment in the catastrophic plan.

Comment: Some commenters requested that the Exchange's eligibility standards for enrollment through the Exchange in a QHP that is a catastrophic plan align with preamble language in the Market Reforms proposed rule at 77 FR 70601 such that an enrollee who turns 30 in the middle of a coverage year would remain enrolled in the catastrophic plan for the duration of the plan year. One commenter also sought clarification that for coverage obtained through the Exchange, the first day of the plan year will always be the first of the year.

Response: The eligibility standards related to age described in this provision follow the approach discussed within the Market Reforms proposed

rule at 77 FR 70601. As such, we clarify that an enrollee turning 30 in the middle of a coverage year could remain enrolled in a QHP that is a catastrophic plan through the Exchange for that particular coverage year as long as he or she was not 30 prior to beginning of the plan year. We note that § 147.104(b)(1)(ii) clarifies that in the individual market, the coverage effective dates must align with § 155.410 regarding initial open enrollment, and as such, for coverage obtained in the individual market through the Exchange, the first day of the plan year will always be the first day of the calendar year.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.305 of the proposed rule with two slight modifications: to remove the clause ''unless another Exchange verifies that the individual meets the residency standard of such Exchange'' in paragraph (a)(3)(v), and to revise paragraph (h)(1) to clarify an applicant must be eligible for enrollment in a QHP through the Exchange to be determined eligible for enrollment through the Exchange in a QHP that is a catastrophic plan.

9. Eligibility Process (§ 155.310)

In § 155.310, we proposed to add paragraph (i) regarding a certification program under the Secretary's program for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions in accordance with section 1411(a) of the Affordable Care Act. We noted that this certification program would be distinct from the notice to employers required by section 1411(e)(4)(B)(iii) of the Affordable Care Act and paragraph (h) of § 155.310. We proposed that the certification to the employer would consist of methods adopted by the Secretary of Treasury as part of the determination of potential employer liability under section 4980H of the Code. We clarified that the certification program would address not only individuals on whose behalf advance payments of the premium tax credit and cost-sharing reductions are provided, but also individuals claiming the premium tax credit only on their tax returns. We solicited comments on this proposal.

We proposed to amend previous language from paragraphs (i) and (i)(1), and combine those paragraphs in new paragraph (j), to align with proposed revisions in § 155.335, which specified that the Exchange will redetermine eligibility on an annual basis for all qualified individuals, not only enrollees. We proposed to remove the previous paragraph (i)(2), which addressed situations in which a qualified individual did not select a plan before the date on which his or her eligibility would have been redetermined as a part of the annual redetermination process. Due to the proposed change to § 155.335(a), this paragraph would no longer be necessary. We received the following comments concerning the proposed provisions:

Comment: One commenter expressed support for the proposal to implement a certification process consisting of methods adopted by the Secretary of Treasury as part of the determination of potential employer liability under section 4980H of the Code, as described in proposed § 155.310(i). In addition, several commenters expressed concern over the disclosure of applicant information to the employer for use in the certification process. Commenters were concerned that disclosing names in this context could have a chilling effect on employees who wish to seek Exchange coverage, making it less likely that individuals would enroll.

Response: For purposes of the certification program proposed and finalized in § 155.310(i), we believe that only the minimum personally identifiable information necessary should be released to an employer. Additional information regarding the certification program is found in the regulations associated with § 4980H of the Code.

Comment: Commenters recommended removing the provision specifying that the Exchange will have an applicant attest to the accuracy of the information on file for him or her when he or she was previously determined eligible for enrollment in a QHP through the Exchange, did not select a QHP during his or her enrollment period, or was ineligible for an enrollment period, and then seeks a new enrollment period prior to his or her annual redetermination. Commenters characterized this as an undue burden on qualified individuals, since enrollees are not required to make the same attestation about their eligibility criteria remaining constant.

Response: This provision was largely carried over from the Exchange final rule, with modifications to address changes proposed in § 155.335. It is important for the Exchanges to ensure all eligibility criteria are satisfied with accurate information, before determining eligibility for benefits, some of which the enrollee could be liable to repay if eligibility information is not accurate at the time of enrollment. Moreover, enrollees are required to report changes that may affect their eligibility based on the standards in § 155.305 throughout the year, and thus no additional burden is being placed on qualified individuals. Lastly, one alternative to this proposal would be to require qualified individuals who do not enroll in coverage when initially determined eligible to file a new application, which would be more burdensome than the approach in § 155.310(j). Accordingly, we are finalizing § 155.310(j) as proposed, with a slight technical correction for clarity to note that this paragraph only refers to an applicant who is determined eligible for enrollment in a QHP through the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.310 of the proposed rule with a technical correction to specify that paragraph (j) only refers to an applicant who is determined eligible for enrollment in a QHP through the Exchange .

10. Verification Process Related to Eligibility for Enrollment in a QHP Through the Exchange (§ 155.315)

In § 155.315, we proposed a technical correction in paragraph (b)(2) to clarify the procedures for an Exchange when the Social Security Administration indicates an individual is deceased.

We proposed to clarify the circumstances that trigger the inconsistency process described in paragraph (f)(1) and (2), such as when required electronic data is not contained within the electronic data source, and when sources of required data are not reasonably expected to be available within two days of the initial attempt to reach the data source. We also proposed to amend paragraph (f)(4) to clarify that during the clerical error resolution period provided in paragraph (f)(1), as well as during the period provided in paragraph (f)(2)(ii), the Exchange proceeds with the eligibility determination and provides eligibility for enrollment in a QHP and advance payments of the premium tax credit and cost-sharing reductions, as applicable, during such period, to the extent the applicant is otherwise qualified and meets the standards specified in paragraph (f)(4).

We proposed to add paragraph (j) concerning the verification process related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. We proposed that the Exchange may either accept the applicant's attestation of age without further verification or examine available

electronic data sources that have been approved by HHS for this purpose. To verify an applicant's exemption from the shared responsibility payment, we proposed that this would be accomplished either through use of the Exchange's records, or through verification of paper documentation if the certificate was issued by a different Exchange. In terms of the inconsistency process described in paragraph (f) of this section, we noted that applicant would not be determined eligible for enrollment through the Exchange in a QHP that is a catastrophic plan until verification of necessary information can be completed. We received comments that addressed both the eligibility standards and verification process related to QHPs that are catastrophic plans offered through the Exchange, and have addressed those comments above the preamble to § 155.305(h). As such, we are finalizing this paragraph as proposed.

Comment: Several commenters supported our proposed technical correction in paragraph (b)(2) regarding situations in which the Social Security Administration indicates that an individual is deceased. Others recommended allowing additional time, and many commenters suggested providing an additional 90 days when an applicant has demonstrated a good faith effort to resolve the issue. Some commenters sought clarification on the availability of appeal rights regarding inconsistencies with Social Security Administration data, specifically, whether individuals had the right to appeal during the 90-day period or whether they must wait until after a final determination has been made.

Response: As noted in § 155.315(f)(3), the Exchange has the authority to extend the inconsistency period within § 155.315(f)(2)(ii) based on a good faith effort on the part of the applicant. We note that an applicant will not be able to appeal an eligibility decision until he or she receives a notice containing an approval or denial of eligibility. Further details regarding appeals will be provided in subsequent rulemaking. We continue to work with the Social Security Administration and other federal agencies to determine the role of other federal agencies in the appeals process. Accordingly, we are finalizing the provision as proposed.

Comment: Some commenters disagreed with the proposal at § 155.315(f) that specifies that the Exchange must trigger the inconsistency period when electronic data is required but it is not reasonably expected that data sources will be available within 2 days of the initial request to the data source. Commenters recommended that if verification cannot occur promptly, or in ''real time,'' the inconsistency period should be triggered immediately, along with the provision of eligibility based on an applicant's attestation. Some commenters mentioned specifically that an inability to verify citizenship and immigration status through electronic data should lead to the immediate trigger of the inconsistency period, to align with Medicaid regulations.

Commenters supported timelines according to which the Exchange should be required to contact the application filer for documentation or additional information when data sources are unavailable. Some commenters supported the requirement of a 2-day period prior to requesting information from the application filer, and some recommended extending it to 5 days. Commenters also recommended that the Exchange continue to attempt data matches after notifying the application filer so the entire burden is not immediately shifted to the application filer.

Response: Since the publication of the proposed rule, we have confirmed that data from IRS, SSA, and DHS should be available every day. Accordingly, we are modifying the proposed provision to finalize the rule to reduce the waiting period reduced from 2 days to 1 day. Further, we also add new paragraph (f)(6) to clarify the applicability of § 155.315(f).

First, in paragraph (f)(6), we specify that that the Exchange will not apply such a waiting period when electronic data to support the verifications specified in § 155.315(d) (residency), or § 155.320(b) (minimum essential coverage, other than minimum essential coverage in an eligible employer-sponsored plan) is required but it is not reasonably expected that electronic data sources will be available within 1 day of the initial request to the data source; instead, the Exchange will accept the applicant's attestation regarding the factor of eligibility for which the unavailable data source is relevant. While the data matching described in this subpart for these factors of eligibility is important, we do not believe that it should hold up an eligibility determination or cause the eligibility process to default to paper documentation when electronic data sources are unavailable. We also note that the use of electronic data as a primary method of verification of residency is an option for Exchanges. In addition, we clarify that § 155.320(d)(3)(iii) specifies that when the Exchange does not have information from data sources for the verifications related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange will move forward with a sampling process.

Second, we clarify that § 155.320(c)(3) (family size and income for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions) already specifies procedures to address situations in which electronic data sources with information about current, MAGI-based income are unavailable. We believe that these procedures should continue to govern these situations.

We acknowledge commenters' concerns about providing eligibility determinations in a timely fashion when electronic data sources are delayed in responding or do not respond. The proposed language at § 155.315(f) minimizes the administrative and consumer burden associated with requesting documentation and providing coverage for a short period of time (when electronic data sources may quickly become available and indicate eligibility for a different insurance affordability program), with the need to provide prompt eligibility determinations. Accordingly, when electronic data from IRS, SSA, or DHS is necessary but unavailable, and it is reasonably expected that the necessary electronic data source will be available within 1 day, the Exchange will wait 1 day before making an eligibility determination, so as to not generate an eligibility determination that may be shown to be invalid less than 24 hours later. This approach also avoids the need to request documentation when an electronic data match will make the documentation request unnecessary less than 24 hours later. If it is not reasonably expected that the necessary electronic data source will be available within 1 day, or it is reasonably expected that the necessary electronic data source will be available within 1 day, but this expectation proves incorrect, then the Exchange will determine the applicant's eligibility using his or her attestation regarding the factor of eligibility for which the electronic data source is unavailable, and will follow the remaining procedures in § 155.315(f) to attempt to complete the verification. We believe this approach is responsive to commenters' concerns and satisfies the need to reduce administrative burden and the burden on application filers while still ensuring accurate eligibility determinations. We also note that the Exchange has the flexibility to continue checking whether such data sources

have become available leading up to the triggering of the inconsistency period and during such inconsistency period.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.315 of the proposed rule, with a few modifications. We are modifying paragraph (f) to provide that if key electronic data sources are unavailable and not reasonably expected to be available within 1 day, the Exchange will make an eligibility determination based on an applicant's attestation and trigger the inconsistency period in paragraph (f). The proposed language specified a 2-day period. We also added a new paragraph (f)(6) to clarify that the Exchange will accept an applicant's attestation regarding three specific factors of eligibility when electronic data is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source. We are also modifying paragraph(f)(5) of this section by deleting paragraph (f)(5)(ii) and combining paragraph (f)(5)(i) with paragraph (f)(5), because the language that previously appeared in paragraph (f)(5)(ii) regarding effective dates conflicted with the requirements under § 155.330(f). Lastly, we modify the language in paragraph (j) related to the verification of eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan for purposes of clarity.

11. Verifications Related to Eligibility for Insurance Affordability Programs (§ 155.320)

In § 155.320, we proposed to amend and make technical corrections in paragraph (c)(1), in accordance with the legislative change made by Public Law 112–56 concerning the treatment of Social Security benefits related to MAGI, to incorporate Social Security benefits when verifying projected annual household income. We also proposed to remove language concerning an adoption taxpayer identification number, and to replace references to section 36B of the Code with the applicable Treasury regulation. We received comments supporting these revisions without further suggestions, and are thus finalizing the amendments and technical corrections as proposed.

We proposed to amend and make technical corrections in paragraph (c)(3) to specify that the Exchange verify that neither advance payments of the premium tax credit nor cost-sharing reductions are already provided on behalf of an individual, and align with the revised policy that the Exchange incorporate Social Security benefits when verifying projected annual household income. We did not receive specific comments regarding the proposed changes to paragraph (c)(3), and are thus finalizing the changes as proposed.

We proposed to clarify when additional verification is necessary as part of the process to verify an expected increase in projected annual household income when compared to annual income data. We proposed to add language regarding the circumstances under which annualized current income data will be sufficient to support an expected decrease in projected annual household income. We also proposed to replace references to section 36B of the Code with references to the applicable Treasury regulation.

We proposed to consolidate paragraphs (d) and (e), currently entitled ''Verification related to enrollment in an eligible employer-sponsored plan'' and ''Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan,'' respectively, into new paragraph (d). The standards proposed in paragraph (d) set forth the rules for verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. We proposed that the Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. As a result of the proposed consolidation of paragraphs (d) and (e), we proposed to redesignate paragraph (f) as paragraph (e).

In paragraph (d)(2), we proposed the data sources the Exchange will use to verify access to employer-sponsored coverage, which include (1) Data about enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan from any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden; (2) data regarding enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment obtained by transmitting identifying information specified by HHS to HHS; (3) data from the SHOP that operates in the state in which the Exchange is operating; and (4) any available data regarding the employment of an applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), from any electronic data sources that are available to the Exchange and have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

We proposed that data regarding employment would not be used to identify inconsistencies that need to be resolved to maintain eligibility, and would instead only be used to determine whether an individual should be part of the pool of individuals from which a sample is taken for review. We solicited comment on whether data regarding employment should only be used as a point of information for applicants to help prompt accurate attestations, and not as a point of comparison for the purposes of identifying inconsistencies as part of the verification described in this paragraph, since these data sources do not directly address enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan. We also solicited comment on the feasibility of making the necessary systems connections by October 1, 2013, and whether alternative approaches should be considered for the first year of operations.

To verify enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, we proposed that the Exchange follow the inconsistency process specified in § 155.315(f) if an applicant's attestation is not reasonably compatible with information from a data source authorized by HHS, data regarding federal employment, data from SHOP, or other information provided by the application filer or in the records of the Exchange. Further, if the Exchange does not have any of the information from a data source authorized by HHS, from data regarding federal employment, or from data from the SHOP for an applicant, and either does not have any available electronic data regarding the employment of an applicant and the members of his or her household or an applicant's attestation is not reasonably compatible with any available data regarding the employment of an applicant and the members of his or her household, we proposed that the Exchange would place the applicant into a pool of applicants from which it would select a statistically-significant sample of applicants, from whose employers the Exchange would request information regarding enrollment in an

eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.

We solicited comments on whether handling inconsistencies with any available data regarding the employment of an applicant and the members of his or her household through the sampling process, rather than through the procedures specified in § 155.315(f), is a suitable approach.

We requested comments on a methodology by which an Exchange could generate a statistically significant sample of applicants and whether there are ways to focus the sample on individuals who are most likely to have access to affordable, minimum value coverage.

In clause (d)(3)(iii)(A), we proposed that the Exchange would provide notice to an applicant who is selected as part of the sample indicating that the Exchange would be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We sought comment on ways the Exchange may communicate this sampling process to consumers with the intention of minimizing confusion.

We proposed that the Exchange would proceed with all other elements of the eligibility determination using the applicant's attestation while the sample-based review is occurring, and provide eligibility for enrollment in a QHP through the Exchange to the extent that an applicant is otherwise qualified. Consistent with § 155.315(f), we proposed that during the sample-based review, the Exchange would ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in under § 155.305 of this subpart, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

When an applicant is selected for the sample-based review, we proposed in clause (d)(3)(iii)(D) that the Exchange make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

We discussed one alternative approach, under which the Exchange would request documentation from consumers who were selected as part of the sample, instead of attempting to contact their employers. We chose not to propose this approach since the application will already solicit all necessary information from consumers, so it is unclear what would be gained through a second information request to consumers. We solicited comment on this alternative and other alternatives to implement this process while minimizing burden on consumers, employers, and Exchanges. We also sought comment on ways the Exchange can most efficiently interact with employers, including other entities that employers may rely upon to support this process, such as third-party administrators.

In clause (d)(3)(iii)(E), we proposed that if the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan as a result of the sample-based review, the Exchange would determine the applicant's eligibility based on such information and in accordance with the effective dates specified in § 155.330(f) of this subpart and, if such information changes the applicant's eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in § 155.310(g) and (h) of this part.

We also proposed that if, after a period of 90 days from the date on which the notice specified in clause (d)(3)(iii)(A) is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange will determine the applicant's eligibility based on his or her attestation regarding that employer. We solicited comment on this proposal to not provide an additional notice to the applicant and his or her employer when the applicant's eligibility does not change as a result of the sample-based review and whether it is preferable to include an additional notice to the applicant and employer at the end of the 90-day period.

In clause (d)(3)(iii)(G), we proposed that to carry out the sampling process described above, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee. We solicited comments on this proposed approach and whether there are ways these procedures can further minimize burden on the Exchange, employers, and consumers.

We also highlighted steps we are taking to help consumers with providing information related to access to employer-sponsored coverage on the application. We suggested the use of a voluntary pre-enrollment template to assist applicants in gathering the information about access to coverage through an eligible employer-sponsored plan as required by the Exchange to determine eligibility for advance payments of the premium tax credit and cost-sharing reductions. We sought comments on the use of this pre-enrollment template and ways it could be used to assist consumers with providing the necessary information to complete the verification described in paragraph (d) while minimizing burden on employers.

Lastly, in paragraph (d)(4), we also proposed that the Exchange may rely on HHS to conduct this verification. We proposed that under this option, the Exchange would send applicant information to HHS; HHS would take on all verification activities specified in regulation, including data matching with the Office of Personnel Management (OPM), SHOP, available employment data, and the sample-based review; and the Exchange would integrate the result into its eligibility process and send the individual and employer notices described in § 155.310(g) and (h) of this part. Further, we proposed that under such an arrangement, the Exchange and HHS would enter into an agreement specifying their respective responsibilities in connection with the verifications described in paragraph (d); other activities required in connection with the verifications described are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement; and the Exchange provides all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay. We solicited comments on this proposed option.

Comment: In reference to the proposed language at § 155.320(c)(3)(vi)(C), which specifies that the Exchange will request additional information regarding projected annual household income when an application filer's attestation is in excess of annual income data, but below annualized current income data by a ''significant amount,'' commenters recommended that the phrase ''significant amount'' be replaced with a percent threshold. Some commenters

recommended a threshold of 20 percent, specifically.

Response: To preserve the Exchange's flexibility to determine what may constitute a significant amount, we are finalizing this provision as proposed.

Comment: Commenters recommended replacing the standard ''not reasonably compatible'' with the term ''significantly and materially incompatible,'' defined further by commenters as ''making an important change to the outcome.'' Such commenters suggested only using the process described in § 155.315(f) if an attestation is significantly and materially incompatible with other information. Further, commenters suggested easing verification rules for individuals who comply with information requests, including attestations, and for whom required data is not available.

Response: In § 155.300(d) of the Exchange final rule, we include in the definition of ''reasonably compatible'' that the ''difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credits or category of cost-sharing.'' This definition allows for Exchange flexibility in verifying application information, and where appropriate, the final rule provides for a more prescriptive reasonable compatibility standard, in reference to specific verifications. We believe it is an ideal approach to provide flexibility in the case of many verifications, but for areas in which the outcome of the eligibility determination is sensitive to small changes, provide a more specific approach. Therefore, we finalize the reasonable compatibility standards used in § 155.320(c), with some changes described herein, and without changing the overall definition of ''reasonable compatibility,'' defined in § 155.300(d), which is used throughout Exchange and Medicaid regulations.

For income verification, for the first year of operations, we are providing Exchanges with temporarily expanded discretion to accept an attestation of projected annual household income without further verification, as described below. Under current regulations, when data described in paragraph (c)(1)(i) of this section is available for the tax household but the attested annual household income is more than 10 percent below the annual income computed in accordance with clause (c)(3)(ii)(A) of this section, the Exchange must use annualized data from the MAGI-based income sources, specified in paragraph (c)(1)(ii), to the extent it is available, to verify the attestation of annual household income. If such data is not available or does not support the attestation, clause (c)(3)(vi)(C) specifies that the Exchange must follow the procedures specified in § 155.315(f)(1) through (4), which includes requesting documentation to verify the attestation of project annual household income. The attestation is not supported by the data when the attestation is more than 10 percent below the annual income as computed using data sources. For the first year of operations, we will exercise enforcement discretion under this provision such that each Exchange will have the option, only when the attestation under (c)(3)(ii)(B) is greater than ten percent below the annual household income computed in accordance with clause (c)(3)(ii)(A) and MAGI-based income data from the sources specified in paragraph (c)(1)(ii) is unavailable to request a reasonable explanation for the discrepancy from the applicant, and if such explanation is insufficient, follow the procedures specified in § 155.315(f)(1) through (4) for a statistically significant sample of the population that would otherwise be subject to such procedures under clause (c)(3)(vi)(D). For those individuals who are not part of this sample, the Exchange may accept the attestation of projected annual household income without further verification for purposes of the Exchange's eligibility determination. We expect that any Exchange that exercises this option will monitor the process closely and adjust the targeting and size of the sampled population as needed to ensure an effective verification process. We note that we believe this exercise of enforcement discretion concerning the Exchange's obligations to verify income information in these specific circumstances is made in the context of all information—including the actual household income amounts for 2014—being available at the end of the year for the reconciliation performed under section 36B(f) of the Code.

Comment: We received comments that asked if, following the 90-day inconsistency period under § 155.315(f), when invoked under clause (c)(3)(vi)(C) of this section, the applicant has not responded and data sources indicate that the applicant is eligible for Medicaid or CHIP, the Exchange should notify the applicant and offer to enroll him or her in Medicaid or CHIP, in states where the Exchange can make that determination, or transmit the file to the Medicaid or CHIP agency if the Exchange cannot make that determination.

Response: This recommendation is not specific to § 155.320(c)(3). However, we note that, under § 155.320(c)(3)(iii), an attestation that reflects an increase compared to the tax data would generally be accepted without further verification (for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions); therefore, if an applicant attests to a projected annual household income that would qualify him or her for advance payments of the premium tax credit or cost-sharing reductions but MAGI-based income sources indicate that income is lower than the applicant's attestation, even if such data indicates Medicaid or CHIP eligibility, the attestation would be accepted without further verification. We note that this scenario assumes that the applicant has not attested to projected annual household income that would be consistent with eligibility for Medicaid or CHIP under the applicable MAGI standard.

Comment: One commenter expressed support for continuing to examine ways in which employer reporting under the Affordable Care Act can be streamlined both in timeframe and in the number of elements to prevent inefficient or duplicative reporting.

Response: We agree with the commenter. As stated in the proposed rule, the Administration will continue to consider ways to streamline reporting under the Affordable Care Act.

Comment: One commenter recommended that applicants should first attest to whether or not they have any offer of coverage. The commenter suggested it is unnecessary to verify enrollment in or eligibility for qualifying coverage in an eligible employer-sponsored plan for everyone who applies for insurance affordability programs. Another commenter recommended that the Exchange only ask for general information about employee contributions to the employer-sponsored plan, eligibility for the plan, and whether the plan provides minimum value rather than specifically identifying to the employer the particular employee who has requested premium tax credits.

Response: We appreciate the commenter's suggestion regarding ways to expedite the application process, and are working to consider similar suggestions received based on the public comment period for the single, streamlined application. To this end, we have designed the employer-sponsored coverage section of the single, streamlined application to ask a threshold question of whether the individual has an offer of coverage through a job, including an offer through a spouse or parent's job and then if the answer is ''no,'' allow the

individual to skip the remaining employer-sponsored coverage questions on the application. We will also collect employer contact information as necessary to send the employer notice described in § 155.310(h). The paper application for enrollment in a QHP through the Exchange and insurance affordability programs can be found at: *http://www.cciio.cms.gov/resources/other/Files/AttachmentC_042913.pdf.*

Comment: We received several comments regarding available data sources proposed in § 155.320(d)(2). Some commenters suggested that HHS work on developing an employer-sponsored coverage data source that would be available to states at a significantly reduced cost.

One commenter specifically recommended that data sources that reflect information regarding employment be used as a point of information for applicants only, and not as a basis for identifying an inconsistency that must be resolved to maintain eligibility. The commenter suggested that relying on employment data to support the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan may create a barrier to coverage and unduly delay enrollment of eligible applicants.

One commenter requested that data regarding federal employment as specified in § 155.320(d)(2)(ii) be made available through the federal data services hub and requested that HHS release a technical description of the service as soon as possible.

Response: As one commenter noted, HHS conducted an extensive search of available data sources and found that no comprehensive data source will be available by October 1, 2013. Current legislative and operational barriers prohibit HHS from requiring employers to report information directly to Exchanges or requiring Exchanges to obtain employer data from the Internal Revenue Service. The proposed rule included an interim solution to support this verification until a more robust verification process can be developed. We remain committed to working with any interested parties on solutions that make employer reporting more efficient.

We agree with the comment above suggesting that employment data not be used as the basis for generating inconsistencies or identifying individuals for inclusion in the sample-based review, since it is not specific to employer-sponsored coverage. Accordingly, we do not believe that it is necessary to specify the use of employment data, and so are removing paragraph (d)(2)(iv) and modifying paragraph (d)(3)(iii) to remove the provision specifying that the Exchange will obtain employment data. We clarify that notwithstanding this deletion, Exchanges may use employment data as a tool to assist consumers in providing accurate attestations to the Exchange regarding employer-sponsored coverage.

Lastly, we are currently working with our federal partners at the Office of Personnel Management to develop a service through the hub to verify data regarding federal employment as is necessary to implement proposed 155.320(d)(2)(ii). We expect to release a detailed technical description of this service in the near future.

Comment: We received several comments on the pre-enrollment template developed to assist consumers with collecting information related to eligibility for qualifying coverage in an eligible employer-sponsored plan. Many commenters expressed support for the voluntary template and efforts to facilitate employers reporting such information to Exchanges. One commenter suggested that employers pre-populate the form and distribute it online to employees without being specifically requested to do so by individual employees. Another commenter expressed concern over asking employees to gather information from employers, suggesting that it could pose problems and force employees not to seek Exchange coverage.

A few commenters suggested ways to implement the template including providing the template on the date of hire or in conjunction with other information about employer-sponsored coverage provided by the employer to employees. One commenter suggested large employers have an incentive to report this information to employees to avoid having employees request information from them on an individual basis. Another commenter suggested that the template would need to allow employers to report multiple premium contributions and/or plan actuarial values.

Response: We developed the pre-enrollment template, which is a tool to help an individual complete the questions related to employer-sponsored coverage on the single, streamlined application, based on extensive input from employers and other stakeholders. While the use of the template is voluntary, we believe it will facilitate the collection of related employer-sponsored coverage information from employers, and in doing so, streamline the application process, and increase the accuracy of eligibility determinations. To this end, we also note that employers have the option of combining the employer coverage tool with the notice specified under section 18B of the Fair Labor Standards Act, as added by section 1512 of the Affordable Care Act found at this link, *http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf.* As noted in the proposed rule, we also anticipate that employers will find additional ways to provide this information to their employees, including posting this pre-populated tool on a company Web site, or making this information available during benefit fairs, and we are supportive of additional efforts by employers to disseminate this information efficiently. The employer coverage tool can be found at: *http://cciio.cms.gov/resources/other/Files/AttachmentC_042913.pdf.*

Comment: Several commenters generally supported the sampling approach proposed in § 155.320(d)(3)(iii) and noted that contacting the employer directly is the most accurate and efficient way to verify information regarding access to qualifying employer-sponsored coverage. One commenter specifically supported the proposed approach to rely on the Exchange to reach out to employers for information about employer-sponsored coverage rather than relying on individuals to get the information from their employer.

Some commenters expressed concern over the sampling approach, suggesting the process was burdensome for employers and Exchanges. Commenters urged HHS to develop sampling procedures that are as unobtrusive as possible and do not create confusion for an individual or an individual's employer. One commenter urged the Administration to encourage States to use uniform processes in conjunction with HHS. One commenter recommended that final regulations specify timelines and specific information required for employer responses under § 155.320(d)(3)(iii). Another commenter also recommended that final regulations permit employers to designate third-party administrators to respond and act on their behalf for the sample-based review.

Some noted that contacts to employers create risks for employees who may have a very weak position or status with employers. Some commenters suggested that employees should be able to opt out of having the Exchange contact their employer. One commenter suggested that any verification process adopted by HHS should not invite retaliation against employees in any way. Another commenter suggested that the notice to

employers in § 155.310(h) communicate that employers are explicitly prohibited from retaliating against employees and provide accessible information about how employees may pursue a complaint or seek redress, including the time limit for filing a complaint.

Response: We believe the sampling approach proposed in § 155.320(d)(3)(iii) is the best interim approach for effectively completing this verification while minimizing burden on Exchanges and employers. As noted in the proposed rule, we believe that employers are in the best position to provide information regarding the employer-sponsored coverage that they offer to their employees. We maintain the approach of relying on Exchanges to reach out to a select number of employers to verify applicant information with some minor clarifications.

We also appreciate the concerns raised related to burden on Exchanges and employers. We intend for Exchanges to contact employers in a standardized manner and only ask for information that is necessary for verifying access to qualifying employer-sponsored coverage. We do not include a timing standard for employers to respond to Exchange inquiries; however we expect that employers will respond to Exchange inquiries in a timely manner. With that stated, as proposed and finalized in § 155.320(d)(3)(iii)(F), after a period of 90 days, the Exchange will conclude the sample-based review.

Regarding the recommendation that final regulations permit employers to designate third-party administrators to respond and act on their behalf for this verification, we note that this rule finalizes standards related to Exchanges and therefore standards regarding activities of employers are outside the scope of this regulation. However, we believe that this would be a feasible approach, as long as it is consistent with any other authorities that may govern the delegation of employer responsibilities to other entities.

We also acknowledge the comment expressing the concern that contacting employers might create risks for employees who may have a very weak position or status with employers. Section 18C of the Fair Labor Standards Act, as added by section 1558 of the Affordable Care Act, provides protections for employees that prohibit discrimination because the employee has received advance payments of the premium tax credit or cost-sharing reductions, and for other specified reasons.

Allowing an individual to opt out of the sampling process under § 155.320(d)(3)(iii) would prevent the Exchange from receiving accurate information for some individuals and increase the potential for a tax liability for the tax filer at tax filing. The opt-out process would also compromise the randomness, and potentially the statistical validity of the sample. Accordingly, we do not adopt this suggestion.

Comment: We received several comments strongly supporting the approach in § 155.320(d)(3)(iii)(C), reflecting the statutory requirement in section 1411(e)(4) of the Affordable Care Act, allowing an individual to receive advance payments of the premium tax credits and cost-sharing reductions during the 90-day sampling period if the individual is otherwise qualified. One commenter supported the recognition that applicants should be made aware that any advance payments of the premium tax credit could be subject to reconciliation. We also received comments in support of the provision in § 155.320(d)(3)(iii)(F) allowing the Exchange to use an applicant's attestation if no information is received from the employer. Another commenter noted that the burden of resolving inconsistencies should fall first on the Exchanges and only reach individuals when the Exchanges have exhausted all available means to resolve the inconsistency.

Response: We believe it is important for the eligibility determination process to be consistent in how and when the Exchange requests supporting documentation throughout the eligibility determination process and to avoid unnecessary delay in eligibility determinations. We agree with commenters regarding the importance of collecting an attestation from a tax filer regarding his or her understanding of reconciliation prior to making advance payments of the premium tax credit, and therefore maintain this in the final rule. Additionally, we are finalizing our proposal to rely on an applicant's attestation if the Exchange is unable to obtain the necessary information from an employer.

Comment: One commenter was concerned that the timeframe for employers to provide information (within 90 days of notice regarding the Exchange's intent to verify the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage through an eligible employer-sponsored plan) is too long and recommended shortening this period to 30 days.

Response: In proposed section § 155.320(d)(3)(iii), which we maintain in the final rule, we provide that an Exchange will proceed with an applicant's eligibility determination during the sampling process and ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions. This process is intended to ensure that eligibility determinations are not delayed due to the Exchange not being able to contact an employer. Under our authority under section 1411(a) and (d) of the Affordable Care Act and after consideration of a shorter timeframe, we came to the conclusion that 90 days is consistent with other similar processes, such as the inconsistency period specified in § 155.315(f), and will also allow an appropriate opportunity for receiving a response from employers.

Comment: Commenters supported the option to allow an Exchange to fulfill the requirements of this verification by relying on HHS to perform it. One commenter noted that this option is particularly helpful as no acceptable data sources will be available in their state by October 1, 2013. One commenter was pleased with this provision, noting that it welcomed efforts to reduce administrative and cost burdens involved with Exchange eligibility determination processes. One commenter expressed the need for more information from HHS specifying the steps it will take to complete this verification, and detail on the particular information HHS anticipates it will need. One commenter suggested a provision be included in the agreement between HHS and the Exchange to hold applicants harmless if a glitch in communication occurs. The commenter also suggested that consumers should not be required to submit duplicative information. One commenter asked that HHS consider expanding its employer-sponsored plan enrollment and eligibility verification process to include the sending of notices to individuals and employers described in § 155.310(g) and (h), which occurs after an eligibility determination is made.

Response: After reviewing and considering the appropriate public comments and completing a technical analysis, we have concluded that the service described in the proposed rule is not feasible for implementation for the first year of operations. This service would involve a large amount of systems development on both the state and federal side, which cannot occur in time for October 1, 2013. As such, in the final rule, we maintain the proposed language, with a clarification that the option to rely on HHS to perform this verification is effective for eligibility

determinations that are effective on or after January 1, 2015—meaning that the Exchange will be able to rely on HHS to perform this function as part of the eligibility determination system under section 1411 of the Affordable Care Act beginning with open enrollment for the 2015 plan year.

To provide relief to state-based Exchanges that were planning to rely on this service, we note that we are also delaying the date by which an Exchange must implement the sample-based review. For eligibility determinations for insurance affordability programs that are effective before January 1, 2015, we added paragraph (d)(3)(iv) to specify that if the Exchange does not have any of the information specified in § 155.320(d)(2)(i) through (d)(2)(iii) for an applicant, the Exchange may accept the applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification, instead of following the procedure in § 155.320(d)(3)(iii).

While we believe it is important for Exchanges to implement the procedure in § 155.320(d)(3)(iii) to support program integrity and minimize financial risks on behalf of the tax filer at reconciliation, we acknowledge that some Exchanges may not have the resources and operational capability to conduct the sampling process in the first year. We note that the FFE will implement the verification process as specified in § 155.320(d).

For October 1, 2013, we expect that Exchanges will use OPM data provided by HHS and available through the hub and SHOP data available through the SHOP that corresponds to the individual market Exchange to identify inconsistencies with attested information, and follow the process established in § 155.315(f) to resolve any such inconsistencies. We plan to continue working closely with Exchanges, and may propose regulatory amendments as necessary, to implement an increasingly effective verification process over time.

We also note that we considered whether the distribution of notices could be part of a future service performed by HHS. The eligibility notices cited by the commenter involve information beyond what is involved with this verification service, including individual eligibility results, and the commenter's proposal therefore would add significant complexity to an already-complex service. Accordingly, we are finalizing this provision as proposed.

Comment: We solicited comment regarding the feasibility of making the necessary systems connections to support the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan by October 1, 2013, and whether alternative approaches should be considered for the first year of operations. Several commenters expressed general support of the approach to verifying access to qualifying employer-sponsored coverage. However, one commenter expressed concern over the complexity of the verification procedures and questioned whether Exchanges will be able to implement these processes consistently by October 1, 2013. A small number of commenters recommended that HHS consider limiting verification to those situations in which it is essential to comply with the Affordable Care Act. One commenter agreed with the recommendation that the proposed strategy for verification should be temporary and that it should be revisited in 2016 when more data become available.

Response: We appreciate feedback from commenters on the proposed approach. We acknowledge the timing concerns with implementing the policies in the proposed rule for October 1, 2013 and will continue to work with Exchanges to develop interim solutions within the general construct of these regulations and related guidance. We believe that the proposed approach is minimally burdensome, particularly based on the approval of use of a sample-based review provided in § 155.320(d)(3)(iii) instead of an inconsistency process, and another approach would necessitate manual review for a larger number of individuals. Accordingly, in the final rule, we maintain the provisions proposed in § 155.320(d) with continued anticipation that the strategy will evolve as additional data and data sources become available and as more information is gained when the sample-based review is implemented.

Comment: One commenter recommended that HHS allow Exchanges the flexibility to define the factors that would trigger the sample-based review and how to conduct the necessary investigations. Another commenter proposed that Exchanges should have flexibility to use whatever information they have at their disposal to identify individuals who are likely to have employer-sponsored coverage and to conduct a minimum number of follow up reviews.

Response: We recognize that some Exchanges may have access to additional data sources that could be useful for these purposes. We note that proposed § 155.320(d)(2)(i), which we are finalizing as proposed, allows the use of electronic data sources that are approved by HHS, which could include state-based or state-developed data sources. We encourage states to work with HHS to incorporate these data sources and other existing processes into the Exchange verification process.

Comment: We received several comments on standards related to notices proposed throughout § 155.320. Commenters suggested that any notices be clearly written in plain language at an appropriate reading level for employees with limited education and LEP individuals. One commenter recommended that notice of applicants' appeal rights be provided to applicants if information from an employer results in a change to their eligibility status.

Specifically regarding the notice described in § 155.320(d)(3)(iii), one commenter suggested the notice clearly specify that the employee was selected as part of a purely random sample, rather than due to any indication of misinformation or inappropriate action on the part of the employee. Additionally, one commenter supported HHS developing notices and otherwise educating employers to help employers understand their potential tax liabilities. Finally, one commenter urged Exchange personnel, Navigators, certified application counselors and all consumer assistance personnel to be trained on these verification procedures.

Response: All notices described in this part are subject to the general notices standards under § 155.230, which include standards related content provided in the notice, including notice of appeal rights, and that the notices must conform to accessibility and readability standards. We agree that information regarding this verification will be important for Navigators and other entities helping consumers apply for coverage and intend to include information about this verification process related in training materials and other guidance documents produced by HHS.

Comment: One commenter raised concerns over the potential for confusion that could result from unnecessary notifications to employers by Exchanges, for example, when employers receive the notice specified in § 155.310(h) regarding potential tax liability under § 4980H of the Code even

though the employer may not in fact have any tax liability.

Response: The proposed rule did not modify the requirements related to the employer notice as described in § 155.310(h) and therefore the comment is outside of the scope of this rule.

Comment: One commenter recommended that the verification process and information supplied should be considered confidential, and recommended that the final rule include language clarifying this and prohibiting the sharing of this information with anyone not directly required to verify the information. The commenter specified that the employer representative verifying the information at request of the Exchange should be prohibited from sharing the Exchange's request for the information with any person not directly responsible for providing the information.

Response: We agree with the suggestion that information supplied during the verification process described in § 155.320(d)(3)(iii) should be protected and not disclosed to unauthorized parties. When an Exchange reaches out to an employer to confirm whether an applicant is enrolled in an eligible employer-sponsored plan or eligible for qualifying coverage in an eligible employer-sponsored plan, we do not intend for the Exchange staff to disclose the employee's household income or any other taxpayer information, except the employee's name or other identifying information. The employer would need to identify the employee to provide the Exchange with information about the plan options available to the employee. The Exchange would rely on information provided by the employee or employer when communicating with the employer, so that only the appropriate employer representatives are consulted during the sample-based review. We also note that like all information created, collected, used, or disclosed by the Exchange, information regarding employer-sponsored coverage is subject to the privacy and security protections established in § 155.260.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.320(c) without modification. We are finalizing the provisions proposed in § 155.320(d), with a few modifications. In paragraph (d)(2)(iii), we clarify that the Exchange must obtain any available data from the SHOP that corresponds to the state in which the Exchange is operating. In paragraph (d)(3)(iii), we modify language to specify that the Exchange must select a statistically significant random sample of applicants for whom the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii). Based on comments suggesting that employment data only be used to prompt applicants to encourage accurate attestations, we removed paragraph (d)(2)(iv). Additionally, we clarified paragraph (d)(4) to specify that the ability for the Exchange to satisfy the provisions of paragraph (d) by relying on HHS is effective for eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions that are effective on or after January 1, 2015, and to clarify that the division of responsibilities under this option is subject to guidance issued by the Secretary. To accommodate this change, we added paragraph (d)(3)(iv) to clarify that for eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions that are effective before January 1, 2015, if the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) for an applicant, the Exchange may accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested, without further verification under paragraph (d)(3)(iii) of this section. Additionally, we deleted paragraph (d)(4)(iv) to remove the agreement associated with having HHS conduct this verification. Finally, we removed paragraph (e) and redesignated paragraph (f) as paragraph (e). As a result of the consolidation of former paragraphs (d) and (e) in paragraph (d) of this final rule, we also make a technical correction to § 155.615(f)(2)(i) to modify the cross-reference in that provision to reference § 155.320(d).

12. Eligibility Redetermination During a Benefit Year (§ 155.330)

In § 155.330, we proposed to amend paragraph (d)(1) to clarify that the Exchange would only conduct periodic examination of data sources to identify eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, for enrollees on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided. We also proposed revising paragraph (e) to specify how the Exchange would proceed when data matching indicates that an individual is deceased, such that the Exchange would modify eligibility status to account for the data after 30 days without a response to the notice sent. In situations where the Exchange identifies updated information regarding income, family size, or family composition, except information regarding death, we clarified that the enrollee-reported information would be subject to verification.

We also solicited comments about adding a provision to specify that Exchanges would include language in the eligibility determination notice after a redetermination resulting in a change in an enrollee's level of cost-sharing reductions to also describe the specific changes to an enrollee's deductible, co-pays, coinsurance, and other forms of cost-sharing reductions if they remained enrolled in the same QHP.

We proposed to amend paragraph (f) to incorporate changes as a result of eligibility appeals decisions, as well as changes that affect only enrollment or premiums, but do not affect eligibility. The proposed changes to paragraph (f) were designed to align eligibility effective dates and enrollment effective dates with one another, and to accommodate the limited situations in which retroactive eligibility may be necessary.

In paragraph (f)(1), we proposed that changes resulting from a redetermination, from an appeal decision, or affecting enrollment or premiums only, be implemented on the first day of the month following notice of the change. In paragraph (f)(2), we proposed that the Exchange may determine a reasonable point in a month, no earlier than the 15th, after which a change will not be effective until the first day of the month after the month specified in paragraph (f)(1).

In paragraph (f)(3), we proposed that the Exchange must implement changes resulting in a decreased amount of advance payments of the premium tax credit or cost-sharing reductions that occur after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1). In paragraph (f)(4), we proposed that the Exchange must implement changes that result in an increased level of cost-sharing reductions that occur after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1). Changes that result in an increased amount of advance payments of the premium tax credit would be implemented under paragraphs (f)(1) and (f)(2).

In paragraph (f)(5), we proposed that the Exchange implement a change associated with birth, adoption, placement for adoption, marriage, or loss of minimum essential coverage, on the coverage effective dates described in § 155.420(b)(2)(i) and (ii). In paragraph

(f)(6), we proposed that the Exchange may implement a change associated with the events described in § 155.420(d)(4), (d)(5), and (d)(9) on an effective date that is based on the specific circumstances of each situation. In redesignated paragraph (f)(7), we proposed to maintain the existing language of what was originally paragraph (f)(3).

Comment: Commenters expressed general support for HHS' proposal regarding when the Exchange determines through periodic data matching that an individual is deceased. One commenter sought clarification about whether the Exchange could terminate coverage retroactively to the date of death to align with non-group market standards.

Response: In response to comments, we clarify in finalizing § 155.430(d) that the Exchange will terminate coverage retroactively to the date of death. This revision is discussed in more detail in the response to comments regarding that provision below.

Comment: Multiple commenters expressed strong support for including a provision in the final rule such that Exchange would include language regarding a change in an enrollee's level of cost-sharing reductions as a result of a redetermination in the eligibility determination notice sent to the enrollee. Several commenters requested that the notice also include information about the enrollee's eligibility for a special enrollment period as well as the deadline to make a decision to select a new plan if they so desired. Commenters also recommended that the notice include the potentially negative financial impact of changing QHPs. One commenter requested additional guidance regarding the implementation of cost-sharing reductions generally, and another stated that it could not comply with such a proposed change in Exchange design at this stage.

Response: We clarify that § 155.230(a)(1) specifies that the Exchange will provide language in the eligibility determination notice to the enrollee explaining the action reflected in the notice, which in this case includes the fact that an enrollee has been determined eligible for a new cost-sharing reduction level, his or her eligibility for a special enrollment period, the requisite deadlines, and the possible ramifications if an enrollee decides to change QHPs (for example, deductible resetting, whereby an individual who had accrued expenses towards the deductible cap for his or her previous QHP would have to start again from $0 in making cost-sharing payments towards the deductible and out-of-pocket limit). Since regulations do not specify that the Exchange will provide detailed, plan-specific information on cost-sharing reductions after initial plan selection, we will not require that it be provided by the Exchange when a change occurs. Rather, we expect that QHPs will make this information available. We will also not specify that the Exchange will describe the specific changes that could occur in different plans, which could require as many variations as there are plans. Exchanges maintain the flexibility to provide more detail. HHS provided general guidance regarding the implementation of cost-sharing reductions in subpart E of the final Payment Notice at 78 FR 15410, 15474 *et. seq.*

Comment: Commenters generally supported the effective dates we proposed in § 155.330(f). Several commenters urged HHS to prioritize continuity of coverage in defining effective dates. Other commenters cautioned against requiring eligibility effective dates that would necessitate the return or repayment of claims, premiums, advance payments of the premium tax credit, or cost-sharing reduction payments.

Response: We appreciate the importance of continuity of coverage, as well as the importance of clarity for consumers. As such, we are finalizing the provisions proposed in § 155.330(f), with two modifications for clarity. First, we consolidate the provisions formerly proposed in § 155.330(f)(3) and § 155.330(f)(4) into a single provision covering decreases in advance payments of the premium tax credit and changes in cost-sharing reductions. Second, we remove the requirement formerly proposed in § 155.330(f)(7), because the termination of coverage requirement in § 155.430(d)(3) renders § 155.330(f)(7) duplicative.

Comment: Commenters requested that HHS require transparency and plain language in communicating effective dates to consumers, given the complexity of changing benefits, programs, and coverage.

Response: We agree that transparency and plain language are of the upmost importance, and urge states and QHP issuers to share successful communication strategies among one another. We note that § 155.230(b) specifies that all notices will be in plain language. HHS will also share model notice language for Exchanges to adapt to their specific needs.

Comment: Some commenters questioned why advance payments of the premium tax credit and cost-sharing reductions could not always be implemented as of the first of the following month.

Response: The 15th-of-the-month cutoff specified in § 155.330(f)(3) concerning changes that result in a decreased amount of advance payments of the premium tax credit and changes in levels of eligibility for cost-sharing reductions aims to prevent consumers from incurring financial liabilities that may result from such changes in eligibility, which could also be very problematic for QHP issuers to implement. However, as noted above, Exchanges have flexibility to set a reasonable cut-off date for implementing changes that result in an increased level of advance payments of the premium tax credit, such that they could always be implemented on the first day of the following month, Accordingly, we are finalizing this provision as proposed.

Comment: Some commenters sought reassurance that Exchanges would remain the system of record—the final authority on applicants' and enrollees' eligibility for enrollment through the Exchange and receipt of advance payments of the premium tax credit and cost-sharing reductions—and that all changes would be communicated to QHP issuers. Some commenters also requested flexibility for issuers to communicate changes to enrollees, consistent with current practices.

Response: Exchanges are intended to be the final authority on applicants' and enrollees' eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions (subject to applicable appeals). As specified in § 155.310(g) and § 155.400(b)(1), Exchanges will communicate information about all eligibility and enrollment changes to both enrollees and their health insurance issuers in a timely fashion. We also encourage QHP issuers to communicate transparently with enrollees regarding changes to their coverage, including how changes in an enrollee's eligibility for cost-sharing reductions may affect the enrollee's out-of-pocked costs related to coverage, provided that such communications are not confusing for consumers.

Comment: Commenters supported our proposal in paragraph (f)(4) of this section to align enrollment effective dates with eligibility effective dates, but sought clarification on eligibility effective dates for individuals who opt not to select a new plan upon experiencing one of the special enrollment period triggering events described in § 155.420(b)(2).

Response: We clarify that the eligibility effective dates in

§ 155.330(f)(4) apply only in situations in which an individual uses the special enrollment period to select a plan upon experiencing one of the triggering events described in § 155.420(b)(2). Eligibility for individuals who experience a change related to marriage, birth, adoption, placement in foster care, or loss of minimum essential coverage, and who opt to maintain their existing QHP, follows the effective dates otherwise specified within § 155.330(f).

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.330, with some modifications. First, we clarified that the effective dates in paragraph (f)(1)(ii) are based on the date specified in the appeal decision, and removed cross-references to appeals provisions in paragraph (f)(1)(ii), as we are not finalizing provisions related to eligibility appeals at this time. However, we maintain the substance of the provision, and intend to replace the cross-references when we finalize subpart F. Second, we consolidated the provisions formerly proposed in § 155.330(f)(3) and § 155.330(f)(4) into a single requirement in paragraph (f)(3) for decreases in advance payments of the premium tax credit and changes in cost-sharing reductions. Third, we modified newly designated (f)(4) to clarify that the Exchange will implement a change associated with the events described in § 155.420(b)(2)(i) and (ii) of this part on the effective dates described in § 155.420(b)(2)(i) and (ii) of this part respectively, instead of on the first day of the following month. Fourth, we removed the requirement formerly proposed in § 155.330(f)(7), because the termination of coverage requirement in § 155.430(d)(3) renders § 155.330(f)(7) duplicative.

13. Annual Eligibility Redetermination (§ 155.335)

In § 155.335, we proposed to amend paragraphs (a), (b), (c), (e), (f), (g), (h), (k), and (l) of this section to specify that subject to the limitations specified in paragraph (l) and new paragraph (m), the Exchange will conduct an annual eligibility redetermination for all qualified individuals, not only those who are enrolled in a QHP. Our proposal was to replace the word ''enrollee'' with the term ''qualified individual'' in these paragraphs.

We proposed to amend paragraph (b) to include data regarding Social Security benefits as defined under 26 CFR 1.36B–1(e)(2)(ii). This reflects the revision we proposed to make in § 155.320(c)(1)(i)(A).

We proposed to make technical corrections to paragraph (l) to specify that, if the Exchange does not have authorization to use a qualified individual's tax information, the Exchange will redetermine the qualified individual's eligibility only for enrollment in a QHP through the Exchange.

We proposed to add new paragraph (m), which would provide that, if a qualified individual does not select a QHP before the redetermination described in this section, and is not enrolled in a QHP through the Exchange at any time during the benefit year for which such redetermination is made, the Exchange must not automatically conduct a subsequent redetermination of his or her eligibility for a future benefit year.

Comment: Commenters supported HHS' proposal to allow all qualified individuals to be redetermined for eligibility for enrollment in a QHP through the Exchange, regardless of whether they have enrolled in a QHP through the Exchange during the coverage year. Several commenters recommended omitting § 155.335(m), the special rule, to allow states to continue redeterminations for non-enrolled qualified individuals, for at least 3 more years.

Response: We continue to believe that one redetermination for a qualified individual who does not select a QHP represents an appropriate balance between providing consumers with a streamlined ability to obtain coverage and the burden on the Exchange associated with redeterminations and on consumers who are not interested in enrolling. We intend to monitor take-up rates within the FFE and encourage state-based Exchanges to do the same, as this data will inform whether changes to this policy might be appropriate in the future. Accordingly, we are finalizing this provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.335 of the proposed rule without modification, except we reserve paragraphs (c)(1) and (c)(2) as we continue to evaluate the appropriate information that will be included in the annual redetermination notice, and modify paragraph (c)(3) such that the previous reference to paragraph (c)(1), which is now reserved, instead refers to paragraph (b), which accurately refers to the updated information being retrieved by the Exchange.

14. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§ 155.340)

In § 155.340, we proposed technical corrections in paragraphs (b) and (c) to replace the reference to section 36B of the Code to the applicable Treasury regulation. We did not receive specific comments on this section, and are thus finalizing the provision as proposed.

Summary of Regulatory Changes

We are finalizing the technical corrections proposed in § 155.340 of the proposed rule to specify the appropriate definition of minimum value.

15. Coordination With Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan (§ 155.345)

In § 155.345, we proposed to make a technical correction to paragraph (a) to clarify that the agreements that the Exchange enters into with the agencies administering Medicaid, CHIP, and the BHP, if applicable, must include a clear delineation of the responsibilities of each ''agency'' as opposed to each ''program.'' We proposed to amend paragraph (a)(2) to specify that the agreement the Exchange enters into with other agencies administering insurance affordability programs addresses the responsibilities of each agency to ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to, or redetermination is initiated by, the Exchange or another agency administering an insurance affordability program. We proposed to change the ordering of agencies listed for purposes of clarity. We also proposed to redesignate paragraph (a)(3) as paragraph (a)(4), and add a new paragraph (a)(3) to ensure that, as of January 1, 2015, the agreement delineates responsibilities for the provision of a combined eligibility notice, as defined in § 435.4, to individuals and members of the same household, to the extent feasible, for enrollment in a QHP through the Exchange and for all insurance affordability programs. Section 155.345(a)(3)(i) proposed that prior to January 1, 2015, the notice include coordinated content, as defined in § 435.4, while § 155.345(a)(3)(ii) and (g)(7) addressed the implementation of a combined eligibility notice requirement as of January 1, 2015.

We proposed a phased-in approach for the provision of a combined eligibility notice in cases where the Exchange is performing assessments of

eligibility for Medicaid and CHIP based on MAGI.

We noted that, based on the operational readiness of the Exchange and other agencies administering insurance affordability programs, combined eligibility notices may be implemented earlier that January 1, 2015, but that in states where the FFE is conducting assessments rather than final determinations of eligibility, the FFE will only be able to provide an eligibility notice that includes coordinated content prior to January 1, 2015 (and not combined eligibility notices) for eligibility determinations made by the FFE.

We proposed to make a technical correction in paragraph (f) to cite to the applicable Treasury regulation instead of Section 36B of the Code.

We proposed a series of technical corrections throughout paragraphs (f) and (g) to clarify various provisions and to redesignate paragraphs as necessary to accommodate the changes described in the proposed rule. We proposed to add paragraph (g)(7) to require combined eligibility notices effective January 1, 2015.

Comment: We received comments recommending that notices be consolidated and coordinated for all family members applying together even when individuals are eligible for different programs, at the very least for the initial eligibility determination notice. Commenters suggested that all notices need to clearly state by name all individuals to whom the notice applies, especially when notices are regarding termination. Some commenters indicated that the notice with coordinated content should clearly inform an individual what he or she is or may be eligible for, and should never begin with the ineligibility information. Commenters suggested that all agreements between the Exchange and the agencies administering Medicaid and CHIP be approved by HHS and be made publicly available, including on a public Web site. Some commenters stated that the public should be given an opportunity to provide input on the agreements and any changes that are made to the agreements.

Response: We are finalizing this section as proposed, with minor modifications to reserve two provisions for finalization at a future date. We anticipate that initial eligibility determination notices will be consolidated for family members who apply together. Additionally, we expect that information about the program for which an individual is eligible, if any, will be displayed in notices before information about programs for which the individual is not eligible. We are reserving paragraphs (a)(3) and (g)(7), regarding coordinated content and combined notices, respectively, which we intend to finalize at a later date with the parallel Medicaid provisions. The Federally-facilitated Exchange will provide coordinated content in notices for October 1, 2013. We will take these recommendations into consideration as we develop model eligibility determination notices. We are not specifying that agreements between Medicaid and CHIP agencies and Exchanges be approved by HHS, as we think that the standards included in regulation represent an appropriate level of federal oversight at this time. However, we will work with Exchanges to monitor operations over time, and reevaluate this decision as needed.

Comment: Many commenters expressed support for combined eligibility notices. Some commenters expressed general support of the phased in approach for combined eligibility notices, but strongly recommended minimizing the delay in the implementation of combined notices so that it only affects the initial annual open enrollment period. Commenters suggested that the requirement for a combined eligibility notice should be effective for redetermination notices and eligibility notices for the open enrollment period beginning on October 15, 2014. Some commenters were supportive of the January 1, 2015 implementation date of combined eligibility notices, while others recommended a January 1, 2016 implementation date. One commenter recommended that the effective date be set as January 1, 2014, and that HHS allow those states that cannot update their technology in time for January 2014 to seek approval from HHS for delaying implementation, rather than a nationwide delay in implementation. Many commenters asked HHS to reiterate that the phased-in approach does not diminish the principles of the Affordable Care Act to promote coordination between the Exchange, Medicaid, and CHIP, beginning in October 2013.

Response: We appreciate commenters' suggestions. We intend to finalize this provision at a future date with the parallel Medicaid provision, and so have reserved paragraph (g)(7) for the purposes of this rule. The Federally-facilitated Exchange will provide coordinated content in notices for October 1, 2013.

Comment: Several commenters noted that state flexibility is important in determining when to issue combined or separate, coordinated eligibility notices. One commenter opposed the requirement for agencies administering insurance affordability programs to provide coordinated content in notices before January 1, 2014, and specifically recommended that at initial annual open enrollment each agency should be responsible for issuing its own eligibility determination notice based on the eligibility determination completed for the program or programs that agency administers, without regard for the other insurance affordability programs. Many other commenters, however, expressed support for a coordinated eligibility notice prior to the implementation of a combined eligibility notice. Another commenter believed that the state is best suited to determine which agency should provide the notice of eligibility determination, and opposed to the requirement under § 155.345(a)(3)(ii) that the combined eligibility notice be provided by the agency that makes the last determination of eligibility. One commenter noted that HHS should consider additional situations where a combined eligibility notice is feasible, but not beneficial to the applicant(s). Another commenter suggested that HHS consider additional flexibility for notices to be sent immediately for consumers who receive a final eligibility determination, and include an explanation in the notice about the status of any other determinations that are in progress for other applicants in the household.

Many commenters stated that HHS should ensure that the combined eligibility notice includes complete information about Medicaid appeal rights. Other commenters stated that the combined eligibility notice should include a statement that the individual might be eligible for additional benefits and more affordable coverage through Medicaid, and specify how the individual can be screened for Medicaid eligibility.

Response: In the proposed rule, HHS noted two situations in which the combined eligibility notice would not be advantageous for consumers, and HHS sought comment on additional situations in which the combined eligibility notice would not be advantageous. As one commenter suggested, HHS explained one situation in which a combined eligibility notice is not appropriate is where multiple family members apply together, and some members receive a final eligibility determination while other members need to be transferred to a different agency for a final determination to be made for other insurance affordability programs. We will work closely with states to determine when the issuance of

a combined eligibility notice is not appropriate, including situations in which it is not advantageous for the last agency that makes a determination of eligibility based on MAGI to issue a combined eligibility notice. Furthermore, we clarify that while the Exchange will make determinations or assessments of MAGI-based eligibility for Medicaid and CHIP in accordance with § 155.305(c) and (d), and § 155.302(b), the Exchange is not required to complete the Medicaid and CHIP enrollment process for eligible individuals.

We expect that combined eligibility notices will include a description of appeal rights in accordance with § 155.230(a)(5), including Medicaid appeal rights, as well as information about how an individual can request a full eligibility determination from the state Medicaid or CHIP agency. And, as noted above, we intend to finalize paragraphs (a)(3) and (g)(7) at a future date alongside parallel Medicaid provisions, and we are reserving these paragraphs for the purposes of this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.345 of the proposed rule with a few minor modifications. We reserve §§ 155.345(a)(3) and (g)(7) for finalization at a later date. Pursuant to the discussion in the preamble associated with 42 CFR 431.10(c) and (d), we add new paragraph (h) to clarify that the Exchange and the Exchange appeals entity must adhere to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency, which is consistent regardless of whether the Exchange is making eligibility determinations or assessments for Medicaid and CHIP. Accordingly, we redesignate previous paragraphs (h) and (i) as paragraphs (i) and (j).

16. Special Eligibility Standards and Process for Indians (§ 155.350)

In § 155.350, we proposed to make a technical correction in paragraph (a)(1) to replace the reference to section 36B of the Code with a reference to the applicable Treasury regulation. We did not receive specific comments on this section, and are thus finalizing the provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.350 of the proposed rule without modification.

17. Enrollment of Qualified Individuals Into QHP's (§ 155.400)

In § 155.400, we proposed to add paragraph (b)(3) to clarify the requirement that the Exchange send updated eligibility and enrollment information for all enrollment-related transactions to HHS promptly and without undue delay. This added further specificity to the existing requirement that the Exchange send eligibility and enrollment information to HHS under paragraph (b)(1) of this section. After considering several comments in response to this proposal, we are finalizing the provision as proposed.

Comment: Commenters were supportive of the proposal that the Exchange would send updated information for all enrollment-related transactions to HHS promptly and without undue delay. One commenter sought clarification about cancellations, and wanted to ensure that QHP issuers did not violate the Affordable Care Act's ban on discrimination in coverage of benefits related to preexisting conditions. Another commenter inquired about whether the specific issuer reporting requirements associated with this provision may vary according to the different Exchange models.

Response: We note that the cancellations by QHP issuers referred to in the preamble to this provision in the proposed rule could occur for various reasons, such as when an individual voluntarily cancels his or her health insurance selection before the coverage effective date. In terms of issuer reporting requirements, each Exchange maintains flexibility to determine its own issuer reporting requirements relative to enrollment transactions, consistent with the law and applicable regulations. This provision specifically addresses only the requirement that the Exchanges report updated eligibility and enrollment information to HHS.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.400 of the proposed rule without modification.

18. Special Enrollment Periods (§ 155.420)

In § 155.420, we proposed to clarify the scope of the special enrollment periods throughout this section and add paragraph (a)(2) clarifying that our usage of ''dependent'' refers to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual enrollee.

We proposed to amend paragraph (b) to specify that the effective dates described therein apply both to qualified individuals first enrolling in a QHP through the Exchange through a special enrollment period, as well as to current enrollees. As the effective dates regarding advance payments of the premium tax credit and cost-sharing reductions are now addressed in § 155.330(f), we proposed removing such language in paragraph (b)(2)(i). We also solicited comments as to whether we should expand the special effective dates in paragraph (b)(2)(i) concerning birth, adoption, or placement of adoption to cover children placed in foster care as well, which would also necessitate a corresponding change to the triggering events described within paragraph (d)(2) that specifically address that special enrollment period.

We proposed to add paragraph (b)(2)(iii) regarding the effective dates for a special enrollment period under paragraphs (d)(4), (d)(5), and (d)(9) to align with a similar provision proposed in § 155.330(f). This would ensure that the Exchange could tailor an effective date based on the circumstances surrounding an error by the Exchange, a contract violation by the QHP issuer, or other ''exceptional circumstances''.

To align the effective dates under this section with the effective dates for eligibility as proposed in § 155.330(f), we proposed to add paragraph (b)(4) to ensure that the Exchange adhere the modified effective dates related to advance payments of the premium tax credit and cost-sharing reductions proposed in § 155.330(f). As such, we proposed to remove language in paragraphs (b)(2) and (b)(3) that previously addressed this issue.

We also proposed to amend paragraph (d) to specify which triggering events will allow a qualified individual or enrollee, or his or her dependent to qualify for a special enrollment period. This was designed to permit all members of a household, in certain situations, to enroll in or change QHP's together in response to an event experienced by one member of the household, and we proposed technical corrections throughout paragraph (d) to ensure that the revised language allows for the dependent to qualify for a special enrollment period as well, subject to whether the QHP covers the dependent. While we did not modify the scope of each triggering event described within paragraph (d), we solicited comments regarding whether we should permit such movement of related individuals for other special enrollment periods.

We proposed to add language specifying that the triggering event in the case of a QHP decertification is the date of the notice of decertification,

whereas the triggering event in all other cases associated with a qualified individual or his or her dependent losing minimum essential coverage is the date the individual or dependent loses eligibility for minimum essential coverage.

We also proposed to amend paragraphs (d)(6)(i) and (ii) to specify that the Exchange will provide a special enrollment period for an enrollee or his or her dependent enrolled in the same QHP who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or who experiences a change in eligibility for cost-sharing reductions. We also modified the language within paragraph (d)(6)(iii) to allow a qualified individual or his or her dependent who is enrolled in qualifying coverage in an eligible employer-sponsored plan and who are determined newly eligible for advance payments of the premium tax credit to qualify for this special enrollment period prior to when he or she will cease to be eligible for qualifying coverage in an eligible employer-sponsored plan, provided that eligibility for advance payments of the premium tax credit and cost-sharing reductions are not available for an individual who is enrolled in an eligible employer-sponsored plan. Allowing these qualified individuals or dependents to be determined eligible for this special enrollment period up to 60 days prior to the end of his or her employer-sponsored coverage protects them from potential gaps in coverage.

Finally, we proposed to add a new paragraph (d)(10) to provide a special enrollment period for a qualified individual or his or her dependent that is enrolled in an eligible employer-sponsored plan that does not provide qualifying coverage, and is allowed to terminate his or her existing coverage. The Exchange would allow such an individual to access this special enrollment period up to 60 days prior to the end of his or her coverage in an eligible employer-sponsored plan, to protect them from potential gaps in coverage.

Comment: Several commenters supported our clarification in paragraph (a) aligning the definition of ''dependent'' to refer to those family members that would be eligible to enroll in coverage under a QHP, and commended HHS for allowing dependents to change QHPs or enroll in a new QHP together with their family members for certain special enrollment periods when eligible. Some commenters wanted to ensure that family members would be adequately informed about the benefits of enrolling in plans together as well as the potential drawbacks of failing to do so. However, several comments also raised concerns that this proposed definition was too plan-specific and would ultimately lead to greater confusion among families in terms of eligibility for special enrollment periods. Other commenters sought flexibility for the definition of ''dependent'' to correspond with state law, as opposed to a potentially narrower definition set by a QHP issuer.

Response: We believe that clarifying that the meaning of ''dependent'' aligns with 26 CFR 54.9801–2, the regulation implementing section 9801(f) of the Code, throughout this section, including for the special enrollment periods not specified in section 9801(f) of the Code, helps to promote efficient operations and uniform standards to guide QHP issuers and Exchanges. Furthermore, this will ensure that state laws regarding the definition of ''dependent'' will be maintained within the Exchange, as this does not contradict state laws, but rather corresponds with state laws that already require issuers cover certain dependents. We intend to provide the appropriate information through the eligibility determination notice to an individual and their family members to adequately inform them of all of their options when determined eligible for a special enrollment period.

Comment: Some commenters supported our proposal to expand certain special enrollment periods to dependents to allow family members to enroll in a new QHP together in response to an event experience by one member of the tax household, while others sought clarification or an expansion of this approach to other triggering events. Commenters requested clarification as to whether the proposed rules sought to limit the applicability of special enrollment periods to dependents enrolled in the same QHP with an enrollee, or to members of the tax household who may be receiving a portion of the advance payments of the premium tax credit, as well as if paragraph (d)(2) limited the special enrollment period to only the qualified individual and the ''new'' dependent. Other commenters recommended that the special enrollment period in paragraph (d)(3) related to citizenship or immigration status should apply both to the individual who is newly qualified along with eligible dependents.

Response: As noted above regarding the definition of ''dependent'', family members eligible to enroll in a QHP are determined eligible for a special enrollment period when specified in paragraph (d) of this section. This is not limited to only those members of a tax household on whose behalf advance payments of the premium tax credit are provided or who are enrolled in the same QHP. When a family member who experiences any of the triggering events in paragraph (d) of this section, that includes dependents in addition to qualified individuals or enrollees, selects a QHP as part of a special enrollment period, the Exchange will permit all members of the tax household to enroll together assuming they are all eligible to enroll in the particular QHP. If a specific family member experiences a triggering event, but fails to select a QHP within the relevant special enrollment period, his or her dependent does not have the ability to choose a different QHP during this period separately. Furthermore, in response to comments, we clarify that the special enrollment period in paragraph (d)(3) of this section, related to citizenship or immigration status, will apply to both the individual who is newly qualified as well as his or her dependents, if eligible for coverage under a QHP. We note that the special enrollment period described in paragraph (d)(3) only applies to an individual who was not previously a citizen, national, or lawfully present, as opposed to an individual switching between one of these statuses.

Comment: In response to HHS' solicitation for comments regarding modifying the special effective dates in paragraph (b)(2), which correspond directly to the triggering events described within paragraph (d)(2), many commenters urged HHS to include the placement of a foster child as a triggering event within the special enrollment period. Several commenters also raised concerns about our proposed modifications to the triggering event for the special enrollment period described in paragraph (d)(6), related to being newly eligible or ineligible for advance payments of the premium tax credit, or a change in eligibility for cost-sharing reductions. Some commenters opposed our proposal that only enrollees would be eligible for this special enrollment period if newly eligible or ineligible for advance payments of the premium tax credit instead of qualified individuals at any point during the coverage year, and recommended that we not finalize this proposal in favor of retaining the language adopted in the Exchange final rule.

Response: We appreciate the comments regarding placement in foster care as it related to special effective dates, and will add language in paragraph (b)(2) to include the placement of a foster child as one of the triggering events listed therein, as well as make the corresponding change

regarding the special enrollment period in paragraph (d)(2). We note, however, that due to the availability of Medicaid to foster children, it is unclear how frequently this special enrollment period will be used. Due to ongoing considerations regarding the risk pool, we are finalizing our proposed modifications to paragraph (d)(6) to specify that this special enrollment period only applies to those individuals who are already enrolled in a QHP through the Exchange.

Comment: Multiple commenters expressed general support for the modifications we proposed to special enrollment periods throughout paragraph (d), including our proposal to allow a prospective special enrollment period for qualified individuals enrolled in eligible employer-sponsored coverage to prevent gaps in coverage. In regards to the proposed revision to paragraph (d)(6)(iii) related to employer-sponsored coverage, some commenters suggested that the triggering event should not be limited to when an individual is enrolled in employer-sponsored coverage, but should also cover non-enrolled individuals whose offer of employer-sponsored coverage does not meet the affordability or minimum value standards. Other commenters wanted HHS to allow a qualified individual to be determined eligible for advance payments of the premium tax credit within the window of their special enrollment period, but prior to when their employer-sponsored coverage ended.

Response: We believe that individuals with an affordable offer of employer-sponsored coverage that meets minimum value should be encouraged to enroll in a plan with their employer. If after enrolling, their lowest-cost self-only plan option changes during the coverage year such that it no longer meets the affordability and minimum value standards, and an individual reports this to the Exchange, the Exchange will accordingly determine them eligible for a special enrollment period under paragraph (d)(6). As such, this provision creates incentives for individuals to enroll in affordable employer-sponsored coverage, while also minimizing potential gaps in coverage if a change in coverage occurs during the year such that an applicant would be newly eligible for advance payments of the premium tax credit if their employer terminates coverage or changes their plan options. In addition, we are consolidating proposed paragraph (d)(10), which provided a special enrollment period to an individual who was enrolled in non-qualifying coverage in an eligible employer-sponsored plan, into paragraph (d)(6) and modifying it to clarify that consistent with the eligibility standards for advance payments of the premium tax credit, the special enrollment period is available for an individual who is enrolled in any eligible employer-sponsored plan, and is not eligible for qualifying coverage in an eligible employer-sponsored plan. For example, this modification ensures that an individual who is enrolled in family coverage but for whom the lowest-cost self-only plan is unaffordable in accordance with the Code can access this special enrollment period, as intended in the proposed regulation. We will maintain the prospective ability for an enrollee to select a QHP up to 60 days before their eligible employer-sponsored coverage ends or their employer allows him or her to drop coverage if the lowest-cost self-only plan offer is non-qualifying. We note that the Exchange cannot provide an individual with advance payments of the premium tax credit while he or she is enrolled in eligible employer-sponsored coverage, as specified in 26 CFR 1.36B–2(a)(2).

Comment: A few commenters raised concerns regarding the notice that individuals would receive if determined eligible for a special enrollment period, and wanted to ensure that the notice would prevent confusion by providing clear guidance to individuals by helping them understand the premiums they would be responsible for, and to help them enroll in a QHP in a timely fashion.

Response: The Exchange will not have information regarding actual premiums at the time of an initial eligibility determination notice, since an individual will not have selected a plan at that point. HHS also developed model notices, released alongside this final rule, that reflect how an Exchange should clearly communicate an individual's eligibility for an SEP and the instructions for how he or she can enroll in a QHP.

Comment: Several commenters also urged HHS to specify additional triggering events for special enrollment periods. Some commenters recommended additional triggering events described in Medicare Part D, unaffordable rate increases, and misinformation provided to an individual regarding minimum essential coverage or advance payments of the premium tax credit or cost-sharing reductions. One commenter wanted HHS to include any change in family size as a triggering event, raising particular concerns about pregnancy to allow a woman enrolled in a catastrophic plan to change QHPs prior to the birth of a newborn. Several commenters requested that HHS clarify that certain triggering events would qualify as a special enrollment period under ''exceptional circumstances'' described in paragraph (d)(9) of this section, such as provider religious objections to covering certain health services to women.

Response: We believe that the current special enrollment periods previously proposed appropriately account for changes in circumstances that necessitate when individuals would need to select a new or different QHP and balance these needs with considerations regarding the risk pool. In addition, we note that § 147.104(b)(2) specifies that in 2014, an Exchange must provide a special enrollment period for individuals enrolled in non-calendar year individual health insurance policies beginning on the date that is 30 days prior to the date the policy year ends in 2014.

Furthermore, a state may establish additional special enrollment periods to supplement those described in this section as long as they are more consumer protective than those contained in this section and otherwise comply with applicable laws and regulations.

HHS intends to issue further guidance related to how Exchanges will determine the triggering events that constitute ''exceptional circumstances'' under paragraph (d)(9) of this section. For the issue raised regarding provider religious objections, we believe that there are other remedies available to consumers who encounter such situations.

Comment: One commenter sought clarification that the special enrollment periods only apply to the individual market as opposed to the small group market.

Response: We confirm that the language in § 155.420 regarding special enrollment periods only applies in its entirety to the individual market. Separate provisions pertain to the small group market as discussed at § 155.725(a)(3), which excludes § 155.420(d)(3) and (d)(6).

Comment: Some commenters raised concerns regarding our proposals within this section that pertain to effective dates. Commenters requested clarification on whether the effective dates related to errors by the Exchange or contract violations by QHP issuers would involve setting retroactive enrollment dates. Some commenters suggested that the Exchange provide flexibility to individuals related to retroactivity for errors as some

individuals may not want the Exchange to implement an earlier effective date. If allowing for retroactivity, commenters urged that the Exchange's flexibility related to errors or contract violations should only be provided to correct the unfair outcome. Commenters asked that the effective date be set for the individual on what it would have been without the error, and requested that the Exchange only set the effective date according to paragraph (b)(1) of this section if the date on which the determination would have been effective without the error cannot be ascertained. Several commenters also raised concerns about HHS' proposal to remove the language about effective dates for advance payments of the premium tax credit and cost-sharing reductions within this section. Some commenters worried about an Exchange instituting earlier effective dates under paragraph (b)(3) of this section, particularly the FFE in 2014.

Response: Outside of a technical correction within paragraph (b)(3) of this section, we did not propose any changes to the provision related to the Exchange instituting earlier effective dates if all participating QHP issuers agree to effectuate coverage in a shorter timeframe. We believe that there are sufficient regulatory safeguards for QHP issuers in 2014 if they inform the Exchange that they are not prepared to institute earlier effective dates. In terms of the Exchange's flexibility related to retroactive eligibility and enrollment in cases of errors or contract violations, we note that the outcome is still contingent on an individual selecting a QHP when determined eligible for a special enrollment period. This preserves the ability for an individual to choose to enroll on a particular date, or to choose not to enroll.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.420 of the proposed rule with the following modifications. First, in paragraphs (b)(2)(i) and (d)(2), we expand the special enrollment period and special effective dates for birth, adoption, and placement for adoption to also include placement in foster care. Second, in paragraph (d)(3), we clarify that the special enrollment period for an individual who was not a citizen, national, or lawfully present non-citizen and gains such status also applies to his or her dependents, if eligible under the Exchange eligibility rules. Third, we modify paragraph (d)(6) to incorporate the special enrollment period proposed in paragraph (d)(10), with modifications to reflect that it accommodates individuals who are enrolled in an eligible employer-sponsored plan, but are not eligible for qualifying coverage in an eligible employer-sponsored plan. Accordingly, we delete paragraph (d)(10).

19. Termination of Coverage (§ 155.430)

In § 155.430, we proposed to amend paragraph (b)(1) to clarify that it specifically refers to enrollee-initiated terminations. We proposed to add paragraph (b)(1)(i) to account for circumstances in which, through periodic data matching, an Exchange finds an enrollee eligible for other minimum essential coverage, thus resulting in the enrollee's ineligibility for advance payments of the premium tax credit. We also proposed in paragraph (b)(1)(ii), that at the time of plan selection, the Exchange would provide a qualified individual with the opportunity to choose to remain enrolled in a QHP if the Exchange identifies that he or she has become eligible for other minimum essential coverage, and the enrollee does not request a termination in accordance with paragraph (b)(1)(i).

We proposed to amend paragraph (d)(1) to specify that changes in advance payments of the premium tax credit and cost-sharing reductions, including terminations, adhere to the effective dates specified in § 155.330(f).

Comment: Several commenters cautioned against requiring retroactive termination effective dates that would necessitate the return or repayment of claims, premiums, advance payments of the premium tax credit, or cost-sharing reduction payments. However, other commenters urged HHS to modify termination effective dates in § 155.430(d) such that for qualified individuals who gained, or were going to gain other coverage, the termination effective dates would be the day before the other coverage begins, regardless of when the enrollee notifies the Exchange of his or her other coverage.

Response: We appreciate the comments concerning this provision, and have modified the termination effective date at § 155.430(d)(2)(iii) for enrollee-requested terminations such that QHP issuers and Exchanges may only terminate coverage effective on or after the date on which the enrollee requests termination, and not retroactively. We have also clarified in § 155.430(d)(2)(iv) that the last day of coverage in a QHP for an enrollee who is determined eligible for Medicaid, CHIP or the BHP is the day before the individual is determined eligible for such coverage, rather than retroactive to the Medicaid or CHIP eligibility effective date.

Comment: One commenter recommended amending § 155.430(d) to specify that changes in eligibility, including terminations, must adhere to the effective dates specified in § 155.330(f), to ensure alignment of processes.

Response: We agree with the commenter, and have modified the termination effective dates in § 155.430(d)(3) to cross-reference § 155.330(f).

Comment: Commenters sought clarification of why an enrollee who is eligible for other minimum essential coverage would elect to remain enrolled in a QHP without advance payments of the premium tax credit.

Response: While 26 CFR 1.36B–2 specifies that premium tax credits are not available to support enrollment in a QHP through the Exchange for an individual who is eligible for other minimum essential coverage, such an individual is free to remain enrolled in a QHP through the Exchange, without advance payments of the premium tax credit and cost-sharing reductions, if he or she remains eligible for enrollment in a QHP through the Exchange. It is possible that an individual would want to maintain enrollment without advance payments of the premium tax credit and cost-sharing reductions for continuity of coverage reasons. As we proposed in 155.430(b)(2)(ii), the Exchange must provide an opportunity at the time of QHP selection for an individual to choose to remain enrolled in a QHP if he or she has become eligible for other minimum essential coverage. If the individual does not choose to remain enrolled in a QHP upon such a change, the Exchange would initiate termination upon completion of the redetermination process specified in § 155.330.

Comment: Commenters recommended that in addition to the opportunity at plan selection, enrollees should be given a second opportunity to elect to remain enrolled in a QHP without advance payments of the premium tax credit and cost-sharing reductions when the Exchange finds the enrollee is eligible for other minimum essential coverage through a periodic data match.

Response: Exchanges are free to provide additional opportunities for individuals to request termination, or to request to remain enrolled in a QHP without advance payments of the premium tax credit or cost-sharing reductions, upon losing eligibility for such benefits. In paragraph (b)(1)(ii), we have clarified that the opportunity provided at the time of plan selection is effective both in cases of periodic data matching as well as when an enrollee reports gaining eligibility for other

minimum essential coverage that would make him or her ineligible for advance payments of the premium tax credit and cost-sharing reductions.

Comment: A commenter raised a concern that the proposed revision to the termination provision in § 155.430(b)(2) broadly permits an individual whose coverage was already effectuated during the initial open enrollment period to notify the Exchange or QHP issuer of his or her termination of coverage, and switch QHPs.

Response: Individuals are free to terminate enrollment in a QHP through the Exchange at any time. Individuals who wish to begin other coverage in a QHP through the Exchange must be within an open or special enrollment period to do so. Each Exchange has the flexibility to decide whether to allow enrollees for whom coverage has been effectuated to change QHPs during any remaining time in an open or special enrollment period. For October 1, 2013, the FFE will not permit an enrollee to change QHPs in such a situation. As noted above, such an individual may qualify for a new special enrollment period as specified in 45 CFR 155.420.

Comment: One commenter noticed that the proposed provisions did not clarify whether the Exchange would be permitted to terminate coverage retroactively to the date of death. The commenter recommended that the Exchanges have the flexibility to align with non-group market standards, and allow for retroactive terminations when the Exchange obtains updated information regarding a death.

Response: We agree with the commenter, and have added paragraph § 155.430(d)(7) to clarify that in the case of termination due to death, the last day of coverage is the date of death, which means that coverage could be terminated retroactively.

Comment: A commenter noticed that there were conflicting provisions regarding terminations at § 155.430 and § 156.270(b). Section 156.270(b) specifies that QHP issuers must notify both the Exchange and enrollees of the effective date and reason for termination at least 30 days prior to the last day of coverage, and § 155.430(d) specifies that in some cases, QHP issuers may effectuate termination in fewer than 30 days.

Response: We have modified § 156.270(b) in this final rule to align the coverage termination standards for Exchanges and QHP issuers. We have also clarified that QHP issuers will promptly notify both enrollees and the Exchange of the termination reason and termination effective date when the QHP initiates a termination.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.430 of the proposed rule, with the following modifications: We modified paragraph (b)(1)(ii) to specify that the opportunity provided by the Exchange at the time of plan selection for an individual to choose to remain enrolled in a QHP if he or she becomes eligible for other minimum essential coverage applies both to situations in which eligibility for other minimum essential coverage is identified via a periodic data match, as well as situations in which the individual reports the change to the Exchange. We modified the termination effective date provision at paragraph (d)(2)(iii), for enrollee-requested terminations, such that QHP issuers and Exchanges may only terminate prospectively, not retroactively. We modified paragraph (d)(2)(iv), which concerns terminations for enrollees who are determined eligible for Medicaid, CHIP or the BHP, such that the last day of coverage is the day before the individual is determined eligible for such coverage, rather than retroactive to the Medicaid or CHIP eligibility effective date. We also modified the termination effective dates in paragraph (d)(3) to cross-reference § 155.330(f). We added paragraph (d)(7) to clarify that in the case of termination due to death, the last day of coverage is the date of death. In addition, we are finalizing an amendment to § 156.270(b) to align the coverage termination requirements for Exchanges and QHP issuers.

D. Medicaid Premiums and Cost Sharing

1. Responses to General Comments (§ 447.51 through § 447.57)

Comment: Many commenters supported the streamlined and consolidated approach to the revised cost sharing rules. One commenter believed that removing the distinction between the requirements of sections1916 and 1916A of the Act was confusing and lost some of the differences in the statutory provisions. The commenter was also concerned that under the revised rules, states will no longer have to explicitly invoke the use of alternative (section 1916A of the Act) cost sharing through the state plan amendment process. One commenter stated that CMS should not provide more specific requirements in the regulations to give states more flexibility.

Response: We maintain the streamlined and consolidated structure in the final regulation, which we believe is consistent with the flexibilities and limitations provided in both sections 1916 and 1916A of the Act. We believe that consolidation will simplify the rules for beneficiaries, providers, and states, and will also simplify the state plan amendment (SPA) process. States will continue to be required to submit a SPA to impose new or revised cost sharing or premiums, and CMS will review such SPAs to ensure compliance with the regulations and statute.

Comment: Two commenters recommended that rather than remove current § 447.58 and reserve it, this provision should be used to implement the long-standing statutory provision that the cost sharing provisions of sections 1916 and 1916A of the Act cannot be waived unless a state meets the criteria required under section 1916(f) of the Act.

Response: The terms of section 1916(f) of the Act, relating to the requirements states must meet for the Secretary to approve a waiver of the cost sharing provisions of sections 1916 and 1916A of the Act are clear. We do not believe it is necessary at this time to issue regulations setting forth the Secretary's substantive authority under section 1115 of the Act, and such an action would be outside of the scope of this rulemaking. We note that we issued procedural regulations at 77 FR 11678 (Feb. 27, 2012) governing demonstration applications in accordance with section 1115(d) of the Act (as added by section 10201(i) of the Affordable Care Act).

Comment: One commenter stated that given the statutory constraints implemented in the regulations, states should be given additional flexibility through the use of a standard waiver template applicable to newly eligible adults. One commenter stated that for MAGI-based eligibility groups, states should be able to impose premiums and cost sharing on individuals with income over 100 percent of the FPL that is equivalent to what those individuals would be subject to if they were enrolled in the Exchange.

Response: Section 1916A of the Act and these regulations provide considerable flexibility for states to impose cost sharing on individuals with income over 100 percent of the FPL, including the ability to target cost sharing, charge higher amounts, and make the cost sharing enforceable. But the statute provides for cost sharing protections for the Medicaid population that are not the same as the protections for individuals enrolled in coverage through the Exchange. To waive the

Medicaid cost sharing requirements and go beyond the flexibilities provided in section 1916A of the Act for individuals covered under the state plan, the Secretary must find that the requirements of section 1916(f) of the Act have been met. We do not believe that a template for waiving the cost sharing requirements in accordance with section 1916(f) of the Act is needed at this time. Except for certain specified eligibility groups, sections 1916 and 1916A of the Act limit premiums imposed under the state plan on those with income over 150 percent of the FPL.

Comment: One commenter noted that it appears we left in place §§ 447.66 through 447.82 of the current regulations and suggested that CMS remove these sections.

Response: This was a drafting error and we have removed those sections in the final rule. Those sections reflected alternative premiums and cost sharing requirements under section 1916A of the Act that have been integrated into new streamlined cost sharing regulations that reflect both sections 1916 and 1916A of the Act.

2. Definitions (§ 447.51)

We proposed to add a definition for premiums, which includes enrollment fees and other similar charges. We also proposed to add a definition for cost sharing to encompass deductibles, copayments, coinsurance, and other similar charges. Because each of these charges would be included within cost sharing, we proposed to remove separate requirements related to deductibles, copayments, and coinsurance; instead all cost sharing would be subject to a single set of rules. We also proposed new definitions for purposes of the premium and cost sharing regulations for preferred drugs, emergency and non-emergency services, and alternative non-emergency service providers, since the cost sharing rules vary for these items and services. We received the following comments concerning the proposed definitions:

Comment: Several commenters recommended that we revise the definition of alternative non-emergency service provider at § 447.54 to mean ''a Medicaid-participating provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that *is actually available and accessible* and can provide clinically appropriate services *for the diagnosis or treatment of a non-emergency condition* in a timely manner.''

Response: We are finalizing the definition as proposed in § 447.51. The revisions suggested by the commenters regarding the alternative non-emergency provider being available and accessible and being able to provide for the diagnosis or treatment of a non-emergency condition are implicit in the requirements that must be met at § 447.54(d) before the imposition of cost sharing for non-emergency use of the ED. However, we have revised the definition of non-emergency services for clarity; this revision is not a substantive change.

Comment: Several commenters recommended that we remove the term ''coinsurance'' from the definition of cost sharing at § 447.51, since few states charge coinsurance and the statute does not use the term. They discussed that eliminating the term ''coinsurance'' would further the goal of simplification.

Response: We agree that very few states elect the option to charge coinsurance, but it is still an option available to states under the statute, which allows for other ''similar charges.'' Therefore we are maintaining the term ''coinsurance'' in the definition of cost sharing in the final rule. With the streamlining of the regulations in this final rule, states that do elect to charge coinsurance must ensure it does not exceed the limits defined in § 447.52–54.

Comment: We solicited comments on whether we should add definitions of ''inpatient stay'' and ''outpatient services'' to take into account situations in which an individual is discharged and soon thereafter returns to an inpatient facility for continued treatment of the same condition. One commenter supported the inclusion of a definition of ''inpatient stay'' and recommended that we adopt the approach taken in Medicare to define a ''benefit period'' and prohibit a second copay for any inpatient stay within the same benefit period. Some commenters also supported the addition of a definition of ''outpatient services'' giving states broad flexibility to determine which services may be subject to cost sharing. No commenters opposed adding definitions of these terms.

Response: We are adding a definition of ''inpatient stay'' in the final rule at § 447.51 to mean the services received during a continuous period of inpatient days in either a single medical institution or multiple medical institutions, and also to include a return to an inpatient institution after a brief period when the return is for treatment of a condition that was present in the initial period. We also add that the definition of ''inpatient'' has the same meaning as in § 440.2. We believe this is in the best interest of beneficiaries with chronic conditions who may have frequent visits to the hospital or other institution for treatment of the same condition, and is consistent with the limitations on cost sharing established in the statute. We also add a definition of ''outpatient services'' for purposes of cost sharing to mean any service or supply not meeting the definition of an inpatient stay. This definition will include cost sharing for any services outside an institutional setting, not otherwise exempt by statute or regulations, excluding drugs and non-emergency use of the hospital emergency department which are defined separately. We note that these definitions are applicable only to cost sharing and do not constitute any change in definition specific to the provision of benefits or services.

Comment: One commenter requested CMS provide additional information to states regarding how the proposed definition of cost sharing will affect the offset to expenses that states can report for Medicaid FFP (§ 447.51).

Response: Nothing in the definition of ''cost sharing'' at § 447.51 changes the rule related to FFP. Per § 447.56(e), which is unchanged from current rules, no FFP is available for any premiums or cost sharing that should have been paid by the beneficiary, except for amounts that the agency pays as bad debts of providers who are paid in accordance with Medicare reasonable cost principles.

Comment: One commenter recommended revising the definition of a premium at § 447.51 to exclude enrollment fees because premiums are generally applied on an annual or periodic basis whereas enrollment fees are generally a onetime payment. The commenter recommends that states should have the flexibility to require an enrollment fee in addition to premiums.

Response: The statute defines a premium to include any enrollment fee or similar charge, and therefore the limitations on total premium charges include both premiums and enrollment fees. As the Secretary does not have the authority to change this requirement, we are finalizing the definition of premiums as proposed. States do have the flexibility to impose both a monthly premium and an initial enrollment fee within the limitations for premiums described in this rule.

3. Update to Maximum Nominal Cost Sharing (§ 447.52)

We proposed to implement sections 1916(a)(3) and (b)(3) of the Act relating

to nominal cost sharing, and to revise the maximum amount of nominal cost sharing for outpatient services. For beneficiaries with incomes at or below 100 percent of the FPL, cost sharing for outpatient services may not exceed nominal. For those with income above 100 percent of the FPL, cost sharing can either be limited to nominal or may extend up to 10 or 20 percent of the cost of the service, depending on the income of the beneficiary. Currently, maximum allowable nominal cost sharing is tied to what the agency pays for the service, not to exceed $3.90 for services for which the state pays more than $50. Because this can be confusing and burdensome for states, providers, and beneficiaries, we proposed to allow instead a flat $4 maximum allowable charge for outpatient services. This is a modest $0.10 increase from the current maximum, and as we noted as a basis for the proposed rule, the majority of state services are reimbursed at more than $50. The proposed changes are discussed in more detail in the January 22, 2013 Medicaid Eligibility Expansion proposed rule (78 FR 4658 and 4659). We received the following comments concerning the proposed update to the maximum nominal cost sharing provisions:

Comment: Many commenters wanted CMS to eliminate cost sharing for Medicaid beneficiaries altogether because of the extensive research showing that cost sharing on low-income populations creates barriers to accessing needed care, with particular consequence for those with special health care needs. One commenter recommended that CMS revise the cost sharing regulations to align with the lowest eligibility threshold for Medicaid based on modified adjusted gross income created by the Affordable Care Act (for example, 133 percent of the FPL) and create two tiers of cost sharing—one for those with income at or below 133 percent of the FPL and one for those with income above 133 percent of the FPL. One other commenter recommended that individuals with income below 133 percent of the FPL should be exempt from cost sharing.

Response: We recognize the studies indicating that cost sharing may impact beneficiaries' access to needed and prescribed services, given the low incomes of most of those who are enrolled in Medicaid. However, the statute authorizes states to impose cost sharing, subject to certain limitations. Additionally, the Affordable Care Act did not modify the cost sharing provisions of sections 1916 and 1916A of the Act. Section 1916A of the Act distinguishes between individuals with income at or below 100 percent of the FPL, those with income above 100 and at or below 150 percent of the FPL, and those with income above 150 percent of the FPL. We do not have the authority to revise the income thresholds set out in statute or to preclude states from imposing cost sharing on individuals with income under 133 percent of the FPL consistent with the limitations in sections 1916 and 1916A of the Act, as implemented in these regulations. States do not, of course, have to implement cost sharing to the extent authorized by the statute, and most do not do so. We note that in § 447.51 of the final rule we add a definition of Federal poverty level (FPL) to use the acronym throughout the regulation. No substantive change is intended.

Comment: Several commenters stated that cost sharing is unnecessary in the context of managed care because the point of managed care is to manage utilization and ensure care is provided in the most appropriate settings. The commenters argue that managed care already achieves the goals that states are attempting to achieve through cost sharing and that cost sharing interferes with the medical management effectuated through managed care programs. Another commenter believed the rules did not provide enough flexibility in the managed care context. One commenter requested that CMS clarify that Medicaid agencies can permit managed care organizations to not impose cost sharing on enrollees.

Response: While managed care can play a role in ensuring more appropriate utilization of health care services, the statute does not limit the imposition of cost sharing to fee-for-service delivery systems. In general, states may not establish different cost sharing requirements for beneficiaries served by a fee-for-service versus a managed care delivery system unless all beneficiaries have the same opportunity to participate in fee-for-service versus managed care and to enjoy the benefits of lower cost sharing imposed under one service delivery mechanism versus the other. Section 4708(b) of the Balanced Budget Act of 1997 specifically removed the statutory cost sharing exemption for enrollees in managed care organizations. Managed care organizations may choose not to impose state plan cost sharing on their members, but the state must still consider the amount of cost sharing under the state plan in determining the actuarial soundness of the capitated payment to the managed care organization. Section 1916A of the Act allows states to target cost sharing to specified eligibility groups, as described at § 447.52(d) of this final rule, and states may target cost sharing specifically to those eligibility groups who may be enrolled in managed care, but the targeting must be based on the eligibility group and not solely on the basis of enrollment in managed care. However, states may charge different co-pays to incentivize the use of certain care models—for example lower co-pays to encourage use of primary care medical homes or other patient-centered coordinated care models—to the extent that those models provide a different service from those offered at a more traditional medical provider, and the particular model of care is broadly available to beneficiaries. This is permissible because the state is differentiating co-payments based on the service provided, and because all individuals have the choice to receive such services, comparability is met.

Comment: Some commenters recommended that CMS should restore the use of the term ''nominal,'' as that term is used in the existing regulations. They argue that the Act specifically limits cost sharing to ''nominal'' amounts and directs the Secretary to determine what constitutes a ''nominal'' amount each year to ensure that cost sharing amounts are not onerous for beneficiaries.

Response: The streamlining proposed does not negate the requirements at section 1916 of the Act that cost sharing for certain populations be nominal in amount. Section 1916 of the Act gives the Secretary authority to define nominal cost sharing, which we do at proposed §§ 447.52, 447.53 and 447.54. The amounts described in these sections are the maximum that can be imposed on individuals with income at or below 100 percent of the FPL, since these individuals may not be subject to the higher cost sharing allowable under section 1916A of the Act. The proposed amounts will be updated annually based on the CPI–U, starting October 1, 2015. As mentioned, in streamlining the regulations implementing sections 1916 and 1916A of the Act, we did not use the term ''nominal'' in the regulatory text, but the amounts permitted were set based on the determination that they were nominal amounts.

Comment: Many commenters agreed with severing the tie between maximum cost sharing amounts and what the agency pays for the service but believed that a flat $4 maximum amount proposed at § 447.52 was too burdensome for Medicaid beneficiaries with income at or below 100 percent of the FPL. Many commenters recommended that CMS should set maximum cost sharing amounts based on the income and health status of the

beneficiaries and recommended using Medicare as a model, which establishes two tiers for Part D copayments for individuals with income at or below 100 percent of the FPL and individuals with incomes over 100 percent of the FPL, and recommend the Medicaid cost sharing maximum should be limited to $2.10 for those at or below 100 percent of the FPL which is the approximate average of the FY 2013 maximum copayment amounts.

Response: Sections 1916 and 1916A of the Act allow for different levels of cost sharing for individuals with income at or below 100 percent of the FPL versus those with income over 100 percent of the FPL, similar to the two-tiered structure established for Medicare Part D which the commenters recommend. Section 1916A of the Act further differentiates maximum cost sharing levels for those with income above 100 or at or below 150 percent of the FPL and those with income over 150 percent of the FPL. Current regulations already allow states to charge all non-exempt beneficiaries up to $3.90 for many services, and as described previously, we believe the $4 maximum charge is comparable, particularly given that the next update to this nominal amount has been postponed under this rule until October 1, 2015. We also note that while this is the maximum level at which states may set their cost sharing obligations, they may establish lower levels of cost sharing.

We note that under current regulations at § 447.56, states have the option to establish different cost sharing charges for individuals at different income levels. We inadvertently omitted this section from the proposed rule and are restoring this option in the final rule at § 447.52(g). We specify in the final rule that if the state imposes cost sharing charges that vary by income, it must ensure that lower income individuals have lesser cost sharing than higher income individuals.

Comment: One commenter expressed concern that the simplified $4 maximum for individuals with income at or below 100 percent of the FPL would create a disparity with the percentage-based maximum cost sharing for individuals with income above 100 percent of the FPL.

Response: It was not our intent to establish a cost sharing system under which lower income beneficiaries could be subjected to higher cost sharing than their higher income counterparts. Our intent was to define maximum nominal cost sharing, as described under sections 1916(a)(3) and (b)(3) of the Act, as $4 for outpatient services. If a state seeks to use the authority provided under section 1916 of the Act to impose nominal cost sharing on individuals with income at or below 100 percent of the FPL, such cost sharing must also be applied to individuals with income above 100 percent of the FPL. Section 1916 of the Act does not allow for targeted cost sharing on different groups of individuals, so any cost sharing established under this authority is applicable to all non-exempt individuals. The 10 and 20 percent maximums established for individuals with income over 100 percent of the FPL are specific to cost sharing established under the authority of section 1916A of the Act. This authority specifically allows for cost sharing of up to 10 percent of the cost of the service for individuals above 100 and at or below 150 percent of the FPL and 20 percent for individuals with income above 150 percent of the FPL, with slightly different maximums for drugs and non-emergency use of the emergency department. For a specific outpatient service, a state may establish nominal cost sharing under the authority of section 1916 of the Act for all non-exempt individuals covered under the state plan in an amount not to exceed $4 (as adjusted for inflation), and the state may also establish targeted cost sharing for specified individuals under section 1916A of the Act for that same outpatient service, in an amount not to exceed 10 percent of the cost of the service. In such a case, the cost sharing imposed under the section 1916 authority may not exceed 10 percent of the cost of the service if that amount is less than the maximum nominal amount allowed for individuals with income under 100 percent of the FPL, because the state must ensure that lower income individuals are charged less than individuals with higher income, as described at § 447.52(g).

Comment: We solicited comments on the best approach to cost sharing for an inpatient stay for individuals with income at or below 100 percent of the FPL. We indicated we were considering a maximum cost sharing amount less than what is allowed in current regulation. Most commenters believed that the current regulations allowing cost sharing of up to 50 percent of what the agency pays for the first day of inpatient care was too great a burden for individuals at this income level. A few commenters recommended a maximum copayment of $10, one commenter recommended $100, and many recommended that the cost sharing for inpatient care should be the same as for outpatient services and be limited to $4.

Response: We are revising the regulations to limit maximum cost sharing charges for an inpatient stay, for individuals with income at or below 100 percent the FPL, to $75. This $75 limit will encompass most hospital cost sharing established by state Medicaid programs today and will align with the ratio of cost sharing for inpatient versus outpatient services with similar charges provided under private insurance plans. To provide a transition period for the small number of states with existing inpatient cost sharing exceeding $75, we are adding a new paragraph at § 447.52(b)(2). Under paragraph (b)(2), states with inpatient cost sharing that exceeds $75, as of July 15, 2013, must submit a plan to CMS that provides for reducing inpatient cost sharing to $75 by July 1, 2017. We redesignate the succeeding paragraphs, accordingly.

Comment: We solicited comments on whether we should define nominal cost sharing differently for community-based long term services and supports (LTSS) due to the frequency with which these services are provided and utilized by beneficiaries. Many commenters supported a separate approach to LTSS because they are concerned about the financial burden that an individual needing these services could face if a state were allowed to charge up to $4 for each service and most recommended that such services be exempted from cost sharing. Commenters were also concerned that allowing cost sharing for LTSS would discourage individuals from utilizing LTSS and leave many to opt for institutional care, which is more costly for states in the long run. Some commenters recommended that consideration be given to limiting the number of copayments permitted per week, month, or other specified timeframe for those with significant service needs, including adults with serious mental illness. One commenter opposed establishing different limits for community-based long term services and supports as it would be administratively burdensome for states. This commenter also pointed out that no specific mention is made in the regulations to long-term care community-based services provided under sections 1915(c), 1915(d), 1915(i), or 1915(k) of the Act. The commenter suggested that perhaps these defined packages are the more appropriate starting place if separate cost-sharing rules for these services are considered, but we need to take into account the fact that some individuals already contribute to the cost of these services in accordance with the post-eligibility treatment of income rules under part 435 subpart H.

Response: We agree with commenters that additional protections for non-

exempt individuals receiving community-based LTSS are appropriate to ensure that receiving care in the community, rather than in an institution, remains a financially viable option for such individuals, but the statute does not authorize the Secretary to require an exemption. We note that few states now impose cost sharing on LTSS. We encourage all states to consider the significant consequences of imposing cost sharing on such services, and remind states that they are required to comply with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act as interpreted in the *Olmstead* v. *L.C.* and *E.W (''Olmstead'')* to ensure they are not placing individuals at risk of institutionalization. While we are not directing an exemption for LTSS, we agree with commenters that additional protections are necessary for individuals with high service needs, and we are revising the proposed aggregate limit for premiums and cost sharing to protect all beneficiaries with high medical needs. As discussed further under § 447.56, the 5 percent aggregate limit applies to all individuals regardless of income. In addition, if premiums and cost sharing could exceed 5 percent of family income, states are required to have a mechanism to track such premiums and cost sharing in a manner that does not rely on beneficiaries. To provide protections to individuals with high service needs and ensure their cost sharing does not exceed the aggregate limit, we encourage states to consider prospectively ending a beneficiary's cost sharing obligation at a specified time of the applicable month or quarter given the frequency of utilization and the predictability of services provided under an approved plan of care, for example. We note that such an approach must take into account the cost sharing for items or services that may be received outside the plan of care, such as drugs for example, which would also contribute to the 5 percent aggregate limit.

We considered different options for a separate definition of nominal cost sharing specific to LTSS but have determined the most effective way to ensure ongoing affordability of care for beneficiaries who are frequent and regular consumers of care, including but not limited to those who need LTSS, is to ensure that there is an effective aggregate cap on cost sharing. Aggregate out of pocket limits are a common practice in the commercial market and we believe the extension of the aggregate limit is consistent with industry practice and will provide the greatest protections for beneficiaries, consistent with statutory provisions, while still maintaining states' flexibility to establish appropriate cost sharing mechanisms for their programs.

Comment: One commenter believed that proposed § 447.52(b)(2), which relates to maximum allowable cost sharing when the state does not have fee-for-service payment rates, is confusing and could be read to only apply to those with income at or below 100 percent of the FPL.

Response: We agree and have revised the paragraph, redesignated in this final rule as § 447.52(b)(3), to be clear that, ''in states that do not have fee-for-service payment rates, any cost sharing imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 100 percent of the FPL.'' The same clarification to the regulation text is made at § 447.53(c).

Comment: Some commenters recommended that the Secretary provide states the flexibility to determine the cost sharing methodology that best aligns with their delivery system and provider categories, for example allowing flat co-payments and premiums, co-payments based on a percentage of what the agency pays for the service, or premiums calculated as a percentage of family income.

Response: The regulations at proposed §§ 447.52, 447.53 and 447.54 establish maximum limits on the cost sharing that states can impose. While we are no longer requiring that the maximum cost sharing amounts be based on what the agency pays for the service, nothing in the regulations preclude states from setting their cost sharing amounts on such basis provided that the amounts charged do not exceed maximum permissible levels. Similarly, provided that the specific limits set out in the statute and codified in the regulations—including the aggregate limit not to exceed 5 percent of family income—are respected, states have the flexibility under § 447.55 to structure premiums in the manner suggested, although, as noted, statutory authority to impose premiums is limited.

Comment: We received several comments suggesting we clarify that states can apply different levels of cost sharing for their current Medicaid populations as compared to adults who will become eligible under the adult group.

Response: In general, any cost sharing established under the state plan must apply to all beneficiaries who are not specifically exempted per the requirements at § 447.56(a) to ensure comparability. There are two exceptions to this requirement, as follows. First, states may vary the cost sharing obligation by income level, reflected at § 447.52(g) of the final rule, such that individuals with family income below a certain threshold could be subject to lower cost sharing than those at higher income levels. A state could, for example, decide not to impose cost sharing on individuals with incomes below 50 percent of the FPL, and to impose a $1 copayment on individuals with income above 50 percent of the FPL. We note that states should have adequate processes in place to ensure providers and beneficiaries are aware of who can be charged what cost sharing so it is appropriately applied. Second, reflected at § 447.52(d), as redesignated in the final rule, states may establish different levels of cost sharing for targeted groups of individuals with income above 100 percent of the FPL. In this final rule, we clarify that for cost sharing imposed for non-preferred drugs and non-emergency services furnished in an ED, states may target to specified individuals with income below 100 percent of the FPL as well as those above, as discussed below. Thus, states could impose different cost sharing on individuals eligible in the new Adult group, or any other eligibility group, with income greater than 100 percent of the FPL than that imposed on other beneficiaries.

Comment: One commenter stated that proposed § 447.52(f), which lists the information that must be included in the state plan for each cost sharing charge imposed, is revised from the current regulations at§ 447.53(d) but that we did not provide a rationale for the revisions.

Response: We consolidated the state plan requirements currently contained in §§ 447.53(d) and 447.68 into one new section, redesignated as § 447.52(i) in the final regulation. The state plan requirements for tracking beneficiary cost sharing related to the aggregate limit are contained in § 447.56(f)(2) of this final rule. In consolidating the state plan requirements for cost sharing under the authority of both sections 1916 and 1916A of the Act, we sought generally to maintain the current requirements, while removing any unnecessary regulatory provisions. For example, we removed the requirement that states describe the basis for determining the charge, because these regulations no longer require states to base their cost sharing charges on what the agency pays for the service and this provision was no longer necessary. We note that we are making minor technical changes to paragraph § 447.52(i)(4) to improve the structure of the paragraph

and delete extraneous language. No substantive changes are intended.

Comment: One commenter recommended that CMS require that state plans identify whether a cost sharing charge is being imposed under the authority of section 1916 or section 1916A of the Act.

Response: With the streamlining of the regulations we do not believe it is necessary for states to specify what authority they are relying on to impose cost sharing. In their state plan, the states seeking to impose or continue cost sharing will need to detail who will be subject to cost sharing, for what service, how much, and whether providers may deny services for lack of payment. We will review state plan amendments to ensure compliance with sections 1916 and 1916A of the Act and these regulations.

Comment: One commenter requested that we clarify that the regulation authorizes states to *allow* providers to deny services for nonpayment of cost sharing, but does not confer authority on states to *require* providers to do so. One commenter recommended that we include a provision that providers are not prevented from reducing or waiving the application of a cost sharing requirement on a case-by-case basis.

Response: The requirements at §§ 447.52(e)(1) and (e)(2), as redesignated in this final rule, are clear that, while states may allow providers to deny services to individuals with income above 100 percent of the FPL who have failed to pay cost sharing charges, states are not required to permit providers to do so (and providers may only deny services if the state opts to permit them to do so). Further, § 447.52(e)(3) is clear that even if the state exercises this option, providers are not prohibited from nonetheless electing to provide the service to individuals who do not pay their cost sharing obligations. This is not at state option—it is a provider option—and we do not believe it is necessary to be included in the state plan.

Comment: A few commenters suggested that the regulations authorize states to allow providers to deny services for non-payment of cost sharing charges in more situations, including for those with income at or below 100 percent of the FPL. The commenters believe that such provider enforcement, particularly in the context of nonemergency use of the emergency room, would be appropriate.

Response: We are unable to extend the scope of the regulations beyond the statutory authority provided in sections 1916 and 1916A of the Act, both of which only allow states to impose provider-enforceable cost sharing to non-exempt individuals with income over 100 percent of the FPL and thereby assure the provision of services to lower income individuals who may not be able to afford the charge. These provisions of sections 1916 and 1916A of the Act cannot be waived unless the state meets the requirements of section 1916(f) of the Act.

Comment: One commenter recommended that the table at § 447.52(b) be clarified to clearly specify that the amounts are maximum amounts to correspond with the language in § 447.52(b).

Response: We agree with the commenter and have made the revision to §§ 447.52(b), 447.53(b) and 447.54(b).

Comment: One commenter asked if cost sharing must be imposed or if it is an allowable activity.

Response: States are not required to impose cost sharing, it is an option. Some states do not impose cost sharing. Furthermore, if a state does impose cost sharing, it has the option to charge less than the maximum amounts. Many states do so today.

Comment: One commenter requested clarification as to whether § 447.52(e) (relating to the prohibition against multiple charges) includes premiums.

Response: § 447.52(e) has been redesignated as § 447.52(f) in this final rule and pertains to cost sharing only, which is defined in § 447.51 to include any copayment, coinsurance, deductible or similar charge. Premiums are not encompassed in this definition, and states may impose both a premium and cost sharing on a given individual subject to the applicable conditions on such charges.

Comment: One commenter recommended revising the rule to allow states to waive or reduce cost-sharing for outpatient services delivered by designated high-value providers or in high-value care settings, even if those services may otherwise be subject to cost-sharing. One commenter requested clarification that the cost sharing rules may not be applied to different types of practitioners based on their licensure and that cost sharing within a category of services is not used to discriminate against health care practitioners acting within their state-defined licensure.

Response: Nothing in the regulations prevents a state from determining which services are subject to cost sharing and the amount charged, or by what type of provider the service is delivered. As suggested by the commenter, states could differentiate cost sharing for services provided by a designated high value provider as long as the state ensures that all beneficiaries have access to such providers.

Comment: One commenter recommended that we include in the final rule, language currently at § 447.60 that was omitted from the proposed rule, which requires that any cost sharing charges imposed by managed care organization on Medicaid enrollees be in accordance with the requirements set forth in the regulations.

Response: We agree with the commenter. The omission of this provision was not intentional and we have included this requirement in the final rule at § 447.52(h).

Comment: One commenter believed that if deductibles are an option for a state, they should be administered at an individual level on an annual basis because the commenter believes monthly and/or family-level deductibles are complex, confusing, and not the standard generally used by health plans especially when combined with other cost sharing.

Response: Deductibles are permitted at an individual level under the statute and these regulations. Any deductible imposed by a state must be within the maximum amounts established in §§ 447.52–54, and subject to the aggregate limit described in § 447.56(f) of this final rule.

4. Higher Cost Sharing Permitted for Individuals With Incomes Above 100 Percent of the FPL (§ 447.52)

We proposed to consolidate the current multiple cost sharing rules implementing sections 1916 and 1916A of the Act, respectively, into one set of streamlined cost sharing regulations for both statutory authorities at proposed § 447.52. Under section 1916 of the Act, states may impose nominal cost sharing on individuals not exempted by the statute. Under section 1916A of the Act, statute states may impose cost sharing at higher than nominal levels for nonexempt individuals with incomes above 100 percent of the FPL. For individuals with income above 100 and at or below 150 percent of the FPL, section 1916A of the Act permits cost sharing for nonexempt services up to 10 percent of the cost paid by the state for such services. (Different rules, discussed below, pertain to cost sharing for drugs and emergency department services). For individuals with income above 150 percent of the FPL, such cost sharing may not exceed 20 percent of the cost paid by the state. We received the following comments concerning the proposed provision for higher cost sharing permitted for individuals with incomes above 100 percent of the FPL:

Comment: A few commenters were concerned that we proposed to permit cost sharing for children.

Response: We did not propose new policy in the proposed rule related to cost sharing for children. Section 1916A of the Act permits states to impose cost sharing on certain children by exempting children covered under mandatory eligibility categories. This statutory option, implemented at § 447.70 of the current regulations, is retained in this rulemaking at § 447.56(a)(1)(i) through (VI). We revised the description of children who are exempt from premiums and cost sharing at § 447.56(a)(1)(i)(iii) to reflect the consolidation of different statutory eligibility groups for children under a single regulatory section at § 435.118 of the March 2012 final rule. We also made a technical change to the description of children exempt from premiums and cost sharing under § 447.56(a)(1)(i)(iv) to reflect the changes in the types of assistance available under Title IV–E of the Act. These are not substantive changes and are intended solely to assist states in appropriately identifying those children who may be charged premiums and cost sharing and exempting those who may not, as described in the statute.

Comment: One commenter recommended that CMS specify health centers' statutory responsibility related to the grants provided under section 330 of the Public Health Services Act (PHSA) to provide services regardless of ability to pay and clarify that states may not impose on health centers any obligations that conflict with these requirements. The same commenter also recommended that CMS add an exception at § 447.56(c)(3), entitling FQHCs to full Medicaid payment in situations in which they are required to collect cost sharing that would directly conflict with the section 330 requirements to waive a portion of the Medicaid cost sharing, and at § 447.56(e)(1) to authorize FFP for cost sharing amounts waived by an FQHC. At a minimum, the commenter recommends that CMS and HRSA issue joint guidance to minimize the tension between the Medicaid and section 330 of the PHSA regulations concerning patient payment obligations for services provided by FQHCs.

Response: The obligations of FQHCs related to their section 330 grants, as well as reimbursement to FQHCs, are beyond the scope of this regulation. This regulation does not require that FQHCs bill patients for cost sharing, but it does require that the payment to the provider take into account the cost sharing obligation. This requirement that states deduct a beneficiary's cost sharing obligation from the payment to providers is not new policy. It is contained in current regulations at §§ 447.57 and 447.82, redesignated at § 447.56(c) in this final rule. FQHC services are not specified as exempt from cost sharing under sections 1916 or 1916A of the Act and we do not believe that the Secretary has authority to mandate that states nonetheless exempt such services from cost sharing based on FQHCs' section 330 obligations. States, however, do have the flexibility to exempt particular services (including FQHC services) from cost sharing and/or to adjust the amount of cost sharing imposed, consistent with the regulations.

Comment: Some commenters recommended permitting flat-dollar copayments for all income groups, which they think would be easiest for enrollees and providers to understand and for Medicaid plans to administer. One commenter requested that we clarify how a limit based on 10 percent of the cost the agency pays for the service for individuals with family income above 100 percent but at or below 150 percent of the FPL and 20 percent of the cost the agency pays for the service for individuals with income over 150 percent of the FPL, would apply to FQHC services reimbursed under the prospective payment system (PPS). The commenter is concerned that because the amount of reimbursement under the PPS varies by health center, the maximum allowable cost sharing obligation for a particular service or visit would differ from health center to health center, and that this would be administratively burdensome for states, managed care plans, and providers; inequitable for beneficiaries; and could impede access to FQHC services. The commenter recommends that we revise the rule to provide that the maximum cost sharing for all individuals for FQHC services reimbursed under the PPS rate be the same as the maximum rate for individuals with income at or below 100 percent of the FPL.

Response: Section 1916A of the Act sets the maximum allowable cost sharing for individuals with income over 100 percent and at or below 150 percent of the FPL at 10 percent of what the agency pays for the service and for individuals with income over 150 percent of the FPL, at 20 percent of what the agency pays. We do not have the authority to change the maximum amount to a flat fee. We note that these percentages represent the maximum allowable charges. States have the flexibility to establish lesser cost sharing amounts for any service, and they may use a flat fee as long as it does not exceed the maximum level permitted. In determining the cost sharing for a particular service, states also can use the average payment made for the service across providers or units of the service to develop a consistent cost sharing amount within the maximum amount allowed by statute and regulation.

Comment: One commenter asked for clarification regarding the definitions of income that states should use in setting cost sharing charges, other than to say that the definitions of household income in § 435.603 should be used in determining the aggregate limit on cost-sharing. The commenter sought further clarification on the meaning of ''family income'' and suggested that states be required to describe their methodology in their state plan for approval by the Secretary as reasonable.

Response: In the interest of streamlining the requirements and reducing administrative burden, we are not requiring states to include, in their state plans, the methodology for determining income specific to premiums and cost sharing. For individuals whose financial eligibility is determined based on modified adjusted gross income (MAGI), ''family income'' for the purposes of imposing premiums or cost sharing or for defining the aggregate limit means ''household income'' using MAGI-based methods, as set forth in § 435.603. For individuals who are exempt from MAGI under section 1902(e)(14)(D) of the Act, implemented at § 435.603(j) of the regulations, we are still examining options related to income determinations.

Comment: One commenter stated that we do not have the authority to allow targeted cost sharing because it would violate comparability and recommended that we delete proposed § 447.52(c), relating to ''targeted cost sharing.'' Another commenter stated that additional targeting and variation of cost sharing within groups would add unnecessary complexity and should not be used.

Response: We are retaining the option for states to target cost sharing to specified groups of individuals. Comparability is required for cost sharing imposed under section 1916 of the Act. However, section 1916A(a)(1) of the Act provides that, ''a State, at its option and through a state plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services . . . and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this

section.'' This provision is codified in current regulations at § 447.62(a). Therefore, at redesignated § 447.52(d) of the final rule states may apply targeted cost sharing on specified groups of individuals; such cost sharing is limited to individuals with income over 100 percent of the FPL, per the requirements of section 1916A of the Act. We have revised § 447.52(d), adding paragraphs (1) and (2) to clarify that for cost sharing imposed for non-preferred drugs and non-emergency services furnished in an ED, the state may target to individuals below 100 percent of the FPL as well as those above, as allowed by section 1916A of the Act.

Comment: We solicited comments on whether the regulations should specify ways in which states may target different defined groups of individuals (with income over 100 percent of the FPL) for differential cost sharing under proposed § 447.52(c). One commenter suggested that the regulation should make it clear that targeting must be reasonable, that individuals with lower incomes may not be charged more than those with higher incomes, and that targeting may not discriminate based on gender, physical or mental disability, age, race, ethnicity, or any other protected classification. Another commenter requested that the Secretary include criteria that must be considered by states in targeting cost sharing to particular types of beneficiaries.

Response: Section 1916A of the Act gives states authority to target premiums and cost sharing to any group of individuals with income above 100 percent of the FPL (for cost sharing imposed for non-preferred drugs or non-emergency use of the emergency department, states can target to individuals at all income levels as discussed above), and to vary such premiums and cost sharing among the groups. In examining all the possible ways in which targeting could be applied, we believe targeting based on eligibility group or income level are the only targeting methods consistent with section 1916A of the Act, which will not lead to discriminatory practices. Thus, states can choose to impose premiums or cost sharing on individuals with income above 100 percent of the FPL in particular eligibility groups and to vary them by income level within the group. States may not target solely on the basis of delivery system—managed care, fee-for-service, and primary care case management—but may target eligibility groups covered through a specific service delivery system like managed care. States may not target based on disease-type or chronic condition. We note that states can impose cost sharing on whichever non-exempt service they choose for individuals at any income level subject to limitations in the regulations, and are not required to impose cost sharing on all non-exempt services in the state plan. For the recommendation regarding lower income versus higher income individuals, as noted above, we added § 447.52(g) to specify that if a state imposes income-related charges, it may not impose a higher charge for lower-income individuals than is charged for higher-income individuals.

5. Cost Sharing for Drugs (§ 447.53)

We proposed to establish a single provision governing cost sharing for drugs which would apply to nonexempt individuals at all income levels. To provide additional flexibility to states, and to further encourage the use of preferred drugs, we proposed to define ''nominal cost sharing'' as no more than $8 for non-preferred drugs and $4 for preferred drugs for individuals with income at or below 150 percent of the FPL. For individuals with family income above 150 percent of the FPL, per section 1916A(c) of the Act, a higher cost sharing charge may be established for non-preferred drugs, not to exceed 20 percent of the cost the agency pays for the drug. While states may not impose cost sharing on exempt individuals for preferred drugs, states may elect to impose cost sharing for non-preferred drugs on individuals who are otherwise exempt up to the nominal cost sharing amount. Cost sharing for a non-preferred drug must be limited to the amount imposed for a preferred drug if the individual's prescribing provider determines that the preferred drug for treatment of the same condition either will be less effective for the individual or will have adverse effects for the individual or both. Under the proposed rule, states would have the flexibility to apply differential cost sharing for preferred versus non-preferred drugs. For example, a state may charge $1 for preferred and $5 for non-preferred drugs or $0 for preferred and $8 for non-preferred drugs. We received the following comments concerning the proposed cost sharing for drugs provisions:

Comment: A few commenters suggested we take an approach that distinguishes between formulary generic and formulary brand drugs (instead of preferred and non-preferred). One commenter noted that this approach may be more helpful in the managed care context. One commenter requested clarification as to whether the requirement that all drugs be considered preferred for cost sharing purposes if the agency does not differentiate between preferred and non-preferred, is a de facto preferred status. The commenter was concerned that this could result in lower cost sharing for more expensive brand name drugs that are not identified by the state as non-preferred. One commenter was opposed to the definition of preferred drugs at proposed § 447.51 to include all drugs if the agency does not differentiate between preferred and non-preferred drugs.

Response: Section 1916A of the Act allows states to have different cost sharing levels for preferred and non-preferred drugs, but does not speak to generic versus brand name drugs. States may use a variety of methods to determine preferred and non-preferred drugs including whether the drug is a brand or generic. States also maintain other cost control measures, such as mandatory generic substitution policies. The definition of preferred drugs, which includes all drugs if the agency does not differentiate between preferred and non-preferred drugs, is consistent with section 1916A(c) of the Act and current regulations at § 447.70(a).

Comment: Several commenters disagreed with the proposed policy to allow cost sharing for up to $4 for preferred drugs and $8 for non-preferred drugs. They described research showing that even low prescription drug copayments may cause very low income people to defer filling prescriptions. The commenters argue that Medicaid beneficiaries cannot be incentivized to select a preferred drug, as is accomplished with some success among middle class consumers; instead, with such high cost sharing differentials, Medicaid enrollees will go without the ''non-preferred'' drug even if it is medically necessary and would work far more effectively than a preferred drug. These commenters recommend that CMS define nominal drug cost sharing in relation to the income and health status of the Medicaid population and amend the table at § 447.53(b) to establish maximum cost sharing as follows: individuals with family income at or below 150 percent of the FPL—Preferred drugs: $1.10, Non-preferred drugs: $3.30; individuals with family income exceeding 150 percent of the FPL—Preferred drugs: $1.10; Non-preferred drugs: $4.20. Two other commenters expressed concern with the $8 copay for non-preferred drugs if states have latitude to classify most or all of the brand-name drugs in a therapeutic class as non-preferred. One commenter stated the proposed increase in cost sharing is unnecessary because states already have many tools to

control prescription drug costs and have high utilization of generic drugs. Other commenters appreciated the flexibility proposed for cost sharing. One commenter welcomed the increased maximum cost sharing, and one commenter stated that allowing states to charge higher cost sharing for non-preferred drugs, when effective, lower-cost alternatives are available, is a reasonable policy.

Response: We agree that cost sharing is just one of many tools that states may use to manage drug utilization, and states may determine that higher cost sharing does not enhance their efforts to promote the use of preferred drugs. However, we also agree that it is a tool permitted under the statute. In the final rule we are maintaining the option for states to impose cost sharing of up to $4 for preferred drugs and $8 for non-preferred drugs for all individuals, including those with income at or below 150 percent of the FPL, and for those with income above 150 percent of the FPL, to continue to establish higher non-preferred drug cost sharing of up to 20 percent of the cost of the drug. As described at § 447.53(e), as revised in the final rule, if a prescriber finds that the non-preferred drug is medically necessary, the state must have a process in place to limit cost sharing for that drug to the amount for preferred drugs.

Comment: One commenter suggested that the final rule require a cap on cost sharing for non-preferred drugs as a necessary protection for this vulnerable population.

Response: The 5 percent aggregate limit on cost sharing in the current regulation and included in this final regulation at § 447.56(f) applies to all cost sharing, including that for non-preferred drugs. States have the option to establish additional cost sharing limits for particular services, such as drugs at § 447.56(f)(5) of the final rule, but we do not have the authority to mandate a cost sharing cap specific to non-preferred drugs.

Comment: A few commenters stated that CMS was circumventing the statutory requirements of section 1916A of the Act by setting two different maximum ''nominal'' amounts for preferred and non-preferred drugs because the Act requires that cost sharing for all drugs imposed on individuals with income under 150 percent of the FPL must not exceed the ''nominal'' cost sharing as otherwise determined under section 1916 of the Act. Additionally, the commenter notes that section 1916A of the Act explicitly allows states to charge up to twice the nominal amount for non-emergency care furnished in an emergency department, so if Congress intended to allow the same for non-preferred drugs, Congress would have provided such an option in the statute.

Response: Section 1916 of the Act gives the Secretary the authority to define nominal cost sharing. There is nothing in the statute which requires a single definition of what is considered to be nominal. Moreover, the general cost differential between preferred and non-preferred drugs merits a different nominal maximum for each type, therefore we believe it is appropriate to establish a $4 nominal maximum for preferred drugs and an $8 nominal maximum for non-preferred drugs.

Comment: One commenter expressed concern for vulnerable populations that require certain classes of drugs, such as HIV antiretroviral drugs, and recommended they be available at the ''preferred'' drug cost-sharing level.

Response: States have the discretion to designate which covered drugs within each class of drugs will be considered preferred or non-preferred. Beneficiaries must always have access to necessary drugs at the preferred drug rate because a given drug cannot be considered non-preferred unless the state has an equivalent drug available at the preferred rate. In addition, § 447.53(e), as revised in this final rule, requires states to provide a non-preferred drug at the preferred drug cost sharing level, if the prescribing provider determines that the preferred drug would be less effective or have adverse effects on the individual.

Comment: A few commenters recommended that we convert the non-preferred prescription drug copayment to a flat dollar amount for individuals with incomes over 150 percent of the FPL instead of basing cost sharing on what the agency pays for the drug.

Response: As discussed above, section 1916A of the Act sets the maximum allowable non-preferred drug cost sharing level for individuals with income over 150 percent of the FPL at 20 percent of what the agency pays for the drug. CMS does not have the authority to change the maximum amount allowed to a flat fee, but states may construct their charges as flat fees as long as such fees are within the maximums established by law.

Comment: One commenter supported the proposed increase of allowable cost sharing for non-preferred drugs when Medicaid recipients and not Medicaid pharmacy providers bear responsibility for the higher cost sharing. The commenter requested that, when enhanced cost sharing for prescription drugs is implemented, we mandate states to condition services on the payment of such cost sharing. Alternatively, the commenter requested that CMS mandate states to develop a mechanism whereby participating pharmacies can submit unpaid cost sharing amount to the state for payment. One commenter recommended that HHS require states to implement cost sharing provisions for prescription drugs and to permit providers to withhold medication (whether preferred or non-preferred) from beneficiaries for failure to pay cost sharing.

Response: The imposition of premiums or cost sharing is an option permitted states under sections 1916 and 1919A of the Act and cannot be mandated by the Secretary. The statute stipulates that providers, including pharmacies, may not deny services to individuals with income at or below 100 percent of the FPL due to inability to pay their cost sharing obligation. States have the option to allow providers to deny services to individuals with income over 100 percent of the FPL if they do not pay required cost sharing. If a state opts to allow providers to deny services if the individual does not pay the cost sharing, this must be indicated in their state plan. Regardless of whether an individual pays the cost sharing, states must deduct the payment made to the provider by the amount of the individual's cost sharing obligation in accordance with § 447.56(c) of this final rule. We do not have the statutory authority to alter these requirements in the manner being suggested by the commenters.

Comment: One commenter requested clarification as to whether states have the option to impose cost sharing for non-preferred drugs on individuals otherwise exempt from cost sharing. One commenter recommended that states should have the option to impose cost sharing on exempt individuals for certain classes of prescription drugs that the state identifies as elective or controversial, such as narcotics.

Response: Section 1916A of the Act allows states to impose cost sharing for non-preferred drugs on otherwise exempt individuals, provided that such cost sharing does not exceed a nominal amount. At § 447.53(b) of the final rule, we have defined nominal cost sharing for preferred drugs as no more than $4 and for non-preferred drugs at no more than $8. We are revising § 447.53(d) in the final rule to clarify that cost sharing for non-preferred drugs imposed on otherwise exempt populations cannot exceed the nominal amount defined in § 447.53(b) in accordance with section 1916A(c) of the Act. While states may impose cost sharing on some drugs and not other drugs, all cost sharing must be

consistent with the requirements of § 447.53(b) and, if there are no drugs identified as non-preferred drugs in a class, cost sharing for drugs in that class cannot exceed the nominal amounts for preferred drugs. Identification of ''elective'' or ''controversial'' drugs is beyond the scope of this regulation.

Comment: A few commenters stated that the proposed cost-effectiveness standard for determining which drugs are non-preferred is inappropriate and does not include the anti-discrimination protections contained in the Affordable Care Act. The commenter believed that this standard would threaten access to needed treatment and would result in broad, one-size-fits-all policies that do not reflect important differences in individual beneficiary needs and circumstances. One commenter recommended that the definition of preferred drugs not be restricted to low-cost or exclusively generic agents, and should encourage the inclusion of high-value brand agents, especially when a generic equivalent is not available. The commenter believed that preferred and non-preferred drugs should be chosen based on clinical value, not solely on the basis of acquisition price. One commenter recommended that the definition of preferred and non-preferred drugs be determined based on clinical assessment of the individual. One commenter recommended that the definition of preferred drugs be expanded to include the generic equivalent of brand named drugs.

Response: The definition of preferred drugs for cost sharing purposes at § 447.51 does not prescribe the type of drugs that the state designates as preferred or non-preferred, and requiring the inclusion of certain drugs on a state's preferred drug list is beyond the scope of this regulation. However we do not believe that preferred drug programs limit individuals' access to necessary drugs. These regulations require that states establish a process through which a beneficiary can access a non-preferred drug, which his or her provider has determined to be medically necessary for the beneficiary, with cost sharing limited to the amount applicable to preferred drugs. We believe that this policy would not violate any non-discrimination standards since all beneficiaries are subject to the Medicaid requirements of the preferred drug list, which direct that it be developed in a manner that does not discriminate against any particular class of individual, or type of disability or disease. In addition, as previously noted in guidance (SMDL #04–006, September 9, 2004), states need to assure that patients continue to have access to needed medications so in addition to cost considerations, a preferred drug list should be based on clinical criteria that considers the efficacy of the drug to others in that class.

Comment: Several commenters were concerned that allowing states to impose cost sharing of up to 20 percent of what the agency pays for a non-preferred drug, for individuals with income over 150 percent of the FPL, would be overly burdensome for individuals with chronic conditions.

Response: Section 1916A(2)(B) of the Act provides for the flexibility to impose cost sharing at these levels for individuals with incomes above 150 percent of the FPL. We did not propose to change this flexibility, which is codified at § 447.74 of the current regulations, and is moved to § 447.53 in this final rule. The Secretary does not have the authority to change or reduce the percentage of the cost of the item or service that is the maximum allowable cost sharing because the statute is clear. We note that such cost sharing is subject to the aggregate limit codified at § 447.56(f) of this final rule.

Comment: Several commenters suggested that we revise § 447.53(e) to provide more detailed requirements for the process states must have in place to allow for cost sharing at the preferred drug level, in the case of a non-preferred drug that the prescribing provider has determined would be less effective or may adversely affect the individual. The commenters stated that any process should take into account the electronic claims processing used by pharmacies and pharmacists and should be easy for the prescriber to invoke. Several commenters also recommended that states be required to describe their process in the state plan and provider manuals. One commenter believed that this requirement undermined the intent of the regulations to encourage the use of less expensive preferred drugs because for a state to actually cover a non-preferred drug, the prescriber already has to receive prior-authorization, meaning most, if not all non-preferred drugs would have to be provided at the lower cost sharing amount.

Response: States must have a process in place for providing prior authorization of medically necessary drugs that meets the existing requirements at section 1927(d)(5) of the Act, therefore we are not prescribing additional requirements in this regulation or requiring states to describe the process in their state plan. However, we are revising the final rule to add the word ''timely'' to the process states must use to allow for cost sharing at the preferred drug level in accordance with the section 1927 of the Act. We will monitor state implementation and determine whether additional guidance is necessary.

6. Cost Sharing for Emergency Department (ED) Services (§ 447.54)

Sections 1916(a)(3) and 1916(b)(3) of the Act, allow states to obtain a waiver to impose cost sharing for non-emergency use of the ED that does not exceed twice the nominal amount for other outpatient services. Section 1916A(e)(2)(A) of the Act also allows cost sharing for individuals with income above 100 percent of the FPL and at or below 150 percent the FPL in an amount not to exceed twice the nominal amount as determined by the Secretary. We proposed to consolidate current regulations at § 447.54(b) and § 447.72 related to non-emergency use of the ED into proposed § 447.54. To facilitate states' ability to utilize flexibility provided in existing regulations, for all individuals with income at or below 150 percent of the FPL, we proposed to allow cost sharing of no more than $8, which represents twice nominal, for non-emergency use of the ED without requiring a waiver. The proposed changes are discussed in more detail in the January 22, 2013 Medicaid Eligibility Expansion proposed rule (78 FR 4659 and 4660). We received the following comments concerning the proposed provision for cost sharing specific to non-emergency use of the ED:

Comment: Many commenters opposed the policy to allow up to $8 for non-emergency use of the ED because it might cause individuals with incomes at or below 150 percent of the FPL to forego necessary services, including potentially lifesaving services, and because many Medicaid beneficiaries go to the ED because they lack access to regular sources of primary care. Foregoing necessary services may result in adverse health outcomes requiring more expensive care later. Many commenters recommended that the maximum allowable cost sharing should be set at $3.30 for individuals with family income at or below 100 percent of the FPL, $6.30 for individuals with family income from 101–150 percent of the FPL and $12.00 for individuals with family income above 150 percent of the FPL. Several other commenters recommended that the maximum allowable cost sharing amount for non-emergency use of the ED be limited to $4 to align with what is proposed for other services. Several commenters recommended that CMS allow states the flexibility to impose cost sharing for

non-emergency use of the ED that exceeds $8, to decrease inappropriate use of the ED. One commenter recommended that up to three times the outpatient services copayment (rather than two) should be allowed in states that are working to expand access to alternative options for care. Many commenters recommended that for individuals with family income at or below 100 percent of the FPL, we revise the regulations to allow cost sharing for non-emergency use of the ED, only when no cost sharing (rather than lesser cost sharing) is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital ED involved.

Response: We believe it is important for states to have options to incentivize care in the most appropriate settings and to encourage individuals to develop a regular source of care, to the extent that beneficiaries are assured timely access to needed care. One option to achieve this is through cost sharing initiatives, therefore, we are finalizing § 447.54(b) as proposed, however we note that we have made some minor technical changes in the final rule to spell out the term emergency department instead of using the acronym ED and to refer to non-emergency services instead of treatment. The technical changes are for clarification only and are not intended to be substantive. The $8 maximum for non-emergency use of the ED is twice the nominal amount for outpatient services, which is the maximum allowable cost sharing permitted under sections 1916 and 1916A of the Act for individuals with income at or below 150 percent of the FPL. The statute does not limit the amount states can impose for non-emergency use of the ED on individuals with income over 150 percent of the FPL (other than through the aggregate cap of 5 percent of family income), and we do not have the authority to limit such cost sharing through regulation. Section 1916 of the Act requires that there be an accessible alternative provider to provide the services, but does not require that there be no cost sharing for such services and section 1916A of the Act requires there be lesser cost sharing for services provided by the alternative provider, or no cost sharing if the cost sharing is being applied to an otherwise exempt individual. To streamline the requirements to make it administratively feasible for states to meet this requirement, we are maintaining the proposed policy in the final rule that services provided by an alternative provider must be available with lesser cost sharing or no cost sharing only if the individual is otherwise exempt from cost sharing. We note that for individuals with income at or below 100 percent of the FPL the state may not allow a provider—including a hospital ED—to deny services in the event that an individual is unable to pay the cost sharing.

We note that in the final rule we are deleting § 431.57 of this subchapter relating to the waiver of cost sharing requirements for states to impose cost sharing for non-emergency services furnished in an ED. This language is redundant with § 447.54(b) of the final rule, which allows states may impose cost sharing up to twice the nominal amount for such services through the state plan. In addition to this technical change, we updated the citations to the cost sharing regulations at §§ 435.121, 435.831, 436.831, 438.108, 440.250, 447.15, 447.20, and 457.540.

Comment: One commenter recommended that CMS make public the amount of documented Medicaid savings in states that have imposed cost sharing for non-emergency use of the ED.

Response: We are not revising the rule to require states to document savings. However, we will examine available options for sharing best practices and other data available from states with successful ED diversion programs.

Comment: Several commenters noted a drafting error at § 447.54(c), which they believe should be revised to read: ''. . . not to exceed the maximum amount established in paragraph (b) of this section. . .'' The commenters also believed we made an error in § 447.54(d), which they think should read ''. . . to impose cost sharing under paragraph (a), (b) or (c) of this section of non-emergency. . . .''

Response: We agree that there was a drafting error in paragraph (c) and have corrected the provision in this final rule. However, paragraph (d) was written as intended, and is finalized as proposed. Paragraphs (a) and (c) provide the authority to impose cost sharing, while paragraph (b) describes the maximum allowable amounts.

Comment: One commenter recommended that cost sharing for non-emergency use of the ED should be permitted for any visit to the ED that does not result an inpatient stay.

Response: Sections 1916 and 1916A of the Act prohibit cost sharing for emergency services. As there are many emergency conditions and services that do not result in an inpatient stay, the commenters' suggested policy would violate the statute.

Comment: Many commenters recommended that states that impose cost sharing for non-emergency services provided in an ED be required to permit newly-enrolled individuals to make at least one non-emergency ED visit before requiring them to pay this cost-sharing obligation.

Response: States have the option to establish such a policy under current regulations and the new rule as finalized, but we do not think it appropriate to require it.

Comment: Some commenters suggested that we designate underserved areas and/or certain periods of time in which insufficient access warrants exemption from cost sharing for non-emergency use of the ED.

Response: Per § 447.54(d), before imposing cost sharing for non-emergency use of the ED, the hospital must provide the individual with a name of and location of an available and accessible provider and provide a referral to coordinate scheduling. If geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

Comment: Several commenters asked that we refrain from adding more specificity or requirements in the regulation itself, for example imposing further requirements or pre-conditions on a state's authority to impose cost sharing for non-emergency services provided in an ED, which they believed would limit the ability of states to account for variation across states. A few commenters were concerned that we had added a new requirement in stipulating that hospitals ensure that an alternative provider is available to provide needed services with lesser or no cost sharing. They were concerned the use of the term ''ensure'' in proposed § 447.54(d)(2)(ii) would require hospitals to ''ensure'' something beyond their control, presenting unnecessary administrative burden for state administrators and hospitals. Many commenters stated that CMS should remove the requirements at proposed § 447.54(d)(2)(iii) that ED staff provide a referral and coordinate scheduling with an available and accessible alternative non-emergency services provider, because it is administratively burdensome and takes time and resources away from patient care. In addition, they argue that compliance is infeasible given hospitals' limited access to current, accurate information on the availability of appointments with other providers. The commenters believed that these requirements will make it difficult for states to take up the

option afforded under the statute and that it would be less costly for an ED to provide treatment for the non-emergency conditions than to coordinate a referral. One commenter stated that the requirement to provide a referral is unnecessary because in many state managed care programs, every enrollee has a primary care provider and 24-hour call-in lines are available, enabling hospitals providing the care to contact either the enrollee's primary care provider or the 24-hour call-in line as an alternative to following the steps listed in § 447.54(d). Another commenter stated that the language in proposed § 447.54(d)(2)(iii) differs from the requirement at current § 447.80(b)(2)(iii), and that the revised language would impose additional burdens on states' ability to effectively implement cost sharing. The commenter noted that current § 447.80(b)(2)(iii) requires hospitals to provide ''a referral to coordinate scheduling of treatment by an available and accessible alternative non-emergency services provider,'' while proposed § 447.54(d)(2)(iii) requires hospitals to ''coordinate scheduling and provide a referral for treatment by this provider.''

Response: We did not intend to add additional requirements for hospitals related to cost sharing for non-emergency use of the ED. Rather, our intent was to clarify the existing language. To eliminate any confusion, we are replacing the word ''ensure'' with ''determine'' in § 447.54(d)(2)(iii), as redesignated in the final regulation. This is consistent with the statutory requirement that before collecting cost sharing for non-emergency use of the ED, hospitals must provide individuals with the name and location of an available and accessible provider that can provide the service with lesser or no cost sharing. States share in this responsibility, of course, and will need to work with hospitals to ensure that hospitals are able to determine whether such care is available and accessible. The goal underlying the policy is to ensure that the right care is provided at the right time in an appropriate setting.

The language in proposed § 447.54(d)(2)(iii), redesignated at § 447.54(d)(2)(iv) of this final rule, was intended to clarify the referral requirement, which is in current regulation at § 447.80(b)(2), and which reflects statutory language. We did not intend to change the substance of the rule. However, to avoid any confusion we are revising § 447.54(d)(2)(iv) to reinstate the language from the current rule that hospitals must provide a referral to coordinate scheduling for treatment by an alternative provider. To confirm that the alternative non-emergency services provider is ''actually available and accessible'' as required by statute, it is important that scheduling be done onsite, with the beneficiary present, to the maximum extent possible. We recognize that this may not be possible during certain hours of the night, in which case follow-up scheduling may be necessary. Hospitals can and should take advantage of the existence of a call line and assigned primary care providers in satisfying the coordination requirements in the statute and regulations, and states should assure, before imposing such cost sharing, that procedures are in place that can facilitate hospitals' ability to carry out these responsibilities, including outside of regular business hours.

Comment: One commenter requested clarification of the referral requirement, including whether a patient should have a scheduled appointment, or just the information necessary to make an appointment, with an alternative provider when he or she leaves the hospital; whether community clinics or FQHCs may serve as alternative, non-emergency providers for referral from the ED; and the appropriate process for completing a referral when physician offices are closed. One commenter requested that we define ''timely manner'' in proposed § 447.54(d)(2)(ii).

Response: The regulations are not prescriptive on the exact process to be used by hospitals. States have flexibility to establish processes to meet the coordination goals in the statute and regulations in a manner that best accommodates their systems and provider networks. The extent to which a state relies on managed care or establishes patient centered medical homes, for example, may impact how a state would meet the requirements in the regulation. As noted above, whenever possible, hospitals should attempt to schedule the appointment while the patient is present, but if that is not feasible, the hospital would need to follow up to ensure that an alternative provider is ''actually available and accessible'' in a timely manner, as required by statute.

Section 1916A (e)(4)(B) of the Act describes an alternative non-emergency services provider as one ''that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department.'' Any Medicaid participating providers, including clinics that can do so, are acceptable. Because we do not think that there is a uniform definition of timeliness that is appropriate for all situations, we are not defining ''timely manner'' in the regulation. In meeting a general timeliness standard, however, states should direct hospitals to consider the medical needs of the individual to assess (1) whether care is needed right away or if a short delay in treatment would be sufficient, and (2) any particular challenges the person may face in accessing follow-up care, such as leave from employment, child care, or ability to receive language assistance services or accessible care for people with disabilities. States will need to work with the hospitals, non-emergency providers, and managed care organizations participating in their Medicaid programs to design a referral network and system that fulfills the statutory requirements prior to imposing cost sharing amounts for non-emergency services provided by a hospital ED. The intent of this provision is to provide an additional tool to ensure that care is provided in a timely and appropriate manner to drive better quality at lower costs. It is not to be implemented in a way that results in people not getting the care they need.

Comment: One commenter believed that we omitted from proposed § 447.54(d) some of the statutory requirements that hospitals must meet before collecting cost sharing for non-emergency use of the ED, including the obligation to inform the recipient that he or she does not have an emergency medical condition and the requirement to notify the recipient of the applicable cost sharing for treatment of a non-emergency condition in the ED.

Response: We did not omit any of the statutory requirements in the proposed rule. The requirement that the hospital inform individuals whether or not they need emergency services, and of the cost sharing obligation to receive services in the ED is implicit in the requirements that the assessment be performed and that the hospital provide the individual with the name and location of an available and accessible alternative provider that can provide services with lesser or no cost sharing. We do not see a need to state as much explicitly in the text of the regulation. However, for clarity, we have added a new paragraph (i) at § 447.54(d)(2) requiring hospitals to ''inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department.'' Proposed §§ 447.54(d)(2)(i) through (iii) are redesignated in this final rule as §§ 447.54(d)(2)(ii) through (iv), respectively.

Comment: A few commenters recommended that the Secretary ensure that the safeguards at § 447.54(d) are observed by states that impose cost sharing for non-emergency use of the ED.

Response: We will ensure through the state plan amendment process that the requirements of § 447.54(d) are met, and expect to oversee implementation to the extent feasible.

Comment: One commenter recommended that the final rule include requirements for oversight and reporting to ensure that higher cost-sharing is not imposed without verification of the availability of alternative providers able to furnish non-emergency care. In addition, the commenter recommended enhanced requirements for verification in rural and other areas with a shortage of primary care physicians and specialists that will see Medicaid patients that there is available and accessible care by an alternative provider. A few commenters recommended that, at a minimum, the ED should be required to specify what the particular patient's cost-sharing obligation will be, including in the case of a patient with income above 150 percent of the FPL, that the patient may be responsible for 100 percent of the charges. The commenter also believed that, prior to an emergency room providing non-emergency care to a Medicaid beneficiary the hospital should be required to obtain written consent from the individual to receive the non-emergency care in the ED and to take responsibility for any cost-sharing obligation for such care.

Response: The statute, codified at § 447.54(d) in this rulemaking, sets forth clear requirements that states must effectuate to establish cost sharing for non-emergency use of the ED, including a requirement that hospitals provide information on available and accessible providers who can provide the needed non-emergency services with lesser or no cost sharing. States must ensure that hospitals are able to meet these requirements, whether in a rural, suburban, or urban setting. We ensure that states are in compliance with the statute and regulations through the state plan amendment process and will consider whether further reporting is necessary for oversight purposes. For cost sharing for individuals with income above 150 percent of the FPL, we note that the statute does not require states to make such patients responsible for 100 percent of the charges for non-emergency use of the ED, but also does not limit the cost sharing that states can impose on individuals in this income bracket for non-emergency use of the ED. At proposed § 447.52(b)(3), finalized in this rulemaking at § 447.52(c), any cost sharing imposed for any service may not equal or exceed the amount the agency pays for the service; such cost sharing is also limited by the 5 percent aggregate limit described at § 447.56(f).

Comment: Several commenters stated that the rule does not provide a clear methodology for determining ''non-emergency'' status. One commenter highlighted the preamble discussion in the proposed regulation about the difficulty in determining whether a service is needed to address an emergency situation based on Current Procedural Terminology (CPT) codes alone, and the lack of guidance on other standards that could be used, and requested that CMS more clearly define ''non-emergency'' or provide states latitude to define as needed. Another commenter shared our concerns about CPT codes and noted that, while the imposition of non-emergency ED cost sharing is not administratively feasible without some type list, any protocols must also avoid violation of the emergency screening requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA). One commenter stated that the EMTALA requirements are sufficient to determine which individuals should be subject to cost sharing for non-emergency use of the ED, and that states should not have to describe the processes in the state plan. Another commenter expressed concern about beneficiaries' general ability to distinguish between ''emergency'' and ''non-emergency'' symptoms. The commenter was concerned that adequate protections be in place to ensure that beneficiaries are not punished for seeking emergency care when doing so is appropriate under a prudent layperson standard. Another commenter agreed that in distinguishing between ''emergency'' and ''non-emergency'' conditions, hospitals must use the prudent layperson definition, not a discharge diagnosis. One commenter stated clinical reviews of ER claims to look at presenting conditions such as chest pain seem would be administratively burdensome, and could delay treatment, referral, or payment to providers. Other commenters requested that we either clearly define ''non-emergency'' services or provide states with the latitude to define them as needed, and several commenters asked us to maintain the maximum level of flexibility in the rule to facilitate appropriate and feasible implementation of non-emergency ED cost sharing.

Response: ''Non-emergency'' services are defined at § 447.51, which cross references to the current definition of emergency services at § 438.114. This definition relies on a prudent layperson standard, in that a medical condition manifests itself by acute symptoms of sufficient severity that a prudent layperson that possesses an average knowledge of health and medicine could deduce that they need emergency medical attention. We agree that it is difficult to implement a system to differentiate non-emergency from emergency services for cost sharing purposes in a way that ensures beneficiary protections consistent with the prudent layperson standard. We continue to believe that the use of diagnosis and procedure codes alone is not an appropriate process for determining non-emergency services, as doing so would not adequately protect beneficiaries legitimately seeking ED services based on the prudent layperson standard, for whom a CPT code assigned after care is provided may indicate a non-emergency condition. We sought comments on feasible methodologies for states and hospitals to use to make this distinction, but did not receive any recommendations. Therefore, we are not making any revisions in the final rule to prescribe how states can and should distinguish between ''emergency'' and ''non-emergency'' conditions for cost sharing purposes. We remain open to states' proposals for distinguishing between ''emergency'' and ''non-emergency'' conditions and will review such proposals through the state plan amendment process. As successful models emerge we will develop further guidance.

Comment: One commenter asked if would be reasonable to have the Medicaid agency reimburse hospitals for the medical screening that they must conduct. Another commenter asked if a hospital could be reimbursed for providing a referral and giving advice on other appropriate providers.

Response: To the extent the provider properly bills the Medicaid agency for an assessment or evaluation conducted on a Medicaid beneficiary, the provider would be entitled to payment for the service as provided for in the state's Medicaid State plan. States may also establish payment specifically for the medical screening exam required by EMTALA and/or for coordination of referrals to alternative non-emergency services providers.

Comment: One commenter suggested that CMS allow hospitals to charge the maximum allowable cost-sharing amount for non-emergent care, and then refund the beneficiary if needed. The

commenter expressed concern that hospitals will not be able to impose cost sharing on beneficiaries after they have left the ED.

Response: The statute requires that before providing and imposing cost sharing for non-emergency services in an ED, the hospital must inform the beneficiary of the cost sharing obligation tied to those services and provide the name and location of an available, accessible, alternative provider that can provide the services with no or lesser cost sharing. This allows the beneficiary to forgo treatment in the ED if they do not have the ability to pay the cost sharing. If the individual decides to stay and receive the services at the ED, the hospital can impose the cost sharing while the person is still present.

Comment: One commenter stated that for hospitals, the collection of Medicaid cost-sharing amounts for non-emergency care in ED settings can prove difficult, leading to lack of payment and increases in bad debt.

Response: The statute allows states to impose cost sharing for non-emergency care in an ED and sets out the requirements that hospitals must meet to collect such cost sharing. We do not have the authority to take away this option or ignore the statutory requirements and will work with states and the hospital community to share best practices and potentially issue further guidance.

Comment: One commenter requested clarification as to whether urgent care centers are subject to the guidelines for cost sharing for non-emergency use of the ED.

Response: No, this rule only pertains to non-emergency services furnished in an ED.

Comment: A few commenters supported what they believed was a new option regarding cost sharing for non-emergency services provided in the ED to beneficiaries who are otherwise exempt from cost sharing.

Response: This is not a new option. This is a statutory option described at section 1916A(e)(2)(B) of the Act and codified in current regulations at § 447.70(b).

Comment: One commenter stated that instead of focusing on cost sharing, which could result in harm to patients, we should focus on best practices for medically sound ways of reducing unnecessary emergency department visits, such as electronic exchange of patient information, care coordination, patient education on appropriate use of the ED, and guidelines for prescribing narcotics. One commenter was concerned that focusing on cost sharing does not address why patients seek care in an ED, and that hospitals trying to decrease non-emergency ED use will inadvertently run afoul of either EMTALA or their state's emergency access rules. The commenter recommended that some form of safe harbor be established for hospitals trying, in good faith, to encourage the most appropriate use of resources for non-emergency care.

Response: We agree that there are many strategies which states can and have implemented to address the problem of non-emergency use of hospital EDs. However, whether or not cost sharing is the most effective way to address non-emergency use of the ED, it is an option provided to states in the statute. We are available to work with all states in exploring the full range of options to reduce non-emergency use of the ED, and to share best practices which emerge.

7. Premiums (§ 447.55)

We proposed one simplified, consolidated section of the regulations to implement the options authorized under sections 1916 and 1916A of the Act relating to the imposition of premiums on individuals with family income above 150 percent of the FPL, and describe the options to impose premiums for specific populations. The proposed changes are discussed in more detail in the January 22, 2013 Medicaid Eligibility Expansion proposed rule (78 FR 4660). We received the following comments concerning the proposed premiums provisions:

Comment: Several commenters recommended that we revise proposed § 447.55(a)(2) to clarify that states are allowed to impose premiums on qualified disabled and working individuals if the individual's income exceeds 150 percent of FPL. The commenters also noted that proposed § 447.55(c) does not reflect statutory requirements in section 1916 of the Act that limit aggregate premium expenses for individuals provided medical assistance under section 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), to no more than 7.5 percent of the individual's family income for those whose annual income does not exceed 450 percent of the FPL.

Response: We agree with the commenters. Due to a drafting error, the allowable premiums and limitations described at proposed § 447.55 were not clear. We have revised paragraph (a) and paragraph (c) (redesignated as paragraph (b) for clarity), of § 447.55 to address this error. Paragraph (b)(1) describes the limitations on prepayment; paragraph (b)(2) describes the options for terminating an individual for failure to pay, paragraph (b)(3) describes the statutory requirements noted by the commenter for individuals receiving medical assistance under TWWIIA, and paragraph (b)(4) describes the state's option to waive premiums for any individual or family. In addition to these clarifications, we revised the description of pregnant women who may be charged premiums at § 447.55(a)(1) to reflect the consolidation of different statutory eligibility groups for pregnant women under a single regulatory section at § 435.116 of the March 2012 final rule. This is not a substantive change and is intended solely to assist states in appropriately identifying those beneficiaries who may be charged premiums, as described in the statute. As noted above, we made a similar revision to the description of children who are exempt from premiums and cost sharing at § 447.56(a)(1)(i) through (iii) of this final rule.

Comment: Several commenters recommended that § 447.55 be revised to clarify that premiums can only be imposed on medically needy individuals after their spend-down amount is met and they are receiving Medicaid; they cannot be included as part of the spend down.

Response: An individual cannot be subject to a premium unless he or she is eligible for Medicaid. States may not impose a premium until the month in which the individual has met his or her spend-down and becomes eligible.

Comment: Several commenters recommended that the regulations require a process for waiving premiums in cases of undue hardship; and that the process adopted by a state should be set forth in the state plan and reflected in state law and other public documents. One commenter asked for CMS to provide examples of ''hardship.''

Response: The decision to waive premiums due to hardship is a matter of state policy. Such policies do not require prior authorization from the Secretary. Therefore we are not revising the regulations as suggested.

Comment: One commenter stated that ''sliding scale'' premiums imposed on the medically needy under § 457.55 must actually ''slide'' so that there is a lowest-income group of individuals for whom there is no premium and that premiums for higher income individuals increase linearly or quasi-linearly up to $20 for those at or near 150 percent of the FPL. One commenter stated the $20 allowable premium should be removed from the regulation.

Response: Section 1916 of the Act expressly permits states to impose premiums on medically needy individuals on a sliding scale, but does not require that the lowest income medically needy individuals are charged $0 premiums. Current regulations at § 447.52 allow for premiums on a sliding-scale basis up to $19, and we are finalizing the proposal to increase that amount to $20. We have revised the regulations at § 447.55(a)(5) to clarify that, if premiums are imposed on medically needy individuals on a sliding scale, the agency must impose an appropriately higher premium for individuals at higher levels of income, with $20 being the maximum allowable premium at the highest income level. States may choose to set their highest premium at a level below $20.

Comment: One commenter asked for clarification of the consequences for ''non-payment'' that are described at proposed § 447.55(c)(1)(ii) and (2)(ii). The commenter recommends that termination be allowed for failure to make full payment, and that partial payment is not adequate to prevent termination from the program.

Response: As noted previously, due to a drafting error, we have revised § 447.55(c) (redesignated as paragraph (b) of the final rule) to clarify the consequences for non-payment for all individuals subject to premiums. As described in paragraph (2), except for medically needy individuals, states have the option to terminate any individual who has failed to pay all or part of his or her premium obligation. The state may not terminate an individual prior to 60 days after the failure to pay the premium. The state may not terminate an individual who, during that time period, has paid the premium due in full. To reiterate current policy, we also added a new paragraph (5) to § 447.56(b) to indicate that no further consequences can be applied for non-payment of Medicaid premiums, including ''lock-out'' periods. We note that we redesignated paragraph (c) as paragraph (b) in the final rule to move the state plan requirements after the section related to consequences for non-payment. This change is to improve the flow of the regulation and is not intended to be substantive.

Comment: One commenter was concerned that proposed § 447.55(c) would permit states to terminate Medicaid coverage for failure to pay premiums for as little as 60 days. While the commenter calls this an improvement over the current regulation, which they believe does not establish any minimum grace period, the commenter believed that states should be encouraged to work with beneficiaries on a payment schedule to avoid a termination.

Response: Proposed § 447.55(c), redesignated as § 447.55(b) in the final rule, does not represent new policy. This option, established under both sections 1916 and 1916A of the Act, is currently codified at § 447.80 for individuals with income over 150 percent of the FPL who are subject to premiums under section 1916A of the Act. In this final rule, we are simply codifying the requirements as they relate to premiums imposed under the authority of section 1916(c) of the Act.

8. Limitations on Premiums and Cost Sharing (§ 447.56)

We proposed a single streamlined approach to implement the limitations on premium and cost sharing established under sections 1916 and 1916A of the Act wherever the policies align. Sections 1916(a), (b), and (j), and 1916A(b)(3) of the Act specify certain groups of individuals as exempt from premiums and/or cost sharing, including certain children, pregnant women, certain American Indians and Alaska Natives (AI/ANs), certain individuals residing in an institution, individuals receiving hospice care and individuals eligible under the optional eligibility group for individuals with breast and cervical cancer under § 435.213 of this part. The proposed changes are discussed in more detail in the January 22, 2013 Medicaid Eligibility Expansion proposed rule (78 FR 4660 and 4661). We received the following comments concerning the proposed limitations on premiums and cost sharing provisions:

Comment: Two commenters recommended that proposed § 447.54(c), which permits states to impose cost sharing for non-emergency use of the ED on individuals otherwise exempt from cost sharing, should not apply to AI/AN beneficiaries who are exempt from cost sharing.

Response: We are finalizing the regulation as proposed. Sections 1916A(c)(2)(B) and 1916A(e)(2)(B) of the Act permit states to charge nominal cost sharing to individuals otherwise exempt from cost sharing under section 1916A(b)(3)(B) of the Act for non-preferred drugs and non-emergency use of an ED. There is no differential treatment under the statute for AI/ANs as compared to other individuals who are otherwise exempt from cost sharing. However, such cost sharing must be limited to the nominal and neither a pharmacy nor a hospital ED may deny services if the individual does not pay the cost sharing.

Comment: We solicited comments about requiring states to periodically renew an AI/AN's cost sharing exemption based on current or previous use of a service from an Indian health care provider or through referral under contract health services. A number of commenters supported proposed § 447.56(a)(1)(vii) to exempt AI/ANs who are currently receiving, or have ever received a service from an Indian health care provider or through referral under contract health services from any cost sharing. Several commenters were concerned that requiring renewal of status for the exemption would be administratively burdensome for both AI/AN individuals and state Medicaid agencies and could lead to exempt individuals being subject to impermissible cost sharing. A few commenters recommended that if renewal of the AI/AN exemption status is required, that such renewal be limited to no more than once every three years, which is the period of time used by IHS for determining ''active users'' in an IHS or tribal service unit. No commenters supported a renewal policy for AI/AN exemption.

Response: We are adopting the AI/AN exemption as proposed because we do not see any particular utility in requiring renewal of status, since the underlying eligibility for IHS or tribal health services is unlikely to change, and we agree that renewal of status can be burdensome for both the beneficiary and the provider. Once the exemption for an individual at § 447.56(a)(1)(x), as redesignated in this final rule, is established, a renewal of such exemption will not be necessary. We note that we added a definition of contract health service at § 447.51 for clarity and made a technical correction under the definition of Indian to reflect revised citations to 25 U.S.C due to changes made by the Affordable Care Act. We do not intend these to be substantive changes to the regulations.

Comment: One commenter recommended we permit states to implement specific processes to track separate cost sharing for AI/ANs related to the 5 percent aggregate limit as permitted by current regulation.

Response: We do not see a need for states to separately track cost sharing for AI/AN beneficiaries, the majority of whom are exempt from cost sharing under the regulations. For any individuals permissibly subject to cost sharing, the same 5 percent aggregate limit applied to other beneficiaries, and the same requirement to track cost sharing charges, would apply.

Comment: A few commenters suggested states should have broad latitude in applying verification procedures to exempt AI/ANs who are eligible for or currently or have ever received a service from an Indian provider or through referral under contract health services (CHS) from premiums and cost sharing respectively, and that procedures that create the least burden on individuals, including electronic processes, be employed by states. They recommended that self-attestation of status for the AI/AN cost sharing exemption be permitted, that if verification is required that electronic data matching should be used to the maximum extent possible, and that we provide a list of possible documents which states could use when electronic verification is not available.

Response: There are no specific federal requirements regarding the process for verifying premiums and cost sharing exemptions for AI/ANs. States have flexibility to establish their own processes for verifying who is eligible to receive or has ever received a service from an Indian provider or through referral under CHS, including the use of self-attestation, electronic data matches or reasonable paper documentation, as long as the process is not unduly burdensome on AI/ANs.

Comment: One commenter requested that CMS clarify that family planning supplies are exempt from differential cost-sharing for non-preferred drugs. Another commenter recommended that CMS clarify that the limitations on premiums and cost sharing also apply to family planning-related services, including office visits. Commenters believed that this clarification is particularly important for coverage of family planning under the state plan, permitted under section 1902(a)(10)(A)(ii)(XXI) of the Act, as added by section 2303 of the Affordable Care Act, which defines ''medical assistance'' covered under this option to include both family planning and family planning-related services.

Response: Under sections 1916 and 1916A of the Act and § 447.53 and § 447.70 of the current regulation, family planning services and supplies, including contraceptives and pharmaceuticals for which the state properly claims or could claim at an enhanced federal match, are exempt from cost sharing. We did not propose any changes to this exemption, which is codified at § 447.56(a)(2)(ii) of this final rule. We do not have the statutory authority to require states to exempt ''family planning-related services,'' which are a separate category of services, but states have the option to do so.

Comment: One commenter requested that we clarify that pregnant women receiving services during a period of presumptive eligibility are also exempt from premiums and cost sharing.

Response: Individuals who are receiving benefits during a presumptive eligibility period, but who have not yet been determined Medicaid eligible by the agency, based on a regular application, including pregnant women, may not be subjected to the premiums. In addition, all pregnancy-related services are exempt from cost sharing, including during a period of presumptive eligibility. As described in the March 2012 final eligibility rule, ''Pregnancy related services'' is presumed to include all services otherwise covered under the state plan unless the state has justified classification of a service as not pregnancy-related in its state plan.

Comment: Many commenters supported the provision in proposed § 447.56(a)(1)(v) to give states the option to exempt individuals from cost sharing if they are receiving long term services and supports in a home or community-based setting and are required to contribute to the cost of care in a manner similar to the post-eligibility treatment of income for institutionalized individuals under part 435 subpart H of the regulations. Many commenters recommended that we require states to exempt such individuals because imposing cost sharing could push individuals into more restrictive settings in violation of the requirements of the Americans with Disabilities Act (ADA), as applied by the Supreme Court in the *Olmstead* decision. A few commenters recommended that we require states to exempt all individuals receiving services in a home and community-based setting regardless of whether they are required to contribute to the cost of their care. Finally, one commenter asked that we clarify that we are not proposing to extend the same post-eligibility treatment of income rules used for institutional services to individuals receiving services in a home and community-based setting who, in addition to any contribution for the cost of their care, also generally have to cover other basic living expenses, such as for housing and food, and would not be able to cover such expenses if they were required to contribute all but a nominal amount of their income to cover the cost of the services received, as is the case for institutionalized individuals.

Response: As noted above, we do not see a statutory basis to require this exemption, therefore in the final rule, at § 447.56(a)(1)(viii), as redesignated, we maintain the option for states to exempt individuals receiving services in a home and community-based setting, whose medical assistance is reduced by amounts reflecting available income other than required for personal needs. This option is consistent with state authority under section 1916A of the Act to target cost sharing to specified groups. In addition, states may target cost sharing at particular types of services, and could determine not to impose cost sharing on home and community-based services. We also note that if an individual has his or her medical assistance reduced to account for available income, the individual would be able to deduct any premiums or cost sharing from the calculation of available income used to determine the level of medical assistance provided. There would be no modification of current regulations relating to post-eligibility treatment of income or share-of-cost. Again, we remind states of their obligations under *Olmstead.*

Comment: One commenter recommended that former foster care children covered under § 435.150 should be exempt from premiums and cost sharing. Several commenters recommended that states be given the express option to exclude medically frail individuals from cost sharing.

Response: While we understand that these are populations upon which states may not wish to impose cost sharing, we do not see a clear basis to support a federally-mandated exemption. States are free to use targeted cost sharing, in accordance with § 447.52(d), to limit the impact of cost sharing as needed to address issues of non-exempt populations that the state determines are particularly vulnerable.

Comment: One commenter requested clarification on the provision at § 447.56(c)(3), which is specific to providers that the agency reimburses under Medicare reasonable cost reimbursement principles. The commenter asked whether the policy that an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of such providers was a change or consistent with current law.

Response: This policy is contained in the current regulations at § 447.57(b). However, consistent with the new definition of cost sharing included at § 447.51 of this final rule, we are replacing the reference to ''deductible, coinsurance, copayment, or similar'' with ''cost sharing'' in the final rule.

Comment: Many commenters recommended that we amend sections 1916 and 1916A of the Act to clarify that the preventive services included in the EHBs are exempt from cost sharing, because low income individuals enrolled in Medicaid ABPs may be responsible for cost sharing for some of the preventive services that are available to higher income individuals in the private market with no cost sharing.

Response: Section 1916A of the Act and the final rule at § 447.56(a)(2)(iii) do require exemption of preventive services for children under age 18. At a minimum such services must include those specified at § 457.520, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics. We do not see a basis to broaden this statutory exemption under the Medicaid program to extend to preventive services for older individuals. States have the flexibility to exempt additional services from cost sharing and could determine to exempt preventive services for all beneficiaries.

Comment: Many commenters recommended that we exempt services associated with ''never events'' from cost sharing.

Response: We agree with commenters that services associated with ''never events'' should not be subject to cost sharing. In accordance with § 447.26(c)(1), ''no medical assistance will be paid for ''provider preventable conditions'' as defined in this section. We interpret medical assistance in this context to include any state plan imposed cost sharing, and providers, who are not permitted to claim reimbursement from the agency for these services, also are not entitled to charge the beneficiary any cost sharing amount. To clarify this requirement, we have included provider-preventable services, also known as ''never events,'' among the list of exempted services at § 447.56(a)(2)(v).

Comment: One commenter recommended that we revise § 447.56(a)(2)(iv) to require that all services provided to pregnant women be considered as pregnancy-related, except those services specifically identified in the state plan as not being related to the pregnancy, only if the state is able to justify and the Secretary concurs, that the service is not pregnancy-related.

Response: States have the discretion to determine pregnancy-related services within the parameters of § 440.210(a)(2). We are seeking to align the standard related to cost sharing with what is required for the provision of pregnancy-related services, and maintain in the final rule that all services provided to pregnant women will be considered pregnancy related unless the state has justified classification of a service as not pregnancy-related in its state plan.

Comment: One commenter asked that we clarify what is meant by ''nonexempt'' and ''otherwise exempt populations,'' per the reference to allowing states to impose cost-sharing at higher than nominal levels for nonexempt individuals and applying cost sharing to otherwise exempt populations at § 447.56.

Response: Exempt populations are defined at sections 1916(a), (b) and (j) and 1916A(b) of the Act and at § 447.53 and § 447.70 of the current regulations. These populations are exempt from cost sharing under section 1916 and 1916A(a) of the Act, respectively, but are not exempt from cost sharing under section 1916A(c) or (e) of the Act, which pertain to alternative cost sharing for non-preferred drugs and non-emergency use of the ED. These exemptions were consolidated at § 447.56(a) of the proposed rule and maintained in the final rule. When using the term ''nonexempt'' we are referring to beneficiaries who do not fall into one of the groups exempted under § 447.56(a) of the final rule and therefore may be subject to cost sharing. ''Otherwise exempt populations'' refers to those populations that are generally required to be exempted from cost sharing but are not exempt from cost sharing under section 1916A(c) or (e) of the Act. Section 1916A of the Act allows states to impose cost sharing for drugs and non-emergency use of the ED on ''otherwise exempt populations,'' meaning that such cost sharing may be imposed on beneficiaries who are exempted from all other cost sharing per § 447.56(a).

Comment: Many commenters were concerned that the aggregate limit described in proposed § 447.56(f) does not apply to individuals with income at or below 100 percent of the FPL. Another commenter was concerned that these rules created a new requirement for states to apply the aggregate limit to cost sharing imposed under section 1916 of the Act. A few commenters urged the Secretary to lower the aggregate limit to something less than 5 percent.

Response: Under sections 1916 and 1916A of the Act, aggregate premiums and cost sharing imposed may not exceed 5 percent of an individual's income. This is a statutory limit and we do not have the authority to require states to apply a lower cap. However, we are revising the final regulation at § 447.56(f)(1), and redesignating the succeeding paragraphs accordingly, to provide that the aggregate limit applies to all premiums and cost sharing incurred by all individuals in the Medicaid household, at all income levels. At § 447.56(f)(2) of the final rule, we maintain the requirement in current regulation that states must track all incurred Medicaid premiums and cost sharing for all members of the Medicaid household, if such premiums and cost sharing could place any family member at risk of reaching the aggregate limit.

Comment: Many commenters recommended we revise proposed § 447.56(f)(3) to require states to inform beneficiaries, at risk of reaching the aggregate limit, of the automated process used to track premiums and cost sharing, and how they can obtain ongoing information about how far they are from reaching the limit.

Response: Section 447.56(f)(2), as redesignated in this final rule, requires that if a state imposes cost sharing that could result in individuals reaching the aggregate limit, the state must describe their process for tracking the premiums and cost sharing in their state plan. Current regulations at § 447.64(d)(2), redesignated at§ 447.56(f)(3) in this final rule, do require the state to notify beneficiaries and providers when the beneficiary reaches the cap. We are revising this paragraph to restore language currently in § 447.68(d) that was inadvertently removed in the proposed rule indicating that the state must inform beneficiaries and providers of the beneficiaries' aggregate limit. States must also have a process in place for beneficiaries to request a reassessment of their aggregate limit. We believe these rules provide the best balance between minimizing administrative burden on states and modernizing the Medicaid program to ensure beneficiaries are not charged amounts in excess of the aggregate. We do not believe these rules prevent states from establishing processes by which beneficiaries can regularly check their status regarding the aggregate limit. To allow states flexibility, we are not specifying the mechanisms by which such notifications must occur.

Comment: One commenter recommended that the regulation should use a single, annual (not monthly) cost sharing maximum, such as that used for the Part D low-income subsidy, since renewals are completed on an annual basis, and therefore cost-sharing maximums are most effectively implemented on a well-established calendar-year basis.

Response: Section 1916A of the Act requires that the aggregate limit be applied on a monthly or quarterly basis

as determined by the state; an annual limit is not permitted under the statute.

Comment: One commenter requested that we clarify what is meant by ''premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit'' in proposed § 447.56(f)(3).

Response: If a state imposes premiums and/or cost sharing at a level that could result in cumulative premiums and cost sharing exceeding 5 percent of a beneficiary's family income (for all family members on Medicaid, over the course of a month or quarter as determined by the state), the state must implement an effective tracking mechanism to ensure the cap is not exceeded. For example, a state may establish a prescription drug copayment targeted to individuals with family income above 150 percent of the FPL, and set the copay at $1 for preferred drugs and $2 for non-preferred drugs. If this is the only cost sharing to which these individuals are subject, and they do not pay a premium, then it is unlikely that any beneficiary would accumulate cost sharing charges in excess of 5 percent of his or her family income, and the state would not have to establish a tracking mechanism. However, if these same beneficiaries were also assessed a premium of 4 percent of family income, beneficiaries may be at risk of reaching the aggregate limit and the state would need to establish a tracking mechanism. Anyone with income under 100 percent of the FPL, who is subject to any cost sharing would likely be at risk of reaching the aggregate limit and a tracking mechanism would likely be required. We will work with states to determine their need for a tracking mechanism through the state plan amendment process.

We note that if more than one Medicaid beneficiary resides in a household, then the premiums or copayments of each beneficiary in the household would count toward the aggregate limit. We do not specifically define when cost sharing may place beneficiaries at risk of reaching the aggregate limit, because of the many different combinations of cost sharing and premium charges which it would be possible for states to impose. We will monitor state compliance through the state plan amendment process.

Comment: One commenter requested further guidance on ways to track cost sharing for beneficiaries who change plans during the year.

Response: For individuals who change plan mid-year, the state must establish a mechanism to continue tracking through the transition to ensure that they do not exceed the cap. Alternatively, a state could suspend any additional cost sharing until the next monthly or quarterly period begins. We have in the past encouraged, and continue to encourage, states to track cost sharing through their Medicaid Management Information System (MMIS). As we review state plan amendments and conduct audits, we will share best practices that emerge among states to promote effective and efficient tracking systems.

Comment: Many commenters recommended that we remove the requirement at proposed § 447.56(f)(3) that states have an automated mechanism for tracking each family's incurred premiums and cost sharing because it is costly and presents a substantial administrative and operational burden on state Medicaid agencies, their contractors, and providers. Instead, the commenters recommended that the state should have an opportunity to develop its own mechanism for tracking a Medicaid enrollee's premium and cost sharing spending. A few commenters also recommended that states should have the option of having the enrollees track their own information. One commenter asked that we clarify that a state that delegates responsibility for the administration of cost sharing to managed care organizations must ensure the availability of complete and timely information necessary for performing this role.

Response: We have revised § 447.56(f)(2) in this final rule to remove the word ''automated'' and replace it with ''effective.'' CMS will review state proposals through the state plan amendment process to ensure that tracking mechanisms employed by states are effective in ensuring that incurred premiums and cost sharing do not exceed the aggregate limit and that the tracking mechanism does not rely on beneficiaries. We note that under current regulations states must account for cost sharing amounts in their MMIS to ensure appropriate provider payment and must calculate each family's aggregate limit—from data in the state's eligibility system—and provide that information to the beneficiary. States may claim federal matching funds to update their MMIS and eligibility systems as necessary to implement a tracking system that uses the data already available in their systems to implement the aggregate limit. States have the flexibility to develop any effective process that does not rely on beneficiaries, and contains timely and accurate information so that beneficiaries do not exceed their aggregate limits. In addition, a state may delegate this responsibility, as appropriate, to their managed care organizations although we are not requiring that they do so. Tracking of premiums and cost sharing is standard industry practice among health plans, including those that participate in the Medicaid program, and is consistent with implementing the requirements of the Affordable Care Act out-of-pocket limits for all Americans, which will require tracking by all private health insurance plans.

Comment: One commenter stated that the flexibilities provided in the proposed rule, including the higher cost sharing limits, are negated by the continued application of the aggregate limit. The commenter argues that the high cost sharing limits effectively will serve as a provider rate cut, which will trigger further decrease in access to health care for Medicaid beneficiaries. The commenter recommends that we allow exceptions to the 5 percent aggregate limit and the automated tracking requirements, allowing states to propose in their state plan reasonable assumptions and methodologies to limit maximum out-of-pocket costs at an individual or family level. The commenter believed such an approach, coupled with provisions for exceptions and an appeals process involving clear timelines to preserve access to care, would be consistent with the spirit of the statute.

Response: We do not understand the connection that the commenter is making between the aggregate limit and effective provider reimbursement rates. Once the limit is reached, the beneficiary may not be charged any cost sharing amounts, and providers will be paid the full reimbursement rate by the state. Regardless, the application of an aggregate limit, which is common practice in commercial insurance as well, is required by section 1916A of the Act, as added by the Deficit Reduction Act of 2005; we do not have authority to eliminate this requirement through regulation.

9. Beneficiary and Public Notice Requirements (§ 447.57)

We proposed to codify existing policy to ensure that beneficiaries, providers, and the general public all have access to effective notice of Medicaid premium and cost sharing charges. Appropriate vehicles for providing notice might include the agency Web site, newspapers with wide circulation, web, and print media reaching racial, ethnic, and linguistic minorities, stakeholder meetings, and formal notice and comment in accordance with the state's

administrative procedures. We received the following comments concerning the proposed provisions for beneficiary and public notice requirements:

Comment: One commenter asked for clarification on what constitutes a method to which applicants, beneficiaries, and providers are ''likely to have access,'' and whether publication on a state Web site would be an acceptable method. One commenter strongly disagreed that state legislative hearings do not provide sufficient public, beneficiary and provider notice and recommended that such hearings be included as one of the options for providing sufficient notice.

Response: To allow flexibility for different state processes while ensuring provision of meaningful notice, we are not prescribing the particular method or format that states must use to provide the required notice, but instead proposed parameters at § 447.57, finalized with one revision (discussed below) in this rulemaking, regarding what constitutes sufficient notice. We provided examples of acceptable methods in the preamble to the proposed rule, including notice on the state agency's Web site. As stated in the preamble to the proposed rule, we do not believe that legislation discussed at a hearing or posted on a Web site is adequate, since state legislation and legislative hearings often are not accessible or understandable to many beneficiaries, providers or other interested members of the public.

Comment: Many commenters supported the proposal to require that states provide additional public notice if proposed cost sharing is substantially modified during the state plan amendment (SPA) approval process. Many of these same commenters also recommended that we require states to provide at least a 30-day comment period on any revisions to a SPA involving premiums or cost sharing charges. A few commenters were concerned that the proposed rule would be too burdensome on states and recommended that no additional public notice requirements be imposed on states.

Response: We have revised the regulations at § 447.57(c) to require states to provide additional public notice if proposed cost sharing is substantially modified during the SPA approval process. We are also applying this rule to premiums that are substantially modified during the SPA process. We are not, however, accepting the recommendation that states should have to provide a second 30 day comment period for any revisions made to the state's cost sharing policy during the SPA approval process, as we believe this would be overly burdensome on states and significantly delay the SPA process.

III. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. We received many comments about the complexity of the proposed rules and the significance of the changes that need to be made to fully implement the provisions of the Affordable Care Act. Many commenters were concerned about the short timeframes for implementation and about states' ability to make needed changes to policy, operations, and information technology systems. We recognize that the timing of this rule may result in implementation challenges, especially from a systems perspective. Therefore, we have evaluated the provisions of the January proposed rule that are necessary to meet the deadlines and are finalizing in this rule only those provisions that we believe states will be reasonably able to (or have already been planning to) implement by January 1, 2014. Remaining provisions will be finalized in future rulemaking. Those provisions, included in this final rule, that differ from the proposed rule are as follows:

Change to § 431.10

- Clarified responsibilities of single state agency related to delegation of fair hearings.

Change to § 431.201

- Added the definition of ''send.''

Change to § 431.205

- Clarified language in § 431.205(b).

Change to § 431.206

- Clarified in § 431.206(d) that an individual has a right to a hearing before the Medicaid agency instead of the Exchange or Exchange appeals entity.

Change to § 435.603

- Specified in § 435.603(d)(4) that the 5 percent disregard should be applied to the highest income standard in the applicable Title of the Act under which the individual may be determined eligible using MAGI-based methodologies.

Change to § 435.908

- Deleted paragraph § 435.908(c)(3)(i).

Change to § 435.918

- Allowed for delayed implementation of electronic notices and required that the Agency ensure that an individual's election to receive notices electronically is confirmed by regular mail and that the individual is informed of his or her right to change such election.

Change to § 435.923

- Clarified in § 435.923(a) that any authorization granted under operation of state law may serve in place of written authorization by the applicant or beneficiary.

Change to § 435.1015

- Clarified that states are required to consider the cost sharing requirements of the private health plan when determining whether premium assistance is a cost-effective option.

Changes to § 435.1110

- Revised § 435.1110(c)(1) to make clear that states electing to limit the presumptive eligibility determinations which hospitals can make must permit the hospitals to make presumptive eligibility determinations based on income for all of the populations included in § 435.1102 and § 435.1103.
- Adding paragraph (d)(3) to provide that the agency may disqualify a hospital as a qualified hospital only after it has first provided the hospital with additional training or taken other reasonable corrective action measures.

Change to § 435.1200

- Codified § 435.1200(d)(5) of proposed rule at § 435.1200(d)(6).

Changes to § 447.51

- Added definition of ''inpatient stay'' and ''outpatient services.''
- Added definition of *Federal poverty level (FPL)* to use the acronym throughout the regulation. No substantive change is intended.
- Added a definition of contract health service, for clarity (not a substantive change to the regulations).

Changes to § 447.52

- Revised the maximum cost sharing allowed for an inpatient stay to $75 and added a new paragraph at (b)(2), to require states with inpatient cost sharing that exceeds the amount in the final rule, as of July 15, 2013, to submit a plan to CMS that provides for reducing inpatient cost sharing to $75 on or before July 1, 2017.
- Revised paragraph (b)(3) to be clear that, ''in states that do not have fee-for-service payment rates, any cost sharing imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 100 percent of the FPL.

• Revised § 447.52(d), adding paragraphs (1) and (2) to clarify that for cost sharing imposed for non-preferred drugs and for non-emergency services provided in a hospital emergency department under, the agency may target to a specified group of individuals regardless of income.

• Added and amended paragraph (g) to restore the option to establish different cost sharing charges for individuals at different income levels.

• Added paragraph (h) to restore requirement that any cost sharing charges imposed by managed care organization on Medicaid enrollees be in accordance with the requirements set forth in the regulations.

• Added paragraph (i) to consolidate the state plan requirements currently contained in § 447.53(d) and § 447.68.

Changes to § 447.53

• Revised paragraph (d) to clarify that cost sharing for non-preferred drugs imposed on otherwise exempt populations cannot exceed the nominal amount defined in § 447.53(b) in accordance with section 1916A(c) of the Act.

• Revised paragraph (e) to require that states must have a timely process to allow for cost sharing at the preferred drug level if the prescribing provider determines that the preferred drug would be less effective or have adverse effects on the individual to ensure that access to necessary drugs is not delayed.

Changes to § 447.54

• Amended paragraph (d)(2)(iii) to replace the word ''ensure'' with ''determine.''

• Added new paragraph (i) at § 447.54(d)(2) requiring hospitals to inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the ED.

Changes to § 447.55

• Due to a drafting error we revised this section to accurate reflect who can be charged premiums and what consequences for non-payment exist for specified groups.

• Revised at paragraph (a)(1) the description of pregnant women who can be charged premiums to reflect the consolidation of different statutory eligibility groups for pregnant women under a single regulatory section at § 435.116 of the March 2012 final rule. This is not a substantive change and is intended solely to assist states in appropriately identifying those pregnant women who may be charged as described in the statute.

• Revised paragraph (a)(5) to clarify that, if premiums are imposed on a sliding scale, the agency must impose an appropriately higher premium for individuals at higher levels of income, with $20 being the maximum allowable premium at the highest income level.

• Added a new paragraph (5) to § 447.55(b) to indicate that no further consequences can be applied for non-payment of Medicaid premiums, including ''lock-out'' periods.

Changes to § 447.56

• Revised at paragraph (a)(1)(i) the description of children who are exempt from premiums and cost sharing at § 447.56(a)(1)(i) through (iii) and (iv) to reflect the consolidation of different statutory eligibility groups for children under a single regulatory section at § 435.118 of the March 2012 final rule, and to reflect the changes in the types of assistance available under Title IV–E of the Act. These are not substantive changes and are intended solely to assist states in appropriately identifying those children who may be charged premiums and cost sharing and exempting those who may not, as described in the statute.

• Amended paragraph (a)(2)(v) to include provider-preventable services, also known as ''never events,'' among the list of exempted services.

• Revised paragraph (f)(2) to restore language currently in § 447.68(d) that was inadvertently removed in the proposed rule indicating that the state must inform beneficiaries and providers of the beneficiaries' aggregate limit.

Changes to § 447.57

• Revised language at paragraph (c) to require states to provide additional public notice if proposed cost sharing is substantially modified during the SPA approval process.

Change to § 457.110

• Required that states provide individuals with a choice to receive notices and information required under this subpart and subpart K of this part, in electronic format or by regular mail.

Change to § 457.570

• Adding paragraph (c)(2).

Change to § 457.810

• Added language requiring protections against substitution of coverage in states that operate premium assistance programs.

Changes to § 155.20

• Clarifies the definition of advance payments of the premium tax credit.

Changes to § 155.200

• Removes the reference to subpart F, as it will be finalized in a future rule.

Changes to § 155.227

• Clarifies that for the purpose of § 155.227, the terms ''applicant'' and ''enrollee'' describe people on whose behalf authorized representatives are acting, and that the term ''person'' describes an individual acting as an authorized representative.

• Clarifies that authorized representatives are permitted to provide assistance in the individual and SHOP Exchanges, as well as for individuals seeking an exemption from the shared responsibility payment.

• Adds language ensuring that the Exchange provides information to both the applicant or enrollee and the authorized representative regarding the powers and duties of an authorized representative.

• Adds language allowing an Exchange to permit an applicant or enrollee to authorize their representative to perform fewer than all of the activities described in this section, provided that the Exchange tracks the specific permissions of each authorized representative.

• Clarifies that an authorized representative will notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

• Clarifies that the Exchange, not the applicant or enrollee, will notify the authorized representative when an applicant or enrollee notifies the Exchange that an authorized representative is no longer acting on his or her behalf.

• Removes the provision that organizations as well as staff and volunteers of organizations must enter an agreement with the Exchange.

Changes to § 155.230

• Clarifies electronic notice standards for an individual market Exchange, and specifies that the individual market Exchange may choose to delay the implementation of the process described in § 435.918(b)(1) regarding sending a mailed confirmation of the choice to receive electronic notices.

• Adds standards to distinguish notice standards for a SHOP and adds language to allow an employer or employee in any SHOP to elect to receive electronic notices.

Changes to § 155.300

• Clarifies the appropriate cross-reference for the definition of minimum value.

Changes to § 155.302

• Clarifies that any contracting arrangement for eligibility determinations for Medicaid and CHIP is subject to the standards in § 431.10(c)(2).

• Clarifies that the Exchange appeals entity, in addition to the Exchange, must adhere to the eligibility determination or appeals decision for Medicaid or CHIP made by the Medicaid or CHIP agency, or the appeals entity for such agency.

• Specifies that the agreement under § 155.302(b)(6) will be made available to HHS upon request.

Changes to § 155.305

• Removes the clause ''unless another Exchange verifies that the individual meets the residency standard of such Exchange'' related to temporary residence.

• Clarifies that an applicant must be eligible for enrollment in a QHP through the Exchange to be determined eligible for enrollment through the Exchange in a QHP that is a catastrophic plan.

Changes to § 155.310

• Clarifies that the provision regarding duration of eligibility determinations without enrollment only refers to an applicant who is determined eligible for enrollment in a QHP through the Exchange.

Changes to § 155.315

• Modifies procedures for situations in which key data sources are unavailable and not reasonably expected to be available within 1 day, such that the Exchange will make an eligibility determination based on an applicant's attestation and trigger the inconsistency period in paragraph (f).

• Clarifies that the Exchange will accept an applicant's attestation regarding three specific factors of eligibility when electronic data is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, and that for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, other sections in this subpart already address situations in which data regarding MAGI-based income is unavailable.

• Clarifies that paragraph (f)(5)(i) of this section will follow the effective dates specified in § 155.330(f).

• Modifies the language concerning the verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan for the purpose of clarity.

Changes to § 155.320

• Clarifies that the Exchange must obtain any available data from the SHOP that corresponds to the State in which the Exchange is operating.

• Modifies language to specify that the Exchange must select a statistically significant random sample of applicants for whom the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii).

• Removes language specifying that the Exchange must use any available data regarding employment of an applicant and members of his or her household.

• Specifies that for eligibility for enrollment in a QHP through the Exchange that is effective before January 1, 2015, if the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) for an applicant, the Exchange may accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification, instead of following sampling procedures.

• Clarifies that the ability for the Exchange to satisfy the provisions of paragraph (d) of this section by relying on HHS is effective for eligibility for enrollment in a QHP through the Exchange that is effective on or after January 1, 2015, and clarifies that the division of responsibilities under this option is subject to guidance issued by the Secretary.

• Removes language concerning the agreement associated with having HHS conduct this verification.

Changes to § 155.330

• Removes cross-references to appeals provisions, and clarifies that an Exchange must implement changes resulting from an appeal decision on the date specified in the appeal decision.

• Consolidates standards for decreases in advance payments of the premium tax credit and changes in cost-sharing reductions.

• Specifies that a change associated with birth, adoption, placement for adoption and placement in foster care must be implemented on the coverage effective date described in § 155.420(b)(2)(i) and (ii).

• Removes duplicative cross-references regarding termination of coverage.

Changes to § 155.340

• Clarifies the appropriate cross-reference for the minimum value standard.

Changes to § 155.345

• Reserves paragraphs (a)(3) and (g)(7) for future finalization.

• Clarifies that the Exchange and Exchange appeals entity will adhere to the eligibility determination or appeals decision relating to an individual's eligibility for Medicaid or CHIP made by the state's Medicaid or CHIP agency or the appeals entity for such agency.

Changes to § 155.420

• Clarifies that the special effective dates for birth, adoption, and placement for adoption also apply to placement in foster care.

• Expands special enrollment period for birth, adoption, and placement for adoption to also include placement in foster care.

• Clarifies that the special enrollment period for an individual who was not a citizen, national, or lawfully present non-citizen and gains such status also applies to his or her dependents, if eligible for coverage through the Exchange.

• Modifies the special enrollment period for enrollees newly eligible or ineligible for advance payments of the premium tax credit or who experience a change in eligibility for cost-sharing reductions to reflect that the special enrollment period accommodates individuals enrolled in an eligible employer-sponsored plan, but not eligible for qualifying coverage in an eligible employer-sponsored plan.

Changes to § 155.430

• Modifies language to allow applicants and enrollees to request termination from their QHP, in the event they report access to other minimum essential coverage and become ineligible for advance payments of the premium tax credit and cost-sharing reductions.

• Modifies standards for enrollee-requested termination effective dates, such that QHP issuers and Exchanges may only terminate prospectively, and not retroactively.

• Clarifies that terminations for enrollees who are determined eligible for Medicaid, CHIP or the BHP, such that the last day of coverage is the day before the individual is determined eligible for such coverage, rather than

retroactive to the Medicaid or CHIP eligibility effective date.

- Aligns termination effective dates to appropriately cross-reference with eligibility effective dates.
- Adds language to clarify that in the case of termination due to death, the last day of coverage is the date of death.

Changes to § 156.270

- Modifies coverage termination requirements such that standards for QHP issuers align with those for Exchanges.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, 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 Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our 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.

In the January 22, 2013 (78 FR 4593) proposed rule, we requested public comment on each of the rule's information collection requirements (ICRs). The comments and our response are discussed below.

Background

This final rule continues to implement key provisions of the Affordable Care Act including the completion of the streamlining of eligibility for children, pregnant women, and adults that were initiated in the Medicaid eligibility final rule published on March 23, 2012 (77 FR 17144). This rule also modifies CHIP rules relating to substitution of coverage and premium lock-out periods, which are important to a coordinated system of coverage across programs. Finally, this rule includes provisions related to authorized representatives, the procedures for verifying access to qualifying employer-sponsored coverage, catastrophic coverage and other provisions related to eligibility and enrollment.

The policies in this rule will result in a reduction in burden for individuals applying for and renewing coverage, as well as for states. The Medicaid program and CHIP will be made easier for states to administer and for individuals to navigate by streamlining Medicaid eligibility and simplifying Medicaid and CHIP eligibility rules for most individuals. Even though there are short-term burdens associated with the implementation of the final rule, the Medicaid program and CHIP will be easier for states to administer over time due to the streamlined eligibility and coordinated efforts for Medicaid, CHIP, and the new affordable insurance exchanges.

The final rule also continues to implement provisions related to the establishment of Exchanges. This final rule: (1) Specifies standards related to authorized representatives, (2) outlines criteria related to the verification of enrollment in and eligibility for minimum essential coverage through an eligible employer-sponsored plan, and (3) further specifies or amend standards related to other eligibility and enrollment provisions. The description of the burden estimates associated with these provisions is included in the information collection requirements outlined in section D.

Section A outlines the information collection requirements that involve Medicaid and CHIP eligibility and enrollment. Section B outlines the information collection requirements that involve Exchange eligibility and enrollment.

We used data from the Bureau of Labor Statistics to derive average costs for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the June 2012 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics.

A. Medicaid and CHIP Information Collection Requirements (ICRs) To Be Addressed Through Separate Notices and Comment Process Under the Paperwork Reduction Act

1. ICRs Regarding State Plan Amendments

1a. Sections 431.10, 431.11, 431.206, 431.211, 431.213, 431.230, 431.231, 431.240, 435.110, 435.116, 435.603, 435.907, 435.908, 435.918, 435.1101, 435.1102, 435.1103, 435.1110, 435.1200, 435.1205, 440.130, 440.210, 440.220, 440.305, 440.315, 440.330, 440.335, 440.345, 447.52–54, 457.110, 457.340, 457.350, 457.351, 457.355, 457.570, and 457.805

These amendments to the Medicaid and CHIP state plans are necessary to reflect changes in statute and federal policy. While we are aware of the need to estimate the PRA burden associated with the submission of state plan amendments related to the provisions identified above, those amendments will be addressed as part of the electronic state plan filing process being developed by CMS (the MACPro system) and submitted to OMB for approval under OCN 0938–1188 (CMS–10434).

1b. Sections 435.113, 435.114, 435.223, and 435.510

Since we are eliminating the provisions in §§ 435.113, 435.114, 435.223, and 435.510, states will no longer be required to submit state plan amendments related to those provisions. The provisions have been approved by OMB under OCN 0938–1147).

B. Medicaid Eligibility and Enrollment

1. ICRs Regarding Delegation of Eligibility Determinations and Appeals (§§ 431.10(c), 431.11. and 457.1120)

In § 431.10(c), a state may delegate authority to make eligibility determinations and to conduct fair hearings. States generally have written agreements with various entities for similar purposes. Under this final rule, agreements may need to be modified or new agreements established. However, states that use the same agency to administer more than one program (for example, Medicaid and the Exchange) will not need an agreement for the determination of eligibility by that agency.

Delegation of eligibility determinations was approved under OMB control number 0938–1147. This rule sets out changes in the existing requirement related to the type of agencies that can make Medicaid and CHIP eligibility determinations. These amendments do not change the burden associated with the requirement. Medicaid and CHIP agencies will need to establish new agreements to delegate authority to conduct eligibility appeals. The burden associated with the delegation of appeals is the time and effort necessary for the Medicaid and CHIP agencies to create and execute the agreements with the organization to which they are delegating authority.

There are 53 Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies, for a total of 96 agencies. For the

purpose of developing the cost, we estimate that half of these agencies will establish an agreement with an organization to conduct fair hearings. We estimate a one-time burden of 50 hours to develop an agreement that can be used with the organization. It will take an additional 10 hours for Medicaid and 10 hours for a separate CHIP agency to negotiate and execute the agreement with the organization for a total time burden of 2,880 hours [(53 + 43)/2 × (50 + 10)] across all agreements. For the purpose of the cost, we estimate it will take a health policy analyst 40 hours at $49.35 an hour and a senior manager 10 hours at $79.08 an hour to complete the model agreement (for a total of $2,764.80) plus 10 additional hours ($49.35) for a health policy analyst to execute a completed agreement with each organization. The estimated cost for each agreement is $3,258.30 for a total cost of $156,398.40.

2. ICRs Regarding Fair Hearing Processes (§§ 431.205(e), and 431.206(d) and (e))

In §§ 431.205(e) and 431.206(e), the hearing system and information must be accessible to persons who are limited English proficient and to persons with disabilities. While states are required to make the hearing system accessible, we believe the associated burden is exempt from the PRA (see 5 CFR 1320.3(b)(2)) since we believe that the time, effort, and financial resources necessary to comply with this requirement will be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

In § 431.206(d), states are required to inform individuals that they may have their hearing before the agency (instead of the Exchange or the Exchange appeals entity) and the method by which the individual may make such election. There are 53 Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies for a total of 96 agencies that will be subject to this requirement. The burden associated with providing this choice is developing the process and workflow to enable the choice and sending the request for the fair hearing to the appropriate agency. We estimate it will take each agency an average of 70 hours to create the process and workflow required in providing the choice. For the purpose of the cost, we estimate it will take a health policy analyst 40 hours at $49.35 an hour, a senior manager 10 hours at $79.08 an hour, and a computer programmer 20 hours at $52.50 to complete the process and workflow. The estimated cost for each agency is $3814.80. The total estimated cost is $366,220.80.

3. ICRs Regarding Application Counselors (§ 435.908(c))

In § 435.908(c), states have the option to authorize certain staff and volunteers of organizations to act as certified application counselors. The burden associated with the requirements to assist individuals with the application process is the time and effort necessary for the state to create agreements with these organizations, to create a registration process for assistors, and to train staff on the eligibility and confidentiality rules and requirements and how to assist applicants with the completing the application.

We estimate the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa will establish agreements with on average 20 organizations in their state or territory for a total of 1,060 agreements related to application assistance. As part of this estimate, we assumed that state Medicaid and CHIP agencies will be party to the same agreements and, therefore, will not establish separate agreements.

The first burden associated with this provision is the time and effort necessary for the state Medicaid and CHIP agencies to establish an agreement. To develop an agreement, we estimate that it will take each of the 53 states and territories 50 hours to develop a model agreement. For the purpose of the cost, we estimate it will take a health policy analyst 40 hours at $49.35 an hour and a senior manager 10 hours at $79.08 to develop an agreement. The estimated cost is $2,764.80 (per state) or $146,534.40 (total) while the total annual hour burden is 2,650 hours.

To negotiate and complete the agreement, we estimate that each of the 53 states/territories will execute 20 agreements. For the purpose of the cost, we estimate it will take a health policy analyst 10 hours at $49.35 an hour to execute each agreement. The estimated cost is $9,870 (per state) or $523,110 (total) while the total annual hour burden is 10,600 hours.

To develop and execute the model agreements, the total cost is $669,644.40 for 13,250 hours of labor.

The next burden associated with this provision is the time and effort necessary for the 53 states and territories to establish the registration process and workflow for the application counselors. We estimate it will take each state or territory an average of 70 hours (3,710 total hours) to create the registration process and workflow for the application counselors. For the purpose of the cost, we estimate it will take a health policy analyst 40 hours, at $49.35 an hour, a senior manager 10 hours, at $79.08 an hour, and a computer programmer 20 hours at $52.50 to complete the registration process and workflow. The estimated cost for each state or territory is $3,814.80. The total estimated cost is $202,184.40.

The next burden associated with this provision is the time and effort necessary for the 53 state Medicaid and CHIP agencies to provide training to the application counselors. For the purpose of the cost, we estimate it will take a training specialist 40 hours at $26.64 an hour and a training and development manager 10 hours at $64.43 an hour to develop training materials for the application counselors, for a total time burden of 2,650 hours. The estimated cost for each state or territory is $1,709.90. The total estimated cost is $90,624.70.

Lastly, we estimate that each state or territory will offer 50 hours of training sessions to train individuals to assist applicants with Medicaid and CHIP applications for a total time burden of 2650 hours. For the purpose of the cost, we estimate it will take a training specialist 50 hours at $26.64 an hour to train the application counselors. The estimated cost for each agency is $1,332. The total estimated cost is $70,596.

4. ICRs Regarding Eligibility Determination Notices (§ 435.918, § 457.110)

In § 435.918 and § 457.110, states must electronically provide notices to individuals when elected.

The burden associated with the requirements to deliver notices is the time necessary for the state staff to: (1) Familiarize themselves with the requirements related to notices; (2) develop the language for approval, denial, termination, suspension, and change of benefits notices; and (3) program the language in the Medicaid and CHIP notice systems so that the notice can be populated and generated based on the outcome of the eligibility determination and be delivered in an electronic format.

We estimate 53 state Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies (in states that have a separate or combination CHIP), totaling 96 agencies, will be subject to this requirement. We estimate that it will take each Medicaid and CHIP agency 194 hours annually to develop,

automate, and distribute the notice of eligibility determination. For the purpose of the cost burden, we estimate it will take a health policy analyst 138 hours at $49.35 an hour, a senior manager 4 hours at $79.08, an attorney 20 hours at $90.14, and a computer programmer 32 hours at $52.50 to complete the notices. The estimated cost burden for each agency is $10,609.42. The total estimated cost burden is $1,018,504.30, and the total annual hour burden is 18,624 hours.

5. ICRs Regarding Authorized Representatives (§ 435.923(a))

Section 435.923(a) sets out minimum requirements for the designation of authorized representatives. We are also applying these provisions to state CHIP agencies through the addition of a cross reference in § 457.340.

We are aware of the need to estimate the PRA burden associated with the collection of information related to authorizing an individual to act as a representative of an applicant, to permit self-attestation for individuals who do not have access to documentation, and the citizenship and immigration verification requirements. These requirements were addressed as part of the single, streamlined application under OCN 0938–1191 (CMS–10440).

6. ICRs Regarding Presumptive Eligibility Determined by Hospitals (§ 435.1110)

Under § 435.1110(d)(1), states may establish state-specific standards for qualified hospitals that conduct presumptive eligibility determinations related to the success of assisting individuals determined presumptively eligible who submit a regular application and/or are approved for eligibility by the agency. States also have a great deal of flexibility in determining and implementing the standards appropriate for their programs as well as appropriate corrective action measures for hospitals which do not meet the state standards.

This change is necessary to reflect changes in federal policy. A state's election of state-specific standards will affect their Medicaid state plan. While we are aware of the need to estimate the burden associated with the submission of the state plan amendment, that amendment will be addressed under the electronic state plan filing process being developed by CMS (the MACPro system) and submitted to OMB for approval under OCN 0938–1188 (CMS–10434). The amendment and its estimated burden will also be made available for public comment through the PRA process.

In §§ 435.1101(b) and 457.355 (by reference to § 435.1101), states are required to provide qualified entities with training in all applicable policies and procedures related to presumptive eligibility. The burden associated with this provision is the time and effort necessary for the states and territories to provide training to the hospitals. We estimate 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa will be subject to this requirement. As part of this estimate, we assumed that state Medicaid agencies and CHIP agencies, where there are separate agencies, will develop and use the same training.

For the purpose of the cost, we estimate it will take a training specialist 40 hours at $26.64 an hour and a training and development manager 10 hours at $64.43 an hour to develop training materials for the qualified entities, for a total time burden of 2,650 hours. The estimated cost for each state or territory is $1,709.90. The total estimated cost is $90,624.70.

We also estimate that each state or territory will offer 50 hours of training sessions to qualified entities, for a total time burden of 2,650 hours. For the purpose of the cost, we estimate it will take a training specialist 50 hours at $26.64 an hour to train the qualified entities. The estimated cost for each agency is $1,332. The total estimated cost is $70,596.

7. ICRs Regarding ABP SPA-Related Requirements (§§ 440.305, 440.315, 440.330, 440.335, 440.345, 440.347, 440.360, and 440.386)

In the proposed rule, CMS requested comment on habilitative services (§ 440.347(d)) and on the ''medically frail'' definition (§ 440.315(f)). Comments and CMS' response can be found in section B.3.a of this preamble. We also requested comment on essential health benefits (rehabilitative and habilitative services and devices) (§ 440.347). See section II.B. of this preamble for the comments and our response. Additional comments were solicited for exempt individuals (modifying definition of ''medically frail'') (§ 440.315). Comments and CMS' response can be found in the ABP portion of this preamble.

CMS also received many comments on the proposed changes to: (1) The public notice requirement in § 440.386 (see section II.B.7.b. of this preamble for the comment and our response); (2) public notice in § 440.386 and prescription drug coverage in § 440.345(f) (see section II.B.3.i. of this preamble for the comment and our response); (3) essential health benefits (non-discrimination policy) under § 440.347 (see section II.B.2.d of this preamble); and (4) EPSDT and other required benefits (family planning services and supplies) under § 440.345 (see the comments and responses section of the ABP portion of this preamble). As a result of comments received, CMS is finalizing the public notice requirements in this final rule without change.

We also received a number of comments requesting clarification to our statement in the preamble that the section 1927 requirements apply to the ABP prescription drug benefit. Specifically, commenters requested clarification, as part of this final rule, as to how section 1927 of the Act applies to prescription drug coverage under the ABP since ABP requirements for prescription drug coverage must meet the minimum EHB prescription drug requirements at section 1937 of the Act. Based upon those comments, we have clarified in the regulation that when states pay for covered outpatient drugs under a state's ABP, the section 1927 requirements apply. There is no additional information collection burden associated with this clarification.

While this rule has finalized policy related to these provisions, these policies do not result in any additional information collection requirements. Rather, the policy clarifications are interpretations of information that is already being collected.

The information collection requirements and burden estimates associated with §§ 440.305, 440.315, 440.330, 440.335, 440.345, 440.347, 440.360, and 440.386 have been approved by OMB through March 31, 2016, under OCN 0938–1188 (CMS–10434). This rule will not impose any new or revised SPA-related reporting, recordkeeping, or third party disclosure requirements and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

8. ICRs Regarding Cost Sharing and Premiums (§§ 447.52, 447.53, 447.54, 447.55 and 447.56)

The Deficit Reduction Act of 2005 (DRA) established a new section 1916A of the Act, which gives states additional flexibility, allowing for alternative premiums and cost sharing, beyond what is allowed under section 1916 of the Act, for somewhat higher income beneficiaries. Such alternative cost sharing may be targeted to specific groups of beneficiaries and payment may be required as a condition of

providing services. Thus, in accordance with the DRA we reviewed and made changes to the current cost sharing and premiums regulations under §§ 447.52 through 447.56.

In a review of these sections we found that 45 states including the District of Columbia impose cost-sharing and 40 states impose premiums on beneficiaries. While these provisions are subject to the PRA, we believe that any changes a state makes to its current state plan under any of these sections is a usual and customary practice under 5 CFR 1320.3(b)(2) and, as such, the burden associated with it is exempt from the PRA.

For those states electing to impose cost-sharing or premiums for the first time will only need to submit a state plan amendment one time for review. We estimate it will take each agency in this circumstance an average of 2 hours to fill out the state plan pre-print for either cost-sharing or premiums and submit it for approval. Thus we anticipate six states may impose cost-sharing and 11 states and the District of Columbia may impose premiums on beneficiaries. For the purpose of the cost burden, we estimate it will take a health policy analyst 1 hour at $49.35 an hour and a senior manager 1 hour at $79.08 an hour to complete the process and submission of each new state plan amendment. The estimated cost burden for each agency is $128.43. The total estimated cost burden is $2,183.31.

9. ICRs Regarding Beneficiary and Public Notice Requirements (§ 447.57)

In § 447.57(a), 53 Medicaid agencies will be required to make available a public schedule describing current premiums and cost sharing requirements containing the information in paragraphs (a)(1) through (6). In § 447.57(b), agencies are required to make the public schedule available to those identified in paragraphs (b)(1) through (4).

Prior to submitting a SPA for Secretary approval to establish or modify existing premiums or cost sharing or change the consequences for non-payment, § 447.57(c) requires that the state: (1) Provide the public with advance notice of the SPA (specifying the amount of premiums or cost sharing and who is subject to the charges); (2) provide a reasonable opportunity to comment on SPAs that propose to substantially modify premiums and cost sharing; (3) submit documentation to demonstrate that these requirements were met; and (4) provide additional public notice if cost sharing is modified during the SPA approval process.

In § 447.57(d), the information must be provided in a manner that ensures that affected beneficiaries and providers are likely to have access to the notice and are able to provide comments on proposed state plan amendments.

We estimate it will take each Medicaid agency an average of 6 hours to create the process and workflow required in providing the schedule and notice. For the purpose of the cost burden, we estimate it will take a health policy analyst 4 hours at $49.35 an hour and a senior manager 2 hours at $79.08 an hour to complete the process and workflow. The estimated cost burden for each agency is $355.56. The total estimated cost burden is $18,844.68.

C. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

For purposes of presenting an estimate of paperwork burden, we reflect the participation of 18 State-Based Exchanges. It is important to note that the Exchange provisions found in part 155, subparts D and E discussed below involve several information collections that will occur through the single, streamlined application for enrollment in a QHP and for insurance affordability programs described in § 155.405. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS–10440; OCN 0938–1191).

We also highlight that the Supporting Statement includes several information collections from regulatory provisions finalized in the Exchange final rule (77 FR 18310). We have included these information collections in this PRA package to address PRA requirements related to those provisions as they were not included in the information collection section of the Exchange final rule.

Lastly, we have not included information regarding information collections associated with certified application counselors, eligibility appeals, and SHOP coordination with individual market Exchanges, which we will finalize at a future date with the corresponding regulatory provisions.

1. ICRs Regarding Authorized Representatives (§ 155.227)

Section 155.227(a) provides that an applicant or enrollee, subject to applicable privacy and security requirements, may designate an individual person or organization as his or her authorized representative. One method for designating an authorized representative is by submitting legal documentation of the representative's authority. Exchanges have the option to make available an ''Appointment of Authorized Representative Form'' at the time of application or anytime thereafter for an individual to designate an authorized representative. Such a form would collect identifying and contact information about the applicant, enrollee, and requested authorized representative. Requested data elements would include the following for both the applicant or enrollee and the requested representative: name, address, phone number, email address, date of birth, and relationship. The applicant, enrollee, or authorized representative could obtain the form from the Exchange Web site or from an assister (such as a Navigator, non-Navigator in-person assister, etc.), and could submit it to the Exchange by mail or online at any time. We expect that the Exchange would use this information to authorize the authorized representative to act on behalf of the applicant or enrollee. An authorized representative could also submit this form if the applicant or enrollee is unable to do so.

HHS is currently developing a model Appointment of Authorized Representative Form to be used by the Federally-facilitated Exchanges and will make that form available to State-based Exchanges, which would also decrease the burden on State-based Exchanges to develop such a form. If a state opts not to use the form provided by HHS, we estimate the burden associated for the time and effort necessary for a State-based Exchange to develop the Appointment of Authorized Representative Form to be 30 hours. This includes a 10 hours from a mid-level health policy analyst at an hourly cost of $49.35 and 10 hours from an operations analyst at an hourly cost of $54.45 for drafting the form with 4 hours of managerial oversight at an hourly cost of $79.08 and 6 hours of legal review at an hourly cost of $90.14. The estimated cost per State-based Exchange is $1,895, for a total cost of $34, 113 for 18 State-based Exchanges.

For an applicant, enrollee, or prospective authorized representative, we estimate that it will take up to 5 minutes to review instructions and complete an Appointment of Authorized Representative Form. While we expect most applicants, enrollees, or prospective authorized representatives to complete the Authorized Representative Form, an applicant, enrollee, or prospective authorized

representative may also comply with this provision by providing the necessary information online, by phone, by mail, or in-person. We expect a similar burden on the applicant, enrollee, or authorized representative to comply with this provision through such means. If the applicant, enrollee, or authorized representative chooses to submit an ''Appointment of Authorized Representative Form,'' the burden for a State-based Exchange to process the submitted information will be approximately 10 minutes at a cost of $3.39 per submission. We anticipate that an eligibility support staff person will scan, digitize, and link the form to an applicant's or enrollee's account, review the submitted information, and update the authorized representative's and applicant's or enrollee's account, if applicable.

2. ICRs Regarding Notices (§§ 155.302, 155.310, 155.315, 155.320, 155.330, 155.335, 155.345, 155.355, 155.410, 155.715, 155.720, 155.725, and 155.1080)

Several provisions in subparts D and E outline specific scenarios in which the Exchange will send a notice to individuals and employers throughout the eligibility and enrollment process. HHS is currently developing model eligibility determination notices and several other models for notices described in 45 CFR parts 155, 156, and 157 which will decrease the burden on Exchanges to establish such notices. For some notices, the Exchange will include specific notice text in another notice, such as the eligibility determination notice, rather than send an entirely separate notice (effectively, two notices are combined into one). The purpose of these notices is to alert the individuals and employers who receive the notice of actions taken by the Exchange. When possible, we anticipate that the Exchange will consolidate notices when multiple members of a household are applying together and receive an eligibility determination at the same time. The notice may be in paper or electronic format but must be in writing and sent after an eligibility determination has been made by the Exchange. We anticipate that a large volume of enrollees will request electronic notification while others will opt to receive the notice by mail. As a result of certain enrollees opting to receiving the notice by mail in some instances, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to enrollees as appropriate.

We expect that the electronic eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application throughout the eligibility determination process. To develop the paper and electronic notices, Exchange staff will need to learn eligibility rules and draft notice text for various decision points, follow up, referrals, and appeals procedures. A health policy analyst, senior manager, and legal counsel will review the notice. The Exchange will then engage in review and editing to incorporate changes from the consultation and user testing including review to ensure compliance with plain writing, translation, and readability standards. We intend that Exchanges will work closely with the state Medicaid or CHIP agency to develop coordinated notices. Finally, a developer will program the template notice into the eligibility system so that the notice may be populated and generated in the correct format according to an individual's preference to receive notices, via paper or electronically, as the applicant moves through the eligibility process.

If a state opts not to use the model notices provided by HHS, we estimate that the Exchange effort related to the development and implementation of the eligibility notice will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn eligibility rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and 4 hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each Exchange, at a cost of approximately $5,971 per Exchange and a total cost of $107,478 for 18 State-Based Exchanges. We expect that the burden on the Exchange to maintain this notice will be significantly lower than to develop it.

Section 155.310(h) specifies that the Exchange will notify an employer that an individual in an employee's tax household has been determined eligible for advance payments of the premium tax credit and/or cost-sharing reductions based in part on the employer not offering minimum essential coverage or not offering qualifying coverage in an eligible employer-sponsored plan. Upon making such an eligibility determination, the Exchange will send a notice to the employer with information identifying the employee, along with a notification that the employer may be liable for the payment under section 4980H of the Code, and that the employer has a right to appeal this determination. Because this notice will be sent to an employer at the address as provided by an application filer on the application, we anticipate all of these notices will be sent by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to employers. Like the eligibility notice, the employer notice above will be developed and programmed into the eligibility system. However, unlike the eligibility notice, we expect the information on the employer notice to be minimal in comparison to the eligibility notice and therefore the burden on the Exchange to develop the notice to be substantially less. Further, as with the individual eligibility notice, HHS will provide model notice text for Exchanges to use in developing this notice.

3. ICRs Regarding Verification of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan (§ 155.320)

Section 155.320(d) proposes the process for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Paragraph (d)(2) specifies that the Exchange will obtain relevant data from any electronic data source available to the Exchange which has been approved by HHS, as well as data from certain specified electronic data sources. This will involve the development and execution of data sharing agreements; however, this burden is already captured in the data sharing agreements described in § 155.315. As these verification activities will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

Paragraph (d)(3)(iii)(A) proposes that the Exchange provide notice to certain applicants indicating that the Exchange will be contacting any employer identified on the application to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. The burden associated with this notice to certain applicants is addressed in 155.310(g) as this will not be a separate notice, but incorporated into the eligibility determination notice described in the above paragraph.

In paragraph (d)(3)(iii)(D), we propose that the Exchange make reasonable attempts to contact any employer to which the applicant attested

employment to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We note that the flexibility we provide to State-Based Exchanges for the first year of operations will significantly reduce the burden of this information collection in the first year.

It is difficult to estimate the burden associated with this information collection as the calculation involves identifying the number of individuals for whom employer-sponsored coverage information will be unavailable. As such, below, we estimate the time and cost associated with the Exchange making a reasonable attempt to contact one employer. We estimate the time associated with this information collection to be a total of 2.2 hours per employer at a total cost of $34.

4. ICRs Regarding Electronic Transmissions (§§ 155.310, 155.315, 155.320, and 155.340)

Sections 155.310, 155.315, 155.320, 155.330, and 155.340 involve the electronic transmission of data to determine eligibility for enrollment in a QHP and for insurance affordability programs. Section 155.310(d)(3) specifies that the Exchange must notify the state Medicaid or CHIP agency and transmit all information from the records of the Exchange for an applicant determined eligible for Medicaid or CHIP to the Medicaid or CHIP agency to ensure that the Medicaid or CHIP agency can provide the applicant with coverage promptly and without undue delay. This applicant information will be transmitted electronically from the Exchange to the agency administering Medicaid or CHIP once a determination has been made that the applicant is eligible for such program. The purpose of this data transmission is to notify the agency administering Medicaid or CHIP that an individual is newly eligible and thus the agency should facilitate enrollment in a plan or delivery system. Data will be transmitted through a secure electronic interface.

Sections 155.315 and 155.320 include transactions necessary to verify applicant information. We expect there to be no transactional burden associated with the electronic transactions needed to implement §§ 155.315 and 155.320. As these transmission functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

In § 155.340, the Exchange must provide the relevant information, such as the dollar amount of the advance payment and the cost-sharing reductions eligibility category, to enable advance payments of the premium tax credit and cost-sharing reductions, reconciliation of the advance payments of the premium tax credit, and administration of the employer responsibility requirements. As we anticipate that these transmissions of information will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

5. ICRs Regarding Reporting Changes (§§ 155.315, 155.330, and 155.335)

Section 155.315(f) outlines the process for resolving inconsistencies identified through the verification process. In § 155.330(c)(1), we state that the Exchange will verify any information reported by an enrollee in accordance with the processes specified in §§ 155.315 and 155.320 prior to using such information in an eligibility redetermination. Section 155.335(e) provides that the Exchange will require a qualified individual to report any changes for the information listed in the notice described in § 155.335(c) of this section within 30 days from the date of the notice. It is not possible at this time to provide estimates for the number of applicants for whom a reported change will necessitate the adjudication of documentation, but we anticipate that this number will decrease as applicants become more familiar with the eligibility process and as more data become available. As such, for now, we note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes (or 0.2 hours) for eligibility support staff at an hourly cost of $28.66 to review the documentation.

6. ICRs Regarding Enrollment and Termination (§§ 155.400, 155.405, and 155.430)

In part 155, subpart E, we describe the requirements for Exchanges in connection with enrollment and disenrollment of qualified individuals through the Exchange. These information collections are associated with sending eligibility and enrollment information to QHP issuers and to HHS, maintaining records of all enrollments in QHPs through the Exchange, reconciling enrollment information with QHP issuers and HHS, and retaining and tracking coverage termination information. The burden estimates associated with these provisions include the time and cost to meet these record requirements. We estimate that it will take 142 hours annually for an Exchange to meet these recordkeeping requirements for a total of 2,556 hours for 18 State-Based Exchanges.

In the case of the requirement related to termination standards, the burden includes estimates related to the maintenance and transmission of coverage termination information, as well as the time and effort needed to develop the system to collect and store the information. We estimate that it will take 30 hours of a health policy analyst at an hourly rate of $58.05, 20 hours for a computer programmer at an hourly rate of $52.50, and 20 hours for an operations analyst at an hourly rate of $54.45 for a total of 70 hours annually per Exchange and a total of 1,260 hours for 18 Exchanges, for the time and effort to meet this standard. We estimate a cost of $3,881 for one Exchange and a total cost of 69,858 for 18 State-Based Exchanges.

7. ICRs Regarding Agreements (§§ 155.302 and 155.345)

Section 155.345(a) specifies that an Exchange and the corresponding state Medicaid and CHIP agencies will enter in to an agreement regarding the coordination of eligibility determinations, and § 155.302(b)(6) specifies that to the extent that an Exchange is making assessments of eligibility for Medicaid and CHIP, rather than determinations, the Exchange will enter into an agreement with the state Medicaid and CHIP agencies regarding this arrangement. These agreements are necessary to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay and to provide standards for transferring an application between the Exchange and other entities administering insurance affordability programs. The specific number of agreements needed may vary depending on how states choose to divide responsibilities regarding eligibility determinations; where the Exchange is making assessments, we expect that the agreement described in § 155.302(b)(6) will be combined with the agreement in § 155.345(a).

The burden associated with this provision is the time and effort necessary for the Exchange to establish or modify an agreement for eligibility determinations and coordination of eligibility and enrollment functions. If an Exchange chooses to draft separate agreements for each insurance affordability program, then the estimate will likely increase.

In either case, we estimate it will take each Exchange an average of 105 hours to create a new agreement, although we assume that such agreements will be largely standardized across states, and that HHS will provide model agreements for state Medicaid and CHIP agencies and the Exchange to use. This includes a mid-level health policy analyst and an operations analyst reviewing the agreement with managerial oversight and comprehensive review of the agreement by operations analyst. We estimate a cost of $6,733 per Exchange.

8. ICRs Regarding Notices From QHP Issuers (§§ 156.260, 156.265, 156.270, and 156.290)

First, § 156.260(b) provides that QHP issuers will notify a qualified individual of his or her effective date of coverage, in accordance with the effective dates of coverage established by the Exchange in accordance with § 155.410(c) and (f). Second, under § 156.270(b), QHP issuers will send a notice of termination of coverage to an enrollee if the enrollee's coverage in the QHP is being terminated in accordance with § 155.430(b)(1)(i), (b)(2)(ii) or (b)(2)(iii). Third, § 156.270(f) provides that QHP issuers will provide enrollees with a notice about the grace period for non-payment of premiums. QHP issuers will send this notice to enrollees who are delinquent on premium payments. Fourth, § 156.265(e) provides that QHP issuers will provide new enrollees with an enrollment information package, which we anticipate that issuers may combine with the notification of coverage effective date described in § 156.260(b). Lastly, under § 156.290(b), QHP issuers will provide a notice to enrollees if the issuer elects not to seek recertification of a QHP.

We anticipate that some of the above QHP issuer required notices are similar in nature to the notices that issuers currently send to enrollees. For example, it is standard practice for issuers to provide new enrollees with information about their enrollment in a plan, their effective date of coverage, and if and when their coverage is terminating. Accordingly, we anticipate that QHP issuers will review, update, and revise notice templates that they utilize currently as they work to address the notice requirements described below and to ensure that the notices include the appropriate information. Similar to notices that will be issued by the Exchange, we expect that for QHP-issued notices, an analyst will develop text, and a peer analyst, manager, and legal counsel for the issuer will review the notices, including a review to ensure compliance with plain writing, language access, and readability standards as required under § 156.250(c). Finally, a developer will need to incorporate programming changes into the issuer's noticing system to account for the changes and updates that will be necessary to ensure that the QHP issuer is in compliance with the notice standards set forth in this rule and to ensure the notice can be populated and generated according to an individual's preference to receive notices. We estimate that the burden related to the development and implementation of this notice will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn appeals rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and four hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each QHP issuer, at a cost of approximately $5,971 per issuer. We expect that the burden on QHP issuers to maintain this notice will be significantly lower than to develop it.

However, we believe that the burden estimate described under § 155.310(g) likely represents an upper bound estimate of the burden on issuers to develop each of these notices as in some cases the notice described under § 155.310(g) will be somewhat more dynamic to address the additional information we expect to be included in that notice.

Since the above estimate applies to one notice, and we described 5 notices under part 156, the total burden estimate is $40,710. Due to uncertainty regarding the number of individuals who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part, we have only included an estimate of the printing and mailing costs for a QHP issuer to send one notice to a qualified individual or enrollee.

9. ICRs Regarding Notices and Third-Party Disclosures in the SHOP (§§ 157.205(e) and (f))

45 CFR part 157 includes several instances in which qualified employers participating in the SHOP Exchange will need to provide information to employees or to the SHOP Exchange. We include the data elements for these notifications in appendix A of this PRA package. For the individual market Exchange, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. We do not make this assumption for notices described here as we expect that qualified employers would provide notices to employees in whatever format the qualified employer usually provides notices to employees; in paper, electronically, or in a combination of both formats. We estimate that the associated printing costs for paper notices will be approximately $0.10 per notice. We do not take mailing costs into consideration for notices provided by qualified employers, as we expect that if qualified employers provide notices in paper format, the employer may provide the employee with the notice in person, instead of mailing the notice. We do not have a reasonable way to estimate total printing costs for notices provided by qualified employers in the SHOP Exchange due to uncertainty regarding the number of employees who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part.

First, § 157.205(e) specifies that a qualified employer provide an employee with information about the enrollment process. A qualified employer will inform each employee that he or she has an offer of coverage through the SHOP Exchange, and instructions for how the employee can apply for and enroll in coverage. We anticipate that the qualified employer will also provide information about the acceptable formats in which an employee may submit an application; online, on paper, or by phone, as described under § 157.205(c). If the employee being offered coverage was hired outside an initial or annual enrollment period, the notice will also inform the employee if he or she is qualified for a special enrollment period. Second, in § 157.205(f) we provide that a qualified employer will notify the SHOP Exchange regarding an employee's change in eligibility for enrollment in a QHP through the SHOP Exchange, including when a dependent or employee is newly eligible, or is no longer eligible.

We expect that the information that qualified employers will provide to employees and the SHOP Exchange, as described above, will be somewhat standardized. Additionally, we anticipate that qualified employers will generate notices using a manual process. We expect that for a qualified employer to establish a notice, the qualified employer will need 20 hours from a human resources specialist at an hourly cost of $40.68 to develop the text; and

four hours from a human resources manager at an hourly cost of $75.01 and ten hours from an attorney at an hourly cost of $90.14 to review the notices. We do not anticipate that a developer will be needed to develop the notices described in this part since we expect that in most cases, these notices will be manually generated on demand. Accordingly, we expect that the burden hours for developing each of the notices will be approximately 34 hours, for a total of 68 hours per qualified employer, at a total cost of $4,030. We expect that the burden on the qualified employer to maintain the notices will be significantly lower than to develop the notices.

D. Summary of Annual Burden Estimates

TABLE 1—PROPOSED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s)	OMB & CMS ID #s	Respondents	Responses (total)	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Total cost ($)
42 CFR 431.10, 431.11, and 457.1120.	OCN 0938–New; CMS–10456.	48	48	60	2,880	3,258 (per respondent).	156,398
§§ 435.917, 435.918, 457.110, and 457.340.	OCN 0938–New; CMS–10456.	96	96	194	18,624	10,609 (per respondent).	1,018,504
§§ 435.923 and 457.340 (develop and execute agreements).	OCN 0938–New; CMS–10456.	53	1060	12.5	13,250	12,635 (per respondent).	669,644
§§ 435.923 and 457.340 (create registration process and work flow).	OCN 0938–New; CMS–10456.	53	53	70	3,710	3,815 (per respondent).	202,184
§§ 435.923 and 457.340 (develop training materials).	OCN 0938–New; CMS–10456.	53	53	50	2,650	1,710 (per respondent).	90,625
§§ 435.923 and 457.340 (train application assistors).	OCN 0938–New; CMS–10456.	53	53	50	2,650	1,332 (per respondent).	70,596
§§ 435.1101(b) and 457.355.	OCN 0938–New; CMS–10456.	53	53	50	2,650	1,710 (per respondent).	90,625
§ 447.57	0938–New; CMS–10456.	53	53	6	318	210 (per respondent).	11,130
§ 155.227 (ICRs Regarding Authorized Representatives).	OCN 0938–New; CMS–10400.	18	18	30	540	1,895 (per respondent).	34,113
§§ 155.302, 155.310, 155.315, 155.320, 155.330, 155.335, 155.345, 155.410, 155.715, 155.720, 155.725, and 155.1080 (ICRs Regarding Notices).	OCN 0938–New; CMS–10400.	18	18	100	1,800	5,971 (per respondent).	107,478
§ 155.320 (ICRs Regarding Verification of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan).	OCN 0938–New; CMS–10400.	1	.....	2.2	.....	34 (for one respondent).	.....

TABLE 1—PROPOSED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS—Continued

Regulation section(s)	OMB & CMS ID #s	Respondents	Responses (total)	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Total cost ($)
§§ 155.315, 155.330, 155.335 (ICRs Regarding Reporting Changes).	OCN 0938–New; CMS–10400.	18	18	.2	.....	29 (for one respondent).	5.73
§§ 155.400 and 405 (ICRs Regarding Enrollment).	OCN 0938–New; CMS–10400.	18	18	142	2,556	7,254 (per respondent).	136,314
§ 155.430 (ICRs Regarding Termination).	OCN 0938–New; CMS–10400.	18	18	70	1,260	3,881 (per respondent).	69,858
§§ 155.302, 155.345 (ICRs Regarding Agreements).	OCN 0938–New; CMS–10400.	18	18	105	1,890	6,733 (per respondent).	121,194
§§ 156.260, 156.265, 156.270, and 156.290 (ICRs Regarding Notices from QHP Issuers).	OCN 0938–New; CMS–10400.	18	18	100	1,800	5,971 (per respondent).	107,478
§ 157.205(e) and (f) (ICRs Regarding Notices and Third Party Disclosures in the SHOP).	OCN 0938–New; CMS–10400.	.....	.....	68	.....	4,030 (per respondent).	.....
Total	.....	.....	.....	.....	55,578	.....	2,886,146.73

E. Submission of PRA-Related Comments

We have submitted a copy of this final rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the CMS Web site at *http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html*, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this final rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–2334–P) Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov*. PRA-specific comments must be received by August 5, 2013.

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). 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). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). The Office of Management and Budget has determined that this rulemaking is ''economically significant'' within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any one year. Accordingly, we have prepared a Regulatory Impact Analysis that presents the costs and benefits of this rulemaking. The RIA published with the March 2012 Medicaid eligibility final rule detailed the impact of the Medicaid eligibility changes related to implementation of the Affordable Care Act. The majority of Medicaid eligibility provisions included in this final rule were described in that detailed RIA and do not need to be repeated here. In the April 30, 2010 final rule on State Flexibility for Medicaid Benefit Packages, the assumptions utilized in modeling the estimated economic impact of the associated provisions took into perspective the costs of the benefit package for the new adult group. Coverage of these benefits was already accounted for in the April 30, 2010 final rule, and therefore, does not need to be repeated here.

For coverage beginning on or after January 1, 2014, individuals and small businesses will be able to purchase private health insurance—known as qualified health plans—through competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges.'' This final rule: (1) outlines criteria related to the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible

employer-sponsored plan in connection with advance payments of the premium tax credit and cost-sharing reductions; and (2) further specifies or amends other eligibility and enrollment provisions to provide detail necessary for state implementation. This rule continues to afford states substantial discretion in the design and operation of the Exchange established by a state, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

B. Estimated Impact of the Medicaid Premium and Cost Sharing Provisions

The provisions in this final rule related to Medicaid premiums and cost sharing clarify and update existing flexibilities and provide new flexibility for states for cost sharing for outpatient services, drugs, and non-emergency use of the emergency department. As states contemplate the changes required under the Affordable Care Act, more states may consider utilizing these flexibilities to either establish or expand cost sharing. We believe these proposed policies will encourage less costly care and decreased use of unnecessary services, which will reduce state and federal costs for the specified services. The following chart summarizes our estimate of the anticipated effects of this final rule.

TABLE 2—ESTIMATED TOTAL IMPACT OF CHANGES IN MAXIMUM MEDICAID COST SHARING, FY 2014–2018

[In millions of dollars]

Year	2014	2015	2016	2017	2018	2014–2018
Federal	−25	−45	−70	−70	−70	−280
State	−15	−30	−45	−45	−50	−185
Total	−40	−75	−115	−115	−120	−465

Source: CMS' Office of the Actuary

We estimate that this final rule will result in total savings of $465 million over 5 years, including $280 million in cost savings to the federal government and $185 million in savings to states. These savings may be attributed primarily to the increased maximum allowable cost sharing for outpatient services, drugs, and non-emergency use of the emergency department. Such savings are offset only nominally by the decreased maximum allowable cost sharing for an inpatient stay. In addition to direct savings from increased cost sharing, we assume some declines in utilization as enrollees subject to new cost sharing requirements choose to decrease their use of services.

C. Estimated Impact of Exchange Provisions

The provisions in this final rule amend select provisions of the Exchange Establishment final rule (77 FR 18319, March 27, 2012). Our approach in this regulatory impact analysis was to build off of the analysis presented in the Exchange Establishment final rule, available at *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf*. We do not believe the provisions in this final rule significantly alter our prior estimates of the impact of Exchanges on the budget or on enrollment in health insurance, and therefore, this final rule does not significantly alter the regulatory impact analysis drafted as part of such rulemaking. This section summarizes benefits and costs of the Exchange provisions presented in this final rule.

1. Methods of Analysis

The estimates in this analysis reflect estimates from the FY 2014 President's Budget for State Planning and Establishment Grants, which incorporate the costs associated with state implementation of the provisions proposed in this rule.

2. Benefits of the Proposed Regulation

The provisions included in this final rule amend provisions of the Exchange Establishment final rule. We do not believe the modifications made significantly alter the benefits associated with these provisions. Therefore, we refer to the benefits discussion included in the regulatory impact analysis associated with the Exchange Establishment final rule for a full analysis. The Exchange Establishment final rule regulatory impact analysis can be found at *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf*.

3. Costs of the Proposed Regulation

The Affordable Care Act and the implementing regulations found in subpart D of this final rule and the Exchange Establishment final rule provide for a streamlined system based on simplified eligibility rules, and an expedited process that will facilitate enrollment of eligible individuals and minimize costs to states, Exchanges and to the federal government. To support this new eligibility structure, states seeking to operate Exchanges are expected to build new or modify existing information technology (IT) systems. We believe that how each state builds and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. It is important to note that, although states have the option to establish and operate an Exchange, there is no federal requirement that each state establish an Exchange. We believe the proposed provisions provide options and flexibility to states that minimize costs and burden on Exchanges, consumers, employers and other entities. We also believe that overall administrative costs may increase in the short term as states build IT systems; however, in the long term, states may see savings through the use of more efficient systems.

Any administrative costs incurred in the development of IT infrastructure to support the Exchange may be funded through Exchange Planning and Establishment Grants to states. The federal government expects that these grants will fund the development of IT systems that can be used by many states who either develop their own Exchanges or who partner with the federal government to provide a subset of Exchange services.[3] Costs for IT infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a 90 percent federal matching rate to assist in development.[4]

[3] For example, CMS has awarded a number of Early Innovator grants to develop efficient and replicable IT systems that can provide the foundation for other states' work in this area. These amounts vary from $6 million to $48 million per state.

[4] Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, Final rule, 75 FR 21950 (April 19, 2011).

In general, as noted in our discussion of benefits, we anticipate that the final rule will increase take-up of health insurance; therefore, one type of rule-induced cost will be associated with providing additional medical services to newly-enrolled individuals. A recent study found that insured individuals received more hospital care and more outpatient care than their uninsured counterparts.[5]

Below we include estimated federal government payments related to grants for Exchange startup. States' initial costs due to the creation of Exchanges will be funded by these grants. Performing eligibility determinations is a minimum function of the Exchange; therefore the Exchange costs to develop the infrastructure for the provisions included in this final rule are covered by these grant outlays.

TABLE 3—ESTIMATED FEDERAL GOVERNMENT OUTLAYS FOR THE AFFORDABLE INSURANCE EXCHANGES FY 2013–FY2017

[In billions of dollars]

Year	2013	2014	2015	2016	2017	2013–2017
Grant Authority for Exchange Start up [a]	1.5	2.1	1.7	0.8	0.2	6.2

[a] FY 2014 President's Budget.

D. Alternatives Considered

We considered two alternatives to the Exchange provisions.

• *Alternative #1:* Require paper documentation to verify access to employer-sponsored coverage.

Section 155.320(d) of the final rule provides a process for verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. The proposed process relies on available electronic data sources, with the use of paper documentation in situations in which information submitted by an applicant is not reasonably compatible with information in electronic data sources, along with a sample-based review for situations in which no data is available.

The alternative model we considered would require the Exchange to require individuals to submit paper documentation to verify this information in all circumstances. This may increase the burden on individuals to submit this documentation to the Exchange, which may not be readily available to the applicant, but on employers, who will have to produce this information at the request of applicants, and will also require additional time and resources for Exchanges to accept and process the paper documentation needed for an eligibility determination. In addition, it could ultimately increase the amount of time it will take for an individual to receive health coverage through the Exchange or an insurance affordability program, could reduce the number of states likely to operate an Exchange due to increased administrative costs, and could dissuade individuals from seeking coverage through the Exchange.

• *Alternative #2:* Require Paper Notices from the Exchange

In § 155.230(d), we provide that the Exchange will provide the option to an individual or employer to receive notices electronically. We anticipate that this will be accommodated by the Exchange generating electronic notices, storing them on a secure Web site, and notifying individuals and employers through a generic email or text message communication that a notice is available for review.

The alternative model would require the Exchange to send all notices in paper form via US mail. This would significantly increase administrative costs for printing and mailing, and also generate significant volumes of undeliverable mail which would be returned to the Exchange.

Summary of Costs for Each Alternative

The paper-driven process outlined under alternatives 1 and 2 would ultimately increase the amount of time it would take for an individual to receive health coverage through the Exchange or an insurance affordability program, would increase administrative costs, and would dissuade individuals from seeking coverage through the Exchange.

E. Limitations of the Analysis

A number of challenges face estimators in projecting the Exchange, Medicaid, and CHIP benefits and costs under the Affordable Care Act and its implementing regulations, including this final rule. Health care cost growth is difficult to project, especially for people who are currently not in the health care system—the population targeted for the Medicaid eligibility changes and new insurance affordability programs. Such individuals could have pent-up demand and thus have costs that may be initially higher than other enrollees in health coverage, while they might also have better health status than those who have found a way (for example, ''spent down'') to enroll in Medicaid.

For the Exchange provisions, we use the President's Fiscal Year 2014 Budget as an estimate of the costs associated with the Exchange provisions. It is difficult to isolate the effects associated with these particular provisions of the Affordable Care Act, and therefore, in this analysis, we discuss the evidence relating to the provisions of this final rule in combination with related provisions of the Affordable Care Act. Further, with limited previous data and experiences, there is even greater uncertainty than in estimating the implications of modifying a previously existing program. Accordingly, we supplement the regulatory impact analysis with a qualitative discussion on the specific provisions of this rule.

F. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4/*), in Table X we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this final rule.

[5] Finkelstein, A. et al., (2011). The Oregon Health Insurance Experiment: Evidence from the First Year,'' *National Bureau of Economic Research Working Paper Series,* 17190.

TABLE 4—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED NET COSTS AND TRANSFERS

[In millions]

Category	Estimates	Units		
		Year dollar	Discount rate	Period covered
Benefits				
Annualized Monetized ($million/year)	Not Estimated Not Estimated	2012 2012	7% 3%	2013–2017 2013–2017
Qualitative	The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including reduced morbidity and fewer medical bankruptcies. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience.			
Costs*				
Annualized Monetized ($million/year)	1,311 1,283	2012 2012	7% 3%	2013–2017 2013–2017
Qualitative	Unquantified costs include State implementation costs above the amount covered by Federal grants; and increased medical costs associated with more widespread enrollment in health insurance.			
Transfers				
Annualized Monetized ($million/year)	54.4 55.3	2013 2013	7% 3%	2014–2018 2014–2018
From Whom to Whom	Beneficiaries to Federal Government			
Annualized Monetized ($million/year)	35.8 36.5	2013 2013	7% 3%	2014–2018 2014–2018
From Whom to Whom	Beneficiaries to State Governments			

* These costs include grant outlays to States to establish Exchanges; most of these Exchange-establishment costs been included in the accounting statement for the Exchange final rule.

G. Regulatory Flexibility Analysis

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act 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 as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this final rule is necessary to implement certain standards related to the establishment and operation of Exchanges as authorized by the Affordable Care Act. Specifically, this final rule: (1) provides criteria related to the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan; and (2) further specifies or amends standards related to other eligibility and enrollment provisions to provide detail necessary for state implementation.

The intent of this rule is to continue to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

For the purposes of the regulatory flexibility analysis, we expect the following types of entities to be affected by this final rule—(1) QHP issuers; and (2) employers. We believe that health insurers will be classified under the North American Industry Classification System (NAICS) Code 524114 (Direct Health and CMS–9989–P 166 Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $7 million or less will be considered small entities this NAICS code. Health issuers could also possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard will be $30 million or less.

1. QHP Issuers

This rule proposes standards for Exchanges that affect eligibility determinations for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP. Although these standards are for Exchanges, they also affect health plan issuers that choose to participate in an Exchange. QHP issuers receive information from an Exchange about an enrollee to enable the QHP issuer to process the correct level of advance payments of the premium tax credit and cost-sharing reductions. The issuer of the QHP will adjust an enrollee's net premium to reflect the advance payments of the premium tax credit, as well as make any changes required to ensure that cost-sharing reflects the appropriate level of reductions. QHP issuers benefit significantly from advance payments of the premium tax credit and cost-sharing reductions, but

may face some administrative costs relating to receiving enrollee information from an Exchange.

As discussed in the Web Portal interim final rule (75 FR 24470, 24481 (May 5, 2010), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the final rule on establishment of the Medicare Advantage program published on August 3, 2004 (69 FR 46866). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for ''small'' business established by the SBA (currently $7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).[6]

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, because it does not include receipts from these companies' other lines of business.

2. Employers

The establishment of SHOP in conjunction with tax incentives for eligible employers will provide new opportunities for employers to offer affordable health insurance to their employees. A detailed discussion of the impact on employers related to the establishment of the SHOP is found in the RIA for the Exchange final rule, 77 FR 18010 (March 23, 2012) and available at *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf.*

Except in the Exchange provisions, few of the entities that meet the definition of a small entity as that term is used in the RFA (for example, small businesses, nonprofit organization, and small governmental jurisdictions with a population of less than 50,000) will be impacted directly by this final rule. Individuals and states are not included in the definition of a small entity. In addition, the impact of the majority of this rule was addressed in the RIA accompanying the March 2012 Medicaid eligibility rule (77 FR 17144, March 23, 2012). Therefore, the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities, and we have not prepared a regulatory flexibility analysis.

Additionally, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, 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 are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this final rule will not have a direct economic impact on the operations of a substantial number of small rural hospitals.

H. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2013, that threshold is approximately $141 million. This final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of $140 million. The majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 2012 Medicaid eligibility rule (77 FR 17144, March 23, 2012). Furthermore, the final rule does not set any mandate on states to set up an Exchange.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. We wish to note again that the impact of changes related to implementation of the Affordable Care Act were described in the RIA of the March 2012 Medicaid eligibility rule (77 FR 17144, March 23, 2012). As discussed in the March 2012 RIA, we have consulted with states to receive input on how the various Affordable Care Act provisions codified in this final rule will affect states. We continue to engage in ongoing consultations with Medicaid and CHIP Technical Advisory Groups (TAGs), which have been in place for many years and serve as a staff level policy and technical exchange of information between CMS and the states. Through consultations with these TAGs, we have been able to get input from states specific to issues surrounding the changes in eligibility groups and rules that will become effective in 2014.

Because states have flexibility in deciding whether to implement an Exchange and, if a State opts to, in the design of its Exchange, state decisions will ultimately influence both administrative expenses and overall premiums. However, because states are not required to create an Exchange, these costs are not mandatory. For states electing to create an Exchange, the initial costs of the creation of the Exchange will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources left to the discretion of the state. In the Department's view, while this final rule does not impose substantial direct effects on state and local governments, it has federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each state electing to establish a State-Based Exchange must adopt federal standards contained in the Affordable Care Act and in this final rule, or have in effect a state law or regulation that implements these federal standards. However, the Department anticipates that the federalism implications (if any) are substantially mitigated because states have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require states to establish an Exchange; but if a state elects not to establish an Exchange or the state's Exchange is not approved, HHS will

[6] Table of Size Standards Matched To North American Industry Classification System Codes,'' effective November 5, 2010, U.S. Small Business Administration, available at *http://www.sba.gov.*

establish and operate an Exchange in that state. Additionally, states will have the opportunity to participate in state Partnership Exchanges that will allow states to leverage work done by other states and the federal government.

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 Department has 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 officials on an individual basis.

In accordance to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached proposed regulation in a meaningful and timely manner.

J. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), 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, this final rule, and has been transmitted to Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs—health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), and Virgin Islands.

42 CFR Part 438

Grant programs—health, Medicaid, and Reporting and recordkeeping requirements.

42 CFR Part 440

Grant programs—health, Medicaid.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, state and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

■ 2. Section 431.10 is amended by revising paragraph (a), adding paragraph (b)(3), and revising paragraphs (c), (d), and (e) to read as follows:

§ 431.10 Single State agency.

(a) *Basis, purpose, and definitions.* (1) This section implements section 1902(a)(4) and (5) of the Act.

(2) For purposes of this part—

Appeals decision means a decision made by a hearing officer adjudicating a fair hearing under subpart E of this part.

Exchange has the meaning given to the term in 45 CFR 155.20.

Exchange appeals entity has the meaning given to the term ''appeals entity,'' as defined in 45 CFR 155.500.

Medicaid agency is the single State agency for the Medicaid program.

(b) * * *

(3) The single State agency is responsible for determining eligibility for all individuals applying for or receiving benefits in accordance with regulations in part 435 of this chapter and for fair hearings filed in accordance with subpart E of this part.

(c) *Delegations.* (1) Subject to the requirement in paragraph (c)(2) of this section, the Medicaid agency—

(i)(A) May, in the approved state plan, delegate authority to determine eligibility for all or a defined subset of individuals to—

(*1*) The single State agency for the financial assistance program under title IV–A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands;

(*2*) The Federal agency administering the supplemental security income program under title XVI of the Act; or

(*3*) The Exchange.

(B) Must in the approved state plan specify to which agency, and the individuals for which, authority to determine eligibility is delegated.

(ii) Delegate authority to conduct fair hearings under subpart E of this part for denials of eligibility for individuals whose income eligibility is determined based on the applicable modified adjusted gross income standard described in § 435.911(c) of this chapter, to an Exchange or Exchange appeals entity, provided that individuals who have requested a fair hearing of such a denial are given a choice to have their fair hearing instead conducted by the Medicaid agency.

(2) The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis.

(3) The Medicaid agency—

(i) Must ensure that any agency to which eligibility determinations or appeals decisions are delegated—

(A) Complies with all relevant Federal and State law, regulations and policies, including, but not limited to, those related to the eligibility criteria applied by the agency under part 435 of this chapter; prohibitions against conflicts of interest and improper incentives; and safeguarding confidentiality, including regulations set forth at subpart F of this part.

(B) Informs applicants and beneficiaries how they can directly contact and obtain information from the agency; and

(ii) Must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies to ensure compliance with paragraphs (c)(2) and (c)(3)(i) of this section and institute corrective action as needed, including, but not limited to, rescission of the authority delegated under this section.

(iii) If authority to conduct fair hearings is delegated to the Exchange or Exchange appeals entity under paragraph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency may review fair hearing decisions made under that delegation, but that review will be limited to the proper application of federal and state Medicaid law and regulations, including sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial determination.

(d) *Agreement with Federal, State or local entities making eligibility determinations or appeals decisions.* The plan must provide for written agreements between the Medicaid agency and the Exchange or any other State or local agency that has been delegated authority under paragraph (c)(1)(i) of this section to determine Medicaid eligibility and for written agreements between the agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings under paragraph (c)(1)(ii) of this section. Such agreements must be available to the Secretary upon request and must include provisions for:

(1) The relationships and respective responsibilities of the parties, including but not limited to the respective responsibilities to effectuate the fair hearing rules in subpart E of this part;

(2) Quality control and oversight by the Medicaid agency, including any reporting requirements needed to facilitate such control and oversight;

(3) Assurances that the entity to which authority to determine eligibility or conduct fair hearings will comply with the provisions set forth in paragraph (c)(3) of this section.

(4) For appeals, procedures to ensure that individuals have notice and a full opportunity to have their fair hearing conducted by either the Exchange or Exchange appeals entity or the Medicaid agency.

(e) *Authority of the single State agency.* The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

■ 3. Section 431.11 is amended by—

■ A. Removing paragraph (b).

■ B. Redesignating paragraphs (c) and (d), as paragraphs (b) and (c), respectively.

■ C. Revising newly redesignated paragraphs (b) and (c).

The revisions read as follows:

§ 431.11 Organization for administration.

* * * * *

(b) *Description of organization.* (1) The plan must include a description of the organization and functions of the Medicaid agency.

(2) When submitting a state plan amendment related to the designation, authority, organization or functions of the Medicaid agency, the Medicaid agency must provide an organizational chart reflecting the key components of the Medicaid agency and the functions each performs.

(c) *Eligibility determined or fair hearings decided by other entities.* If eligibility is determined or fair hearings decided by Federal or State entities other than the Medicaid agency or by local agencies under the supervision of other State agencies, the plan must include a description of the staff designated by those other entities and the functions they perform in carrying out their responsibilities.

§ 431.57 [Removed]

■ 4. Section 431.57 is removed.

■ 5. Section 431.201 is amended by adding the definition of ''send'' in alphabetical order to read as follows:

§ 431.201 Definitions.

* * * * *

Send means deliver by mail or in electronic format consistent with § 435.918 of this chapter.

* * * * *

■ 6. Section 431.205 is amended by revising paragraphs (b)(1) and (2) to read as follows:

§ 431.205 Provision of hearing system.

* * * * *

(b) * * *

(1) A hearing before—

(i) The Medicaid agency; or

(ii) For the denial of eligibility for individuals whose income eligibility is determined based on the applicable modified adjusted gross income standard described in§ 435.911(c) of this chapter, the Exchange or Exchange appeals entity to which authority to conduct fair hearings has been delegated under § 431.10(c)(1)(ii), provided that individuals who have requested a fair hearing are given the choice to have their fair hearing conducted instead by the Medicaid agency; at state option the Exchange or Exchange appeals entity decision may be subject to review by the Medicaid agency in accordance with § 431.10(c)(3)(iii); or

(2) An evidentiary hearing at the local level, with a right of appeal to the Medicaid agency.

* * * * *

■ 7. Section 431.206 is amended by adding paragraphs (d) and (e) to read as follows:

§ 431.206 Informing applicants and beneficiaries.

* * * * *

(d) If, in accordance with § 431.10(c)(1)(ii), the agency has delegated authority to the Exchange or Exchange appeals entity to conduct the fair hearing, the agency must inform the individual in writing that—

(1) He or she has the right to have his or her hearing before the agency, instead of the Exchange or the Exchange appeals entity; and

(2) The method by which the individual may make such election;

(e) The information required under this section may be provided in electronic format in accordance with § 435.918 of this chapter.

■ 8. Section 431.211 is revised to read as follows:

§ 431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214.

■ 9. Section 431.213 is amended by revising the introductory text to read as follows:

§ 431.213 Exceptions from advance notice.

The agency may send a notice not later than the date of action if—

* * * * *

§ 431.230 [Amended]

■ 10. In § 431.230, amend paragraph (a) introductory text by removing the term ''mails'' and adding in its place the term ''sends''.

■ 11. Section 431.231 is amended by revising the section heading and paragraph (c)(2) to read as follows:

§ 431.231 Reinstating services.

* * * * *

(c) * * *

(2) The beneficiary requests a hearing within 10 days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period; and

* * * * *

■ 12. Section 431.240 is amended by adding paragraph (c) to read as follows.

§ 431.240 Conducting the hearing.

* * * * *

(c) A hearing officer must have access to agency information necessary to issue a proper hearing decision, including information concerning State policies and regulations.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 13. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 14. Section 435.110 is amended by eepublishing paragraph (c) introductory text and revising paragraph (c)(1) to read as follows:

§ 435.110 Parents and other caretaker relatives.

* * * * *

(c) *Income standard.* The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

* * * * *

■ 15. Section 435.116 is amended by republishing paragraph (d)(4) introductory text and revising paragraph (d)(4)(i) to read as follows:

§ 435.116 Pregnant women.

* * * * *

(d) * * *

(4) *Applicable income limit for full Medicaid coverage of pregnant women.* For purposes of paragraph (d)(1) of this section—

(i) The minimum applicable income limit is the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

* * * * *

■ 16. Section 435.119 is amended by revising the introductory text in paragraph (b) to read as follows:

§ 435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

* * * * *

(b) *Eligibility.* Effective January 1, 2014, the agency must provide Medicaid to individuals who:

* * * * *

§ 435.121 [Amended]

■ 17. In § 435.121, amend paragraph (f)(1)(iii) by removing the reference ''§ 447.52 or § 447.53'' and by adding in its place the reference ''§ 447.52, § 447.53, or § 447.54''.

■ 18. Section 435.603 is amended by—

■ A. In paragraph (b), adding the definitions of ''Child,'' ''Parent,'' and ''Sibling'' in alphabetical order.

■ B. Revising paragraphs (c) and (d)(1).

■ C. Adding paragraph (d)(4).

The revisions and additions read as follows:

§ 435.603 Application of modified adjusted gross income (MAGI).

* * * * *

(b) * * *

Child means a natural or biological, adopted or step child.

* * * * *

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

* * * * *

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on ''household income'' as defined in paragraph (d) of this section.

(d) * * *

(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

* * * * *

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

* * * * *

■ 19. Section 435.907 is amended by adding paragraph (h) to read as follows.

§ 435.907 Application.

* * * * *

(h) *Reinstatement of withdrawn applications.* (1) In the case of individuals described in paragraph (h)(2) of this section, the agency must reinstate the application submitted by the individual, effective as of the date the application was first received by the Exchange.

(2) Individuals described in this paragraph are individuals who—

(i) Submitted an application described in paragraph (b) of this section to the Exchange;

(ii) Withdrew their application for Medicaid in accordance with 45 CFR 155.302(b)(4)(A);

(iii) Are assessed as potentially eligible for Medicaid by the Exchange appeals entity.

■ 20. Section 435.908 is amended by adding paragraph (c) to read as follows:

§ 435.908 Assistance with application and renewal.

* * * * *

(c) *Certified Application Counselors.* (1) At State option, the agency may certify staff and volunteers of State-designated organizations to act as application assisters, authorized to provide assistance to applicants and beneficiaries with the application process and during renewal of eligibility. To be certified, application assisters must be—

(i) Authorized and registered by the agency to provide assistance at application and renewal;

(ii) Effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP through the Exchange and all insurance affordability programs operated in the State, as implemented in the State; and

(iii) Trained in and adhere to all rules regulations relating to the safeguarding and confidentiality of information and prohibiting conflict of interest,

including regulations set forth at part 431, subpart F of this chapter, and at 45 CFR 155.260(f), regulations relating to the prohibition against reassignment of provider claims specified in § 447.10 of this chapter, and all other State and Federal laws concerning conflicts of interest and confidentiality of information.

(2) For purposes of this section, assistance includes providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, working with the individual to provide required documentation, submitting applications and renewals to the agency, interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any requests from the agency, and managing their case between the eligibility determination and regularly scheduled renewals. Application assisters may be certified by the agency to act on behalf of applicants and beneficiaries for one, some or all of the permitted assistance activities.

(3) If the agency elects to certify application assisters, it must establish procedures to ensure that—

(i) Applicants and beneficiaries are informed of the functions and responsibilities of certified application assisters;

(ii) Individuals are able to authorize application assisters to receive confidential information about the individual related to the individual's application for or renewal of Medicaid; and

(iii) The agency does not disclose confidential applicant or beneficiary information to an application assister unless the applicant or beneficiary has authorized the application assister to receive such information.

(4) Application assisters may not impose, accept or receive payment or compensation in any form from applicants or beneficiaries for application assistance.

■ 21. Section 435.918 is added to read as follows:

§ 435.918 Use of electronic notices.

(a) Effective no earlier than October 1, 2013 and no later than January 1, 2015, the agency must provide individuals with a choice to receive notices and information required under this part or subpart E of part 431 of this chapter in electronic format or by regular mail and must be permitted to change such election.

(b) If the individual elects to receive communications from the agency electronically, the agency must—

(1) Ensure that the individual's election to receive notices electronically is confirmed by regular mail.

(2) Ensure that the individual is informed of his or her right to change such election to receive notices through regular mail.

(3) Post notices to the individual's electronic account within 1 business day of notice generation.

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to his or her account. The agency may not include confidential information in the email or electronic alert.

(5) Send a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable.

(6) At the individual's request, provide through regular mail any notice posted to the individual's electronic account.

■ 22. Section 435.923 is added to read as follows:

§ 435.923 Authorized Representatives.

(a)(1) The agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. Such a designation must be in accordance with paragraph (f) of this section, including the applicant's signature, and must be permitted at the time of application and at other times.

(2) Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

(b) Applicants and beneficiaries may authorize their representatives to—

(1) Sign an application on the applicant's behalf;

(2) Complete and submit a renewal form;

(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

(c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based. Such notice must be in accordance with paragraph (f) of this section and should include the applicant or authorized representative's signature as appropriate.

(d) The authorized representative—

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(e) The agency must require that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must affirm that he or she will adhere to the regulations in part 431, subpart F of this chapter and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(f) For purposes of this section, the agency must accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives must be accepted through all of the modalities described in § 435.907(a).

■ 23. Add an undesignated center heading and 435.1015 to read as follows:

FFP for Premium Assistance

§ 435.1015 FFP for premium assistance for plans in the individual market.

(a) FFP is available for payment of the costs of insurance premiums on behalf of an eligible individual for a health plan offered in the individual market that provides the individual with benefits for which the individual is covered under the State plan, subject to the following conditions:

(1) The insurer is obligated to pay primary to Medicaid for all health care items and services for which the insurer is legally and contractually responsible under the individual health plan, as required under part 433 subpart D of this chapter;

(2) The agency furnishes all benefits for which the individual is covered under the State plan that are not available through the individual health plan;

(3) The individual does not incur any cost sharing charges in excess of any amounts imposed by the agency under subpart A of part 447; and

(4) The total cost of purchasing such coverage, including administrative expenditures, the costs of paying all cost sharing charges in excess of the amounts imposed by the agency under subpart A of part 447, and the costs of providing benefits as required by (a)(2) of this section, must be comparable to the cost of providing direct coverage under the State plan.

(b) A State may not require an individual to receive benefits through premium assistance under this section, and a State must inform an individual that it is the individual's choice to receive either direct coverage under the Medicaid State plan or coverage through premium assistance for an individual health plan. A State must require that an individual who elects premium assistance obtain through the insurance coverage all benefits for which the insurer is responsible and must provide the individual with information on how to access any additional benefits and cost sharing assistance not provided by the insurer.

Subpart L—Options for Coverage of Special Groups under Presumptive Eligibility

■ 24. The heading for subpart L is revised as set forth above.

■ 25. Section 435.1102 is amended by—

■ A. Revising the section heading.

■ B. Revising paragraph (a).

■ C. Removing ''and'' at the end of paragraph (b)(2)(iv)(B) and adding ''and'' at the end of paragraph (b)(2)(v)(B);

■ D. Adding paragraph (b)(2)(vi).

■ E. Revising paragraph (b)(3).

■ F. Removing paragraph (b)(4).

■ G. Adding paragraphs (d) and (e).

■ The revisions and additions read as follows:

§ 435.1102 Children covered under presumptive eligibility.

(a) The agency may elect to provide Medicaid services for children under age 19 or a younger age specified by the State during a presumptive eligibility period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income (or, at state option, a reasonable estimate of household income, as defined in § 435.603 of this part, determined using simplified methods prescribed by the agency) at or below the income standard established by the State for the age of the child under § 435.118(c) or under § 435.229 if applicable and higher.

(b) * * *

(2) * * *

(vi) Do not delegate the authority to determine presumptive eligibility to another entity.

(3) Establish oversight mechanisms to ensure that presumptive eligibility determinations are being made consistent with the statute and regulations.

* * * * *

(d) The agency—

(1) May require, for purposes of making a presumptive eligibility determination under this section, that the individual has attested to being, or another person who attests to having reasonable knowledge of the individual's status has attested to the individual being, a—

(i) Citizen or national of the United States or in satisfactory immigration status; or

(ii) Resident of the State; and

(2) May not—

(i) Impose other conditions for presumptive eligibility not specified in this section; or

(ii) Require verification of the conditions for presumptive eligibility.

(e) Notice and fair hearing regulations in subpart E of part 431 of this chapter do not apply to determinations of presumptive eligibility under this section.

■ 26 Section 435.1103 is added to Subpart L read as follows:

§ 435.1103 Presumptive eligibility for other individuals.

(a) The terms of § 435.1101 and § 435.1102 apply to pregnant women such that the agency may provide Medicaid to pregnant women during a presumptive eligibility period following a determination by a qualified entity that the pregnant woman has income at or below the income standard established by the State under § 435.116(c), except that coverage of services provided to such women is limited to ambulatory prenatal care and the number of presumptive eligibility periods that may be authorized for pregnant women is one per pregnancy.

(b) If the agency provides Medicaid during a presumptive eligibility period to children under § 435.1102 or to pregnant women under paragraph (a) of this section, the agency may also apply the terms of §§ 435.1101 and 435.1102 to the individuals described in one or more of the following sections of this part, based on the income standard established by the state for such individuals and providing the benefits covered under that section: §§ 435.110 (parents and caretaker relatives), 435.119 (individuals aged 19 or older and under age 65), 435.150 (former foster care children), and 435.218 (individuals under age 65 with income above 133 percent FPL).

(c)(1) The terms of §§ 435.1101 and 435.1102 apply to individuals who may be eligible under § 435.213 of this part (relating to individuals with breast or cervical cancer) or § 435.214 of this part (relating to eligibility for limited family planning benefits) such that the agency may provide Medicaid during a presumptive eligibility period following a determination by a qualified entity described in paragraph (c)(2) of this section that—

(i) The individual meets the eligibility requirements of § 435.213; or

(ii) The individual meets the eligibility requirements of § 435.214, except that coverage provided during a presumptive eligibility period to such individuals is limited to the services described in § 435.214(d).

(2) Qualified entities described in this paragraph include qualified entities which participate as providers under the State plan and which the agency determines are capable of making presumptive eligibility determinations.

■ 27. Section 435.1110 is added to Subpart L to read as follows:

§ 435.1110 Presumptive eligibility determined by hospitals.

(a) *Basic rule.* The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under §§ 435.1102 and 435.1103, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) *Qualified hospitals.* A qualified hospital is a hospital that—

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) *State options for bases of presumptive eligibility.* The agency may—

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for all of the populations described in § 435.1102 and § 435.1103; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases approved under the State plan or an 1115 demonstration.

(d) *Disqualification of hospitals.* (1) The agency may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in § 435.907, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the agency based on such application.

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not—

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

(3) The agency may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

■ 28. Section 435.1200 is amended by revising paragraph (d)(6) to read as follows:

§ 435.1200 Medicaid Agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs

* * * * *

(d) * * *

(6) Notify such program of the final determination of the individual's eligibility or ineligibility for Medicaid.

* * * * *

■ 29. Section 435.1205 is added to read as follows:

§ 435.1205 Alignment with exchange initial open enrollment period.

(a) *Definitions.* For purposes of this section—

Eligibility based on MAGI means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§ 435.110 through 435.119, 435.218 and 435.603.

(b) *Medicaid agency responsibilities to achieve coordinated open enrollment.* For the period beginning October 1, 2013 through December 31, 2013, the agency must

(1) Accept all of the following:

(i) The single streamlined application described in § 435.907.

(ii) Via secure electronic interface, an electronic account transferred from another insurance affordability program.

(2) For eligibility based on MAGI, comply with the terms of § 435.1200 of this part, such that—

(i) For each electronic account transferred to the agency under paragraph (c)(1)(ii) of this section, the agency consistent with either of the following:

(A) Section 435.1200(c), accepts a determination of Medicaid eligibility based on MAGI, made by another insurance affordability program.

(B) Section 435.1200(d), determines eligibility for Medicaid based on MAGI.

(ii) Consistent with § 435.1200(e), for each single streamlined application submitted directly to the agency under paragraph (b)(1)(i) of this section—

(A) Determine eligibility based on MAGI; and

(B) For each individual determined not Medicaid eligible based on MAGI, determine potential eligibility for other insurance affordability programs, based on the requirements which will be effective for each program, and transfer the individual's electronic account to such program via secure electronic interface.

(iii) Provide notice and fair hearing rights, in accordance with § 435.917 of this part, part 431 subpart E of this chapter, and § 435.1200 for those determined ineligible for Medicaid.

(3) For each individual determined eligible based on MAGI in accordance with paragraph (c)(2) of this section—

(i) Provide notice, including the effective date of eligibility, to such individual, consistent with § 435.917 of this part, and furnish Medicaid.

(ii) Apply the terms of § 435.916 (relating to beneficiary responsibility to inform the agency of any changes in circumstances that may affect eligibility) and § 435.952 (regarding use of information received by the agency). The first renewal under § 435.916 of this part may, at State option, be scheduled to occur anytime between 12 months from the date of application and 12 months from January 1, 2014.

(4) For eligibility effective in 2013, for all applicants—

(i) Consistent with the requirements of subpart J of this part, and applying the eligibility requirements in effect under the State plan, or waiver of such plan, as of the date the individual submits an application to any insurance affordability program—

(A) Determine the individual's eligibility based on the information provided on the application or in the electronic account; or

(B) Request additional information from the individual needed by the agency to determine eligibility based on the eligibility requirements in effect on such date, including on a basis excepted from application of MAGI-based methods, as described in § 435.603, and determine such eligibility if such information is provided; and

(C) Furnish Medicaid to individuals determined eligible under this clause or provide notice and fair hearing rights in accordance with part 431 subpart E of this part if eligibility effective in 2013 is denied; or

(ii) Notify the individual of the opportunity to submit a separate application for coverage effective in 2013 and information on how to obtain and submit such application.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

■ 30. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 436.831 [Amended]

■ 31. In § 436.831, amend paragraph (e)(1) by removing the reference ''§ 447.51 or § 447.53'' and by adding in its place the reference ''§ 447.52,, § 447.53, or § 447.54''.

PART 438—MANAGED CARE

■ 32. The authority citation for part 483 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 438.108 [Amended]

■ 33. Section 438.108 is amended by removing the reference ''§§ 447.50 through 447.60'' and by adding in its place the reference ''§§ 447.50 through 447.57''.

PART 440—SERVICES: GENERAL PROVISIONS

■ 34. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 35. Section 440.130 is amended by revising paragraph (c) to read as follows:

§ 440.130 Diagnostic, screening, preventive, and rehabilitative services.

* * * * *

(c) *Preventive services* means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

* * * * *

■ 36. Section 440.305 is amended by revising paragraphs (a) and (b) and removing paragraph (d).

The revisions read as follows:

§ 440.305 Scope.

(a) *General.* This subpart sets out requirements for States that elect to provide medical assistance to certain Medicaid eligible individuals within one or more groups of individuals specified by the State, through enrollment of the individuals in coverage, identified as ''benchmark'' or ''benchmark-equivalent.'' Groups must be identified by characteristics of individuals rather than the amount or level of FMAP.

(b) *Limitations.* A State may only apply the option in paragraph (a) of this section for an individual whose eligibility is based on an eligibility category under section 1905(a) of the Act that could have been covered under the State's plan on or before February 8, 2006, except that individuals who are eligible under section 1902(a)(10)(A)(i)(VIII) of the Act must enroll in an Alternative Benefit Plan to receive medical assistance.

* * * * *

■ 37. Section 440.315 is amended by revising the introductory text and paragraphs (f) and (h) to read as follows:

§ 440.315 Exempt individuals.

Individuals within one (or more) of the following categories are exempt from mandatory enrollment in an Alternative Benefit Plan, unless the individuals are eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Individuals in that eligibility group who meet the conditions for exemption must be given the option of an Alternative Benefit Plan that includes all benefits available under the approved State plan.

* * * * *

(f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

* * * * *

(h) The individual is eligible and enrolled for Medicaid under § 435.145 of this chapter based on current eligibility for assistance under title IV–E of the Act or under § 435.150 of this chapter based on current status as a former foster care child.

* * * * *

■ 38. Section 440.330 is amended by revising paragraph (d) to read as follows:

§ 440.330 Benchmark health benefits coverage.

* * * * *

(d) *Secretary-approved coverage.* Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage. Secretarial coverage may include benefits of the type that are available under 1 or more of the standard benchmark coverage packages defined in paragraphs (a) through (c) of this section, State plan benefits described in section 1905(a), 1915(i), 1915(j), 1915(k) or section 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR 156.100.

(1) States wishing to elect Secretary-approved coverage should submit a full description of the proposed coverage (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package), and of the population to which coverage will be offered. In addition, the State should submit any other information that will be relevant to a determination that the proposed health benefits coverage will be appropriate for the proposed population.

(2) [Reserved]

■ 39. Section 440.335 is amended by—

■ A. Adding paragraphs (b)(7)and (8).

■ B. Revising paragraph (c)(1).

■ C. Removing paragraph (c)(3).

The revisions and additions read as follows:

§ 440.335 Benchmark-equivalent health benefits coverage.

* * * * *

(b) * * *

(7) Prescription drugs.

(8) Mental health benefits.

(c) * * *

(1) In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 1 or more of the standard benchmark coverage packages described in § 440.330(a) through (c) or State plan benefits, described in section 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base-benchmark plans described in 45 CFR 156.100.

* * * * *

■ 40. Section 440.345 is amended by revising the section heading and adding paragraphs (b) through (f) to read as follows:

§ 440.345 EPSDT and other required benefits.

* * * * *

(b) *Family planning.* Alternative Benefit Plans must include coverage for family planning services and supplies.

(c) *Mental health parity.* Alternative Benefit Plans that provide both medical and surgical benefits, and mental health or substance use disorder benefits, must comply with the Mental Health Parity and Addiction Equity Act.

(d) *Essential health benefits.* Alternative Benefit Plans must include at least the essential health benefits described in § 440.347, and include all updates or modifications made thereafter by the Secretary to the definition of essential health benefits.

(e) *Updating of benefits.* States are not required to update Alternative Benefit Plans that have been determined to

include essential health benefits as of January 1, 2014, until December 31, 2015. States will adhere to future guidance for updating benefits beyond that date, as described by the Secretary.

(f) *Covered outpatient drugs.* To the extent states pay for covered outpatient drugs under their Alternative Benefit Plan's prescription drug coverage, states must comply with the requirements under section 1927 of the Act.

■ 41. Section 440.347 is added to read as follows:

§ 440.347 Essential health benefits.

(a) Alternative Benefit Plans must contain essential health benefits coverage, including benefits in each of the following ten categories, consistent with the applicable requirements set forth in 45 CFR part 156:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorders, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices, except that such coverage shall be in accordance with § 440.347(d);

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care, in accordance with section 1905(r) of the Act.

(b) Alternative Benefit Plans must include essential health benefits in one of the state options for establishing essential health benefits described in 45 CFR 156.100, subject to supplementation under 45 CFR 156.110(b) and substitution as permitted under 45 CFR 156.115(b).

(c) States may select more than one base benchmark option for establishing essential health benefits in keeping with the flexibility for States to implement more than one Alternative Benefit Plan for targeted populations.

(d) To comply with paragraph (a) of this section, Alternative Benefit Plan coverage of habilitative services and devices will be based on the habilitative services and devices that are in the applicable base benchmark plan. If habilitative services and devices are not in the applicable base benchmark plan, the state will define habilitative services and devices required as essential health benefits using the methodology set forth in 45 CFR 156.115(a)(5).

(e) Essential health benefits cannot be based on a benefit design or implementation of a benefit design that discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.

42. Section 440.360 is revised to read as follows:

§ 440.360 State plan requirements for providing additional services.

In addition to the requirements of § 440.345, the State may elect to provide additional coverage to individuals enrolled in Alternative Benefit Plans, except that the coverage for individuals eligible only through section 1902(a)(10)(A)(i)(VIII) of the Act is limited to benchmark or benchmark-equivalent coverage. The State must describe the populations covered and the payment methodology for these benefits. Additional benefits must be benefits of the type, which are covered in 1 or more of the standard benchmark coverage packages described in § 440.330(a) through (c) or State plan benefits including those described in sections 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act and any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR 156.100.

■ 43. Section 440.386 is added to read as follows:

§ 440.386 Public notice.

Prior to submitting to the Centers for Medicare and Medicaid Services for approval of a State plan amendment to establish an Alternative Benefit Plan or an amendment to substantially modify an existing Alternative Benefit Plan, a state must have provided the public with advance notice of the amendment and reasonable opportunity to comment for such amendment, and have included in the notice a description of the method for assuring compliance with § 440.345 related to full access to EPSDT services, and the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.

PART 447—PAYMENTS FOR SERVICES

■ 44. The authority citation for part 447 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

■ 45. Section 447.15 is revised to read as follows:

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. The provider may only deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 447.52(e). The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

§ 447.20 [Amended]

■ 46. In § 447.20, amend paragraphs (a)(1) and (2) by removing the reference ''§§ 447.53 through 447.56'' wherever it occurs and adding in its place the reference ''§§ 447.52 through 447.54''.

■ 47a. Remove the undesignated center headings which appear above §§ 447.50, 447.51, 447.53, 447.59, and 447.62.

■ 47b. Add a new undesignated center above revised §§ 447.50 through 447.57 to read as follows:

Medicaid Premiums and Cost Sharing

Sec.

447.50 Premiums and cost sharing: Basis and purpose.
447.51 Definitions.
447.52 Cost sharing.
447.53 Cost sharing for drugs.
447.54 Cost sharing for services furnished in a hospital emergency department.
447.55 Premiums.
447.56 Limitations on premiums and cost sharing.
447.57 Beneficiary and public notice requirements.

Medicaid Premiums and Cost Sharing

§ 447.50 Premiums and cost sharing: Basis and purpose.

Sections 1902(a)(14), 1916 and 1916A of the Act permit states to require certain beneficiaries to share in the costs of providing medical assistance through premiums and cost sharing. Sections 447.52 through 447.56 specify the standards and conditions under which states may impose such premiums and or cost sharing.

§ 447.51 Definitions

As used in this part—

Alternative non-emergency services provider means a Medicaid provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that can provide clinically appropriate services in a timely manner.

Contract health service means any health service that is:

(1) Delivered based on a referral by, or at the expense of, an Indian health program; and

(2) Provided by a public or private medical provider or hospital that is not a provider or hospital of the IHS or any other Indian health program

Cost sharing means any copayment, coinsurance, deductible, or other similar charge.

Emergency services has the same meaning as in § 438.114 of this chapter.

Federal poverty level (FPL) means the Federal poverty level updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Indian means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(1) Is a member of a Federally-recognized Indian tribe;

(2) Resides in an urban center and meets one or more of the following four criteria:

(i) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(ii) Is an Eskimo or Aleut or other Alaska Native;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is determined to be an Indian under regulations promulgated by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Inpatient stay means the services received during a continuous period of inpatient days in either a single medical institution or multiple medical institutions, and also includes a return to an inpatient medical institution after a brief period when the return is for treatment of a condition that was present in the initial period. Inpatient has the same meaning as in § 440.2 of this chapter.

Non-emergency services means any care or services that are not considered emergency services as defined in this section. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Act.

Outpatient services for purposes of imposing cost sharing means any service or supply not meeting the definition of an inpatient stay.

Preferred drugs means drugs that the state has identified on a publicly available schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost effective drugs within each therapeutically equivalent or therapeutically similar class of drugs, or all drugs within such a class if the agency does not differentiate between preferred and non-preferred drugs.

Premium means any enrollment fee, premium, or other similar charge.

§ 447.52 Cost sharing.

(a) *Applicability.* Except as provided in § 447.56(a) (exemptions), the agency may impose cost sharing for any service under the state plan.

(b) *Maximum Allowable Cost Sharing.* (1) At State option, cost sharing imposed for any service (other than for drugs and non-emergency services furnished in an emergency department, as described in §§ 447.53 and 447.54 respectively) may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing for individuals with family income at or below 100 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing		
	Individuals with family income ≤100% of the FPL	Individuals with family income 101–150% of the FPL	Individuals with family income >150% of the FPL
Outpatient Services *(physician visit, physical therapy, etc.)*.	$4	10% of cost the agency pays	20% of cost the agency pays.
Inpatient Stay	75	10% of total cost the agency pays for the entire stay.	20% of total cost the agency pays for the entire stay.

(2) States with cost sharing for an inpatient stay that exceeds $75, as of July 15, 2013, must submit a plan to CMS that provides for reducing inpatient cost sharing to $75 on or before July 1, 2017.

(3) In states that do not have fee-for-service payment rates, any cost sharing imposed on individuals at any income level may not exceed the maximum amount established, for individuals with income at or below 100 percent of the FPL described in paragraph (b)(1) of this section.

(c) *Maximum cost sharing.* In no case shall the maximum cost sharing established by the agency be equal to or exceed the amount the agency pays for the service.

(d) *Targeted cost sharing.* (1) Except as provided in paragraph (d)(2) of this section, the agency may target cost sharing to specified groups of individuals with family income above 100 percent of the FPL.

(2) For cost sharing imposed for non-preferred drugs under § 447.53 and for non-emergency services provided in a hospital emergency department under § 447.54, the agency may target cost sharing to specified groups of individuals regardless of income.

(e) *Denial of service for nonpayment.* (1) The agency may permit a provider, including a pharmacy or hospital, to require an individual to pay cost sharing as a condition for receiving the item or service if—

(i) The individual has family income above 100 percent of the FPL,

(ii) The individual is not part of an exempted group under § 447.56(a), and

(iii) For cost sharing imposed for non-emergency services furnished in an emergency department, the conditions under § 447.54(d) of this part have been satisfied.

(2) Except as provided under paragraph (e)(1) of this section, the state plan must specify that no provider may deny services to an eligible individual on account of the individual's inability to pay the cost sharing.

(3) Nothing in this section shall be construed as prohibiting a provider from choosing to reduce or waive such cost sharing on a case-by-case basis.

(f) *Prohibition against multiple charges.* For any service, the agency may not impose more than one type of cost sharing.

(g) *Income-related charges.* Subject to the maximum allowable charges specified in §§ 447.52(b), 447.53(b) and 447.54(b), the plan may establish different cost sharing charges for individuals at different income levels. If the agency imposes such income-related charges, it must ensure that lower income individuals are charged less than individuals with higher income.

(h) *Services furnished by a managed care organization (MCO).* Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in §§ 447.50 through 447.57.

(i) *State Plan Specifications.* For each cost sharing charge imposed under this part, the state plan must specify—

(1) The service for which the charge is made;

(2) The group or groups of individuals that may be subject to the charge;

(3)The amount of the charge;

(4) The process used by the state to—

(i) Ensure individuals exempt from cost sharing are not charged,

(ii) Identify for providers whether cost sharing for a specific item or service may be imposed on an individual and whether the provider may require the individual, as a condition for receiving the item or service, to pay the cost sharing charge; and

(5) If the agency imposes cost sharing under § 447.54, the process by which hospital emergency room services are identified as non-emergency service.

§ 447.53 Cost sharing for drugs.

(a) The agency may establish differential cost sharing for preferred and non-preferred drugs. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (d) of this section. All drugs will be considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs.

(b) At state option, cost sharing for drugs may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment. Such increase shall not be applied to any cost sharing that is based on the amount the agency pays for the service):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Preferred Drugs	$4	$4.
Non-Preferred Drugs	8	20% of the cost the agency pays.

(c) In states that do not have fee-for-service payment rates, cost sharing for prescription drugs imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 150 percent of the FPL in paragraph (b) of this section.

(d) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in paragraph (b) of this section.

(e) In the case of a drug that is identified by the agency as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a timely process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

§ 447.54 Cost sharing for services furnished in a hospital emergency department.

(a) The agency may impose cost sharing for non-emergency services provided in a hospital emergency department. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (c) of this section.

(b) At state option, cost sharing for non-emergency services provided in an emergency department may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing identified for individuals with family income at or below 150 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Non-emergency Use of the Emergency Department	$8	No Limit.

(c) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-emergency use of the emergency department, not to exceed the maximum amount established in paragraph (b) of this section for individuals with income at or below 150 percent of the FPL.

(d) For the agency to impose cost sharing under paragraph (a) or (c) of this section for non-emergency use of the emergency department, the hospital providing the care must—

(1) Conduct an appropriate medical screening under § 489.24 subpart G to determine that the individual does not need emergency services.

(2) Before providing non-emergency services and imposing cost sharing for such services:

(i) Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

(ii) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(iii) Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

(iv) Provide a referral to coordinate scheduling for treatment by the alternative provider.

(e) Nothing in this section shall be construed to:

(1) Limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

§ 447.55 Premiums.

(a) The agency may impose premiums upon individuals whose income exceeds 150 percent of the FPL, subject to the exemptions set forth in § 447.56(a) and the aggregate limitations set forth in § 447.56(f) of this part, except that:

(1) Pregnant women described in described in paragraph (a)(1)(ii) of this section may be charged premiums that do not exceed 10 percent of the amount by which their family income exceeds 150 percent of the FPL after deducting expenses for care of a dependent child.

(i) The agency may use state or local funds available under other programs for payment of a premium for such pregnant women. Such funds shall not be counted as income to the individual for whom such payment is made.

(ii) Pregnant women described in this clause include pregnant women eligible for Medicaid under § 435.116 of this chapter whose income exceeds the higher of –

(A) 150 percent FPL; and

(B) If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(2) Individuals provided medical assistance only under sections 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), may be charged premiums on a sliding scale based on income.

(3) Disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act, may be charged premiums on a sliding scale based on income. The aggregate amount of the child's premium imposed under this paragraph and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) of the Act, and other cost sharing charges may not exceed:

(i) 5 percent of the family's income if the family's income is no more than 200 percent of the FPL.

(ii) 7.5 percent of the family's income if the family's income exceeds 200 percent of the FPL but does not exceed 300 percent of the FPL.

(4) Qualified disabled and working individuals described in section 1905(s) of the Act, whose income exceeds 150 percent of the FPL, may be charged premiums on a sliding scale based on income, expressed as a percentage of Medicare cost sharing described at section 1905(p)(3)(A)(i) of the Act.

(5) Medically needy individuals, as defined in §§ 435.4 and 436.3 of this chapter, may be charged on a sliding scale. The agency must impose an appropriately higher charge for each higher level of family income, not to exceed $20 per month for the highest level of family income.

(b) *Consequences for non-payment.* (1) For premiums imposed under paragraphs (a)(1), (a)(2), (a)(3) and (a)(4) of this section, the agency may not require a group or groups of individuals to prepay.

(2) Except for premiums imposed under paragraph (a)(5) of this section, the agency may terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) For premiums imposed under paragraph (a)(2) of this section—

(i) For individuals with annual income exceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for individuals whose annual income does not exceed 450 percent of the FPL.

(ii) For individuals whose annual adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds $75,000, increased by inflation each calendar year after 2000, the agency must require payment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Medicaid.

(4) For any premiums imposed under this section, the agency may waive payment of a premium in any case where the agency determines that requiring the payment will create an undue hardship for the individual or family.

(5) The agency may not apply further consequences or penalties for non-payment other than those listed in this section.

(c) *State plan specifications.* For each premium, enrollment fee, or similar charge imposed under paragraph (a) of this section, subject to the requirements of paragraph (b) of this section, the plan must specify—

(1) The group or groups of individuals that may be subject to the charge;

(2) The amount and frequency of the charge;

(3) The process used by the state to identify which beneficiaries are subject to premiums and to ensure individuals exempt from premiums are not charged; and

(4) The consequences for an individual or family who does not pay.

§ 447.56 Limitations on premiums and cost sharing.

(a) *Exemptions.* (1) The agency may not impose premiums or cost sharing upon the following groups of individuals:

(i) Individuals ages 1 and older and under age 18 eligible under § 435.118 of this chapter.

(ii) Infants under age 1 eligible under § 435.118 of this chapter whose income does not exceed the higher of—

(A) 150 percent FPL (for premiums) or 133 percent FPL (for cost sharing); and

(B) If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(iii) Individuals under age 18 eligible under § 435.120–§ 435.122 or § 435.130 of this chapter.

(iv) Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

(v) At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter.

(vi) Disabled children, except as provided at § 447.55(a)(4) (premiums), who are receiving medical assistance by virtue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(vii) Pregnant women, except for premiums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-related, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(viii) Any individual whose medical assistance for services furnished in an institution, or at state option in a home and community-based setting, is reduced by amounts reflecting available income other than required for personal needs.

(ix) An individual receiving hospice care, as defined in section 1905(o) of the Act.

(x) An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all cost sharing.

(xi) Individuals who are receiving Medicaid because of the state's election to extend coverage as authorized by § 435.213 of this chapter (Breast and Cervical Cancer).

(2) The agency may not impose cost sharing for the following services:

(i) Emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a) of this chapter;

(ii) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies;

(iii) Preventive services, at a minimum the services specified at § 457.520 of chapter D, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics; and

(iv) Pregnancy-related services, including those defined at §§ 440.210(a)(2) and 440.250(p) of this chapter, and counseling and drugs for cessation of tobacco use All services provided to pregnant women will be considered as pregnancy-related, except those services specifically identified in the state plan as not being related to the pregnancy.

(v) Provider-preventable services as defined in § 447.26(b).

(b) *Applicability.* Except as permitted under § 447.52(d) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obligations that apply generally to the population at issue.

(c) *Payments to providers.* (1) Except as provided under paragraphs (c)(2) and (c)(3) of this section, the agency must reduce the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing.

(2) For items and services provided to Indians who are exempt from cost sharing under paragraph (a)(1)(x) of this section, the agency may not reduce the payment it makes to a provider, including an Indian health care provider, by the amount of cost sharing that will otherwise be due from the Indian.

(3) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected cost sharing charges that are bad debts of providers.

(d) *Payments to managed care organizations.* If the agency contracts with a managed care organization, the agency must calculate its payments to the organization to include cost sharing established under the state plan, for beneficiaries not exempt from cost sharing under paragraph (a) of this section, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

(e) *Payments to states.* No FFP in the state's expenditures for services is available for—

(1) Any premiums or cost sharing amounts that recipients should have paid under §§ 447.52 through 447.55 (except for amounts that the agency pays as bad debts of providers under paragraph (c)(3) of this section; and

(2) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium, except for amounts for premium assistance to obtain coverage for eligible individuals through family coverage that may include ineligible individuals when authorized in the approved state plan.

(f) *Aggregate limits.* (1) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency.

(2) If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation.

(3) The agency must inform beneficiaries and providers of the beneficiaries aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

(4) The agency must have a process in place for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(5) Nothing in paragraph (f) shall preclude the agency from establishing additional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

§ 447.57 Beneficiary and public notice requirements.

(a) The agency must make available a public schedule describing current premiums and cost sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and/or cost sharing and the current amounts;

(2) Mechanisms for making payments for required premiums and cost sharing charges;

(3) The consequences for an applicant or recipient who does not pay a premium or cost sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the agency Web site.

(b) The agency must make the public schedule available to the following in a manner that ensures that affected applicants, beneficiaries, and providers are likely to have access to the notice:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised, notice to beneficiaries must be in accordance with § 435.905(b) of this chapter;

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a state plan amendment (SPA) to establish or substantially modify existing premiums or cost sharing, or change the consequences for non-payment, the agency must provide the public with advance notice of the SPA, specifying the amount of premiums or cost sharing and who is subject to the charges. The agency must provide a reasonable opportunity to comment on such SPAs. The agency must submit documentation with the SPA to demonstrate that these requirements were met. If premiums or cost sharing is substantially modified during the SPA approval process, the agency must provide additional public notice.

§§ 445.58 through 447.82 [Removed]

■ 47c. Remove §§ 445.58 through 447.82.

PART 457—ALLOTMENTS AND GRANTS TO STATES

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

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

■ 49. Section 457.10 is amended by adding the definitions of ''Exchange appeals entity,'' and ''Premium Lock Out'' to read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Exchange appeals entity has the meaning given to the term ''appeals entity,'' as defined in 45 CFR 155.500.

* * * * *

Premium Lock-Out is defined as a State-specified period of time not to exceed 90 days that a CHIP eligible child who has an unpaid premium or enrollment fee (as applicable) will not be permitted to reenroll for coverage in CHIP. Premium lock-out periods are not applicable to children who have paid outstanding premiums or enrollment fees.

* * * * *

■ 50. Section 457.110 is amended by adding paragraph (a)(1) and a reserved paragraph (a)(2) to read as follows:

§ 457.110 Enrollment assistance and information requirements.

(a) * * *

(1) The State may provide individuals with a choice to receive notices and information required under this subpart and Subpart K of this part, in electronic format or by regular mail, provided that the State establish safeguards in accordance with § 435.918 of this chapter.

(2) [Reserved]

* * * * *

■ 51. Section § 457.340 is amended by revising paragraph (a) and adding paragraph (d)(3) to read as follows:

§ 457.340 Application for and enrollment in CHIP.

(a) Application and renewal assistance, availability of program information, and Internet Web site. The terms of § 435.905, § 435.906, § 435.907(h), § 435.908, and § 435.1200(f) of this chapter apply equally to the State in administering a separate CHIP.

* * * * *

(d) * * *

(3) In the case of individuals subject to a period of uninsurance under this part, the state must identify and implement processes to facilitate enrollment of CHIP-eligible children who have satisfied a period of uninsurance (as described under § 457.805). To minimize burden on individuals, a state may not require a new application or information already provided by a family immediately preceding the beginning of a waiting period. States must also ensure that the proper safeguards are in place to prevent a disruption in coverage for children transitioning from coverage under another insurance affordability program after the completion of a period of uninsurance.

* * * * *

■ 52. Section 457.348 is amended by adding paragraph (c)(6) to read as follows:

§ 457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.

* * * * *

(c) * * *

(6) Notify such program of the final determination of the individual's eligibility or ineligibility for CHIP.

* * * * *

■ 53. Section 457.350 is amended by revising paragraphs paragraph (i) to read as follows:

§ 457.350 Eligibility screening and enrollment in other insurance affordability programs.

* * * * *

(i) *Applicants found potentially eligible for other insurance affordability programs.* For individuals identified in paragraph (b)(3) of this section, including during a period of uninsurance imposed by the state under § 457.805, the state must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the electronic account to the applicable program via a secure electronic interfaces.

(2) [Reserved.]

(3) In the case of individuals subject to a period of uninsurance under this part, the state must notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP.

* * * * *

■ 54. Section 457.370 is added to read as follows:

§ 457.370 Alignment with Exchange initial open enrollment period.

The terms of § 435.1205 apply equally to the State in administering a separate CHIP, except that the State shall make available and accept the application described in § 457.330, shall accept electronic accounts as described in § 457.348, and furnish coverage in accordance with § 457.340.

§ 457.540 [Amended]

■ 55. In § 457.540, amend paragraph (a) by removing the reference ''§ 447.52'' and by adding in its place the reference ''§ 447.52, § 447.53, or § 447.54''.

■ 56. Section 457.570 is amended by revising paragraph (c) and adding paragraph (d) to read as follows:

§ 457.570 Disenrollment protections.

* * * * *

(c) The State must ensure that disenrollment policies, such as policies related to non-payment of premiums, do not present barriers to the timely determination of eligibility and enrollment in coverage of an eligible child in the appropriate insurance affordability program. A State may not—

(1) Establish a premium lock-out period that exceeds 90-days in accordance with § 457.10 of this part.

(2) Continue to impose a premium lock-out period after a child's past due premiums have been paid.

(3) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once the State-defined lock out period has expired, regardless of the length of the lock-out period.

(d) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with § 457.1130(a)(3).

■ 57. Section 457.805 is revised to read as follows:

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

(a) *State plan requirements.* The state plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

(b) *Limitations.* (1) A state may not, under this section, impose a period of uninsurance which exceeds 90 days from the date a child otherwise eligible for CHIP is disenrolled from coverage under a group health plan.

(2) A waiting period may not be applied to a child following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program.

(3) If a state elects to impose a period of uninsurance following the loss of coverage under a group health plan under this section, such period may not be imposed in the case of any child if:

(i) The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;

(ii) The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v).

(iii) The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

(iv) The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;

(v) A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);

(vi) The child has special health care needs; and

(vii) The child lost coverage due to the death or divorce of a parent.

■ 58. Section 457.810 is amended by revising paragraph (a) to read as follows:

§ 457.810 Premium assistance programs: Required protections against substitution.

* * * * *

(a) *Period without coverage under a group health plan.* For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) Any waiting period imposed under the state child health plan prior to the provision of child health assistance to a targeted low-income child under the state plan shall apply to the same extent to the provision of a premium assistance subsidy for the child and shall not exceed 90 days.

(2) States must permit the same exemptions to the required waiting period for premium assistance as specified under the state plan at § 457.805(a)(2), and § 457.805(a)(3) for the provision of child health assistance to a targeted low-income child.

* * * * *

Title 45

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below:

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 59. The authority citation for part 155 is revised to read as follows:

Authority: Sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1413, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413 of the Affordable Care Act, Pub. L 111–148, 124 Stat 199.

■ 60. Section 155.20 is amended by revising the definitions of ''Advance payments of the premium tax credit,'' and adding a definition of ''Catastrophic plan'' to read as follows:

§ 155.20 Definitions.

* * * * *

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

* * * * *

Catastrophic plan means a health plan described in section 1302(e) of the Affordable Care Act.

* * * * *

■ 61. Section 155.105 is amended by revising paragraph (b)(2) to read as follows:

§ 155.105 Approval of a State Exchange.

* * * * *

(b) * * *

(2) The Exchange is capable of carrying out the information reporting requirements of 26 CFR 1.36B–5;

* * * * *

■ 62. Section 155.227 is added to read as follows:

§ 155.227 Authorized representatives.

(a) *General rule.* (1) The Exchange must permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual person or organization to act on his or her behalf in applying for an eligibility determination or redetermination, under subpart D, G, or H of this part, and in carrying out other ongoing communications with the Exchange.

(2) Designation of an authorized representative must be in a written document signed by the applicant or enrollee, or through another legally binding format subject to applicable authentication and data security standards. If submitted, legal documentation of authority to act on behalf of an applicant or enrollee under State law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of the applicant's or enrollee's signature.

(3) The Exchange must ensure that the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by the Exchange.

(4) The Exchange must ensure that the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in this section, to the same extent as the applicant or enrollee he or she represents.

(5) The Exchange must provide information both to the applicant or enrollee, and to the authorized representative, regarding the powers and duties of authorized representatives.

(b) *Timing of designation.* The Exchange must permit an applicant or enrollee to designate an authorized representative:

(1) At the time of application; and

(2) At other times and through methods as described in § 155.405(c)(2).

(c) *Duties.* (1) The Exchange must permit an applicant or enrollee to authorize his or her representative to:

(i) Sign an application on the applicant or enrollee's behalf;

(ii) Submit an update or respond to a redetermination for the applicant or enrollee in accordance with § 155.330 or § 155.335;

(iii) Receive copies of the applicant's or enrollee's notices and other communications from the Exchange; and

(iv) Act on behalf of the applicant or enrollee in all other matters with the Exchange.

(2) The Exchange may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (c)(1) of this section, provided that the Exchange tracks the specific permissions for each authorized representative.

(d) *Duration.* The Exchange must consider the designation of an authorized representative valid until:

(1) The applicant or enrollee notifies the Exchange that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application, as described in § 155.405(c). The Exchange must notify the authorized representative of such change; or

(2) The authorized representative informs the Exchange and the applicant or enrollee that he or she no longer is acting in such capacity. An authorized representative must notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

(e) *Compliance with State and Federal law.* The Exchange must require an authorized representative to comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

(f) *Signature.* For purposes of this section, designation of an authorized representative must be through a written document signed by the applicant or enrollee, or through another legally binding format, as described in § 155.227(a)(2), and must be accepted through all of the modalities described in § 155.405(c).

■ 63. Section 155.230 is amended by revising paragraph (a) and adding paragraph (d) to read as follows:

§ 155.230 General standards for Exchange notices.

(a) *General requirement.* Any notice required to be sent by the Exchange to individuals or employers must be written and include:

(1) An explanation of the action reflected in the notice, including the effective date of the action.

(2) Any factual findings relevant to the action.

(3) Citations to, or identification of, the relevant regulations supporting the action.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

* * * * *

(d) *Electronic notices.* (1) The individual market Exchange must provide required notices either through standard mail, or if an individual or employer elects, electronically, provided that the requirements for electronic notices in 42 CFR 435.918 are met, except that the individual market Exchange is not required to implement the process specified in 42 CFR 435.918(b)(1) for eligibility determinations for enrollment in a QHP through the Exchange and insurance affordability programs that are effective before January 1, 2015.

(2) The SHOP must provide required notices either through standard mail, or if an employer or employee elects, electronically, provided that the requirements for electronic notices in 42 CFR 435.918(b)(2) through (5) are met for the employer or employee.

■ 64. Section 155.300(a) is amended by removing the definition of ''Adoption taxpayer identification number'' and revising the definitions of ''Minimum value,'' ''Modified Adjusted Gross Income (MAGI),'' and ''Qualifying coverage in an eligible employer-sponsored plan'' to read as follows:

§ 155.300 Definitions and general standards for eligibility determinations.

(a) * * *

Minimum value when used to describe coverage in an eligible employer-sponsored plan, means that the employer-sponsored plan meets the standards for coverage of the total allowed costs of benefits set forth in § 156.145.

Modified Adjusted Gross Income (MAGI) has the same meaning as it does in 26 CFR 1.36B–1(e)(2).

* * * * *

Qualifying coverage in an eligible employer-sponsored plan means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in 26 CFR 1.36B–2(c)(3).

* * * * *

■ 65. Section 155.302 is amended by revising paragraphs (a), (b), and (d) to read as follows:

§ 155.302 Options for conducting eligibility determinations.

(a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—

(1) Directly or through contracting arrangements in accordance with § 155.110(a), provided that any contracting arrangement for eligibility determinations for Medicaid and CHIP is subject to the standards in 42 CFR 431.10(c)(2); or

(2) Through a combination of the approach described in paragraph (a)(1) of this section and one or both of the options described in paragraph (b) or (c) of this section, subject to the standards in paragraph (d) of this section.

(b) *Medicaid and CHIP.* Notwithstanding the requirements of this subpart, the Exchange may conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP, provided that—

(1) The Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented by the State Medicaid and CHIP agencies.

(2) Notices and other activities required in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law.

(3) *Applicants found potentially eligible for Medicaid or CHIP.* When the Exchange assesses an applicant as potentially eligible for Medicaid or CHIP consistent with the standards in paragraph (b)(1) of this section, the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface, promptly and without undue delay.

(4) *Applicants not found potentially eligible for Medicaid and CHIP.* (i) If the Exchange conducts an assessment in

accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions and must notify such applicant, and provide him or her with the opportunity to—

(A) Withdraw his or her application for Medicaid and CHIP, unless the Exchange has assessed the applicant as potentially eligible for Medicaid based on factors not otherwise considered in this subpart, in accordance with § 155.345(b), and provided that the application will not be considered withdrawn if he or she appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and the appeals entity described in § 155.500(a) finds that the individual is potentially eligible for Medicaid or CHIP; or

(B) Request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies.

(ii) To the extent that an applicant described in paragraph (b)(4)(i) of this section requests a full determination of eligibility for Medicaid and CHIP, the Exchange must—

(A) Transmit all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency and CHIP agency via secure electronic interface, promptly and without undue delay; and

(B) Consider such an applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP.

(5) The Exchange and the Exchange appeals entity adheres to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

(6) The Exchange and the State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP, and provide a copy of such agreement to HHS upon request.

* * * * *

(d) *Standards.* To the extent that assessments of eligibility for Medicaid and CHIP based on MAGI or eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) or (c) of this section, the Exchange must ensure that—

(1) Eligibility processes for all insurance affordability programs are streamlined and coordinated across HHS, the Exchange, the State Medicaid agency, and the State CHIP agency, as applicable;

(2) Such arrangement does not increase administrative costs and burdens on applicants, enrollees, beneficiaries, or application filers, or increase delay; and

(3) Applicable requirements under 45 CFR 155.260, 155.270, and 155.315(i), and section 6103 of the Code for the confidentiality, disclosure, maintenance, and use of information are met.

■ 66. Section 155.305 is amended by—

■ A. Revising paragraphs (f)(1)(i), (f)(1)(ii)(B), (f)(2)(ii), (f)(2)(iii), (f)(3), and (f)(5).

■ B. Adding paragraphs (a)(3)(v), and (h).

The revisions and additions read as follows:

§ 155.305 Eligibility standards.

(a) * * *

(3) * * *

(v) *Temporary absence.* The Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (a)(3) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished.

* * * * *

(f) * * *

(1) * * *

(i) He or she is expected to have a household income, as defined in 26 CFR 1.36B–1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(ii) * * *

(B) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 26 CFR 1.36B–2(a)(2) and (c).

(2) * * *

(ii) He or she is expected to have a household income, as defined in 26 CFR 1.36B–1(e) of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with 26 CFR 1.36B–2(b)(5).

(3) *Enrollment required.* The Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.

* * * * *

(5) *Calculation of advance payments of the premium tax credit.* The Exchange must calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B–3.

* * * * *

(h) *Eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.* The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange in a QHP that is a catastrophic plan as defined by section 1302(e) of the Affordable Care Act, if he or she has met the requirements for eligibility for enrollment in a QHP through the Exchange, in accordance with § 155.305(a), and either—

(1) Has not attained the age of 30 before the beginning of the plan year; or

(2) Has a certification in effect for any plan year that he or she is exempt from the requirement to maintain minimum essential coverage under section 5000A of the Code by reason of—

(i) Section 5000A(e)(1) of the Code (relating to individuals without affordable coverage); or

(ii) Section 5000A(e)(5) of the Code (relating to individuals with hardships).

■ 67. Section 155.310 is amended by—

■ A. Redesignating paragraph (i) as paragraph (j).

■ B. Adding new paragraph (i).

■ C. Revising newly redesignated paragraph (j).

The addition and revision read as follows:

§ 155.310 Eligibility process.

* * * * *

(i) *Certification program for employers.* As part of its determination of whether an employer has a liability under section 4980H of the Code, the Internal Revenue Service will adopt methods to certify to an employer that one or more employees has enrolled for one or more months during a year in a

QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.

(j) *Duration of eligibility determinations without enrollment.* To the extent that an applicant who is determined eligible for enrollment in a QHP through the Exchange does not select a QHP within his or her enrollment period, or is not eligible for an enrollment period, in accordance with subpart E, and seeks a new enrollment period prior to the date on which his or her eligibility is redetermined in accordance with § 155.335, the Exchange must require the applicant to attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for a special enrollment period, and must process any changes reported in accordance with the procedures specified in § 155.330.

■ 68. Section 155.315 is amended by revising paragraphs (b)(2), (f) introductory text, (f)(4) introductory text, and (f)(5) and by adding paragraphs (f)(6) and (j) to read as follows:

§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

* * * * *

(b) * * *

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

* * * * *

(f) *Inconsistencies.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange:

* * * * *

(4) During the periods described in paragraphs (f)(1) and (f)(2)(ii) of this section, must:

* * * * *

(5) If, after the period described in paragraph (f)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph (g) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation.

(6) When electronic data to support the verifications specified in § 155.315(d) or § 155.320(b) is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange must accept the applicant's attestation regarding the factor of eligibility for which the unavailable data source is relevant.

* * * * *

(j) *Verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.* The Exchange must verify an applicant's attestation that he or she meets the requirements of § 155.305(h) by—

(1) Verifying the applicant's attestation of age as follows—

(i) Except as provided in paragraph (j)(1)(iii) of this section, accepting his or her attestation without further verification; or

(ii) Examining electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must examine information in data sources that are available to the Exchange and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an applicant has a certification of exemption in effect as described in § 155.305(h)(2).

(3) To the extent that the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in paragraphs (j)(1) and (2) of this section, the Exchange must follow the procedures specified in § 155.315(f), except for § 155.315(f)(4).

■ 69. Section 155.320 is amended by—

■ A. Revising paragraphs (c)(1)(i) heading, (c)(1)(i)(A), (c)(1)(ii), (c)(3)(i)(D), (c)(3)(ii)(A), (c)(3)(iii)(A) and (B), (c)(3)(vi), (c)(3)(vii), (c)(3)(viii), and (d).

■ B. Adding paragraphs (c)(3)(i)(E) and (c)(3)(iii)(C).

■ C. Removing paragraph (e).

■ D. Redesignating paragraph (f) as paragraph (e).

The revisions and additions read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(1) * * *

(i) *Data regarding annual household income.* (A) For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B–1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B–1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

* * * * *

(ii) *Data regarding MAGI-based income.* For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B–1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

* * * * *

(3) * * *

(i) * * *

(D) If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible

with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (c)(1)(i) of this section, the Exchange must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in § 155.315(f).

(E) The Exchange must verify that neither advance payments of the premium tax credit nor cost-sharing reductions are being provided on behalf of an individual using information obtained by transmitting identifying information specified by HHS to HHS.

* * * * *

(ii) * * *

(A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section;

* * * * *

(iii) * * *

(A) Except as specified in paragraph (c)(3)(iii)(B) and (C) of this section, if an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation regarding a tax filer's annual household income without further verification.

(B) If data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section indicate that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange must proceed in accordance with § 155.315(f)(1) through (4).

(C) If other information provided by the application filer indicates that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange must utilize data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section to verify the attestation. If such data is unavailable or are not reasonably compatible with the applicant's attestation, the Exchange must proceed in accordance with § 155.315(f)(1) through (4).

* * * * *

(vi) *Alternate verification process for decreases in annual household income and situations in which tax return data is unavailable.* If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph (c)(3)(vi)(A) through (G) of this section.

(A) *Data.* The Exchange must annualize data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section, and obtain any data available from other electronic data sources that have been approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification.

(B) *Eligibility.* To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(vi)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(vi)(A) of this section.

(C) *Increases in annual household income.* If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(vi)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, unless the Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, in which case the Exchange must request additional documentation using the procedures specified in § 155.315(f).

(D) *Decreases in annual household income and situations in which electronic data is unavailable.* If electronic data are unavailable or an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than ten percent below the annual household income as computed using data sources described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4).

(E) If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.

(F) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(D) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and implement such determination in accordance with the effective dates specified in § 155.330(f).

(G) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(D) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in § 155.310(g), and discontinue any

advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in § 155.330(f).

(vii) For the purposes of paragraph (c)(3) of this section, ''household income'' means household income as specified in 26 CFR 1.36B–1(e).

(viii) For the purposes of paragraph (c)(3) of this section, ''family size'' means family size as specified in 26 CFR 1.36B–1(d).

* * * * *

(d) *Verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.* (1) *General requirement.* The Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) *Data.* The Exchange must—

(i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to the Exchange and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

(ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS for HHS to provide the necessary verification using data obtained by HHS.

(iii) Obtain any available data from the SHOP that corresponds to the State in which the Exchange is operating.

(3) *Verification procedures.* (i) Except as specified in paragraphs (d)(3)(ii) or (iii) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) of this section without further verification.

(ii) If an applicant's attestation is not reasonably compatible with the information obtained by the Exchange as specified in paragraphs (d)(2)(i) through (iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

(iii) Except as specified in paragraph (d)(3)(iv) of this section, if the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (iii) of this section for an applicant, the Exchange must select a statistically significant random sample of such applicants and—

(A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of the eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in § 155.330(f), and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in § 155.310(g) and (h);

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation(s) regarding coverage provided by that employer.

(G) To carry out the process described in paragraph (d)(3)(iii) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(iv) For eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions that are effective before January 1, 2015, if the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (iii) of this section for an applicant, the Exchange may accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification, instead of following the procedure in paragraph (d)(3)(iii) of this section.

(4) *Option to rely on verification performed by HHS.* For eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions that are effective on or after January 1, 2015, the Exchange may satisfy the provisions of paragraph (d) of this section by relying on a verification process performed by HHS, provided that—

(i) The Exchange sends the notices described in § 155.310(g) and (h);

(ii) Other activities required in connection with the verifications described in this paragraph are performed by the Exchange in accordance with the standards identified in this subpart or in accordance with guidance issued by the Secretary; and

(iii) The Exchange provides all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay.

* * * * *

■ 70. Section 155.330 is amended by revising paragraphs (d)(1)(ii), (e)(2), and (f), and by removing paragraph (e)(3).

The revisions read as follows:

§ 155.330 Eligibility redetermination during a benefit year.

* * * * *

(d) * * *

(1) * * *

(ii) For an enrollee on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided, eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange.

* * * * *

(e) * * *

(2) *Data matching.* (i) If the Exchange identifies updated information regarding death, in accordance with paragraph (d)(1)(i) of this section, or regarding any factor of eligibility not regarding income, family size, or family composition, the Exchange must—

(A) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information.

(B) Allow an enrollee 30 days from the date of the notice to notify the Exchange that such information is inaccurate.

(C) If the enrollee responds contesting the updated information, proceed in accordance with § 155.315(f) of this part.

(D) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(i)(B), proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(ii) If the Exchange identifies updated information regarding income, family size, or family composition, with the exception of information regarding death, the Exchange must—

(A) Follow procedures described in paragraph (e)(2)(i)(A) and (B) of this section; and

(B) If the enrollee responds confirming the updated information, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(C) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(i)(B) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(D) If the enrollee provides more up-to-date information, proceed in accordance with paragraph (c)(1) of this section.

* * * * *

(f) *Effective dates.* (1) Except as specified in paragraphs (f)(2) through (f)(5) of this section, the Exchange must implement changes—

(i) Resulting from a redetermination under this section on the first day of the month following the date of the notice described in paragraph (e)(1)(ii) of this section; or

(ii) Resulting from an appeal decision, on the date specified in the appeal decision; or

(iii) Affecting enrollment or premiums only, on the first day of the month following the date on which the Exchange is notified of the change;

(2) Except as specified in paragraphs (f)(3) through (5) of this section, the Exchange may determine a reasonable point in a month after which a change described in paragraph (f)(1) of this section will not be effective until the first day of the month after the month specified in paragraph (f)(1) of this section. Such reasonable point in a month must be no earlier than the 15th of the month.

(3) Except as specified in paragraphs (f)(4) and (5) of this section, the Exchange must implement a change described in paragraph (f)(1) of this section that results in a decreased amount of advance payments of the premium tax credit, or a change in the level of cost-sharing reductions, and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1) of this section.

(4) The Exchange must implement a change associated with the events described in § 155.420(b)(2)(i) and (ii) on the coverage effective dates described in § 155.420(b)(2)(i) and (ii), respectively.

(5) Notwithstanding paragraphs (f)(1) through (f)(4) of this section, the Exchange may provide the effective date of a change associated with the events described in § 155.420(d)(4), (d)(5), and (d)(9) based on the specific circumstances of each situation.

■ 71. Section 155.335 is amended by revising paragraphs (a), (b), (c), (e), (f), (g), (h), (k)(1), and (l), and adding paragraph (m) to read as follows:

§ 155.335 Annual eligibility redetermination.

(a) *General requirement.* Except as specified in paragraphs (l) and (m) of this section, the Exchange must redetermine the eligibility of a qualified individual on an annual basis.

(b) *Updated income and family size information.* In the case of a qualified individual who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) of this part, the Exchange must request updated tax return information, if the qualified individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding MAGI-based income as described in § 155.320(c)(1) of this part for use in the qualified individual's eligibility redetermination.

(c) *Notice to qualified individual.* The Exchange must provide a qualified individual with an annual redetermination notice including the following:

(1) [Reserved]

(2) [Reserved]

(3) The qualified individual's projected eligibility determination for the following year, after considering any updated information described in paragraph (b) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions or eligibility for Medicaid, CHIP or BHP.

* * * * *

(e) *Changes reported by qualified individuals.* (1) The Exchange must require a qualified individual to report any changes for the information listed in the notice described in paragraph (c) of this section within 30 days from the date of the notice.

(2) The Exchange must allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2).

(f) *Verification of reported changes.* The Exchange must verify any information reported by a qualified individual under paragraph (e) of this section using the processes specified in § 155.315 and § 155.320, including the relevant provisions in those sections regarding inconsistencies, prior to using such information to determine eligibility.

(g) *Response to redetermination notice.* (1) The Exchange must require a qualified individual, or an application filer, on behalf of the qualified individual, to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that a qualified individual does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (e) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

(h) *Redetermination and notification of eligibility.* (1) After the 30-day period specified in paragraph (e) of this section has elapsed, the Exchange must—

(i) Redetermine the qualified individual's eligibility in accordance with the standards specified in § 155.305 using the information provided to the qualified individual in the notice specified in paragraph (c) of this section, as supplemented with any information reported by the qualified individual and verified by the Exchange in accordance with paragraphs (e) and (f) of this section.

(ii) Notify the qualified individual in accordance with the requirements specified in § 155.310(g).

(iii) If applicable, notify the qualified individual employer, in accordance with the requirements specified in § 155.310(h).

(2) If a qualified individual reports a change for the information provided in the notice specified in paragraph (c) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (e) of this section, the Exchange must redetermine the qualified individual's eligibility after completing verification, as specified in paragraph (f) of this section.

* * * * *

(k) * * *

(1) The Exchange must have authorization from a qualified individual to obtain updated tax return information described in paragraph (b) of this section for purposes of conducting an annual redetermination.

* * * * *

(l) *Limitation on redetermination.* To the extent that a qualified individual has requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange must redetermine the qualified individual's eligibility only for enrollment in a QHP and notify the enrollee in accordance with the timing described in paragraph (d) of this section. The Exchange may not proceed with a redetermination for insurance affordability programs until such authorization has been obtained or the qualified individual continues his or her request for an eligibility determination for insurance affordability programs in accordance with § 155.310(b).

(m) *Special rule.* The Exchange must not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

■ 72. Section 155.340 is amended by revising paragraphs (b) heading, (b)(1), and (c) to read as follows:

§ 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

* * * * *

(b) *Requirement to provide information related to employer responsibility.* (1) In the event that the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, within the standard of 26 CFR 1.36B–2(c)(3)(v), or provide minimum essential coverage that does not meet the minimum value standard of § 156.145, the Exchange must transmit the individual's name and taxpayer identification number to HHS.

* * * * *

(c) *Requirement to provide information related to reconciliation of advance payments of the premium tax credit.* The Exchange must comply with the requirements of 26 CFR 1.36B–5 regarding reporting to the IRS and to taxpayers.

* * * * *

■ 73. Section 155.345 is amended by—

■ A. Revising paragraphs (a) introductory text and (a)(2).

■ B. Redesignating paragraph (a)(3) as paragraph (a)(4).

■ C. Adding reserved paragraph (a)(3).

■ D. Revising paragraphs (f) introductory text, (g) introductory text, and (g)(2) through (5).

■ E. Adding paragraph (g)(6).

■ F. Redesignating paragraphs (h) and (i) as paragraphs (i) and (j).

■ G. Adding new paragraph (h).

The revisions and addition read as follows:

§ 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.

(a) *Agreements.* The Exchange must enter into agreements with agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, as are necessary to fulfill the requirements of this subpart and provide copies of any such agreements to HHS upon request. Such agreements must include a clear delineation of the responsibilities of each agency to—

* * * * *

(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to or redetermination is initiated by the Exchange or the agency administering Medicaid, CHIP, or the BHP;

(3) [Reserved]

(4) Ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

* * * * *

(f) *Special rule.* If the Exchange verifies that a tax filer's household income, as defined in 26 CFR 1.36B–1(e), is less than 100 percent of the FPL for the benefit year for which coverage is requested, determines that the tax filer is not eligible for advance payments of the premium tax credit based on § 155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income, the Exchange must—

* * * * *

(g) *Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP.* The Exchange, in consultation with the agency or agencies administering Medicaid, CHIP, and the BHP if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange must—

* * * * *

(2) Notify such agency of the receipt of the information described in paragraph (g)(1) of this section and final eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions.

(3) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this part.

(4) Not request information or documentation from the individual already provided to another agency administering an insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other agency.

(5) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart.

(6) Follow a streamlined process for eligibility determinations regardless of the agency that initially received an application.

(h) *Adherence to state decision regarding Medicaid and CHIP.* The Exchange and the Exchange appeals entity must adhere to the eligibility

determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

* * * * *

■ 74. Section 155.350 is amended by revising paragraph (a)(1)(ii) to read as follows:

§ 155.350 Special eligibility standards and process for Indians.

(a) * * *

(1) * * *

(ii) Is expected to have a household income, as defined in 26 CFR 1.36B–1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

* * * * *

■ 75. Section 155.400 is amended by adding paragraph (b)(3) to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(b) * * *

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

* * * * *

■ 76. Section 155.420 is amended by revising paragraphs (a), (b)(2), (b)(3), adding paragraph (b)(4), and revising paragraph (d) to read as follows:

§ 155.420 Special enrollment periods.

(a) *General requirements.* (1) The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(2) For the purpose of this section, ''dependent'', has the same meaning as it does in 26 CFR 54.9801–2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(b) * * *

(2) *Special effective dates.* (i) In the case of birth, adoption, placement for adoption, or placement in foster care, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care.

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the first day of the following month.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), or (d)(9) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS. Such date much be either—

(A) The date of the event that triggered the special enrollment period under (d)(4), (d)(5), or (d)(9) of this section; or

(B) In accordance with the regular effective dates specified in paragraph (b)(1) of this section.

(3) *Option for earlier effective dates.* Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(4) *Advance payments of the premium tax credit and cost-sharing reductions.* Notwithstanding the standards of this section, the Exchange must ensure that advance payments of the premium tax credit and cost-sharing reductions adhere to the effective dates specified in § 155.330(f).

* * * * *

(d) The Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or his or her dependent loses minimum essential coverage:

(i) In the case of a QHP decertification, the triggering event is the date of the notice of decertification as described in § 155.1080(e)(2); or

(ii) In all other cases, the triggering event is the date the individual or dependent loses eligibility for minimum essential coverage;

(2) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care.

(3) The qualified individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status;

(4) The qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) The enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) *Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.* (i) The enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;

(ii) The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or

(iii) A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B–2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage. The Exchange must permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she is not eligible for advance payments of the premium tax credit until the end of his

or her coverage in an eligible employer-sponsored plan;

(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move;

(8) The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month;

(9) The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;

* * * * *

■ 77. Section 155.430 is amended by revising paragraphs (b)(1), (d)(1), (d)(2)(iii), *(d)(2)(iv), (d)(3), and by adding paragraph (d)(7) to read as follows:*

§ 155.430 Termination of coverage.

* * * * *

(b) * * *

(1) *Enrollee-initiated terminations.* (i) The Exchange must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

(ii) The Exchange must provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other minimum essential coverage and the enrollee does not request termination in accordance with paragraph (b)(1)(i) of this section. If an enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange must initiate termination of his or her coverage upon completion of the redetermination process specified in § 155.330.

* * * * *

(d) * * *

(1) For purposes of this section—

(i) Reasonable notice is defined as at least fourteen days before the requested effective date of termination; and

(ii) Changes in eligibility for advance payments of the premium tax credit and cost sharing reductions, including terminations, must adhere to the effective dates specified in § 155.330(f).

(2) * * *

(iii) On a date on or after the date on which the termination is requested by the enrollee, subject to the determination of the enrollee's QHP issuer, if the enrollee's QHP issuer agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of QHP coverage is the day before the individual is determined eligible for Medicaid, CHIP, or the BHP.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of QHP coverage is the last day of eligibility, as described in § 155.330(f), unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

* * * * *

(7) In the case of a termination due to death, the last day of coverage is the date of death.

* * * * *

■ 78. Section 155.615 is amended by revising paragraph (f)(2)(i) to read as follows:

§ 155.615 Verification process related to eligibility for exemptions.

* * * * *

(f) * * *

(2) * * *

(i) For any applicant who requests an exemption based on the hardship described in § 155.605(g)(2), the Exchange must verify the unavailability of affordable coverage through the procedures used to determine eligibility for advance payments of the premium tax credit, as specified in subpart D of this part, including the procedures described in § 155.315(c)(1), and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in § 155.320(d), except as specified in § 155.615(f)(2)(ii).

* * * * *

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 79. The authority citation for part 156 continues to read as follows:

Authority: Sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1324, 1334, 1341, 1342, 1343, 1402, 1413, 1321, 1322, 1331, 1332, 1334, 1341, 1342, 1343, 1401, and 1402 of the Affordable Care Act, Pub. L 111–148, 124 Stat 199.

■ 80. Section 156.270 is amended by revising paragraph (b) to read as follows:

§ 156.270 Termination of coverage for qualified individuals.

* * * * *

(b) *Termination of coverage notice requirement.* If a QHP issuer terminates an enrollee's coverage in accordance with § 155.430(b)(1)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay:

(1) Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination.

(2) [Reserved]

* * * * *

Dated: May 28, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 31, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–16271 Filed 7–5–13; 11:15 am]

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Part III

Department of Transportation

Federal Aviation Administration

14 CFR Parts 61, 121, 135, et al.

Pilot Certification and Qualification Requirements for Air Carrier Operations; Final Rule

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 61, 121, 135, 141, and 142

[Docket No. FAA–2010–0100; Amdt. Nos. 61–130; 121–365; 135–127; 141–1; 142–9]

RIN 2120–AJ67

Pilot Certification and Qualification Requirements for Air Carrier Operations

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action creates new certification and qualification requirements for pilots in air carrier operations. As a result of this action, a second in command (first officer) in domestic, flag, and supplemental operations must now hold an airline transport pilot certificate and an airplane type rating for the aircraft to be flown. An airline transport pilot certificate requires that a pilot be 23 years of age and have 1,500 hours total time as a pilot. Pilots with fewer than 1,500 flight hours may qualify for a restricted privileges airline transport pilot certificate beginning at 21 years of age if they are a military-trained pilot, have a bachelor's degree with an aviation major, or have an associate's degree with an aviation major. The restricted privileges airline transport pilot certificate will also be available to pilots with 1,500 flight hours who are at least 21 years of age. This restricted privileges airline transport pilot certificate allows a pilot to serve as second in command in domestic, flag, and supplemental operations not requiring more than two pilot flightcrew members. This rule also retains the second-class medical certification requirement for a second in command in part 121 operations. Pilots serving as an air carrier pilot in command (captain) must have, in addition to an airline transport pilot certificate, at least 1,000 flight hours in air carrier operations. This rule also adds to the eligibility requirements for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate obtained concurrently with a type rating. To receive an airline transport pilot certificate with a multiengine class rating a pilot must have 50 hours of multiengine flight experience and must have completed a new FAA-approved Airline Transport Pilot Certification Training Program. This new training program will include academic coursework and training in a flight simulation training device. These requirements will ensure that a pilot has the proper qualifications, training, and experience before entering an air carrier environment as a pilot flightcrew member.

DATES: *Effective Date:* July 15, 2013.

This final rule will be effective immediately upon publication in the **Federal Register**. Section 553(d)(3) of the Administrative Procedure Act provides that publication of a rule shall be made not less than 30 days before its effective date, except ''for good cause found and published with the rule.'' 5 U.S.C. 553(d)(3). Consistent with section 553(d)(3), and for reasons discussed in Section III.H.6, the FAA finds good cause exists to publish this final rule with an immediate effective date.

Compliance Date: Unless otherwise noted in the regulatory text, compliance with the provisions of this rule is required by August 1, 2013.

FOR FURTHER INFORMATION CONTACT: For technical questions concerning this final rule contact Barbara Adams, Air Transportation Division, AFS–200, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone (202) 267–8166; facsimile (202) 267–5299, email *barbara.adams@faa.gov*.

For legal questions concerning this final rule contact Anne Moore, Office of the Chief Counsel—International Law, Legislation, and Regulations Division, AGC–240, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone (202) 267–3123; facsimile (202) 267–7971, email *anne.moore@faa.gov*.

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

The Airline Safety and Federal Aviation Administration Extension Act of 2010 (Pub. L. 111–216) directed the FAA to conduct a rulemaking to improve the qualifications and training for pilots serving in air carrier operations. Specifically, section 216 of the Act focused on the qualifications of air carrier pilots and directed the FAA to issue a rule that would require all pilots serving in part 121 air carrier operations to hold an ATP certificate by August 2, 2013. Section 217 of the Act directed the FAA to amend 14 CFR part 61 to modify ATP certification requirements to prepare a pilot to function effectively in a multipilot (multicrew) environment, in adverse weather conditions, during high altitude operations, and in an air carrier environment, as well as to adhere to the highest professional standards. Section 217 also directed the FAA to ensure pilots have sufficient flight hours in difficult operational conditions that may be encountered in air carrier operations and stated that the minimum total flight hours to be qualified for an ATP certificate shall be at least 1,500 flight hours. Notwithstanding the stated minimum, the section gave the FAA discretion to allow specific academic training courses to be credited toward the 1,500 total flight hours, provided the academic training courses will enhance safety more than requiring the pilot to comply fully with the flight hour requirement.

In addition to the authority provided in the Act, the FAA has authority under Title 49 of the United States Code. Subtitle I, Section 106 to issue rules on aviation safety. This rulemaking is consistent with the authority described in Subtitle VII, Part A, Subpart III, Section 447—Safety Regulation. Under § 44703, the FAA is charged with prescribing regulations for the issuance of airman certificates when the Administrator finds, after investigation, that an individual is qualified for, and physically able to perform the duties related to, the position authorized by the certificate. This rulemaking is intended to ensure that flightcrew members have training and qualifications that will enable them to operate aircraft safely. For these reasons, the regulation is within the scope of our authority and is a reasonable and necessary exercise of our statutory obligations.

List of Abbreviations and Acronyms Frequently Used In This Document

ANPRM Advance Notice of Proposed Rulemaking
ARC Aviation Rulemaking Committee
ATP Airline Transport Pilot
ATP CTP Airline Transport Pilot Certification Training Program
FFS Full Flight Simulator
FOQ ARC First Officer Qualifications Aviation Rulemaking Committee
FSTD Flight Simulation Training Device
FTD Flight Training Device
NPRM Notice of Proposed Rulemaking
PIC Pilot in Command (Captain)
R–ATP Restricted Privileges Airline Transport Pilot
SIC Second in Command (First Officer)

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I. Overview of Final Rule

This rulemaking modifies requirements for pilots who fly in part 121 air carrier operations. It changes requirements for all pilots seeking an airline transport pilot (ATP) certificate with an airplane category multiengine class rating or an ATP certificate obtained concurrently with an airplane type rating. These new requirements will ensure that all pilots entering air carrier operations have a background of training and experience that will allow them to adapt to a complex, multicrew environment in a variety of operating conditions.

Those most affected by these changes will be pilots applying for an ATP certificate with an airplane category multiengine class rating or an ATP certificate concurrently with an airplane type rating. The changed requirements will also affect anyone wanting to serve as pilot in command (PIC) in part 121 air carrier operations and anyone wanting to serve as PIC in part 91 subpart K operations or part 135 operations as defined by § 91.1053(a)(2)(i) or § 135.243(a)(1).[1] Those wanting to serve as second in command (SIC) in part 121 air carrier operations will also be affected by this final rule. Certificate holders approved under parts 121, 135, 141, or 142 will be affected if they choose to offer the ATP Certification Training Program (ATP CTP).

A general summary of the previous pilot certification requirements versus the pilot certification requirements as defined by this final rule is included in the following table.

TABLE 1—HOW PREVIOUS REQUIREMENTS ARE CHANGED BY THIS FINAL RULE

Previous requirements	Requirements in final rule
Scenario: (1) Receive an ATP certificate with an airplane category and multiengine class rating	
(1) Be at least 23 years old; (2) Hold a commercial pilot certificate with instrument rating; (3) Pass the ATP knowledge test and practical test; and (4) Have at least 1,500 hours total time as a pilot.	(1) Meet all of the previous requirements; (2) Prior to taking the ATP knowledge test successfully complete an ATP CTP;[2] and (3) have a minimum of 50 hours in class of airplane. (Ref. §§ 61.153, 61.156 and 61.159)

[1] These operations currently require the pilot in command to hold an ATP certificate.

TABLE 1—HOW PREVIOUS REQUIREMENTS ARE CHANGED BY THIS FINAL RULE—Continued

Previous requirements	Requirements in final rule
Scenario: (2) Receive an ATP certificate with restricted privileges (restricted to serving as SIC in part 121 operations—multiengine class rating only)	
None.	(1) Be at least 21 years old; (2) Hold a commercial pilot certificate with instrument rating; (3) Prior to taking the ATP knowledge test successfully complete an ATP CTP; (4) Pass the ATP knowledge test and practical test; and (5) Meet the aeronautical experience requirements of § 61.160. A pilot may be eligible if he or she was a military-trained pilot; a graduate of a four-year bachelor degree program with an aviation major; a graduate of a two-year associate degree program with an aviation major; or has 1,500 hours total time as a pilot. (Ref. §§ 61.153 and 61.160)
Scenario: (3) Serve as an SIC (first officer) in part 121 operations	
Hold: (1) An ATP certificate with appropriate aircraft type rating OR—An ATP certificate with restricted privileges and an appropriate aircraft type rating; and (2) An instrument rating; and (3) At least a second-class medical certificate. (Ref. §§ 121.436 and 61.23)	Hold: (1) At least a commercial pilot certificate with an appropriate category and class rating; (2) At least a second-class medical certificate.
Scenario: (4) Serve as SIC in a flag or supplemental operation requiring three or more pilots	
Hold: (1) An ATP certificate with appropriate aircraft type rating; and (2) A first class medical certificate.	Hold: (1) An ATP certificate [3] with appropriate aircraft type rating; and (2) A first class medical certificate. (Ref. §§ 121.436 and 61.23)
Scenario: (5) Serve as PIC in part 121 operations	
(1) Have at least 1,500 hours of total time as a pilot; (2) Hold an ATP certificate with appropriate aircraft type rating; and (3) Hold a first class medical certificate.	(1) Meet all of the previous requirements; and (2) Have a minimum of 1,000 flight hours in air carrier operations as an SIC in part 121 operations, a PIC in operations under either § 135.243(a)(1) or § 91.1053(a)(2)(i), or any combination of these.[4] (Ref. § 121.436)

The costs and benefits of this rule are best described as three major elements—statutory costs, discretionary cost savings, and additional rule provisions, which sum to the total costs and benefits. While the FAA already requires an ATP certificate with 1,500 hours total time as a pilot minimum for part 121 PICs, the statute requirement that SICs in part 121 operations have an ATP certificate is new and will take effect whether or not the FAA issues a regulation. Thus, the costs associated with the requirement for SICs to have an ATP certificate are attributable to the statute, not to this regulation. The FAA exercised its discretion permitted under the statute and reduced the mandated ATP certificate cost by establishing offsetting academic credits. To ensure the intent of increasing safety, the FAA established additional training provisions in the final rule which are justified by expected accident prevention benefits. Table 2 reflects the costs of the ATP certificate requirement for part 121 SICs as well as the discretionary cost savings. In addition, the table shows the expected costs and benefits of the remaining two primary cost drivers of the rule: the aircraft type rating and the ATP CTP.

TABLE 2—STATUTORY COSTS AND BENEFITS/ FINAL RULE COST SAVINGS, COSTS, AND BENEFITS

Statute costs	Total cost ($ mil.)	PVcost ($ mil.)
Part 121 ATP Certificate Requirement	$ 6,374.4	$ 2,213.0

[2] This requirement takes effect after July 31, 2014.

[3] In this scenario a pilot must hold an ATP certificate issued per the requirements of § 61.159. An ATP certificate issued per the reduced flight hours in § 61.160 is not sufficient.

[4] In addition, military PIC time (up to 500 hours) in a multiengine turbine-powered, fixed-wing airplane in an operation requiring more than one pilot may also be credited towards the 1,000 hours.

TABLE 2—STATUTORY COSTS AND BENEFITS/ FINAL RULE COST SAVINGS, COSTS, AND BENEFITS—Continued

Statute costs	Total cost ($ mil.)	PVcost ($ mil.)
Statute benefits	Total benefit	PV benefit
Part 121 ATP Certificate Requirement	No Identifiable Accident Benefits	

Discretionary cost savings	Total cost savings ($ mil.)	PV cost savings ($ mil.)
Academic Training and Experience Credits	$ <2,309.3>	$ <789.8>

Rule additional provision costs	Total cost ($ mil.)	PV[5] cost ($ mil.)
ATP CTP and Type Rating Total Costs	$ 312.7	$ 138.7
Rule additional provision benefits	Total benefit ($ mil.)	PV benefit ($ mil.)
All Safety Benefits[6]	$ 576.8	$ 251.7

	Total cost ($ mil.)	PV[5] cost ($ mil.)
Total Cost of Statute Cost + Cost Savings + Rule Cost	$ 4,377.8	$ 1,561.9
	Total benefit ($ mil.)	PV benefit ($ mil.)
Total Benefits from Statute + Rule	$ 576.8	$ 251.7

II. Background

A. Statement of the Problem

On February 12, 2009, a Colgan Air Bombardier DHC–8–400, operating as Continental Connection flight 3407, was on an instrument approach to the Buffalo-Niagara airport in upstate New York. About 5 nautical miles from the airport, the pilot lost control of the airplane. It crashed into a house in Clarence Center, New York, killing everyone aboard and one person on the ground. This accident focused FAA, NTSB, Congressional, and public attention on multiple aspects of pilot qualifications and air carrier training requirements.

The NTSB's investigation revealed that the pilot had not followed appropriate procedures in handling the aircraft. As the plane leveled at an assigned altitude the captain applied power to increase the airspeed, but the increase in power was insufficient. The airplane's flight displays indicated that its airspeed was slowing, but the flightcrew failed to recognize this. The airspeed continued to decrease, resulting in the stick shaker activating, and warning the pilots of a potential aerodynamic stall (insufficient airflow over the wings). The flightcrew's response to the stall warning system was incorrect and the airplane stalled. The flightcrew subsequently lost control of the aircraft resulting in the accident.

The NTSB's final accident report identified a number of safety issues, including improper handling of the airplane, a failure to adhere to sterile cockpit rules, and questions about the adequacy of flightcrew member training and qualifications. The accident raised questions about whether SICs should be held to the same training and flight hour requirements as PICs, and whether a pilot's overall academic training and quality of flight training were as important as the total number of flight hours. The accident also raised questions about pilot professionalism and whether pilots receive sufficient experience in a multicrew environment.

In early 2010, as a response to the Colgan Air accident, the FAA published an advance notice of proposed rulemaking (ANPRM) entitled ''New Pilot Certification Requirements for Air Carrier Operations'' (75 FR 6164 (February 8, 2010)), asking for input on current part 121 pilot eligibility, training, and qualification requirements for SICs. In July 2010, as a result of public response to the ANPRM, the FAA chartered the First Officer Qualification Aviation Rulemaking Committee (FOQ ARC) which was comprised of a cross section of the aviation industry.

In August 2010, before the ARC submitted its final recommendations, President Obama signed into law the Airline Safety and Federal Aviation Administration Extension Act of 2010 (Pub. L. 111–216 (August 1, 2010)) (the ''Act''). The Act included several specific provisions for modifying ATP certification requirements to prepare air

[5] Present value 7 percent discount rate over 10 years.

[6] Part 121 total safety benefits of $292.5 million are greater than part 121 total costs of $280.4 million. Part 135 total safety benefits of $284.3 million are greater than part 135 total costs of $22.4 million. The FAA does not have a quantitative estimate of benefits for part 91, subpart K. The part 91, subpart K operational rules, to include requiring the PIC of a multiengine airplane to hold an ATP certificate, were modeled after the part 135 on-demand operational rules therefore we believe there is a safety benefit due to the similarity of operations.

carrier pilots to operate more safely. Among those provisions was the requirement that by August 2, 2013, all part 121 flightcrew members hold an ATP certificate. Public Law 111–216, section 216(a)(2)(B)(i). The FAA asked the FOQ ARC to consider the provisions of sections 216 and 217 of the Act in developing its final recommendations. Those recommendations were submitted to the FAA in September 2010.

In addition to the FOQ ARC recommendations, the FAA reviewed recent accidents in parts 121 and 135 to find out whether the certification requirements were sufficient to produce pilots who can enter an air carrier environment and train and perform their duties effectively. The accident reports revealed deficiencies in—

- Training in aircraft manual handling skills,
- stall and upset recognition and recovery,
- high altitude operations,
- pilot monitoring skills,
- effective crew resource management,
- pilot leadership, professionalism, and mentoring skills,
- stabilized approaches, and
- operations in icing conditions.

The FAA considered its accident analysis, the FOQ ARC recommendations, and numerous NTSB Safety Recommendations in developing the Pilot Certification and Qualification Requirements for Air Carrier Operations NPRM (77 FR 12374), which published in the **Federal Register** on February 29, 2012. It proposed to amend the FAA's existing requirements to obtain an ATP certificate with an airplane category multiengine class rating and raise the qualifications of part 121 pilot flightcrew members.

In developing this final rule, the FAA reviewed the requirements set forth in the Act, reconsidered the FOQ ARC recommendations, conducted a new accident analysis,[7] reviewed NTSB Safety Recommendations,[8] and considered the public comments to the NPRM. The provisions of this final rule are consistent with the statutory mandates set forth in the Act. The table below outlines the provisions of sections 216 and 217 of the Act and the parts of the final rule that correspond to them.

TABLE 3—PROVISIONS OF PUBLIC LAW 111–216 AND CORRESPONDING RULE PROVISIONS

Public Law 111–216, The Airline Safety Act, Sections 216 & 217	Final rule
1. All part 121 flightcrew members must hold an ATP certificate by August 2, 2013. (216(c))	1. An SIC in part 121 operations must have one of the following: • ATP certificate • ATP certificate with restricted privileges (§§ 61.160, 61.167)
2. To be qualified to receive an ATP certificate, an individual shall have sufficient flight hours, as determined by the Administrator, to enable a pilot to function effectively in an air carrier operational environment; and have received flight training, academic training, or operational experience* * *to function effectively in an air carrier operational environment. (217(b)). Minimum number of flight hours shall be at least 1,500 flight hours. (217(c)). A pilot need not fully comply with the flight hours requirement above provided that the pilot has taken specific academic training courses, beyond those listed below, as determined by the Administrator. (217(d)).	2. ATP certificate with restricted privileges (§ 61.160).
3. All part 121 flightcrew members must have an appropriate amount of multi-engine flight experience, as determined by the Administrator. (216(a)(2)(B)(ii)).	3. (a) 50 hours of aeronautical experience in class of airplane required for an ATP certificate (§ 61.159); (b) Aircraft type rating for part 121 SICs (§ 121.436(a)(2)); and (c) 1,000-hour minimum air carrier experience to serve as a PIC in part 121 operations (§ 121.436(a)(3)).
4. To be qualified to receive an ATP certificate an individual shall have received flight training, academic training, or operational experience that will prepare a pilot to:. a. function in a multipilot environment;. b. function in adverse weather conditions (icing);. c. function during high altitude operations;. d. adhere to the highest professional standards; and. e. function in an air carrier operational environment. (217(b)(2)(A)–(E)). The total flight hours should include sufficient flight hours in difficult operational conditions. (217(c)(2)).	4. ATP CTP (§§ 61.156, 121.410, 135.336, 141.11, 142.54).
5. Prospective flightcrew members must undergo comprehensive pre-employment screening, including an assessment of the skills, aptitudes, airmanship, and suitability * * * for operating in an air carrier operational environment. (216(a)(2)).	5. (a) Revised ATP requirements (ATP CTP, increased minimum total time as a pilot, and increased minimum multiengine time); (b) Aircraft type rating for the aircraft to be flown in part 121 operations (SIC) (§ 121.436(a)(2)); and (c) 1,000-hour minimum air carrier experience to serve as a PIC in part 121 operations (§ 121.436(a)(3)).

[7] As a result of modifications to the ATP Certification Training Program and comments made regarding some of the accidents used for benefits in the NPRM the FAA conducted a new accident analysis.

[8] The FAA has placed a document in the docket for this rulemaking that provides greater detail on which aspects of the final rule—in particular which items in the curriculum for the ATP CTP—respond to specific NTSB recommendations. That supplementary material can be found at *www.regulations.gov,* Docket No. FAA–2010–0100.

B. FAA Accident Analysis and National Transportation Safety Board (NTSB) Recommendations

Human error, as evidenced in the Colgan Air accident, has been a major factor in many of the commercial airline accidents over the past 10 years. The FAA has identified 31 accidents in part 121 air carrier operations and 27 in part 135 commuter and on-demand operations from fiscal year 2001 through fiscal year 2010 that could have been prevented if the enhanced ATP qualification standards and part 121 requirements required by this final rule had been in effect. Those accidents resulted in 99 fatalities, 28 serious injuries, and 44 minor injuries. A detailed description of this analysis, and how it was conducted, is provided in Section E of the final regulatory evaluation and can also be found in Docket # FAA–2010–0100.

The NTSB investigated these accidents and the changes enacted in this rule address, at least in part, the following NTSB recommendations—

- Train flightcrews to respond to sudden, unusual, or unexpected aircraft upsets (Recommendations A–96–120, A–04–62, A–07–3, and A–09–113);
- Develop and conduct stall recovery training and provide stick pusher familiarization training for pilots of stick-pusher equipped aircraft (Recommendations A–10–22 and A–10–23);
- Enhance training syllabi for operations in high altitude (Recommendations A–07–1 and A–07–2);
- Review training for unusual and emergency situations in transport-category aircraft to make sure pilots are not trained to use the rudder in ways that could result in dangerous situations (Recommendation A–02–2);
- Require procedures and guidance for airport situational awareness (Recommendation A–07–44);
- Ensure that all carriers include criteria for stabilized approach in their flight manuals and training programs (Recommendations A–01–69 and A–08–18);
- Require operators to provide clear guidance to pilots about landing performance calculations (Recommendations A–07–59 and A–08–41);
- Require Crew Resource Management training (Recommendation A–03–52);
- Require operators to verify that their pilot monitoring duties are consistent with AC 120–71A (Recommendation A–10–10);
- Require flight crewmember academic training in leadership, professionalism, and first officer assertiveness (Recommendation A–10–15 and A–11–39);
- Require training in icing conditions (Recommendation A–07–14 and A–11–47);
- Require hypoxia awareness training (Recommendation A–00–110); and
- Require training in crosswinds with gusts (Recommendations A–10–110 and A–10–111).

C. Airline Safety and Federal Aviation Administration Extension Act of 2010 (Pub. L. 111–216)

The Airline Safety and Federal Aviation Administration Act included provisions to improve airline safety and pilot training. Specifically, section 216, Flight Crewmember Screening and Qualifications, focused on the qualifications of airline pilots operating under part 121. In section 217, Airline Transport Pilot Certification, the FAA was directed to modify the requirements for an ATP certificate to better prepare pilots for operating in an air carrier environment. Both sections of the Act are addressed in this rulemaking.

Section 216 directs the FAA to conduct a rulemaking proceeding to require:

- Part 121 air carriers to develop and implement means and methods for ensuring flightcrew members have proper qualifications and experience;
- All flightcrew members in part 121 air carrier operations to hold an ATP certificate and to have obtained appropriate multiengine flight experience, as determined by the Administrator by August 2, 2013; and
- Prospective flightcrew members to undergo comprehensive pre-employment screening, including an assessment of the skills, aptitudes, airmanship, and suitability, of each applicant for a position as a flightcrew member in terms of functioning effectively in the air carrier's operational environment.

Section 216 requires the FAA to issue an NPRM by January 28, 2011, and a final rule by August 2, 2012. Independent of any rulemaking proceeding by the FAA, this section directs that all flightcrew members in part 121 air carrier operations must hold an ATP certificate, issued under part 61, by August 2, 2013.

Section 217 of the Act requires the FAA to issue a final rule by August 2, 2013, modifying the requirements for an ATP certificate in part 61. The section establishes minimum requirements for an ATP certificate that include:

- Sufficient flight hours, as determined by the Administrator, to enable a pilot to function effectively in an air carrier operational environment;
- Flight training, academic training, or operational experience that will prepare a pilot to function effectively in a multipilot (multicrew) environment, in adverse weather conditions, during high altitude operations, and in an air carrier environment, as well as to adhere to the highest professional standards; and
- Sufficient flight hours, as determined by the Administrator, in difficult operational conditions that may be encountered by an air carrier to enable a pilot to operate safely in such conditions.

Section 217 also directs that the minimum total flight hours to be qualified for an ATP certificate shall be at least 1,500 flight hours. Notwithstanding the stated minimum, the section permits the Administrator to allow specific academic training courses to be credited toward the 1,500 total flight hours, provided the Administrator determines that specific academic training courses will enhance safety more than requiring the pilot to comply fully with the flight hours requirement.

Section 217 also requires the Administrator to consider the recommendations from an expert panel established under section 209(b) of the Act. That section focuses on part 121 and part 135 training programs. A report to Congress and to the NTSB was submitted on September 23, 2011.

D. Notice of Proposed Rulemaking (NPRM)

In the Pilot Certification and Qualification Requirements for Air Carrier Operations NPRM (77 FR 12374), the FAA proposed to amend the existing requirements to obtain an ATP certificate with an airplane category multiengine class rating and raise the qualifications of part 121 pilot flightcrew members. Specifically the NPRM proposed to—

- Require an ATP certificate for all pilots operating under part 121 consistent with the self-enacting provision in section 216 of the Act.
- Establish an aeronautical experience requirement for 50 hours in the class of airplane for the ATP certificate sought.
- Establish a requirement for all pilots operating under part 121 to obtain an aircraft type rating for the aircraft to be flown. An SIC in a part 121 flag or supplemental operation that requires three or more pilots is required by existing regulations to hold an ATP certificate with an aircraft type rating for the aircraft being flown, but SICs in

other part 121 operations are not required to have it.

• Establish a requirement for pilots seeking an ATP certificate with an airplane category multiengine class rating or an ATP certificate obtained concurrently with an airplane type rating to complete specific training before taking the ATP knowledge test. The proposed requirements would include academic training and training in a flight simulation training device [9] (FSTD). A draft advisory circular providing additional guidance as to the content of the course and how to obtain FAA-approval was placed in the docket for comment.

• Based on the discretion provided to the Administrator in section 217 of the Act, permit applicants who have completed ''specific academic training courses'' to obtain an ATP certificate with fewer than the minimum 1,500 hours.

• Allow specific academic coursework to be credited towards the total flight hours required for an ATP certificate. The proposed alternative hour requirements for a restricted privileges ATP certificate were—

○ 750 hours for a military pilot; and

○ 1,000 hours for a graduate of a four-year baccalaureate aviation-degree program who also received a commercial certificate and instrument rating from an affiliated part 141 pilot school.

• Establish a requirement that a pilot must have 1,000 hours in air carrier operations to serve as PIC in part 121 operations.

The NPRM provided for a 60-day comment period, which ended on April 30, 2012. One request for extension to the comment period was received, but the FAA declined to extend given the industry input it had received from the advanced noticed of proposed rulemaking published in February 2010, as well as the input it received from the FOQ ARC. In addition, the statutory deadlines imposed by the Act did not afford the FAA additional time to receive comments. The FAA received nearly 600 comments posted to the docket. Commenters included major air carriers, regional air carriers, part 135 operators, cargo air carriers, associations and industry groups, colleges and universities, training centers, flight schools, pilots, and private citizens.

E. Differences Between the NPRM and the Final Rule

TABLE 4—DIFFERENCES BETWEEN THE NPRM AND THE FINAL RULE

Issue	NPRM	Final rule
A. R–ATP certificate	1. Eligible pilots: ○ Military-trained; ○ Graduates of a bachelor's degree program with an aviation major; 2. Proposed minimum age is 21 years; and 3. Proposed minimum cross country time for military pilots is 250 hours; proposed minimum cross country time for graduates with a bachelor's degree is 375 hours.	1. Eligible pilots: ○ Military-trained; ○ Graduates of a bachelor's degree program with an aviation major; ○ Graduates of an associate's degree program with an aviation major; ○ Pilots with 1,500 hours total time as a pilot; 2. Minimum age is 21 years; and 3. Minimum cross country time for all eligible pilots is 200 hours.
B. Aviation Degree Program	A pilot eligible for academic credit towards a restricted privileges ATP certificate needs to have:. 1. Graduated from a four-year aviation-related degree program (bachelor's degree with an aviation major); and 2. Obtained their commercial pilot certificate and instrument rating from an affiliated part 141 pilot school.	1. Established criteria to define what coursework must be completed as part of a bachelor's or associate's degree program with an aviation major; 2. Further defined what an associated part 141 school is; 3. Created a process by which colleges and universities can obtain authority from the FAA to certify their graduates for an R–ATP certificate (new advisory circular 61-School); and 4. More clearly defined what a graduate has to present at the time of the practical test to show eligibility for a restricted privileges ATP certificate.
C. ATP CTP	1. Academic training: 24 hours; 2. FSTD training: 16 hours ○ Level C or higher FFS: 8 hours; ○ Level 4 or higher FTD: 8 hours; and 3. Draft advisory circular.	1. Academic training: 30 hours; 2. FSTD training: 10 hours ○ Level C or higher FFS: 6 hours; ○ Level 4 or higher FTD: 4 hours; and 3. Advisory circular 61–ATP.
D. ATP CTP Instructor Requirements.	1. Hold an ATP certificate with an airplane category multiengine class rating; 2. Meet the aeronautical experience requirements of § 61.159; 3. Have 2-years of air carrier experience; and 4. For training in an FSTD—have an appropriate aircraft type rating which the FSTD represents or have received training in the aircraft type from the certificate holder on those maneuvers they will teach.	1. Hold an ATP certificate with an airplane category multiengine class rating; 2. Meet the aeronautical experience requirements of § 61.159; 3. Have 2-years of air carrier experience; 4. For training in an FSTD—(a) have an appropriate aircraft type rating which the FSTD represents, (b) have received training in the aircraft type from the certificate holder on those maneuvers they will teach, and (c) received training on data and motion limitations of simulation; and 5. Hold a certified flight instructor certificate or complete training in fundamentals of instruction.

[9] A flight simulation training device (FSTD) incorporates both full flight simulators (FFS) and flight training devices (FTD).

TABLE 4—DIFFERENCES BETWEEN THE NPRM AND THE FINAL RULE—Continued

Issue	NPRM	Final rule
E. Reduction in an air carriers' initial training program for Pilots Who Have Completed the ATP CTP.	A principal operations inspector may approve a reduction to an air carrier's initial training program based on material taught by that carrier in the ATP CTP.	A principal operations inspector may approve a reduction to an air carrier's initial training program if the pilot beginning initial training has successfully completed the ATP CTP. The carrier does not have to provide the ATP CTP training to be eligible for a reduction.
F. Medical Certificate	No change proposed to medical requirements in § 61.23. Pilots exercising the privileges of an ATP certificate would be required to hold a first-class medical certificate.	Section 61.23 requires only those pilots exercising the PIC privileges of an ATP certificate and SIC privileges in flag and supplemental operations requiring three or more pilots to hold a first-class medical certificate. An SIC in part 121 may continue to hold a second-class medical certificate.
G. FFS Credit Towards 50 hours of Multiengine Aeronautical Experience.	10 hours of FFS time that represents a multiengine airplane.	25 hours of FFS training time that represents a multiengine airplane and is part of an approved training program.
H. Time Eligible for the 1,000 hours of Air Carrier Experience.	1. All time in part 121 operations; 2. PIC time in § 135.243(a)(1) operations; and 3. PIC time in § 91.1053(a)(2)(i) operations	1. All time in part 121 operations; 2. PIC time in § 135.243(a)(1) operations; 3. PIC time in § 91.1053(a)(2)(i) operations; and 4. Military PIC time in a multiengine turbine-powered, fixed-wing airplane in an operation requiring more than one pilot—up to 500 hours.

F. Related Actions

The Act led to the establishment of ARCs on additional subjects—

- Flight Crewmember Mentoring, Leadership, and Professional Development (Section 206 of the Act)
- Flight Crewmember Training Hours Requirement Review (Section 209 of the Act)
- Stick Pusher and Adverse Weather Event Training (Section 208 of the Act)
- Air Carrier Safety and Pilot Training (Section 204 of the Act)

The FAA has reviewed the recommendations provided by these ARCs and has initiated two rulemaking projects as a result: (1) Flight Crewmember Mentoring Leadership, and Professional Development; and (2) Revisions to the Qualification and Performance Standards in Part 60.

In addition, on May 20, 2011, the FAA published a supplemental notice of proposed rulemaking (SNPRM) proposing to amend the regulations for crewmember and aircraft dispatcher training programs in domestic, flag, and supplemental operations (76 FR 29336). This SNPRM, which was specifically cited in section 209 of the Act, focused solely on part 121 air carrier training program requirements. The comment period for the SNPRM closed on September 19, 2011.

Congress addressed these related topics within discrete sections of the Act, which has resulted in the related rulemaking projects identified. Drafting proposals on related topics simultaneously can give the appearance of overlapping or duplicative requirements. As the final rules are drafted and published to address the discrete sections of the Act, the FAA will minimize any overlapping or duplicative requirements.

The FAA has made regulatory decisions within this rule based upon the best currently available scientific data and information, and is confident the rule incorporates the best available information regarding the relationship between flight hours and types of training. In the future, however, FAA is likely to gather and analyze additional data in this area; for example, through safety outcomes resulting from this rule, and additional information collections associated with other rulemakings. FAA may also consider additional collections of information, and would notify the public of these collections through separate **Federal Register** Notices promulgated under the Paperwork Reduction Act. Further information collected by FAA could be used to inform future analysis.

Because of the likely availability of such data in the future, the FAA may obtain additional empirical evidence relevant to the precise relationship between flight hours and types of training. For example, Phase III of the Pilot Source Study, explained elsewhere in this preamble, suggests areas for further research. The FAA, consistent with its obligations under Executive Order (E.O.) 13563, Improving Regulation and Regulatory Review (Jan. 18, 2011), and E.O. 13610 on the retrospective review of regulations, will review this evidence and may make modifications as necessary and appropriate to improve the effectiveness of this regulatory program. The FAA will consider whether such changes would be necessary or appropriate, and therefore whether this rulemaking would represent a good candidate for a formal retrospective review under E.O. 13610.

III. Discussion of Public Comments and Final Rule

A. ATP Certificate for All Pilots Operating Under Part 121 (§ 121.436)

In the NPRM, the FAA proposed requiring that all SICs in part 121 operations hold an ATP certificate by August 2013. This proposal was meant to be consistent with section 216 of the Act, which mandates that within 3 years of enactment (August 2, 2013), all flightcrew members serving in part 121 operations must hold an ATP certificate. At the time the Act was signed into law, PICs in part 121 air carrier operations as well as SICs of a part 121 flag or supplemental operation requiring three or more pilots were already required to hold ATP certificates. All other SICs in part 121 air carrier operations, however, were not required to hold ATP certificates and were permitted to hold an instrument rating and a commercial pilot certificate with the appropriate category and class rating for the aircraft.

The FAA received more than 200 comments both in support of and in opposition to the ATP certification requirement for part 121 pilots. American Eagle Airlines, Inc., citing a lack of an identified safety benefit, specifically suggested grandfathering all incumbent SICs if they have at least 1,000 hours in the type of aircraft they are flying. American Airlines (AAL) suggested a similar grandfathering provision, but only for pilots who have

been an SIC for at least six years, accrued 1,000 hours in aircraft type as an SIC, and attended recurrent training more than three times.

While the FAA has considered and appreciates all of the comments received, the FAA was not given any discretion to allow pilots serving in part 121 operations to hold any certificate other than an ATP certificate. There is no latitude in the Act to permit a pilot with a commercial pilot certificate who is flying in part 121 today to continue flying beyond the date of this self-enacting provision without having obtained an ATP certificate. Accordingly, the FAA has removed the current certification requirements in § 121.437 and added new §§ 121.435 and 121.436. New § 121.435 contains the existing certification requirements for part 121 pilots; they will be in effect until July 31, 2013. After that date, the requirements of § 121.436 will apply.

B. Medical Certificate (§ 61.23)

Medical certificate requirements are determined by the level of pilot certificate that is required for the operation being conducted. Section 61.23 requires a pilot exercising the privileges of an ATP certificate to hold a first-class medical certificate and a pilot exercising the privileges of a commercial pilot certificate to hold at least a second-class medical certificate.

As a result of the statutory requirement for all pilots in part 121 to hold an ATP certificate, UPS and Spartan College sought clarification regarding whether all SICs in part 121 operations would be required to hold a first-class medical certificate and whether the proposed rule would affect existing SICs who hold only second-class medical certificates.

The FAA did not address medical certification requirements in the NPRM or propose any change to the first-class medical certificate requirement in § 61.23. Without a change, the statutory requirement for all part 121 flightcrew members to hold an ATP certificate would require SICs to hold first-class medical certificates after August 1, 2013.

Requiring a first-class medical certificate for all part 121 SICs could potentially remove qualified and experienced SICs who cannot hold a first-class medical certificate from part 121 air carrier operations. It would also impose additional costs on industry, individual pilots, and the FAA that were not reflected in the initial regulatory evaluation.[10] Rather than impose new requirements without a corresponding safety benefit, the FAA is modifying § 61.23(a)(1), (a)(2), (d)(1), and (d)(2) in the final rule so pilots in part 121 operations exercising SIC privileges (excluding flag or supplemental operations requiring three or more pilots) may continue to hold only a second-class medical certificate. In this regard, the amendment alleviates any increased cost and removes the possibility of inadvertently disqualifying incumbent SICs from part 121 air carrier operations.

C. Aeronautical Experience Requirement in the Class of Airplane for the ATP Certificate Sought (§ 61.159)

Prior to the issuance of this final rule, an applicant for an ATP certificate with an airplane category multiengine class rating was not required to obtain any additional multiengine flight experience above what is required for a commercial pilot certificate with an airplane category multiengine class rating. Section 216 of the Act addresses this issue by requiring all pilot flightcrew members serving in part 121 air carrier operations to have appropriate multiengine flight experience, as determined by the Administrator.

One method the FAA used to address the Act's focus on multiengine experience was by proposing a requirement that pilots obtain 50 hours of flight time [11] in the class of airplane for the ATP certificate sought. The FAA also proposed allowing an applicant to receive credit for up to 10 hours of this flight time in a full flight simulator (FFS) that replicates a multiengine airplane.

Ninety-three commenters addressed the proposed 50-hour requirement. Fifty-nine commenters, including the Airline Pilots Association (ALPA), Airlines for America (A4A), AAL, Aviation Professional Development, LLC, Cargo Airline Association (CAA), Coalition of Airline Pilots Association (CAPA), Embry-Riddle Aeronautical University (ERAU), ExpressJet Airlines, Inc. (ExpressJet), Flight Safety International (FSI), Hyannis Air Service, Inc. (Cape Air), National Air Transportation Association (NATA), Purdue University (Purdue), Saint Louis University—Parks College (Parks College), San Jose State University (SJSU), and the U.S. Airline Pilots Association (USAPA) indicated that 50 hours is adequate to be eligible for an ATP certificate.

The National Association of Flight Instructors (NAFI) added that obtaining 50 hours would not be a significant problem in the industry and would establish a minimum number of hours as a base for pilots to build upon. Farmingdale State College (FSC) added that 50 hours is adequate but it is not a good measure of competencies. The International Air Transport Association (IATA) stated that requiring these 50 hours is appropriate if they are used to develop and reinforce core competencies. Aerosim Flight Academy (Aerosim) stated the 50 hours would be ''okay'' but ''too costly and difficult to obtain.'' JetBlue Airways Corporation (JetBlue) agreed that 50 hours in the class of airplane is sufficient and pertinent and believes it is representative of quality flight experience.

Four commenters, including FSI, said that there would be no additional burden for those who obtain an ATP certificate. FSI said that most pilot candidates exceed the 50-hour requirement before obtaining an ATP certificate. An individual commenter noted that most pilots would earn this by getting a multiengine instructor rating and instructing students.

Six individual commenters did not object to having such a requirement but stated 50 hours is too high. One of them suggested 25 hours in the class of airplane as an alternative. The Ohio State University (OSU) added that current commercial certificate requirements are sufficient and suggested giving credit towards this requirement through completion of an Advanced Jet Training (AJT) program. Boeing also said that 50 hours is too high and that the structured and focused FSTD training proposed in the ATP certification training program provides any needed additional multiengine experience above that which is minimally required by the commercial pilot certificate. The Regional Air Cargo Carrier Association (RACCA) stated that 50 hours is probably adequate but may be unnecessarily high ''presuming the flight time includes adequate training, experience, and motivation by the pilot.''

[10] A first-class medical certificate must be renewed every 12 months for pilots under age 40 and every six months for pilots age 40 and over. A second-class medical certificate, on the other hand, must be renewed every 12 months for all pilots regardless of age. If first-class medical certificates are required, SICs who are age 40 and over will be required to renew their medical certificates every six months (as opposed to every 12 months for a second-class medical certificate). In addition, electrocardiography (EKG) testing is specifically required under first class medical certificate standards while EKG testing is used on a case-by-case basis for second class medical certificates. The FAA has reviewed part 121 accident and incident data dating back to 2001 and found no accidents or incidents attributable to an SIC with a medical condition that may have been detected by electrocardiography testing.

[11] The FAA notes that this 50 hours of flight time counts towards the 1,500 hours of total time required for an ATP certificate.

Three individual commenters noted that 50 hours in class is too low. Two of these commenters recommended 100 hours in class. Ameriflight, LLC (Ameriflight) added that 50 hours of multiengine experience is insufficient for part 121 operations because the remaining 1,450 hours could be in a single-engine airplane. The Allied Pilots Association (APA) recommended 100 hours of flight time in the type of aircraft before a pilot could be eligible for a restricted privileges ATP certificate, because time in the aircraft type makes for a safer pilot.

Thirteen commenters, including, Delta Airlines (Delta), Bemidji Aviation Services, Inc., the Professional Aviation Board of Certification (PABC), Prairie Air Service, Kansas State University—Salina (KSU), and the University Aviation Association (UAA), found the 50-hour requirement unnecessary. Sporty's Academy added that there is no evidence of accident rates to support the requirement. Southern Illinois University—Carbondale (SIU), Western Michigan University (WMU) and CAE, Inc. (CAE) added that the requirement should be competency based. Human Capital Management and Performance, LLC added that time gained in light twin-engine piston aircraft does not prepare pilots for high altitude, swept-wing turbojet operations. The IFL Group believes pilots will get that time in any way possible without a guarantee of receiving specific training, and this may increase the accident rate. The IFL Group also believes there will be an ''increase in the number of pilots who make fake flight time entries into their logbooks because of the cost of obtaining the additional multiengine flight time, thus offsetting any safety benefit and increasing FAA cost as a proportion of them are caught and the FAA incurs the cost of revoking their certificates.''

Six commenters, including Purdue, Spartan College, and the University of Dubuque noted the FAA should consider credit for simulation. An individual commenter stated allowance for simulators should be expanded. CAE stated 50% of the hours should be allowed in a level C or D FFS due to the numerous training advantages of that training environment. Based on hiring data and success rates in airline training and line operations, ExpressJet highly recommended that AJT simulation time (in either a level 5 flight training device (FTD) or FFS) be credited towards the 50 hours of multiengine time. JetBlue believes the capabilities and quality of training possible in an advanced simulation device far exceeds those of the actual aircraft and therefore recommends any time in an FFS should be credited towards the 50 hours.

Congress directed the FAA to ensure that all flightcrew members have an appropriate amount of multiengine experience. Since the ATP certificate is the highest level of pilot certificate currently available, the FAA has determined the minimum multiengine experience required to apply for an ATP certificate should exceed the minimum requirements for a commercial pilot certificate. Additional experience in inherently faster and more complex multiengine airplanes establishes a foundation that provides quality experience to prepare a pilot for a professional piloting career. Multiengine flight experience is essential not only for pilots serving in part 121 air carrier operations but for all pilots who apply for an ATP certificate with an airplane category multiengine class rating. The FAA concedes there are no air carrier accidents that specifically cite a lack of multiengine experience as a probable cause. However, establishing a minimum experience requirement in the class of airplane is consistent with other pilot certificates and supports the requirements of section 216 of the Act, which placed significant emphasis on increased multiengine experience. As proposed, such an hour requirement would have minimal impact on pilots seeking an ATP certificate because the hours will likely be acquired by pilots engaged in other commercial aviation activities such as flight instruction or part 135 operations. This assertion was not disputed by many of the commenters. Additionally, the FAA reviewed the hiring minimums for part 121 air carriers and found most have established hiring minimums for multiengine time which equal or exceed the proposed rule, further minimizing the cost of this provision.

In response to commenters who suggested increasing the minimum hours in class of airplane above 50 hours, the FAA accepts the recommendation of the FOQ ARC. The FAA agrees that time in the class of airplane alone may not prepare a pilot for operating a large swept-wing turbojet at high altitudes nor does it necessarily ensure competency. For that reason there are additional building block requirements in this final rule for obtaining an ATP certificate with a multiengine class rating, such as the ATP certification training program and a practical test to determine a pilot's competency prior to issuance of an ATP certificate. The FAA notes that pilots will seek opportunities to acquire time in the class of airplane, which is no different than current practice. For that reason the FAA disagrees with the IFL Group's assertion that pilots seeking experience in multiengine aircraft will result in an increase in accidents. To the extent that commenters have suggested that, as a result of the multiengine flight time requirement, pilots may be encouraged to falsify their logbooks, the FAA cautions that the regulations (14 CFR 61.59) prohibit the falsification of logbooks.

A majority of the commenters supported the proposed requirement for 50 hours in the class of airplane to obtain an ATP certificate; therefore, the FAA has retained this provision in the final rule. Based on the comments suggesting that the FAA increase the amount of FFS time that may be credited towards the 50 hours, the FAA agrees that the quality of training and experience gained from flying an FFS is valuable and additional time should count. Advanced simulation training devices readily provide additional training opportunities in turbine aircraft utilizing multicrew concepts and may include training in difficult operational conditions beyond that required of existing pilot licensing requirements. The FAA disagrees with commenters that believe all of the multiengine experience could be gained in an FFS. The FAA believes accruing multiengine experience in an airplane is important and would eliminate the possibility of a pilot carrying passengers in a multiengine airplane without previous multiengine airplane experience. Accordingly, the FAA has amended § 61.159 in the final rule. Specifically, § 61.159(a)(3) will permit pilots to credit 25 hours of flight training in an FFS that represents a multiengine airplane toward the 50 hours of flight time in the class of airplane. The 25 hours must be accomplished as part of an FAA approved training course (e.g., part 121 air carrier training program).[12] The FAA notes that an aviation training device (ATD) or an FTD cannot be substituted for the FFS in order to obtain the credit toward the 50 hours of multiengine flight time.

[12] The FAA has modified section 61.159(a)(5) to permit pilots to credit FSTD time accomplished in approved training programs under parts 121, 135, and 141 toward the aeronautical experience requirements for the ATP certificate. Under the prior rule, only FSTD time accomplished as part of an approved training course in part 142 could be credited.

D. ATP Certification Training Program for an Airplane Category Multiengine Class Rating or ATP Certificate Obtained Concurrently with an Airplane Type Rating (§ 61.156)

In Section 217 of the Act, Congress directed the FAA ''to modify requirements for the issuance of an airline transport pilot certificate'' to ensure pilots can function effectively in an air carrier/multipilot environment, in adverse weather conditions, during high altitude and icing operations while adhering to the highest professional standards. The public law stated that the FAA could consider academic training, flight training, or operational experience as a means of ensuring pilots have the skills identified in the public law.

In the NPRM, the FAA proposed to require applicants for the ATP knowledge test complete an ATP Certification Training Program (ATP CTP) comprised of academic and FSTD training. The training program, as proposed, focused on the areas set forth in the Act and a majority of the competencies identified in the FOQ ARC report. The FAA included a draft advisory circular (AC) in the docket that provided further detail on the content and the structure of the course.

1. Required Training for an ATP Certificate

The FAA received over 120 comments regarding whether the FAA should require a training course prior to taking the ATP knowledge test. More than 30 commenters, including Delta, A4A, CAPA, CAA, Parks College, and the Families of Continental Flight 3407, generally supported such a training course. An equal number of commenters including the University of Dubuque, Delaware State University (DSU), and numerous individual commenters generally stated such a course is unnecessary. Many commenters addressed specific elements of the proposal and suggested some alternatives which will be addressed later in the document.

IATA stated that the additional training for the ATP certificate is appropriate because the current requirements are inadequate and have become irrelevant. Boeing agreed with the FAA's rationale for the ATP CTP and asserted that pilots who successfully complete the program would have the needed ''foundational knowledge to operate as second in command (SIC) in part 121 operations.'' AAL echoed Boeing, indicating that the added training would provide valuable experience to future part 121 pilots. The National Air Disaster Alliance Foundation (NADA/F) was also supportive of the proposed course and highlighted the use of a standardized course of training. USAPA supports the additional training maintaining that it is more effective than just having a multiple choice exam. UAA supported pilots completing ground training prior to taking a knowledge test.

Several commenters, including Aerosim, Middle Tennessee State University (MTSU), FSC, and WMU, support additional training but disagree with it being required for the knowledge test. ERAU, KSU, and 20 individual commenters support the additional training being part of a degree program or collegiate flight training program. Spartan College suggested it be part of an overall collegiate curriculum rather than a single course.

Purdue, OSU, and the University of North Dakota (UND) suggested allowing the academic and FSTD portions of the proposed course to be completed at separate times enabling students to complete the academic portion as part of their degree program. The universities added that many of the topics are already covered as part of the degree program and graduates should get credit for the academic portion of the proposed course and therefore only have to complete the FSTD portion at a later time. They also suggested allowing the knowledge test to be completed following the academic portion, which falls more in line with how knowledge areas for other FAA pilot certificates are tested.

ExpressJet supported imbedding the ATP CTP training into an air carrier's initial training program. The Aircraft Owners and Pilots Association (AOPA) equated the ATP CTP to the AJT course the FOQ ARC recommended for pilots entering part 121 service and therefore disagrees that the ATP CTP should apply to all pilots required to have an ATP certificate. AOPA suggested the FAA ''reword the AJT requirement so it is required only of individuals employed by part 121 air carriers, prior to flying in revenue service and not as a prerequisite to all ATP certificates.''

OSU generally agreed with the academic portion of the course but believed the FSTD portion of the course ''represents an overwhelming financial burden'' to ATP certificate applicants. Many other individual commenters disagreed with imposing additional training requirements on pilots seeking an ATP certificate, in part due to the additional cost. The General Aviation Manufacturers Association (GAMA) stated an ATP applicant has already gone through ample training and this course would just be an extra cost burden and was unlikely to provide any additional safety benefit. GAMA, however, expressed support for the proposed FSTD portion of the training course, indicating that such training can be ''extremely beneficial.'' NATA believes the course as proposed is too costly. NATA is supportive of modifications to the ATP certification regulations, but indicated the delivery of any new training should be made available through lower cost methods, such as on-line course delivery.

Based on the support for additional training expressed by many of the commenters, the FAA has decided to require academic and FSTD training for the ATP certificate multiengine class rating and the ATP certificate when obtained concurrently with an airplane type rating.[13] This training, required at the ATP certification level, will address the gap in knowledge between a commercial pilot certificate and the knowledge a pilot should have prior to entering an air carrier environment. In addition, the FAA has decided that the safest and most effective way to ensure that applicants for an ATP certificate have met the requirements of section 217 of the Act is to establish specific training requirements and evaluate the pilot's understanding of those areas of instruction consistent with the regulatory framework for other pilot certificates.

To the extent that several commenters suggested that the coursework in university aviation degree programs already may satisfy the academic training requirements of the ATP CTP, the FAA does not agree. Many colleges and universities teach ground school for other certificates and ratings as part of their academic curriculum that include a general overview of topics for which the collegiate program has comprehensive standalone courses. For example, despite most collegiate programs having a separate aerodynamics course, this topic remains a component of private pilot ground school and is generally reinforced in a concurrent flight training lab. The aerodynamics training for private pilots generally applies to small, single-engine, piston-powered aircraft—the type of airplane most people initially learn to fly. Similarly, the academic portion of the ATP CTP (essentially

[13] The FAA notes that a pilot is not required to take the ATP CTP for a type rating added to any other pilot certificate. The requirement only applies to pilots obtaining an ATP certificate concurrently with an airplane type rating. In addition, subsequent airplane type ratings added to an ATP certificate that already has a multiengine class rating would not require taking the ATP CTP.

ground training for ATP certification) will focus on the aerodynamic principles for large turbine aircraft—the type of aircraft flown in part 121 operations as well as many operations in part 135 and subpart K of part 91. The ATP CTP will then incorporate those concepts learned in the academic portion of the course into practical scenarios during the FSTD training to reinforce the critical concepts of operating at high altitudes and its effects on the airplane and the importance of stall recognition and recovery. The FAA supports colleges and universities with FAA certificated part 141 pilot schools teaching the ATP CTP but as a standalone course, just as they do with ground schools and flight labs for other pilot certificates and ratings.

The FAA also maintains that the academic training requirements cannot be separated from the FSTD training. The FAA has acknowledged the value of structured university aviation degree programs in other parts of this final rule; however, the design of the ATP CTP ensures the knowledge gained in the academic portion of the course is directly applicable to air carrier operations and operating sophisticated, high performance, large, turbine aircraft. The training in the FSTD portion of the course consolidates the academic concepts with scenario-based training, practical applications, demonstrations, and multiengine experience. The course will consolidate many broader topics and focus on its applicability to air carrier-like operations. For many pilots who take the ATP CTP, it will likely be their first exposure to large turbine aircraft and how those aircraft perform at high altitude, how they perform in low energy states, and in adverse weather phenomena, like thunderstorms and icing conditions. Combining the academic training requirements with the FSTD experience is the most effective method to consolidate the learning and deliver the training and experience mandated by the Act.

Additionally, the FAA has determined that students must complete both the academic and FSTD training prior to taking the knowledge test. By separating the academics and flight training, possibly by years since a pilot may wait until he or she is further in a professional career, the learning objectives are less likely to be achieved. In light of that fact, the knowledge test cannot be taken following completion of only the academic portion of the course. The FAA is retaining the requirement that a pilot complete all of the ATP CTP to be eligible to take the knowledge test.

To those commenters that suggested the ATP CTP be incorporated into air carrier initial training because the subjects are already taught or because the training only applies to pilots in part 121 operations, the FAA disagrees. The ATP CTP is the base upon which a pilot must build. The concepts in the course will apply to any pilot who flies a large turbine aircraft regardless of operating rule part and therefore has value to pilots flying outside of part 121. The ATP CTP will cover topics the air carrier is not required to teach. For those general knowledge areas that are currently part of a part 121 initial training program, the FAA has modified subpart N to remove those requirements and reduce ground training for those pilots who have completed the ATP CTP. A pilot in an air carrier training program receives training specific to the air carrier's operation and the specific aircraft that pilot is going to fly. Even if the subjects are offered by an air carrier in initial training, the pilot is focused primarily on learning the company operation and the specific type of aircraft they will fly, not on broader, foundational concepts that the ATP CTP is designed to provide.

The FAA recognizes commenters' concerns regarding the cost of the proposed ATP CTP and considered these costs when establishing the requirements for the course. Section 217 of the Act directed the FAA to modify the requirements for ATP certification to include ensuring that applicants for the ATP certificate have sufficient flight hours in difficult operational conditions ''that may be encountered by an air carrier.'' The FAA sought input from the FOQ ARC on how to define difficult operational conditions and how a pilot can best obtain experience in those conditions. As indicated it its report, the FOQ ARC ''extensively discussed the issue of difficult operating conditions and determined that simulator training is an important tool by which to provide flight experience to the pilot for recognition and appropriate response in the difficult environments experienced by air carriers.'' Because of safety concerns, the FOQ ARC did not recommend that pilots be intentionally placed in these difficult conditions in actual aircraft. The FOQ ARC recommended scenario-based training to address difficult operating conditions including thunderstorms, icing, low visibility, maximum crosswinds for takeoff and landing, and contaminated runways.

Generally, pilots from their earliest training are taught to avoid thunderstorms and icing conditions. Even when flying an airplane approved for flight in icing conditions, a pilot is cautioned to minimize time flying in icing conditions. The FAA will not encourage pilots to seek experience in hazardous conditions for the purpose of meeting the aeronautical experience requirements for the ATP certificate required by the Act. The FAA has long recognized that flight simulators and flight training devices provide a safe flight training environment that can reduce the number of training accidents by allowing training for emergency situations, such as fire, total loss of thrust, and systems failures, that cannot be safely conducted in flight. 61 FR 34508 (July 2, 1996). Therefore, the FAA has determined that many of the difficult operational conditions can be most safely demonstrated to students through simulation. Simulation will be discussed in greater detail later in this section.

Although the Act permitted the FAA to consider operational experience as a means of ensuring that a pilot has received adequate flight hours in conditions such as adverse weather, high altitude operations, and an air carrier operational environment, the FAA has determined that it is not appropriate to encourage pilots to seek such conditions in an aircraft. In addition it would be difficult to validate experience in those conditions. Moreover, it would be difficult for pilots to obtain experience in the complex aircraft that would be required to replicate an air carrier operational environment.

Therefore, the FAA has determined that academic and FSTD training, followed by an evaluation through a revised knowledge test that includes the content of the course and subsequent completion of a practical test will meet the requirements of the Act and provide valuable training for the ATP certificate.

2. Training Providers

Due to the FSTD requirement in the ATP CTP, the FAA proposed that the course be conducted only by the following certificate holders who are approved to sponsor an FSTD under 14 CFR part 60: A part 141 pilot school, a part 142 training center, or a part 119 certificate holder authorized to conduct operations under parts 121 or 135.

AOPA was concerned that the FAA ''did not consider the negative impact on independent part 61 flight schools, other training providers who conduct ATP certification training or [designated pilot examiners] who currently conduct ATP certificate testing.'' NAFI commented the proposal completely excludes ''the very broad base of part 61 training providers who have traditionally helped maintain training capacity.'' NAFI further stated that part

61 instructors provide a significant amount of training toward professional pilot careers and to eliminate these instructors may reduce overall training capacity and result in a negative economic impact on these training providers. ALPA recommends the proposed ''authorized training provider'' be clearly defined in the regulations to assure the highest standards and quality of training for ATP applicants. NATA disagreed with part 135 operators being eligible to offer the ATP CTP stating it is impractical for part 135 operators because the required FSTDs are too expensive to acquire and the training must be outsourced. In addition, NATA stated the proposed requirements are a disincentive for part 135 pilots to get an ATP certificate because the proposed training requirements are not all relevant to operations outside of 14 CFR part 121.

The FAA acknowledges that, as a practical matter, pilots preparing for the ATP practical test have sought flight training from certified flight instructors even without explicit regulatory training requirements. Although such training may have covered ground training on the aeronautical knowledge areas in § 61.155, pilots primarily sought flight training in the specific type of aircraft in which they planned to take the ATP practical test. Although fewer pilots may choose to pursue an ATP certificate with a multiengine class rating as a result of the new training requirements, the pilots who seek an ATP certificate outside of an air carrier will continue to seek flight training from certified flight instructors as preparation for the practical test. Additionally, the practical test in many cases will still be given by designated pilot examiners who currently evaluate ATP applicants.

The specified training providers for the ATP CTP were chiefly determined by two factors: (1) The ability to sponsor an FSTD as set forth in 14 CFR part 60; and (2) the structure, systems, and management personnel required to develop, implement and maintain the FAA approved training program. This structure does not typically exist and is not required in part 61 training.

The FAA disagrees with those commenters who suggested part 135 certificate holders should not be eligible to provide this course. Part 135 operators are eligible to sponsor a simulator per the regulations and have approved designated examiners who are authorized to conduct proficiency checks that result in ATP certification. A part 135 certificate holder may choose not to provide the course because its pilots do not require ATP certificates or because it is cost prohibitive to provide to those pilots that do require ATP certificates, but that is not a regulatory decision.

The FAA has determined authorized training providers for the ATP CTP will be limited to certificate holders conducting operations under parts 121 or 135, and pilot schools and training centers certificated under parts 141 or 142, respectively. Each of these certificate holders have defined management structures, FAA approved training programs, and pilot training record retention requirements. Further, each ATP CTP submitted for approval will be reviewed by FAA Headquarters to ensure standardization. The FAA has modified the regulations for parts 121, 135, and 141 to permit those certificate holders to provide the training. Specifically, the FAA has: (1) Added the ATP CTP to the list of pilot school ratings in § 141.11 and to the list of special preparation courses in appendix K of part 141; and (2) established new §§ 121.410 and 135.336 to permit part 121 and part 135 certificate holders to obtain approval to provide the ATP CTP. The applicability provision in part 142 permits those training centers to provide training required by 14 CFR part 61.

3. Instructor Requirements

In the NPRM, the FAA proposed that instructors for the ATP CTP must meet the following requirements:

(1) Hold an ATP certificate with an airplane category multiengine class rating;

(2) have two years' experience in operations that require an ATP certificate to serve as PIC; and

(3) for those instructors that will provide training in an FSTD, have an appropriate aircraft type rating which the FSTD represents or have received training in the aircraft type from the certificate holder on those maneuvers they will teach.

As set forth in the NPRM, the instructors would also meet the individual requirements associated with the applicable part under which they provide the ATP CTP (unless specifically excepted in the proposed regulatory text) to ensure the quality of instruction.

Northern Michigan College supported the proposed instructor requirements and stated an ATP training course taught by qualified training providers should provide higher quality course content than that provided by a local flight instructor, thereby increasing the chance for improved flight safety.'' CAE stated the instructor must have the necessary qualifications and experience requirements to teach the ATP CTP. KSU stated the academic training requirements should be administered by a qualified instructor as part of a collegiate flight education program.

AOPA, UAA, and several individual commenters disagreed with stipulating instructor qualification requirements for the ATP CTP. Boeing recommended removing the two-year experience requirement from the ATP CTP for instructors under 14 CFR parts 121, 135, and 142, and devising an equitable solution for instructors under part 141 to gain line operational experience in order to instruct. Utah Valley University concurred with the requirement for instructors to hold an ATP certificate but was unsupportive of the air carrier experience requirement because very few highly qualified instructor pilots would be interested in low-paying educational positions.

NAFI raised concerns over the apparent prohibition of subject matter experts (SMEs) from teaching in the course, stating ''such a limitation could force the hiring of less knowledgeable instructors who have met the requirements for instruction based solely upon the acquisition of Part 121 experience, and not on individual qualifications.''

In the development of the final rule's instructor requirements, the FAA analyzed the existing training requirements for instructors in each rule part authorized to teach the ATP CTP. Whereas each rule part's instructor requirements are designed to meet the needs of the specific part (e.g. airman certification for part 141, simulator instruction for part 142, and air carrier operations for parts 121 and 135), none sufficiently cover all the competencies necessary to deliver the ATP CTP as designed.

Based on this regulatory review and the public comments, the FAA has assembled a specific set of instructor requirements designed to ensure the ATP CTP instructor: (1) Understands fundamental principles of instruction; (2) has the requisite experience to deliver the training topics with sufficient context to air carrier operations; and (3) if teaching in an FSTD, receives training on the limitations of simulation in order to mitigate the possibility of negative learning. Specifically, the FAA created new §§ 121.410, 135.336, and 142.54 and modified § 141.33 to standardize the instructor requirements for the ATP CTP.

a. Operational Experience

The FAA has determined only instructors with air carrier experience may teach the course because only

pilots with experience in part 121, and PIC experience in parts 135 and 91, subpart K—as defined by § 135.243(a)(1) and § 91.1053(a)(2)(i)—can effectively link the academic content of the course to the practical application of that knowledge in an air carrier environment. The concept and structure of the ATP CTP focuses on delivering the academic subjects and applying that knowledge in an FSTD through scenario-based training emphasizing how each subject area specifically relates to large turbine airplanes and air carrier operations.

In order to clarify the position on the operational experience requirement, the FAA proposed that instructors have at least two years of experience as a pilot in command in operations under § 91.1053(a)(2)(i) or § 135.243(a)(1), or in any operation conducted under 14 CFR part 121. Whereas the experience in part 121 operations is directly applicable, the FAA chose these particular operations in subpart K of part 91 and part 135 because they are air carrier-like operations that require the PIC to hold an ATP certificate. The ability to fly at the ATP certificate level and have demonstrated this proficiency during evaluation is an important regulatory differentiation. Specifically, these pilots will have gained experience as a PIC of a turbojet airplane or an aircraft with seating of 10 or more in operations very closely aligned to part 121 operations.

In addition, requiring air carrier operational experience is consistent with existing instructor requirements. Part 142 training centers are not air carriers, but those part 142 instructors who provide air carrier training must meet operational experience requirements for part 121 and part 135 instructors. The operational experience is necessary to ensure that each subject area specifically relates to transport aircraft and air carrier operations. For that reason, having an instructor with air carrier experience is critical. Further, the FAA believes there are a sufficient number of instructors with the required experience available, many of whom are already employed at likely ATP CTP providers. For example, air carriers that conduct their own training often use their own line pilots for the FSTD training. The FAA recognizes ATP CTP instructors with the requisite experience may require higher pay in comparison to current part 141 instructors and even some part 142 instructors. As a result, the FAA has accounted for a higher hourly wage in its economic analysis of the costs associated with the course.

The FAA also recognizes due to many factors, including air carriers that have terminated operations, employment records to verify air carrier experience may not always be available. The FAA has developed guidance in AC 61–138, Airline Transport Pilot Certification Training Program, which provides a method for a pilot to attest to previous experience.

b. Instructor Training

As part of this final rule, each instructor who provides training for the ATP CTP must receive initial training in the following topics:

- The fundamental principles of the learning process;
- Elements of effective teaching, instruction methods, and techniques;
- Instructor duties, privileges, responsibilities, and limitations;
- Training policies and procedures; and
- Evaluation.

The FAA recognizes that some of these training requirements may be duplicative for holders of a flight instructor certificate that has not expired as well as instructors already qualified under certain rule parts. For example, the fundamentals of instruction are trained and evaluated as part of the practical test standards for receiving a flight instructor certificate under part 61 and as part of the training for instructors under part 142. The fundamentals of instruction are reemphasized for an active flight instructor or through instructor refresher courses and annual training center evaluator/instructor training. As such, with sufficient documentation, the FAA does not believe pilots with current flight instructor certificates or currently qualified part 142 training center personnel need to repeat such training. This accommodation is reflected in the final regulatory text.

With regard to FSTD training the FAA believes well-trained instructors are the best means of ensuring that pilots are receiving effective training through simulation. There are two necessary components for ATP CTP instructors: (1) Training on the use and limitations of simulation; and (2) training on the tasks and maneuvers required in the ATP CTP. With the exception of part 142, no rule part specifically requires this training as a prerequisite to instructing in a simulator. These requirements are especially critical for the delivery of stall training, upset prevention and recovery training, and operations in icing conditions where the risk for negative learning is high.

The final rule ensures that instructors receive initial and recurrent training on the following topics: [14]

- Proper operation of flight simulator and flight training device controls and systems;
- Proper operation of environmental and fault panels;
- Data and motion limitations of simulation;
- Minimum equipment requirements for each curriculum; and
- The tasks and maneuvers that will be demonstrated in the FSTD. The specific training requirements have been added to § 141.33 for those instructors who will provide FSTD training for the ATP CTP. In addition, because part 121 and part 135 instructor requirements for simulator operations and limitations are specific to air carrier training conducted under those parts, the FAA has added this requirement to new §§ 121.410 and 135.336 to ensure that the training across rule parts is consistent with the objectives and requirements of the ATP CTP.

c. Type Rating

The NPRM also proposed the FSTD instructor must either have an appropriate aircraft type rating which the FSTD represents or have received training in the maneuvers they will teach. As noted above, several commenters expressed concern over the potential for negative learning during the FSTD portion of the ATP CTP. As a result the FAA has determined that instructors for the ATP CTP must have a type rating in the airplane that is replicated by the FSTD and receive training on the maneuvers they will teach. Requiring a type rating of instructors is consistent with current regulations for existing air carriers. For the purposes of the ATP CTP, the type rating requirement has been added to new §§ 121.410, 135.336, and 142.54. The requirement for a type rating was not included in part 141 regulatory text because those instructors must already hold a type rating on their pilot certificate in order to conduct training in a type specific aircraft or FSTD.

d. Subject Matter Experts

The FAA has clarified its position on SMEs delivering academic training in the ATP CTP. As identified by commenters, the ATP CTP contains academic subjects for which SMEs might be appropriate. The FAA sees benefit in a SME delivering a

[14] The FAA notes that any instructor providing training in an FSTD should receive training on the topics listed. Making such a regulatory adjustment, however, would be outside of the scope of this rulemaking.

specialized subject such as meteorology, human factors, or flight dispatch. Because the subjects focus on applying knowledge to an air carrier environment, the FAA will allow SMEs to deliver content in the ATP CTP while requiring an instructor with the required air carrier operational experience be present to ensure that the material presented is applied to air carrier operations. The FAA has determined these concepts can only be properly conveyed through an instructor with practical operational experience to meet the objectives of the course.

4. Training Topics and Hours

a. Academic Topics and Hours

The proposed ATP CTP incorporated most of the academic and FSTD competencies identified by the FOQ ARC and also addressed in part numerous NTSB safety recommendations. The proposed program hours for the ATP CTP were based on an assessment of the quantity and complexity of the subject matter. In the NPRM, the FAA was prescriptive for 20 of the 24 proposed academic hours, leaving some discretion to the training providers to determine what subject areas needed additional time. The FAA believed 24 hours of academic training was the minimum amount of time necessary to cover the material and be effective. The FAA further described the academic content in a draft AC that was posted to the docket.

The FAA received more than 80 comments regarding the training topics and training hours for the ATP CTP. Commenters including ALPA, Boeing, and Rocky Mountain College were generally supportive of the topics proposed in the academic portion of the ATP CTP.

Commenters such as A4A, Delta, NTSB, and IATA offered additional academic training topics for the ATP CTP such as human factors, fatigue, error trapping, United States Standard for Terminal Instrument Procedures (TERPS), air law, mentoring, leadership, professional development, decision making, dispatch and flight following. Additional commenters, including NAFI, recommended using the topics presented in the FOQ ARC report. A4A, FedEx Corporation (FedEx), and Parks College recommended additional training hours to teach the material, with total hours ranging between 30 and 50 hours. IATA commented that there should not be a specified number of hours for the ATP CTP, but rather a curriculum should be established and approved by the FAA based on the concept of demonstrated competency for course completion. An individual commenter stated the FAA had not accounted for pre-brief and post-brief time that is generally part of FSTD training.

The FAA concurs with major commenters that additional topics should be added and the training time should increase. Based on the specific topic areas proposed by commenters and the new accident analysis the FAA completed, the FAA reassessed the entire course and expanded the academic portion of the ATP CTP to emphasize certain areas proposed in the NPRM. In particular, the FAA has expanded training on leadership, professional development, CRM, and safety culture. Section § 61.156 requires six hours of training on these topics. Enhancing these training topics in the ATP CTP supports the objectives of Section 206 of the Act by raising the baseline knowledge level of new-hire pilots on these topics; however these provisions do not fully meet the intent of the statute. This will be addressed in the Flight Crewmember Mentoring Leadership, and Professional Development rulemaking project.

Additionally, some subjects, including checklist and MEL/CDL usage and weight and balance, were moved from the FTD portion of the course to the academic portion. The FAA determined these subjects could be taught effectively in the academic portion of the course using alternative devices, if appropriate, that do not require approval under part 60. The expansion of training topics and focus on particular topic areas will remove the 4 hours of discretion to training providers allotted in the NPRM and will increase the total minimum academic program hours from 24 to 30.

As noted by one commenter, the FAA did not account for briefing and debriefing time for FSTD training sessions; a typical component of flight training. The FAA agrees that briefing and debriefing are an important part of flight training because it allows for an explanation of the learning objectives for the training session and the opportunity for the instructor to reinforce the academic topic areas prior to the session and following the training event. As such, the FAA has decided to emphasize briefing and debriefing time before and after each FSTD period in the 61–ATP advisory circular. This additional briefing time (3 hours) will provide a review of the training topics before each FSTD period and tie them directly to the academic portion of the course. Briefing time before and after a flight is not normally a prescriptive time accounted for in the regulations. As such, the FAA has not incorporated this time into the programmatic hours for the ATP CTP in § 61.156; however, the time is accounted for in the economic analysis.

To the extent that commenters recommended that the ATP CTP be competency-based rather than have specific hour requirements, such an approach is not appropriate given the objectives of the ATP CTP. The FAA is very aware of competency-based training and is clearly supportive of its concepts in air carrier training by allowing advanced qualification programs (AQP), which use air carrier-specific data to establish and revise curricula. Training for certification, however, is traditionally and necessarily more prescriptive and based on program hours. Competency-based programs are most effective when the pilot is continually trained and evaluated within the same training program over the course of multiple years like at an air carrier. A pilot typically spends weeks in an air carrier initial training program receiving multiple evaluations prior to the qualification event. Once qualified, the pilot's performance is measured by multiple data sources including line operations. An air carrier's training programs and even its hiring practices can be altered to adjust to inadequacies of its training programs whereas part 61 certification is typically a one-time evaluation of the pilot's skills during a practical test. As such, standardized training requirements are necessary to achieve the level of safety desired. Further, since the training program could be provided across four different rule parts by different certificated air agencies and operators, a structured and approved curriculum combined with mandatory program hours will allow for the consistency desired by the FAA from all providers.

b. FSTD Topics

In the NPRM, the FAA proposed as part of the ATP CTP 16 hours of training in an FSTD qualified under 14 CFR part 60 on topics including low energy states/stalls, upset recovery techniques, adverse weather conditions, aircraft performance, navigation, automation, and CRM. The draft AC that was placed in the docket further defined those subject areas. Because the proposed training was focused on introducing pilots to general concepts affecting all transport category aircraft, the NPRM did not propose that the FSTD training be conducted in a particular aircraft type (non-type specific) as is required for air carrier training. The FAA stated in the AC, however, that the training should take place in an FSTD that

represents an aircraft with a maximum take-off weight of at least 40,000 pounds.

The FAA received nearly 70 comments regarding the appropriateness of requiring FSTD training that is not specific to any aircraft type. Many of the commenters, including AAL, agreed the training course should and can include concepts that are generally universal to transport category aircraft. CAPA noted aircraft performance and high altitude flight environments are universal across the transport category spectrum.

IATA stated the ATP CTP should include training in a non-type specific FSTD because ''the intention of the course is the development of core competencies independent of airplane type and applicable to all types of multi-crew transport category airplane operations.'' KSU stated training on non-type specific FSTDs would be beneficial and would add significant value to the ATP CTP. The University of Dubuque and SCSU stated training in non-type specific FSTDs reinforces and demonstrates concepts covered academically. A4A agreed with this proposal and stated principles of transport category jet operations do not need to be type specific. Boeing noted the concepts proposed to be trained in FSTDs are among those that have been consistently identified as lacking in recent accidents.

Several commenters, including Ameriflight, FSI, and IFL Group, disagreed with permitting portions of the ATP certification training course in a non-type specific FSTD. The UAA disagreed with any FSTD requirement as part of the ATP CTP and noted the phrase ''generally universal to transport category aircraft'' causes problems because it is onerous to pilots seeking an ATP certificate for non-transport category aircraft.

NATA opposed the requirement for general instruction in an FSTD because it shifts the cost to pilots with no benefit because the training would be superseded by air carrier initial training.

The FAA received several comments concerning the possibility for negative training when conducting non-type specific training. NATA acknowledged value in additional training for prospective ATP certificate candidates but stated that the ATP CTP will create negative learning situations by forcing pilots into non-applicable training. NATA believes there are many pilots operating turboprop or piston engine aircraft that will be required to accomplish the training in turbine simulators as part of the ATP CTP. NATA and RACCA believe that requiring these pilots to obtain training that does not apply to their experience and operational goals will lead to a negative experience that does not increase safety.

The FAA has concluded the ATP CTP FSTD training topics are necessary to reinforce the academic topics and to address the requirements of the Act. In addition, the FAA agrees with those commenters that believe the FSTD training can be non-type specific and not result in negative learning and therefore has decided to retain the non-type specific training in an FSTD.

First, the FAA reiterates that this framework of academic training and flight training is consistent with that of other pilot certificates. Pilots routinely receive basic certification flight training in one type of aircraft and then move on to fly many other types of aircraft without a negative transfer of learning. The training received in the ATP CTP will also be the last basic certification training a pilot receives. It will address topics not covered at the commercial pilot certificate level and establish a knowledge base that additional aircraft type-specific and air carrier-specific training can build upon when a pilot is trained to fly for an air carrier.

Second, the ATP CTP is designed to teach high-level concepts that are applicable to operating all large transport aircraft. It will increase knowledge through academic introduction to concepts that are generally true across all large aircraft types and then consolidate those same concepts through demonstration and experience in FSTDs. None of the training tasks will require applicants to perform maneuvers to proficiency, but rather experience critical events (stall onset, low energy states, upset prevention and recovery) with continuous instructor explanation and feedback. By combining this training experience with instructor explanation, the academic portion of the course will be effectively consolidated while reducing the possibility of negative transfer of learning for those pilots who may fly different aircraft types than those used in the course.

c. Level of FSTD and Hours

The FAA proposed 16 hours in an FSTD—8 hours in a Level C or D FFS and 8 hours in a Level 4 or higher FTD. The FAA received more than 130 comments regarding the level of the appropriate device but very little comment concerning the appropriate number of hours.

Many commenters, including the Regional Airline Association (RAA), UND, and FIT, stated that a level 4 or 5 FTD would be an appropriate level of FSTD for the entire course as long as it has visual capabilities and a stick shaker/pusher. Cape Air proposed that a level 5 or 6 FTD with realistic visuals would be sufficient for the course. OSU indicated a level 5 or higher device with visuals would be just as effective as a Level C FFS and would result in reduced costs. The commenters added that FTDs are an acceptable and safe alternative to FFSs. AOPA was particularly concerned that the FAA had not considered whether there was an adequate number of available FSTDs in the United States to accommodate the number of ATP applicants who will require training and raised concerns that compliance may be difficult.

ERAU cited various studies in their response that raised concerns regarding the use of motion-based training devices, including the value of using motion-based training devices in upset maneuvers, and disputed the need for simulator training in extended envelopes. One study asserts there are compromises made between cost and fidelity with the goal of getting the highest degree of transfer of training from the simulation device to the real world (Roscoe, 1980). An additional study that was cited by ERAU expanded upon that finding, indicating that FAA-qualified FFSs are unable to accurately portray how an airplane would react outside of the normal flight envelope—often referred to as extended envelope operations (Schroeder & Grant, 2010). ERAU noted the FAA participates in the International Committee for Aviation Training in Extended Envelopes (ICATEE). ERAU added ICATEE (2012) proposes an approach to examining the issue by first defining training needs and then proposing solutions. The ICATEE solution for training extended envelope flight tasks includes using flight simulation within its limitations. The eight hours of training with motion-based simulation in the ATP CTP will be for tasks in, or near, the extended envelope where the correlation to actual flight conditions is problematic. ERAU concluded its comment with the statement ''[n]o motion is preferable to incorrect motion.''

NTSB commented that, because simulators may not be able to accurately portray stalls and upset recovery, the FAA should allow flexibility in determining what level of simulation or automation is appropriate for specific training.

A number of colleges and universities, including Utah Valley University (UVU) and Rocky Mountain College stated the FFS requirement in the ATP CTP creates a significant obstacle for colleges and universities with aviation degree

programs due to the high costs of obtaining and maintaining those devices. Aims Community College, which operates a Level C FFS, was supportive of the proposed minimum FFS level. Commenters, including KSU, SCSU, USAPA, and WMU, stated the approved curriculum should have specified goals and competencies, not required hours.

The FAA concurs with many of the commenters' assertions regarding the ability to utilize FTDs in an effective training program. While an FTD does not provide the sensory input of motion, the fidelity of the aircraft data and replication of the aircraft controls can be very high. These high fidelity devices without motion can offer effective training benefits for tasks that do not require motion inputs to meet the learning objective (e.g., use of automation and navigational instruments and CRM).

Following a review of the comments and a training task analysis consisting of a re-evaluation of the FSTD topics and proposed device level, the FAA has reaffirmed that it is not possible to train all of the topics in an FTD. Therefore, the FAA has retained the requirement for training certain topics in an FFS. A flight training program that combines effective use of Level 4 and higher FTDs and the benefits of Level C or higher FFSs best ensures that the learning objectives will be effectively met. Notwithstanding the decision to retain training in FSTD, the FAA has modified the training hours in the final rule. Based on the task analysis, rather than the 16 hours of FSTD training proposed in the NRPM, the final rule requires 10 hours of training in FSTDs: Six hours in a Level C or higher FFS and four hours in Level 4 or higher FTD.

As previously stated, the FAA has moved some topics that were originally proposed for the FSTD portion of the course to the academic portion. The FAA has matched the remaining flight training objectives from the ATP CTP with the appropriate level of device and determined the ''FTD topics'' (e.g. flight management systems) could be trained in four hours rather than the eight hours proposed in the NPRM. As a result, the regulatory text of § 61.156 permits up to four hours of the ten hours of FSTD training to be completed in an FTD—which may be conducted in a Level 4 or higher FTD or Level A or higher FFS (with or without motion activated).

In completing the task analysis of the ATP CTP, the FAA also determined that the training that must be completed in a Level C or higher FFS could be accomplished in six hours rather than the eight hours proposed in the NPRM. Many of the maneuvers such as taxi, takeoff, and landing can be conducted only in a Level C or higher FFSs. Neither FTDs nor Level A or B FFSs are evaluated to perform such maneuvers. Additionally, low energy states, stall events, upset prevention and recovery techniques, and adverse weather conditions, including icing, thunderstorms, and crosswinds, require devices with motion cueing to achieve the learning objective. Only Level C or higher FFSs can replicate both the specific aerodynamic characteristics of the aircraft and the sensory perceptions that motion provides, which are necessary to allow the applicant the opportunity to fully grasp the critical concepts of the course. Level C or higher FFSs offer superior training benefits for maneuver-based training that cannot be replicated adequately by an FTD. This determination is based on the conclusion that, while both visual and vestibular systems are directly impacted by simulation, the element of these systems that is critical to satisfactory training is motion on-set (or acceleration) cueing. In addition, for a pilot's first exposure to critical concepts, such as high altitude handling, low energy states, and aircraft handling in adverse weather conditions, Level C or higher devices are necessary in order for the pilot to achieve the learning envisioned by the Act.

Various studies have shown an increase in pilot performance when pilots use simulators with motion. See Showalter, T.W.; Parris, B.L., ''The Effects Of Motion And GSeat Cues On Pilot Simulator Performance Of Three Piloting Tasks,'' Ames Research Center, Jan 1, 1980 (indicating 40% improvement on yaw performance and roll performance, engine out on takeoff with use of motion simulators); Parris, B.L.; Cook, A.M., ''Effects of visual and motion simulation cueing systems on pilot performance during takeoffs with engine failures,'' Ames Research Center, Dec 1, 1978; Hosman, R.J.A.W., & van der Vaart, J.C. ''Effects of vestibular and visual motion perception on task performance,'' (1981); Heintzman, Richard J. ''Determination of Force Cueing Requirements for Tactical Combat Flight Training Devices,'' Training Systems Product Group Aeronautical Systems Center Air Force Materiel Command Wright Patterson AFB, February 1997; Gebman, J.R.; Stanley, W.L.; Barbour, A.A.; Berg, R.T.; Birkler, J.L., ''Assessing the Benefits and Costs of Motion for C–17 Flight Simulators,'' Department of The Air Force, Washington, DC, June 1986. Accordingly, the FAA has determined that maneuver-based tasks must be conducted in a Level C or higher FFSs because the FFSs provide the level of motion cueing necessary to ensure proper response in real flight operations. These simulators most closely represent an aircraft with respect to aerodynamic handling characteristics and possess the motion required to achieve the learning objective of many tasks.

The FAA agrees with ERAU's assertion regarding the limitations of FFS in extended envelope maneuvering and modeling; however, none of the requirements in the ATP CTP involve training in these extended envelopes. The FAA believes the commenter's use of the term extended envelope is referring to theoretical or analytical data used in simulation which may exceed typical manufacturer-captured flight test data. As set forth in AC 61–138, low energy states (slow flight), approach to stalls, and even the upset prevention and recovery training will all be conducted within the manufacturer's supplied and FAA's National Simulator Program validated aerodynamic envelope.

As noted by ERAU, the FAA participates in ICATEE and other research projects in order to develop training tasks within current limitations and research adjusting future simulator modeling where appropriate. The commenter also expresses concerns over the lack of available displacement of hexapod motion platforms that could induce negative transfer training if the training task exceeds the motion capabilities of the device. We concur with this thought but re-emphasize all the training tasks proposed will occur within the validated aerodynamic and simulator motion envelopes. The upset training maneuvers used in the ATP CTP are supported through the research and development of the Airplane Upset Recovery Training Aid (AURTA) and recently validated by the 2012 Loss of Control Avoidance and Recovery Training (LOCART) ARC. The LOCART ARC was sponsored by the FAA and additionally supported by International Civil Aviation Organization (ICAO), the European Aviation Safety Agency, and Transport Canada to develop recommendations for upset prevention and recovery maneuvers in order to minimize the loss of control inflight accidents worldwide. The AURTA was developed by Airbus, Boeing, and the Flight Safety Foundation; it contains effective upset recovery training tools designed to work within the simulator's designed motion platform. This training is intended to increase a pilot's ability to recognize and avoid situations that

can lead to airplane upsets and improve the pilot's ability to recover control of an airplane that has exceeded the normal flight regime. To further mitigate the possibility of negative transfer of training, the FAA has published AC 120–109, Stall and Stick Pusher Training, comprehensive guidance for the training and checking of stall events. The FAA will publish additional guidance material in AC 61–138 for the academic training portion of the course for the aerodynamics, and upset prevention and recovery topics based on the recommendations of the LOCART ARC. The FAA emphasizes instructor training in all of its guidance material relating to stall and upset, for both the operation of the training device and training in the device's limitations, in order to avoid a student's potential for negative learning.

In the draft AC for the ATP CTP that was placed in the docket when the NPRM published, the FAA stated that in order to replicate the high altitude and low energy handling characteristics desired, the FFS should represent a swept-wing transport category airplane with a maximum gross takeoff weight of 50,000 pounds or greater. The FAA did not propose this standard in the regulatory text. Despite receiving significant comment on the training topics listed in the AC as well as what level of device would be appropriate, the FAA received only one comment—which was supportive—regarding the proposed takeoff weight or wing design of the type of airplane the FFS should represent. As part of the evaluation of the FFS training topics and learning objectives, the FAA reviewed all of the approved FFSs under 14 CFR part 60 including the associated weights of the aircraft they represent. Based on that review, the FAA has determined an FFS representing an aircraft with a maximum takeoff weight of at least 40,000 pounds is necessary to meet the objectives of the ATP CTP.

The weight of the aircraft the simulator represents is an important factor in ensuring handling characteristics of a typical transport aircraft. The 40,000 pound minimum requirement will ensure the device can replicate the lower performance margins and handling qualities inherent in transport category aircraft when being operated near their maximum operating weight at altitudes near their service ceiling. Critical concepts such as high speed slowdowns and approach to stall recoveries, which can take thousands of feet to recover at high altitudes, cannot be achieved in lighter aircraft types with higher thrust-to-weight ratios. The FAA notes that 40,000 pounds generally captures most regional aircraft including larger turboprops like the Bombardier DHC–8–400. To ensure that the objectives of the ATP CTP are met, the FAA has incorporated the weight requirement from the AC into § 61.156. Due to the potential for differing interpretations associated with the terms ''swept-wing'' or ''straight wing,'' the FAA has decided to remove that language from the FSTD requirements. The weight requirements described above and listed in the final regulatory language will produce the desired handling qualities sought in order to achieve the objectives of the course.

In response to commenters' concerns over the lack of sufficient number of training devices to deliver the ATP CTP, currently there are 407 FAA-evaluated Level C or higher FFS devices that replicate aircraft with a maximum takeoff weight at or exceeding 40,000 pounds. These devices represent 98% of all Level C and D FFSs that have been approved by the FAA. The FAA has evaluated the average number of ATP certificate applicants per year over the last 10 years (5,500), compared to the number of devices (81 FTDs and 407 FFSs) defined by the rule and recommended for use in the ATP CTP. Being conservative, the FAA assumed that all 10 hours of FSTD training would occur in Level C or higher FFSs. Assuming each FFS is capable of five 4-hour simulator periods per day (allowing for one 4-hour maintenance period per day), the U.S. inventory of these FFSs offers over 700,000 simulator periods. The 5,500 ATP certificate applicants will require 16,500 FFS periods from the U.S. inventory—less than 2% of available simulator time. Use of FTDs in the course will only improve availability. The AC suggests the FTD should replicate multicrew aircraft and be equipped with a flight management system (FMS) and autoflight. Currently, 68% of FAA-evaluated Level 4 or higher FTDs (a total of 81 FTDs) replicate the desired aircraft as defined by AC 61–138. Therefore, the FAA has determined even with moderate usage for non ATP CTP training, there is ample inventory of available FSTD time to accommodate the requirements of the course.

Finally, the FAA has decided to allow for consideration of a deviation from the weight requirement set forth in § 61.156. The FAA established a baseline weight because it believes that having all FFSs representing aircraft weighing 40,000 pounds or more allows for adequate demonstration of the learning objectives described in AC 61–138. The FAA recognizes, however, that there may be FFSs that represent an aircraft weighing less than 40,000 pounds that may be capable of replicating the lower performance margins and handling qualities desired at higher altitudes to meet the learning objectives of the course. If a training provider seeks to use a device that does not meet the weight criteria set forth in § 61.156, it must apply for a deviation. In considering a deviation request, the Air Transportation Division, the National Simulator Program, and the certificate holder's assigned principal inspector or TCPM will work together to determine if the training platform ensures quality, effective training for ATP applicants and provides an equivalent level of safety.

d. FSTD Cost

As reflected in the final regulatory evaluation, the cost to provide the training is estimated to be equivalent across all possible training providers. Although part 121, 135, 141 and 142 certificate holders may sponsor a simulator under part 60, there is no requirement to own a simulator. Many part 121 and part 135 certificate holders currently utilize simulation for training without the ownership and maintenance of the devices. It is common practice for many air carriers to enter into agreements with other carriers and part 142 training centers to lease time in FSTDs. Additionally, there is no requirement to deliver the ATP CTP training program, and each certificate holder must individually determine if providing the course best meets its needs and ability. Although the FAA considered cost when aligning the appropriate device to the training task, meeting the learning objective was the paramount consideration.

5. FAA Knowledge Test for an ATP Certificate

In the NPRM, the FAA proposed to revise the aeronautical knowledge areas in § 61.155 to incorporate the new knowledge areas in the ATP CTP. We noted that such a revision would result in changes to the ATP knowledge test. Commenters such as IATA and the IFL Group believed the current ATP knowledge test is inadequate. Commenters assert the current preparatory products available to applicants of the knowledge test only ensure rapid rote memorization of the material and not knowledge retention. The FAA concurs and has determined academic knowledge gained and evaluated in a classroom setting, reinforced with demonstration and experience in an FSTD, and then validated by a revised written knowledge test gives the applicant the

best chance of knowledge retention. This knowledge will allow the student to perform more effectively upon entering an air carrier environment—the ultimate goal of the Act.

The FAA also proposed to extend the validity period for the knowledge test for an ATP certificate to five years in consideration of the applicant's time and financial commitment to the ATP CTP. The FAA considered the extension appropriate due to the proposed elimination of the ability for air carrier pilots to use expired knowledge tests. The FAA received no comments on this proposal. In the final rule, FAA has retained the five-year validity period for the ATP knowledge test only for those pilots who pass the knowledge test after having completed the ATP CTP—meaning any test passed after July 31, 2014. The FAA has also retained the provision that allows pilots employed by certificate holders in parts 121, 125, or 135 to use expired knowledge tests. As set forth in § 61.39, pilots employed in parts 125 and 135 may use an expired knowledge test if they have completed the ATP CTP and the operator's approved pilot-in-command training or checking program. New hire pilots in part 121 operations may use an expired knowledge test if they have completed the ATP CTP and the operator's initial training program.[15] These pilots employed by air carriers are subject to additional training and evaluation requirements that will ensure that they have a continued understanding of the general concepts of the ATP CTP. If an applicant outside of an air carrier environment fails to take the practical test within five years of taking the knowledge test, he or she must retake the knowledge test to validate retention of the subject areas of the ATP CTP. The FAA has modified § 61.35 to make clear that a person may not take the knowledge test for the ATP certificate with an airplane category multiengine class rating until the person is 18 years of age.

Finally, as set forth in existing § 61.49, those applicants who fail the knowledge test for the ATP certificate after completing the ATP CTP are required to receive the necessary remedial training from an approved ATP CTP training provider and receive an endorsement before retaking the knowledge test.

[15] As set forth in § 61.39(b), the knowledge test results for pilots who pass the knowledge test before August 2014—meaning they have not completed the ATP CTP—will expire 24 months after the date the test was passed. These pilots may not use an expired knowledge test to take the practical test even if they are employed by an air carrier.

6. Credit Toward Air Carrier Training Programs

In the NPRM, the FAA proposed that the ATP CTP would be a basic certification requirement, not an air carrier training program requirement. This position was consistent with the provision in the Act that directed the FAA to modify the ATP certificate to require the specific training previously discussed in this final rule. The FAA specifically asked commenters whether changes or reductions could be made to a part 121 air carrier training program based on the proposed content of the ATP CTP. There were 27 respondents who indicated that air carriers could either incorporate the ATP CTP into their initial program or reduce initial training hours based on the air carrier providing the ATP CTP. Whereas most of the respondents were favorable to air carriers offering the course, commenters were split on the issue of reducing an air carrier's initial training program as a result of the ATP CTP. FlightSafety and Aerosim supported a reduction of initial training if additional subjects were covered by the ATP CTP. RAA indicated that reductions to air carrier flight training programs based on the proposed content of required ATP CTP would be difficult because the content of the ATP CTP was more generic than air carrier training. A4A stated ''a review of initial training should be accomplished'' without further explanation for why such a review should occur. Ameriflight claimed there is no legal basis for air carriers to provide part 61 training.

Although part 121 and part 135 operators may elect to offer this training for their pilots, it would remain separate from part 121 and part 135 training requirements. Because the proposed ATP CTP is part of the basic certification requirements for an ATP certificate, air carriers who elect to offer this training would be required to provide the course to their pilots prior to beginning initial training. The FAA proposed that principal operations inspectors may approve a reduction of hours in an air carrier's initial training program based on material taught in the ATP CTP. However, because the ATP CTP requirements are basic certification requirements, these hours could not be reduced based on the contents of an air carrier's initial training program.

The FAA agrees with many commenters that the initial flight training should not be reduced because type-specific and operator-specific training is critical in the development of air carrier pilots. The FAA conducted a review of the ground training required for initial training in part 121, subpart N. The general subjects that are listed in § 121.419(a)(1) contain many of the more basic knowledge requirements now addressed by the ATP CTP.

The FAA has determined that some reductions in initial training for those more generic items listed in § 121.419(a)(1) can occur. However, in place of requiring POI approval for these reductions, as was proposed in the NPRM, the FAA has decided to amend the general subject areas of initial training for those air carrier new hire pilots who have completed the ATP CTP prior to initial training. As these general subjects will now be taught in the ATP CTP, it will raise the baseline knowledge for all new hire pilots entering part 121 operations. This change will allow for more air carrier specific training to occur in initial training while allowing for reductions in the required program hours. The FAA notes that, until August 1, 2016—the date that all knowledge test results completed without completion of the ATP CTP will have expired—air carrier training classes could be comprised of some pilots who have completed the ATP CTP and some pilots who have not completed the course.

With regard to Ameriflight's comment regarding the impropriety of air carriers providing training that results in part 61 certification, the FAA is unclear of the basis of Amerifight's confusion. Regulations have recognized part 61 certification events for ATP certification and type ratings through air carrier training programs for many years.

7. Additional Course Requirements

The FAA has added provisions to new §§ 121.410, 135.336, and 142.54 to ensure that certificate holders maintain certain standards for the ATP CTP. First, there is a provision in the final rule that prevents certificate holders from issuing graduation certificates unless a student has satisfactorily completed all of the training requirements for the ATP CTP. Second, the FAA is requiring certificate holders to establish a mechanism that insures continued evaluation of the ATP CTP to guarantee that training techniques, procedures, and standards are acceptable to the Administrator. These requirements are in addition to the administrative requirements that are already contained in the various rule parts. Because part 141 pilot schools currently have similar requirements for training courses and are required to renew their certificates every two years, no provisions have been added to that part.

E. ATP Certificate With Restricted Privileges (§ 61.160)

1. Public Law and NPRM

Section 217 of the Act mandates that an applicant for an ATP certificate have ''at least 1,500 flight hours.'' The section gave the FAA discretion to permit applicants to obtain an ATP certificate with fewer than the minimum 1,500 hours if they have completed ''specific academic training courses,'' [16] as determined by the Administrator. The Act permitted a reduction only upon a determination by the Administrator that the courses would ''enhance safety more than requiring the pilot to fully comply with the flight hours requirement.''[17]

Based on the discretion afforded to the Administrator in section 217, the FAA proposed a new section, § 61.160,which set forth two alternative flight hour requirements for an ATP certificate with airplane category multiengine class rating based on academic experience. Specifically, the FAA proposed to permit military pilots who have graduated from an Armed Forces undergraduate pilot training school to obtain an ATP certificate with 750 total flight hours and graduates of four-year aviation degree programs with integrated flight training to obtain an ATP certificate with 1,000 total flight hours.

The FAA proposed to limit the privileges of any pilot who obtains an ATP certificate under the aeronautical experience requirements of new § 61.160. As set forth in the NRPM, a pilot holding an ATP certificate with fewer than 1,500 hours (an R–ATP certificate) would not be permitted to act as PIC in part 121 operations or as PIC in operations conducted under § 91.1053 and § 135.243—the only operations under parts 91 and 135 that require the PIC to hold an ATP certificate. A pilot holding an R–ATP certificate would also not be permitted to serve as SIC of an aircraft in flag or supplemental operations that require three or more pilots because, even prior to the statutory requirement, SICs in those operations were required to hold an ATP certificate.

In addition, the FAA proposed to modify the eligibility requirements of § 61.153 to establish a minimum age of 21 years for an R–ATP certificate. The FAA also proposed amending § 61.167 to preclude a pilot who holds an R–ATP certificate from providing instruction under that section.

2. General Support for and Opposition to an ATP Certificate With Reduced Hours

Sixteen commenters, including APA, CAPA, USAPA, and Kestrel Aviation, LLC, (Kestrel) believe reducing the flight hour requirement to be eligible for an ATP certificate should not be allowed. The Families of Continental Flight 3407 stated that they would like to see ''every pilot required to have the minimum 1,500 actual flight hours before being eligible for an ATP certificate.'' Four New York Congressmen and RACCA opposed a reduction in flight time for everyone except military pilots. Several individual commenters added that completing flight training through a part 141 pilot school or part 142 training center cannot replace flight experience.

CAPA commented that ATP certification is a well-proven system and the 1,500-hour minimum time requirement provides an undeniable basic level of safety and operational proficiency. APA stated: (1) The 1,500 flight hour requirement helps ensure that a mature, experienced aviator will be at the controls; (2) there is no substitute for experience; and (3) the most effective way for pilots to gain essential experience is to fly aircraft. APA noted that, along with total flight hours, ATP certificate requirements include cross country, night, and instrument flight hours that develop pilot skills that cannot be taught in a classroom or properly developed in a simulator. CAPA stated that real-world experience is vital.

NAFI submitted results of a survey it conducted with 427 of its members regarding the proposals and questions presented in the NPRM. A majority of the responders indicated that they did not support an ATP certificate with restricted privileges for pilots with fewer than 1,500 flight hours based on academic training or experience. However, the results of the survey also showed that a significant number of NAFI members (327 respondents) believed that segments of the pilot community other than military pilots and graduates of four-year aviation degree programs should be eligible for an R–ATP certificate.

AmeriFlight commented that the proposed rule will isolate many factions of the industry and funnel students to the cost-prohibitive four-year college flight training programs. AmeriFlight questioned whether the FAA believed that the knowledge gained while attending a four-year postsecondary institution is an adequate replacement for 500 hours of flight time and 175 hours of flight time in cross-country operations. Delta stated that a reduction in hours, training, or experience for pilots exercising the PIC privileges of an ATP certificate is not appropriate based on the statute.

The majority of commenters, including representatives of air carriers, educational institutions, and aviation organizations, were generally supportive of a restricted privileges ATP certificate but recommended alternatives to the proposal and suggested that it be made available to a greater number of pilots.

Fifteen commenters offered opinions and comments on what they referred to as arbitrary hour requirements, including CAA and IATA. A4A stated that flight time alone does not ensure pilot proficiency or professionalism and added that formal education combined with good hiring practices, training, and mentoring will produce the most highly qualified pilots. American Flyers/Nova Southeastern University argued that the FAA should not consider flight hours alone as a satisfactory indicator or piloting ability, judgment, or experience. It stated that the qualification for the R–ATP certificate should be based on a combination of academic training and experience. Several commenters, including AOPA, RACCA, and the University of Dubuque thought the minimum age of 21 for an R–ATP was also arbitrary. One individual commenter added that there was no evidence to suggest age 18 undermined safety.

SAFE stated that academic experience should only be used to reduce flight hours if there is demonstrable evidence to support it. Four commenters, including WMU, and John A. O'Brien Consulting, LLC, agreed that a R–ATP certificate should be permitted based on training or experience.

GAMA argued that there should be no flight hour minimum; rather, the FAA should focus on ensuring the quality of flight training. It added that eligibility for an R–ATP certificate should be determined through evaluation of the quality of the applicant's academic and practical flight training. Three commenters noted that the quality of flight experience was a better indicator of pilot success than only quantity of flight hours. Six commenters contended that the FAA needs to allocate resources to develop a better formula for rating the formal training, education, and experience of candidates for an R–ATP certificate.

The FAA continues to support an ATP certificate with restricted privileges

[16] The Act specified that these training courses must be beyond the additional training required by the Act itself. In other words, the new training mandated by the Act could not be a basis for a reduction in flight hours below 1,500 hours.

[17] Current regulations do not define the term ''flight hours;'' therefore, the FAA assumes that the 1,500 flight hours referenced in the Act represents the 1,500 hours total time as a pilot currently required by § 61.159.

for pilots who are at least 21 years of age. The majority of commenters asserted that allowing a reduction in flight hours based on academic coursework is safe, appropriate, and meets the intent of Congress. For the commenters who disagree with establishing an ATP certificate with fewer than 1,500 hours, the FAA also maintains that flight experience in an aircraft is an important component in developing the knowledge and skills necessary for a pilot to perform effectively in the air carrier environment. However, by granting the FAA discretion to reduce the required flight hours based on specific academic training, the Act acknowledged that flight time is not necessarily the only component to developing a safe and qualified pilot. The FAA concurs and has determined structured academic training integrated with flight training programs can provide more safety benefit than simply meeting the 1,500 hour flight time requirement alone.

Accordingly, the FAA will permit a pilot to obtain an ATP certificate with restricted privileges and serve as an SIC in part 121 operations. The minimum aeronautical experience requirements and age requirements of an R–ATP certificate will greatly exceed the commercial pilot certificate requirements previously required to serve as SIC in part 121 operations. As discussed in greater detail below, the academic coursework prerequisites for the R–ATP certificate together with the additional flight hour experience and the new training required for ATP certification will result in a pilot who is better prepared to enter an air carrier environment than meeting the 1,500 hour requirement alone.

The FAA emphasizes that pilots who meet these alternative hour requirements will be required to pass the same ATP knowledge test and practical test as pilots who obtain an ATP certificate at 1,500 hours. In addition, in the final rule, the FAA is retaining the limitations on the certificates of pilots who obtain an ATP certificate with the reduced flight hours. These pilots will have the following limitation placed on their certificates: ''Restricted in accordance with 14 CFR 61.167'' and ''Holder does not meet the pilot-in-command aeronautical experience requirements of ICAO.'' Pilots who hold ATP certificates with these limitations will not be permitted to act as PIC in any operation that requires an ATP certificate or serve as SIC in flag or supplemental operations that require three or more pilots. The FAA will remove the restriction from the ATP certificate once the pilot provides satisfactory evidence of having met the age requirements in § 61.153(a)(1) and the aeronautical experience requirements of § 61.159.

The flight time requirements for an ATP certificate under § 61.159 are not being altered by this rule. Therefore, pilots acting as PIC under part 121, § 135.243(a)(1), and § 91.1053(a)(2)(i) are still required to have at least 1,500 hours of total time as a pilot. Additionally, the age requirement for obtaining an ATP certificate to serve as PIC is not being altered in § 61.153. Pilots must continue to be at least 23 years old to act as PIC in operations that require an ATP certificate or to serve as SIC in flag or supplemental operations requiring three or more pilots. The FAA agrees with many of the commenters that the existing total time requirements for an ATP certificate are appropriate to act as PIC.

The following sections address specific comments about alternative crediting systems, the eligibility of military pilots and graduates of four-year aviation degree programs as proposed in the NPRM, and specific recommendations from commenters regarding expanding eligibility for the R–ATP certificate beyond those proposed in the NPRM.

3. FOQ ARC Recommendation

The FOQ ARC recommended crediting academic training as well as aeronautical experience. The ARC developed a complex system that not only permitted flight-hour credit for a variety of academic training including both two- and four-year aviation degrees but also allowed weighted credit for various flight experience.

Eleven commenters, including NAFI, Boeing Commercial Airplanes (Boeing), NATA, RAA, JetBlue, WMU, Purdue, and FSC suggested that the FAA implement a system of weighted flight hour reductions based on pilot experience. NAFI noted that the Pilot Source Study and the recommendations of the FAA's FOQ ARC should be referenced in any consideration of credit options. Boeing stated that the FAA should credit all manner of training that would better prepare pilots for air carrier operations. Boeing noted that this would include all college aviation programs, approved courses from part 141 and part 142 certificate holders, and all related experience and courses.

The RAA argued that the FAA should adopt the recommendations of the FOQ ARC. It noted the FOQ ARC recommended an aeronautical experience credit system that incorporated many of the individual recommendations identified by other commenters. The RAA contended that the FOQ ARC credit system is the model for establishing the proper level of eligibility and academic credit levels that should be provided for students of worthy programs. Finally, the RAA added that the NPRM fails to recognize the myriad of important providers of academic education and relevant flight experience that should be considered for flight hour reductions. Additional supporters of the FOQ ARC crediting system included A4A, CAA, American Eagle Airlines, Inc., ExpressJet, Aerosim, FedEx, Cape Air, AAL, John O'Brien Consulting, MTSU, Spartan College, and numerous individual commenters.

The National Training Aircraft Symposium (NTAS), which consisted of 80 industry members from academia, air carriers, and flight training providers, recommended a crediting system very similar to the FOQ ARC crediting system with the only difference in the amount of credit allowed for flight instruction. Supporters of the NTAS system included JetBlue, WMU, Purdue University, and FSC.

The FAA has reconsidered the FOQ ARC crediting system and determined that implementation and oversight of such a complex system, or a variation of it, would be too burdensome. Allowing a large number of crediting options creates a much more complicated process for FAA examiners and designees in determining and validating how much credit a pilot can get to be eligible for an R–ATP certificate. In addition, the weighted flight experience concept gives a multiplier effect to hours that were deemed more applicable to air carrier operations and therefore more valuable to a prospective air carrier flightcrew member. While the FAA finds value in the weighted flight experience concept, the Act does not permit giving flight hour credit to certain types of flight experience to reduce the minimum required flight hours for the ATP certificate.[18]

Considering phases I and III of the Pilot Source Study, the crediting system proposed by the ARC, and the structured academic coursework a graduate completes for an aviation

[18] The FAA notes that Section 217 of the Act directed the FAA to ensure that applicants for an ATP certificate had received ''flight training, academic training, or operational experience'' that would prepare the pilot to function effectively in an air carrier environment. Several paragraphs later in Section 217, Congress gave the Administrator discretion to reduce flight hours for the ATP certificate based on ''specific academic training courses.'' The FAA has determined that the failure to list operational experience in this provision of the Act does not permit the FAA to reduce flight hours based on operational experience.

degree, the FAA has determined that a reduction in flight hours is appropriate, and we have retained credit for academic training in the final rule. In addition to decisions surrounding the crediting system proposed by the ARC, the FAA also engaged in extensive qualitative evaluation of aviation degree programs and courses, which will be discussed in more detail later in this final rule. This evaluation, coupled with the documentation that will be provided by the aviation programs, will help to ensure that crediting hours are only granted for legitimate aviation program coursework.

4. Military Pilots

Commenters submitted 95 responses regarding the proposal to allow military pilots to obtain an R–ATP certificate with 750 hours of flight time. Eighty-eight commenters agreed a restricted privileges ATP certificate is appropriate for military pilots. Several other individual commenters observed that the military operational environment is different than the air carrier environment, so reductions based on military experience are not justified. CAPA specifically stated there is no empirical evidence that a graduate from a military program has better experience or skill than other airman.

Four New York congressmen and RACCA opposed a reduction in flight time for anyone except military pilots. These commenters acknowledged the highly specialized disciplined screening and training procedures military pilots undergo.

Twenty-eight commenters, including Delta, CAA, and RAA, indicated a 750-hour requirement for former military pilots is too high. Most commenters stated 500 hours is more appropriate. Spartan College stated ''the rigor and quality selection process for military pilots linked with highly structured training meets or exceeds the requirements of the NPRM'' and added that 500 hours is appropriate for military pilots who operate in a multi-crew environment.

An additional 17 commenters including ERAU, KSU, JetBlue, NAFI, PABC, GAMA, FSC, CAE, NATA, DSU, and a number of individuals agree military pilots should be eligible for a restricted privileges ATP certificate but did not suggest how much experience is appropriate. Three commenters, including Aerosim, stated 750 hours is too low and suggested 1,000 hours instead. Aerosim conducted a survey of over 300 of its part 141 flight training institutions that indicated that 71% of the respondents support a reduction in flight hours for military pilots, with 55% of respondents stating that 750 hours was adequate.

The FAA has determined that permitting military pilots to obtain an R–ATP certificate with fewer than 1,500 hours is appropriate due to the quality and structure of military training. To be accepted into a pilot training program in one of the branches of the military, a person must undergo a rigorous screening process including an assessment of aviation aptitude. Depending on the branch of the military, an applicant for pilot training must hold an associate's degree or a bachelor's degree. Once accepted into a pilot training program, a person is assigned full-time to aviation training.

As an example, the United States Air Force Specialized Undergraduate Pilot Training (SUPT) includes four to six weeks of academic and preflight training on aerospace physiology, altitude chamber tests, aircraft systems, aviation weather, mission planning, and navigation. After initial academic and preflight training, the Air Force student pilot undergoes 22 weeks of primary aircraft training before transitioning to a track of advanced aircraft training that continues for another 24 to 28 weeks. During flight training, military pilots continue their academic training through detailed briefings and debriefings of their flight training. An Air Force student pilot is committed to a 12-hour duty day while at SUPT, and his or her flight proficiency is continuously assessed. Additionally, during the flight training phases, an Air Force student pilot participates in flight training every day, either in a simulator or an aircraft.

Similarly, a Navy pilot completes a six-week indoctrination program which includes classes in aerodynamics, air navigation, aviation physiology, and engineering. The Navy pilot next completes primary training in approximately 22 weeks. It includes ground-based academics, FSTDs, and flight training. The Navy pilot then continues to advanced flight training.

Based on the comprehensive and demanding nature of military pilot training, the FAA is adopting the proposed requirement to allow military pilots who have graduated from an Armed Forces flight training program to apply for the ATP practical test after obtaining 750 hours of flight time. To the extent that some commenters have suggested a reduction is not appropriate due to operational differences in military operations, the FAA responds that the completion of military pilot training and the accumulation of 750 flight hours does not automatically result in an R–ATP certificate. Rather, a military pilot will still be required to complete the ATP certification training program in new § 61.156, pass the ATP knowledge test, and pass the ATP practical test or air carrier evaluation that results in the issuance of an ATP certificate. In addition, prior to serving in part 121 operations, military pilots will be required to complete an air carrier's initial training program and pass a proficiency evaluation. Accordingly, a military pilot will be required to demonstrate knowledge of civilian operations.

The FAA has modified § 61.39 to require military pilots applying for the ATP practical test to present the documents listed in § 61.160(a) to substantiate eligibility for an R–ATP certificate. These documents include an official U.S. Armed Forces record that shows that the applicant graduated from a U.S. Armed Forces pilot training school and received a rating qualification as a military pilot. Graduation from a training program designed to qualify a military pilot solely for operation of unmanned aircraft systems will not satisfy the requirement in § 61.160(a). Additionally, the FAA notes that regulations do not currently permit the time acquired while operating an unmanned aircraft system to be logged to meet aeronautical experience requirements for FAA certification.

Although several commenters have suggested the FAA allow a further reduction in flight hours for military pilots, the FAA has received no compelling data to support such a reduction. In addition, the FAA notes that, based on averages provided by the military, an additional reduction would have limited impact on those that could take advantage of this provision. Specifically, the majority of military pilots who complete their service obligations will have acquired the 1,500 hours required for an unrestricted ATP certificate. Army pilots who average approximately 800 hours when they complete their service obligations and pilots who are honorably discharged from the military prior to completing their service obligation would be most likely to benefit from the R–ATP certificate.

5. Graduates With a Bachelor's Degree in an Aviation Major

One hundred and seventy-five commenters supported an R–ATP certificate for applicants with a bachelor's degree with an aviation major. Several academic institutions including the Council for Higher Education Accreditation (CHEA), the American Association of Community

Colleges, UAA, Fox Valley Technical College of Aeronautics, WMU, Aims Community College, ERAU, Hesston College, Purdue, KSU, FSC, Westminster College, UVU, SIU, OSU, MTSU, DSU, Spartan College, Nova Southeastern University, and Florida Institute of Technology were supportive of the flight experience reduction based on academics. In addition, several individual commenters stated that graduates of an aviation degree program should be eligible to obtain an R–ATP certificate because the quality of training received at such schools is superior to that received under part 61.

CAPA commented that there is no empirical evidence that a graduate of an aviation degree program has better experience or skill than an airman who has not. CAPA also stated that, because most pilots cannot afford the ''extraordinarily high cost of specialized aviation institutions,'' the reduction in flight hours for these graduates is unfair because an applicant with financial resources can ''purchase'' their qualifications without having to gain flying experience. Moore Air, Inc. stated that permitting pilots from aviation bachelor's degree programs affiliated with part 141 schools discriminates against pilots with fewer economic resources. John A. O'Brien Aviation Consulting, LLC, stated the restricted privileges ATP certificate should not be limited to college graduates from ''select universities.'' AAL commented that the NPRM encourages pilots to attend a four-year aviation college or university but fails to recognize that such paths are available only to those willing and able to afford such educational paths. AAL acknowledges that higher education and quality training should be encouraged but quality training is also available in places outside accredited four-year aviation colleges.

In support of a reduction based on academic credit, Parks College (Parks) stated that its aviation graduates accomplish approximately 220 ''hours of ground and classroom instruction leading to a [commercial pilot certificate] with an instrument rating.'' Parks noted that, in addition to this classroom training for pilot certification, its students complete an additional 480 hours (32 credit hours) of academic coursework on topics related to aviation and air carrier operations. UND also provided information demonstrating that graduates of its professional flight curriculum must complete 464 hours of instruction in required aviation coursework that includes courses on human factors, flight physiology, advanced aerodynamics, and aviation weather. These students must also complete ground and flight training toward a commercial pilot certificate and instrument rating.

Based on the fact that the academic coursework completed as part of an aviation major generally exceeds the time a pilot might spend in ground school outside of that environment, the FAA continues to support a reduction of flight hours for graduates with an aviation major from a four-year institution of higher education who complete ground and flight training as part of approved training courses at a part 141 pilot school that is associated with the institution of higher education. Over the course of several years, these graduates complete significant aviation coursework well above the hours of ground training required for commercial pilot certification. In addition, a student's knowledge and flight proficiency are continuously evaluated throughout the degree program.

Notwithstanding the FAA's continued support for a reduction in required flight hours for these applicants, the FAA has refined, clarified, and expanded some elements of the R–ATP certificate as it applies to graduates of degree programs with aviation majors in the final rule. These modifications are discussed in the following sections.

a. Flight Hour Requirement

Notwithstanding general support for a reduction in hours for these pilots, many commenters recommended reducing the hours below the 1,000 hours proposed in the NPRM.

One hundred sixty-five commenters stated that 1,000 hours is too high, including OSU, Aviation Professional Development, LLC (APD), DSU, and the Pilot Career Initiative. AAL and Westminster College stated 1,000 hours is much too high to provide an incentive for pilots to pursue a formal education.

Most commenters responded that a total flight time of 500 to 750 hours is more appropriate for graduates of a four-year aviation degree program. Many commenters, including Delta, ERAU, and Rocky Mountain College cited the Pilot Source Study as evidence that the FAA should allow pilots with fewer than 1,000 hours to be employed by air carriers. The American Aviation Institute (AAI) along with several other commenters suggested the rule be simplified by establishing the 750-hour threshold for an R–ATP certificate to civilian candidates who have graduated from accredited programs including two- and four-year universities, programs designed for university graduates, and other structured academies run by training organizations and by airlines. AAI also recommended the FAA establish requirements for academies to qualify them. Other commenters suggested that the FAA offer an R–ATP certificate to graduates of a four-year collegiate flight program with fewer total flight hours, generally in the range between 500 and 1,000 flight hours.

Ten commenters, including KSU, SJSU, WMU, UVU, Aerosim, ALPA, American Flyers, and Nova Southeastern University believe the proposed 1,000 hours of flight experience is adequate. Approximately 47 percent of NAFI's members indicated that 1,000 hours is too low but did not specify how many of those responding generally oppose an R–ATP certificate.

The FAA has considered the 2010 and 2012 Pilot Source Studies, the FOQ ARC report, and the structured academic coursework in aviation a graduate receives [19] and has determined that, based on the best currently available information, it is appropriate to retain the minimum 1,000-hour aeronautical experience requirement for graduates of four-year degree program with an aviation major who obtain their commercial pilot certificate and instrument rating from an associated part 141 pilot school. Commenters have not provided compelling evidence to support a further reduction in hours for graduates of these programs. Many commenters referenced the 2010 Pilot Source Study (which indicated that the most successful pilots in initial training, without any consideration of the manner in which they received their aviation training, were those pilots hired with 500–1,000 hours) to justify why they felt the FAA should reduce the hour requirement further.[20] The FAA notes that the third phase of the Pilot Source Study, which was submitted to the docket, indicated that pilots with 1,001–1,500 total flight hours had more completions in training than any other group, including the group with 500–1,000 total flight hours.[21]

[19] There is further discussion of the FAA's review of academic curriculum later in this document. This review provided additional support to the agency's decision to retain the credit for graduates of aviation degree programs.

[21] A summary of the findings of the 2012 Pilot Source Study was submitted to the rulemaking docket. The FAA considered the results along with additional factors during development of the final rule. A recent journal article discussing the results of the 2012 Pilot Source Study concluded that ''flight hours are not a good predictor of performance.'' The journal article can be found in the Journal of Aviation Technology and Engineering, Vol.II, Issue 2 (2013) at: *http://docs.lib.purdue.edu/jate/vol2/iss2/2/*.

b. Institutional Accreditation and ''Aviation Degree Programs''

The FAA proposed in the NPRM to permit a reduced flight hour requirement for applicants who hold a bachelor's degree with an aviation major obtained from a postsecondary educational institution that satisfies the definition of ''accredited'' as established by Department of Education in 34 CFR 600.2. The Department of Education maintains a database of accredited postsecondary institutions and programs available at the following Web site: *http://ope.ed.gov/accreditation/*.

UAA fully supported the proposed requirement that any degree-granting institution qualifying its graduates for reduced flight hours must be accredited by a nationally recognized accrediting agency as defined by the Department of Education in 34 CFR 600.2. UAA contended that this type of accreditation insures the validity of the institution granting the degree and provides the most inclusive form of accreditation possible by which to prepare pilots for the proposed R–ATP certificate. UAA added some of their member institutions hold program-specific accreditation in addition to institutional accreditation, but the majority do not have program accreditation at this time. UAA looked at current, national collegiate flight training and indicated the number of eligible institutions will decrease from over 164 to 29 if program specific accreditation becomes a requirement. UAA noted that two institutions that currently hold program accreditation are phasing out their pilot training programs.

KSU stated that the relationship between the academic institution and the flight training provider signifies a strong commitment to quality pilot education and fosters an environment of professional pilot training. KSU added that Aviation Accreditation Board International (AABI) accreditation and part 141 approval by the FAA provide the needed quality assurances for the quality and integrity of flight training. Purdue added that the same credit should be given to graduates of AABI-accredited flight programs regardless of the part under which the school operates. APD agreed with the proposal to provide an R–ATP certificate but indicated that those R–ATP certificates should be available only for those students attending an AABI-accredited flight school.

The FAA received several comments requesting the FAA further define ''aviation degree program.'' The NTSB supported an ATP certificate with restricted privileges provided standards are established for student performance and the type of degree programs are more clearly defined. An individual commenter also suggested ''aviation-related degree'' is too broad. The commenter suggested the FAA specify the number of hours as well as the subject areas that should be taught. Barbary Coast Consulting expressed concern that the determination of what degree credits would qualify for a reduction in hours would fall to the academic institution and recommended that the FAA should make this determination based on how these classes will actually enhance aviation safety.

The Families of Continental Flight 3407 stated that, while there is value to aeronautical knowledge and training provided by four-year accredited institutions that offer aviation degrees, such graduates should not ''blindly be accorded flight hour credit without carefully evaluating each course to determine if it meets the law's specific criteria[.]'' The Families of Continental Flight 3407 specifically noted that the law required that academic training courses ''enhance safety more than requiring the pilot to fully comply with the flight hours requirement.'' P.L. 111–216, sec. 217(d). The Families of Continental Flight 3407 further stated that the FAA should develop a procedure to carefully evaluate the coursework in each graduate's academic program and only give credit to courses that enhance aviation safety and not courses that focus on ''tangential areas of aviation.'' They indicated that credit should be based on a course-by-course basis and not a blanket 500-hour reduction.

NATA noted that the Act gave the FAA authority to allow for reduced hours based on a safety assessment. It argued that the FAA failed to demonstrate in the NPRM that it had performed a comprehensive analysis. AAI indicated that the FAA should set specific program standards that can be met at the undergraduate or graduate levels at accredited schools and universities.

Spartan College commented that the education program must be well integrated with the university to make sure that classroom and flight lab time match the learning objectives. Spartan College recommended that all academic and ground school courses be taught by faculty and instructional staff employed by the institution. Spartan College indicated, however, that flight training could be taught either by an institution's instructional staff or by one or more qualified contractors through written contract.

The FAA is retaining the requirement for institutional accreditation in this final rule because accreditation ensures that education provided by institutions of higher education meet acceptable levels of quality. Accrediting agencies, as defined by the Department of Education in 34 CFR 600.2, develop evaluation criteria and conduct peer evaluations to assess whether those criteria are met. According to CHEA, accredited status is a signal to students and the public that an institution meets at least threshold standards for its faculty, curriculum, student services, and libraries.

The FAA acknowledges the value of programmatic accreditation, but it is not the sole means of assuring the quality of an aviation degree program for the purpose of qualifying students for an R–ATP certificate. Currently, AABI is the only organization that provides accreditation to aviation degree programs. As noted by UAA, if program-specific accreditation becomes a requirement for the R–ATP certificate, the number of eligible institutions will be reduced to 29.

The FAA agrees, however, with commenters who believe that the requirements of ''aviation degree programs'' must be better defined. The FAA has reviewed aviation degree curriculum requirements from over 100 colleges and universities and found that graduates of four-year universities receive bachelor's degrees with as few as 27 credit hours and as many as 85 credit hours in aviation and aviation-related courses. In addition, required courses and electives within aviation degree programs vary significantly. Many aviation degree programs are not focused primarily on preparing a student for a career as a professional pilot but rather for careers in areas such as air traffic control, aerospace engineering, aircraft maintenance, or business aviation. If the requirements proposed in the NPRM were not refined, graduates of those degree programs could be eligible for an R–ATP certificate without having completed relevant coursework designed to improve their knowledge and skills as a pilot.

For this reason, the FAA has decided that broad approval of aviation degree programs based on accreditation alone is not sufficient. Rather, the most critical element for determining whether a graduate should be eligible for an R–ATP certificate is the body of coursework completed prior to graduating with a degree in an aviation major. Establishing more specific program criteria for eligibility for an R–ATP certificate will better ensure that

academic training courses enhance safety such that a reduction in flight hours is consistent with the Act.

The FAA has modified § 61.160 from that proposed in the NPRM to clarify the academic requirements a student must complete to be eligible for an R–ATP certificate. In the final rule, the FAA has established that a student must:

- Earn a bachelor's degree in an aviation major;
- Complete 60 semester credit hours in aviation and aviation-related coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot;
- Complete ground training for a commercial pilot certificate and an instrument rating under approved part 141 curricula at the institution of higher education;
- Complete flight training for commercial pilot certificate and an instrument rating under approved part 141 curricula at the institution of higher education or at a part 141 pilot school associated with the institution of higher education; and
- Obtain a commercial pilot certificate with airplane rating and an instrument rating upon completion of ground and flight training.

The FAA has established 60 semester credit hours in aviation and aviation-related coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot as the minimum requirement. In determining whether a course is designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot, the institution should consider the objective and purpose of the course. For instance, an introductory course on air traffic control could be designed to provide a foundation for both pilots and for students intending to pursue a career as an air traffic controller. On the other hand, an upper-level or advanced air traffic control course is primarily intended to prepare a person to work as an air traffic controller with little additional benefit to a person seeking a career as a pilot. Although knowledge of tower operations is instructive, an upper-level air traffic control course is not generally designed with the goal of improving and enhancing the knowledge and skills of a person seeking a career as a professional pilot.

These credit hours may include coursework outside the aviation department so long as the course focuses on an aviation-related topic. For example, credit hours obtained in a meteorology course outside the aviation department could count toward the required 60 credit hours because it introduces the student to basic weather theory that will affect flight decisions. As further explained in AC 61–139, Institution of Higher Education's Application for Authority to Certify its Graduates for an Airline Transport Pilot Certificate with Reduced Aeronautical Experience, the FAA believes that courses in subject areas like aircraft performance and aerodynamics, aircraft systems, aviation human factors, air traffic control and airspace, aviation law and regulations, aviation weather, and aviation safety represent courses that are designed to enhance and improve the knowledge and skills of a person seeking a career as a professional pilot. The FAA expects that, in addition to the ground and flight training required for FAA certification, aviation students will have completed coursework in all of these areas as part of their aviation degree.

Finally, an R–ATP certificate applicant must have a commercial pilot certificate with an airplane category and instrument rating earned from a part 141 pilot school that is part of the academic institution or associated with the academic institution through a formal training agreement. Under § 61.160, a graduate must have completed all ground training for the commercial pilot certificate and instrument rating at the institution of higher education. Accordingly, the academic institution must, at a minimum, hold a part 141 pilot school certificate for ground training. This requirement will ensure that the ground training for certification is integrated into the institution's broader academic curriculum. The flight training for the commercial pilot certificate and instrument rating may be completed either at the institution, if it holds a part 141 pilot school certificate for flight training, or at a part 141 pilot school that is associated with the undergraduate institution through a formal training agreement. The FAA notes it has revised § 141.26 to require a pilot school that provides flight training for an institution of higher education that holds a letter of authorization under § 61.169 must have a formal training agreement with that institution of higher education.

Under the standards established in the final rule, the FAA estimates that students who are eligible for an R–ATP certificate will complete over 600 instructional hours [22] in aviation and aviation-related coursework designed to prepare them for a career as a professional pilot. Concurrently with their broader aviation coursework, students will complete the required ground and flight training and pass the practical tests for a commercial pilot certificate and instrument rating. These students are continuously evaluated with academic testing and flight evaluations over the course of several years. Based on these factors, a graduate of a bachelor's degree program who completes the requirements set forth in § 61.160 is eligible for an R–ATP and may apply for the ATP practical test with 1,000 hours total time as a pilot.

In setting the criterion for 60 semester credit hours in aviation and aviation-related coursework, the FAA decided to allow partial recognition for applicants with bachelor's degrees with aviation majors who fall short of the 60 credit hour requirement. Applicants who have completed at least 30 semester credit hours in aviation and aviation-related coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot may apply for an R–ATP certificate with 1,250 hours total time as a pilot. The applicant's coursework must include all of the ground and flight training for a commercial pilot certificate and instrument rating.

c. Cross Country Time for the R–ATP Certificate

To apply for an ATP certificate under § 61.159, a pilot must accumulate 1,500 hours total time as a pilot that must include 500 hours of cross-country flight time. In the NPRM, the FAA proposed to require military pilots who apply for an R–ATP certificate with 750 hours total time as a pilot to have 250 hours of cross-country flight time. The NPRM proposed requiring graduates with aviation majors who apply for an R–ATP certificate with 1,000 hours total time as a pilot to have 375 hours of cross-country flight time. The reduction in the required cross-country flight time was proportional to the reduction in total flight hours.

UND's John D. Odegard School of Aerospace Sciences submitted a research study that was conducted to assess the impact of the proposed rule on the supply of pilots who primarily obtain their flight experience from flight instructing. UND's study concentrated on the nature of flight time acquired as a flight instructor as it relates to the 500 hours of cross-country flight time required to apply for the ATP certificate.

[22] The FAA estimated that, as part of a degree program, students will complete an average of 12–15 credit hours of ground and flight training toward FAA certificates and ratings. Students will complete an additional 45–48 credit hours of broader aviation and aviation-related coursework during 15-week semesters.

The participants in the study included line flight instructors from 17 collegiate aviation programs. Based on its research, UND concluded that the average flight instructor would have to log 2,100 total flight hours before accumulating 500 hours of cross-country flight time. UND recommended that the FAA amend the rule to require a minimum of 200 hours of cross-country flight experience to obtain an R–ATP certificate rather than the 375 hours proposed in the NPRM for graduates of four-year aviation programs.

The FAA has reviewed the information provided by UND and determined that it is appropriate to reduce the cross-country flight time required for all applicants for an R–ATP certificate to 200 hours. In reaching this decision, the FAA considered the past and current requirements of both the commercial pilot and ATP certificates. Although 200 hours is below the requirements for an ATP certificate under § 61.159, the FAA believes pilots will accumulate a significant and relevant amount of cross-country experience as SICs in part 121 operations before being eligible to obtain an unrestricted ATP certificate and upgrade to PIC. The 200 hours of cross-country experience represents a significant increase over the 50 hours of cross-country flight time required for the commercial pilot certificate—the prior requirement to serve as SIC in part 121 operations. Pilots who hold an R–ATP certificate will be required to meet the 500 hours of cross-country flight time required in § 61.159 prior to having the limitation removed from their certificate. The FAA notes that the 200 hours of cross-country flight time is consistent with the ICAO standard for an unrestricted ATP certificate.

d. The Role of the Institution of Higher Education in Certifying Its Students

Under new § 61.169, an institution of higher education may apply for authority to certify that its graduates have met the academic eligibility requirements for an R–ATP certificate. The institution may not certify a student based solely on the degree received or the aviation major that has been completed. Rather, it will be required to evaluate each student's coursework before certifying that a graduate has met all of the academic eligibility requirements.

To obtain authority to certify students for eligibility for the R–ATP certificate under new § 61.160, an institution of higher education must submit an application and supporting documentation, as appropriate, to the FAA that includes:

- List of aviation majors offered by the institution;
- Type of degree offered;
- Institutional accreditation information;
- Part 141 pilot school information;
- List of substantial changes to degree programs in past five years;
- Course descriptions of aviation and aviation-related courses that may be used to satisfy the credit hours required by § 61.160; and
- Training agreements for flight training provided by a part 141 pilot school, if applicable.

The institution must identify on the form those academic courses that satisfy the requirements of § 61.160. Specifically, the institution must demonstrate that a course is designed to improve and enhance the skills and knowledge of a person seeking a career as a professional pilot. These courses will include the ground and flight training courses required for FAA certification as well as other coursework within the aviation department, such as Aviation Law, Human Factors, or Advanced Aircraft Systems. Courses outside the aviation department may also satisfy the requirements of § 61.160. For example, a physics course may qualify as an aviation-related course provided the course description clearly indicates aircraft performance and aerodynamics are the primary focus of the course. The institution must demonstrate that it offers sufficient aviation and aviation-related courses that a graduate could rely upon to meet at least 30 semester credit hours.

The application and FAA review process for institutions seeking a letter of authorization to certify students is further explained in AC 61–139. The AC provides greater detail on the aviation and aviation-related coursework used to satisfy the semester credit hour requirement. In addition, the AC provides information related to the part 141 pilot school requirements, including training agreements, and the institution's responsibility to notify the FAA of any changes that will affect its letter of authorization. Once the FAA has determined that an institution of higher education has met all the requirements, it will issue a letter of authorization granting the school authority to add a certifying statement to a student's transcript or other document deemed acceptable by the Administrator. The certifying statement must denote whether the graduate is eligible to apply for an R–ATP certificate based on the applicable criteria in § 61.160 at 1,000 hours (graduates who have completed at least 60 credit hours), or 1,250 hours (graduates who have completed at least 30 credit hours). A graduate will then be required to present the certifying document, along with all other documentation required in § 61.39, when applying for the practical test for an R–ATP certificate.

6. Recommendations for Expanding Eligibility for the R–ATP Certificate

A significant number of commenters, including air carriers, educational institutions, training providers, instructors, and aviation organizations suggested that a greater number of pilots should be eligible for an ATP certificate with reduced flight hours. Specifically, commenters suggested that the FAA make the R–ATP certificate available to the following candidates:

- Graduates of two-year aviation degree programs with commercial pilot certificates and instrument ratings from an affiliated part 141 pilot school;
- Students who come to eligible programs already holding commercial pilot certificates and instrument ratings;
- Students from non-eligible programs who transfer into and graduate from eligible programs;
- Pilots who are age 21 and have 1,500 hours of flight time;
- Graduates with bachelor's degrees with aviation majors and obtain commercial pilot certificates and instrument ratings from a non-affiliated part 141 pilot school;
- Graduates with bachelor's degrees with aviation majors and obtain commercial pilot certificates and instrument ratings from an affiliated part 61 flight training program;
- Graduates with associate's degrees with aviation majors and obtain commercial pilot certificates and instrument ratings from a non-affiliated part 141 pilot school;
- Graduates with associate's degrees with aviation majors who obtain commercial pilot certificates and instrument ratings from an affiliated part 61 flight training program;
- Pilots who have completed training programs at ''Aviation Academies'' (part 141 pilot school or part 142 training center);
- Pilots who have completed ''other'' aviation courses (e.g. AJT, Upset Prevention and Recovery Training (UPRT));
- Certified Flight Instructors (CFI); and
- Graduates of colleges and universities who do not have aviation degrees

A discussion of the options suggested by commenters follows.

a. Graduates With an Associate's Degree in an Aviation Major

In the NPRM, the FAA did not propose any reduction in total flight time for graduates of two-year aviation degree programs. Thirty six commenters, including Fox Valley Technical College Aeronautics Advisory Committee (FVTC), Experimental Aircraft Association (EAA), Aims Community College, NAFI, Jet Transitions, American Association of Community Colleges, Hesston College, Spartan College, UAA, CAE, and ExpressJet, argued that graduates of pilot schools not associated with a four-year aviation degree program should also be eligible for reduced flight time to be eligible for an R–ATP certificate. Most of the thirty six commenters stated that two-year college flight training programs should be eligible for an R–ATP certificate.

Fox Valley Technical College and the American Association of Community Colleges contended that the proposed rule is arbitrary and discriminatory and that graduates of two-year colleges and universities should be allowed to obtain an R–ATP certificate.

Aims Community College added that its students receive the same focused aviation training discussed in the NPRM and should be eligible for the same credit that graduates of four-year degree programs receive. According to Aims, these students complete the same flight hour and academic instruction requirements as students at four-year institutions, even though they do not complete as many courses unrelated to aviation. Aims indicated that students who earn an Associate of Applied Science degree complete 72 credit hours as part of its fixed-wing professional pilot program. They also stated the two-year college and university system nationwide has been providing well-trained pilots for the airlines and other aviation employers for decades. They suggested that, with the high cost of flight training and college in general, now is not the time to take away an efficient, effective, reasonably priced, educational opportunity from those who cannot afford the cost and time required for a four-year degree program.

CAE contended that quality instruction and flight experience can be delivered in two-year programs affiliated with part 141 pilot schools or part 142 training centers. Spartan College supported academic credit based on a variety of educational tracks including four-year and two-year collegiate aviation degrees. UAA, ExpressJet, and several other commenters argued that the FAA failed to include two-year programs, which should be afforded academic credit as provided in the FOQ ARC report.

The UAA added that two-year college and university aviation degree programs are a key part of the overall collegiate aviation-related pilot supply. To validate the assertion, the UAA conducted a telephone survey in April 2012, which reached a total of 29 community college aviation degree programs out of 40 identified as flight training providers. Based on the data obtained in the survey, the UAA estimates more than 2,000 aviation students are currently enrolled in two-year degree programs. For the 29 respondents, it was found that: ''(1) 1,474 total students were enrolled in aviation flight-related degrees at these institutions, or, on average, 51 students per institution; (2) the student enrollment ranged from a low of 7 students to a high of 292 students; and (3) of the 29 institutions reporting, 18 conducted flight training solely under part 141, 6 operated under part 61, and 5 used a combination of parts 61 and 141.''

UAA recommended changing the proposed § 61.160 to eliminate the differentiation between two- and four-year schools and recommended a 750-hour minimum for the R–ATP certificate. The EAA contended that the FAA should form a working group to explore what modifications should be made to these two-year school accreditation standards in order for their programs and students to qualify for the revised ATP aeronautical experience requirements in § 61.160.

The AAI recommended that the FAA adopt a program-based standard and not define acceptability solely by the length of the program. AAI commented that a student at a four-year institution pursues coursework in non-aviation fields, which is far less relevant than the aviation coursework actually taken.

Based on the FAA's extensive review of two-year and four-year aviation degree programs, the FAA has determined that it is appropriate to permit graduates who obtain an associate's degree with an aviation major to apply for an R–ATP certificate with fewer than 1,500 total hours. The two-year colleges, universities, and their graduates who responded to the NPRM have provided sufficient information to support a reduction in the flight hour requirement for an R–ATP certificate.

The FAA has found that these graduates receive degrees with a range of 24 to 56 credit hours in aviation and aviation-related coursework. On average, however, graduates of associate degree programs complete fewer credit hours in aviation coursework than graduates of bachelor's degree programs. For that reason, the FAA disagrees with giving the same credit to two-year programs. Accordingly, the FAA has modified § 61.160 to permit graduates of approved two-year degree programs with aviation majors to apply for an R–ATP certificate with 1,250 total hours of flight time.

As set forth in § 61.160(c), graduates of two-year programs must complete a minimum of 30 semester credit hours in aviation and aviation-related coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot. The 30 credit hours may include coursework outside of the aviation department so long as the course focuses on an aviation related topic. The FAA assumes on average courses are offered at three semester credit hours per course. The 30 credit hours therefore will include the ground and flight training courses for a commercial pilot certificate and instrument rating and other aviation and aviation-related courses.

As with bachelor's degree programs, the graduate will need to acquire a commercial pilot certificate with an airplane category and instrument rating from a part 141 pilot school that is part of the undergraduate institution. The institution of higher education must hold a part 141 pilot school certificate and provide all ground training for the commercial pilot certificate and instrument rating. This requirement will ensure that the ground training is integrated into the broader academic curriculum. The flight training may be completed either at the institution, if it holds a part 141 pilot school certificate for flight training, or at a part 141 pilot school that is associated with the undergraduate institution through a training agreement.

b. Transfer Students

SIU believes students who move from a two-year aviation degree program to an affiliated four-year aviation program and complete their bachelor's degree and the required flight training under part 141 should be eligible for a restricted privileges ATP certificate. KSU similarly states students who transfer to a four-year collegiate flight training degree program with an affiliated part 141 pilot school should have the same eligibility as a student who solely attends a four-year collegiate flight training degree program with an affiliated part 141 pilot school. KSU noted, however, that the school receiving a transfer student must evaluate the student's performance and

ensure that the school's own performance standard is met before graduation can occur.

The FAA acknowledges students follow a number of different paths for completing post-secondary education at a college or university. Some students start at community colleges and transfer to four-year degree programs while other students transfer between different four-year institutions of higher education. The FAA does not want to deter individuals from seeking alternative paths to achieving an aviation degree and therefore has determined that students who transfer into a two-year or four-year degree program with an aviation major could be eligible for an R–ATP certificate. These graduates would be eligible for an R–ATP certificate provided they complete the applicable requirements of § 61.160, including the semester credit hours and ground and flight training.

The FAA acknowledges that many of the larger four-year degree programs with aviation majors have satellite programs that are two-year programs. The satellite schools follow the same ground and flight training curriculum as the parent school which makes for a smooth transition from the two-year program to the four-year program. The FAA believes those graduates should also be eligible for an R–ATP certificate provided the requirements of § 61.160 are met and documented through official college transcripts and records. Further guidance and clarification on transfer credit is provided in AC 61–139.

c. Pilots With 1,500 Hours Who Are Not Yet 23 Years Old

Three commenters stated pilots should be able to obtain an R–ATP certificate at the age of 21 or less as long as they meet the full aeronautical experience requirements for the ATP certificate, including the 1,500 hours of total flight time. The commenters added that the existing age 23 requirement for the ATP certificate is arbitrary, discriminatory, and not based on science. AOPA commented that the FAA should allow any applicant to obtain an ATP certificate at the age of 21 and receive restricted privileges. NATA supports no age requirement if the ATP minimums are met, stating those pilots should be eligible for a restricted privileges ATP certificate.

Many pilots who have not yet reached the age of 23 have met or exceeded the 1,500 hours of total time as a pilot required for an ATP certificate. The FAA has remained consistent through denials of requests for exemption and previous rulemaking efforts to maintain the eligibility requirement of 23 years of age for an ATP certificate. The FAA has stated that the minimum age requirement of 23 years ensures ''a high maturity level for those pilots who are permitted to operate as PIC in operations requiring an ATP certificate.'' Exemption No. 7472. Commenters have failed to provide any compelling evidence to support a change to the long-standing requirement that a pilot exercising the PIC privileges of an ATP certificate be at least 23 years of age. Therefore, the FAA has not changed the age requirements for pilots serving as PIC in part 121 air carrier operations, SIC in part 121 flag or supplemental operations requiring three or more pilots, or operations conducted under §§ 91.1053(a)(2)(i) and 135.243(a)(1).

Based on the comments, however, the FAA has determined that a pilot who has reached the age of 21, has logged 1,500 hours total time as a pilot, and satisfies the remaining aeronautical experience requirements for an R–ATP certificate should be permitted to apply for an R–ATP certificate and serve as an SIC in part 121 operations. These pilots will exceed the age requirement of 18 years old that is currently required to obtain a commercial pilot certificate which, prior to the final rule, allowed a pilot to serve as SIC in part 121. Additionally, these pilots will have achieved the total flight time for an ATP certificate obtained under § 61.159. The FAA has determined that permitting such pilots to serve as SICs is an increase in the level of safety under current regulations and is consistent with the public law's focus on a higher level of flight experience for pilots serving in part 121 air carrier operations.

As with other applicants for an R–ATP certificate, these pilots will be required to complete 200 hours of cross-country flight time. The remaining 300 hours of cross-country flight time can be completed as an SIC in part 121 operations. The minimum age of 21 for an R–ATP certificate will allow those pilots currently serving as SICs in part 121 operations to continue serving in their current role provided they meet the required aeronautical knowledge and experience requirements and successfully accomplish an evaluation that results in ATP certification and an aircraft type rating.

d. Other Degree Programs

Twenty-seven commenters stated that graduates from four-year universities affiliated with part 61 schools should also be eligible for an R–ATP certificate. One commenter suggested that the FAA establish a fair method whereby flight proficiency could be measured against part 141 standards to allow part 61 students a reduction in flight hours. Another individual commenter pointed out that part 141 schools are given an unfair advantage over part 61 schools. UVU stated that graduates from four-year aviation programs with integrated flight training should qualify for an R–ATP certificate regardless of whether their training was conducted under part 61 or part 141.

Numerous commenters stated that AABI accredited institutions with part 61 schools should be eligible for a restricted privileges ATP certificate at 1,000 flight hours. Purdue believes any AABI-accredited aviation program should be eligible for credit regardless of whether the associated flight training is conducted under 14 CFR parts 61, 141, or 142.

Several commenters, including DSU and CAE, believed pilots with an aviation-related degree and part 141 flight training from a separate organization should be eligible for a restricted privileges ATP certificate. SIU, AAL, and Prairie Air Service, Inc. argued that the FAA should extend eligibility for the R–ATP certificate to any four-year college graduate, regardless of academic major or where flight training was obtained. Westminster College supported academic credit as a substitute for flight experience adding that credit should be extended to graduates of a part 141 pilot school with any four-year college degree or associate's degrees in aviation.

Many commenters disagreed with allowing credit for an ATP certificate for training received from non-affiliated part 141 pilot school. IATA stated that, if this proposition were to become a reality, it would require an unreasonable amount of FAA oversight in determining the adequacy of each applicant's training. ALPA's support of flight hour reduction for the restricted ATP certificate for college or university educated pilots is based on a comprehensive flight training curriculum integrated with the student's education. Several of the individual commenters stated that graduates of an aviation degree program should be eligible to obtain an R–ATP certificate because the quality of training received at such schools is superior to that received under part 61.

The FAA has considered all of the various methods for obtaining academic and flight experience proposed by commenters but decided that degree programs with non-aviation majors, flight training conducted under part 61, and non-integrated flight training

should not be eligible for an ATP certificate with fewer than 1,500 hours. The FAA has permitted a reduction for graduates who receive bachelor's degrees and associate's degrees with aviation majors and receive part 141 ground and flight training for a commercial pilot certificate and an instrument rating as part of a broader aviation curriculum.

The FAA does not agree with those commenters who believe that graduates with degrees unrelated to aviation should be eligible for an R–ATP certificate. These graduates have not completed coursework that prepares them for a career as a professional pilot and such an allowance would not be consistent with the Act. As discussed above, the FAA has emphasized the importance of an aviation curriculum in permitting a reduction in flight hours. It is the significance of aviation coursework above and beyond what is required for pilot certification that is the primary basis for permitting a reduction in flight hours. To underscore this fact, the FAA has established a minimum number of credit hours in aviation and aviation-related coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot that these students must complete to be eligible for an R–ATP certificate. Although completing a bachelor's degree may develop certain qualities in an individual that may assist them in a career as a professional pilot, those qualities are not directly relevant to aviation and should not be the basis for a reduction in flight hours.

For those commenters who believe that the reduction should apply to graduates irrespective of whether they complete ground and flight training through a part 141 pilot school or under part 61, or whether or not the flight training is integrated with the academic coursework, the FAA disagrees. By requiring the institution of higher education to hold a part 141 certificate to teach at least the ground training, the FAA ensures that the training for a commercial certificate and instrument rating is incorporated into the broader academic aviation curriculum. In addition, the FAA has oversight of the training conducted through part 141 program approval. Those pilot schools must renew their certificates every 24 months and demonstrate the quality of the training through an established training standard.

e. Other Approved Training and Specialized Courses

Forty-one commenters, including the Pilot Career Initiative (PCI), AOPA, Paradigm Shift Solutions, Inc., Prairie Air Service, Inc., SIU, MTSU, and Spartan College, encouraged the FAA to permit pilots with other training experiences to qualify for an R–ATP certificate.

AOPA and AAI contend that the FAA defined ''academic credit'' too narrowly. NAFI advised consideration of what would constitute ''academic study'' and recommended that it not be limited only to university or college training programs. NAFI stated that it was possible that other institutions or training providers could develop highly effective ''academic study'' training programs. NAFI added that a standardized criterion that could be applied across various programs would be necessary to allow such a condition to be successful and measurable.

PCI contended that the structured flight academies should qualify for a reduction in hours because they have strong academic and flight training programs conducted through an approved FAA curriculum. John A. O'Brien Aviation Consulting, LLC indicated that aviation academies should be eligible since they provide interaction with experienced airline professionals and flight instruction in accordance with FAA regulations to individuals seeking employment as a pilot at an airline. The training is specialized and regimented for an individual with very little aviation background to acquire the skills and knowledge to graduate from a program, in a short timeframe, with all of the pilot certificates necessary to fly at an air carrier. AOPA is also supportive of credit for training completed at aviation ''academies.''

AOPA and two other commenters stated that the FAA should allow credit for individual academic courses and not simply apply a blanket reduction at graduation. Paradigm Shift Solutions and four additional commenters noted the FAA had not considered Advanced Jet Training for credit—a unanimous recommendation from the FOQ ARC. Another commenter noted the FAA had not considered pilots enrolled in FAA-Industry Training Standards programs or those pilots who complete air carrier training through an Advanced Qualification Program. The Upset Prevention and Recovery Training Association (UPRTA) added that the FAA should issue restricted ATP certificates with reduced flight hour requirements to all ATP candidates, provided they have received academic and flight instruction in upset prevention and recovery from qualified instructors.

NATA recommended that the FAA expand the flight hour credit ''to include a comprehensive framework similar to the recommendations of the FOQ ARC and any other science-based advanced training courses that provide a benefit to safety.'' NATA stated that, if the FAA did not expand the proposal, the NPRM should be withdrawn in its entirety until such time as a more comprehensive framework could be created. The AAI contended that credit should be applied to other structured academies run by training organizations or air carriers.

Twelve commenters, including John A. O'Brien Aviation Consulting, LLC, the AAI, PABC, UAA, Sporty's Academy, and the IFL Group argued that students attending flight schools that are not associated with an accrediting entity, also referred to as flight academies, should be eligible for reduced time to qualify for a restricted ATP certificate.

A4A argued all part 141-trained pilots should be eligible for a restricted ATP because part 141 pilot schools are subject to the same standards, regardless of their affiliation with a four-year college. IFL Group similarly argued that the FAA should extend credit to any commercial, instrument, multi-engine pilot who has graduated from a part 141 pilot school. Aerosim also argued graduates from independent part 141 schools that offer a structured training program, with air carrier procedures, policies, and standards, should be eligible for academic credit.

The FAA does not support a reduction in flight hours for pilots who complete training at an ''aviation academy,'' or for pilots who complete their ground and flight training at a part 141 pilot school. The reduction for graduates who receive bachelor's or associate's degrees with aviation majors was not based solely on the completion of ground and flight training for certification at a part 141 pilot school. Rather, the reduction was based on the content and substance of a broader academic curriculum completed concurrently with ground and flight training for certification. The FAA notes that the regulations already reflect a reduction in flight hours for a commercial pilot certificate completed at a part 141 pilot school or part 142 training center. Pilots who complete a commercial pilot certificate as part of an approved part 141 or part 142 curriculum can apply for a commercial pilot certificate with 190 total flight hours, as opposed to the 250 hours required for those pilots who train under part 61.

The FAA acknowledges that flight academies generally provide focused training to prepare pilots for a professional pilot career; however, the FAA does not agree that the academic curriculum is sufficient to meet the intent of the Act. Flight academies do not spend an abundance of time in aviation coursework, separate from the minimally required ground school, over a period of several years. These academies lack the accredited and structured academic environment that the aviation colleges and universities provide. The courses taught by aviation academies are primarily focused on flight training and obtaining certificates and ratings rapidly. Many programs advertise a person can obtain their private pilot certificate, commercial pilot certificate, instrument rating, and certified flight instructor certificates in 12 months or less.

The FAA also does not support a reduction in flight hours for specialized courses such as upset recovery training and advanced jet training. The FAA encourages pilots to seek additional training that will enhance their skills and abilities; however, the FAA does not have the resources to evaluate every possible course that could be the basis for a reduction in flight hours. The FAA also does not support a reduction in flight hours for those pilots who obtain FAA certificates through a FITS program or who complete air carrier training through AQP. These programs are designed to meet existing regulatory requirements and do not represent additional training courses that merit a reduction in flight time. In addition, allowing a large number of crediting options creates an increasingly complicated process for FAA examiners and designees in determining and validating how much credit a pilot can get to be eligible for an R–ATP certificate.

f. Certified Flight Instructors

Many commenters indicated that the individuals who perform best in air carrier initial training are those that have CFI certificates and were hired with 500 to 1,000 hours. The commenters contended that the Pilot Source Study in 2010 and 2012 provided support with statistically significant results for the argument that CFIs perform better in part 121 training. The pilots that had CFI certificates had more training completions and required fewer extra training events in part 121 training. NTAS, AABI, Spartan College, and one individual commenter stated that credit for CFI ratings and flight instruction given should qualify for a reduction in flight hours. Another individual commenter suggested that a restricted ATP should be available to active CFIs.

The FAA recognizes that, while completing the ground and flight training for a CFI certificate is valuable, it is not the predominant reason that a CFI is recognized for his or her knowledge and skill. It is the time spent in the training environment teaching other pilots that reinforces a CFI's skills and abilities. Therefore, the FAA does not agree with commenters who suggest that this time meets the intent of the academic crediting provision in the statute. The operational experience gained from teaching is what is valuable, not the academic coursework to obtain the certificate. As with specialized courses, the FAA encourages pilots to seek additional training that will enhance their skills and abilities like CFI certificates; however, CFI ground schools are designed to meet existing regulatory requirements and do not represent additional training courses that merit a reduction in flight time as permitted under the Act. In addition, allowing a large number of crediting options creates a much more complicated process for FAA examiners and designees in determining and validating how much credit a pilot can get to be eligible.

7. Summary of FAA Decision

The FAA is adopting the following alternative total flight hour requirements for an R–ATP certificate with airplane category multiengine class rating or an ATP certificate obtained concurrently with an airplane type rating:

- 750 hours for a military pilot who has graduated from a flight training program in the Armed Forces;
- 1,000 hours for a graduate who holds a bachelor's degree with an aviation major (60+ aviation semester credits) from an institution of higher education who also receives a commercial certificate and instrument rating from an associated part 141 pilot school;
- 1,250 hours for a graduate who holds a bachelor's or an associate's degree with an aviation major (30+ aviation semester credits) from an institution of higher education who also receives a commercial certificate and instrument rating from an associated part 141 pilot school; and
- Pilots who have reached age 21, have logged 1,500 hours total time as a pilot, and satisfy the remaining aeronautical experience requirements defined in § 61.160.

F. Aircraft Type Rating for All Pilots Operating Under Part 121 (§ 121.436)

In the NPRM, the FAA proposed requiring all SICs in part 121 operations hold an aircraft type rating for the aircraft flown in revenue service by August 1, 2013. A total of 113 commenters responded to this proposed requirement.

1. Aircraft Type Rating Requirement for Part 121 SICs

Seventy-eight commenters, including A4A, AOPA, APA, CAA, CAPA, Cape Air, Delta, ExpressJet, Parks College, NADA/F, PABC, Aviation Professional Development, FSC, FedEx, IATA, NAFI, UAA, USAPA, and WMU, agreed with the proposed aircraft type rating requirement. ALPA, CAE, and FSI support the proposed requirement because it would require a type rating for part 121 SICs flying domestically; thus harmonizing the U.S. with current ICAO standards. Boeing supported the proposed aircraft type rating requirement for part 121 SICs because it encourages one level of safety for operations involving aircraft that require type ratings. ERAU, Purdue, Rocky Mountain College, and SIU, agreed with the proposed rule requiring SICs in part 121 air carrier operations to hold an aircraft type rating, provided the air carrier is responsible for supplying the type rating to the SIC. An individual commenter said that operators should provide the type rating to decrease costs for new hire pilots. Rocky Mountain College noted that pilot supply would diminish if the cost of the type rating is transferred to the pilot.

Twenty-two commenters, including KSU and GAMA generally disagreed with requiring SICs in part 121 air carrier operations to hold an aircraft type rating. Four commenters, including AAL and the IFL Group, said that requiring SICs in part 121 air carrier operations to hold an aircraft type rating is not necessary and that current regulations and air carrier training programs are sufficient. Ameriflight stated experience, not certification, is the problem. Prairie Air Services ''doubted'' that any accidents would have been prevented if the SIC had a type rating. Bemidji Aviation Services, Inc. indicated that SIC checks achieve the same goal. UPRTA supports upset prevention and recovery training as an alternative to obtaining a type rating. Aerosim and an individual commenter noted that a type rating has not historically been an indicator that SICs are properly trained.

The FAA agrees with the large number of commenters who said that

requiring an aircraft type rating for all SICs serving in part 121 operations would improve safety in part 121 air carrier operations. In addition, this requirement responds to the objectives of section 216 of the Act, which requires the Administrator to determine the appropriate multiengine airplane flight experience for pilot flightcrew members.

The historic division of responsibilities between the PIC and SIC have changed. In today's air carrier environment, both the PIC and SIC share the role of pilot flying and pilot monitoring. Therefore, the FAA has determined that requiring an SIC to train to the same level of aircraft handling proficiency as the PIC by obtaining an aircraft type rating is appropriate. The FAA assumes most pilots will obtain an aircraft type rating at the air carrier as part of initial training. The practical test for an SIC to obtain an aircraft type rating will include the same tasks and maneuvers as those required for a PIC receiving a type rating. Because this practical test would be administered by an FAA inspector or designee, the test would serve as an additional level of oversight of the SICs aircraft handling skills and abilities. The FOQ ARC members unanimously recommended that an SIC hold a type rating in the aircraft to be flown in part 121 air carrier operations.

2. Compliance Time

JetBlue and AAL requested a grandfather clause for existing SICs to enable additional compliance time and reduce the financial burden that would be incurred by requiring unplanned training and evaluation sessions. JetBlue estimated it would cost $6 million to provide a type rating to its current 1,120 SICs who do not hold a type rating for the aircraft they fly. This estimate is based on the cost provided in the FAA's initial regulatory evaluation, which estimated the incremental per-pilot cost of a type rating for existing SICs at $5,389. AAL is concerned about the additional cost burden of providing a type rating to their 852 current SICs who do not have type ratings. AAL added that the FAA should consider allowing qualified simulator instructors or check airmen to validate flying skills for those pilots with at least 1,000 hours in type during their next recurrent training cycle. Upon completion of the evaluation event, AAL suggested having a letter issued to the pilot to take to an FAA office to obtain their ATP certificate. Delta estimated the short-term cost to provide the type rating to its more than 1,800 SICs who already have ATP certificates but not the type rating for the aircraft flown to be $11.6 million dollars.

AAI, A4A, Delta, FedEx, and UPS also requested that the proposed compliance deadline of August 1, 2013 be extended. They specifically proposed a compliance deadline of 5 years or during transition or upgrade training. JetBlue proposed aligning the compliance time frame with initial, transition, or upgrade training. Some commenters indicated that, for current SICs, the compliance period for the type rating requirement should be five years or be aligned with upgrade training. UVU, SJSU, and four individual commenters discussed implementation of a grandfather clause for current students currently enrolled in college to become a pilot.

The FAA estimates that even if an air carrier does not currently provide aircraft type ratings to its SICs, the impact of the proposed rule to its training program would be low. Currently, all SICs in part 121 operations receive extensive training and a thorough evaluation at the end of the air carrier's initial training program. During the evaluation, SICs must demonstrate that they can perform most of the maneuvers and tasks that would be required for an aircraft type rating. The FAA acknowledges that an SIC may need some additional hours of training on tasks and maneuvers required for an aircraft type rating that are not currently required during the SIC evaluation. The FAA believes, however, that the practical test for the aircraft type rating could be performed in the same simulator session currently used for the evaluation. The FAA acknowledges that, unlike an evaluation, which is typically conducted by a check airman, the practical test for an aircraft type rating would have to be administered by an FAA inspector or FAA designee.

As a result of the statutory deadline requiring all part 121 SICs to hold ATP certificates by August 2, 2013, most current part 121 SICs that hold only a commercial pilot certificate will likely receive an aircraft type rating during an ATP certification event administered by the air carrier prior to the deadline. Many air carriers have already initiated a change to their approved training programs to provide ATP certificates and type ratings to SICs who hold only commercial pilot certificates. The FAA assumes the proposed compliance date for the type rating will not be an issue because this population of SICs will receive a type rating simultaneously with an ATP certificate.

In the initial regulatory evaluation, the FAA assumed that air carriers would provide a type rating to their SICs who already hold ATP certificates during annual recurrent training. With the publication of the final rule so close to the proposed compliance date, it is likely that air carriers will have to schedule additional training and testing events for these SICs to obtain a type rating by August 2013 unless the FAA extends the compliance date. To the extent commenters suggested aligning the type rating requirement and upgrade training, the FAA has determined that would result in an unnecessary delay given the assumptions in the initial regulatory evaluation. The time period for upgrade to PIC is approximately 5 years for regional carriers and 10 years for major air carriers.

To balance the cost and timing concerns raised by commenters with the benefits of requiring SICs to hold an aircraft type rating, the FAA has decided to extend the compliance date to January 1, 2016 for pilots who have been employed as part 121 SICs on or before July 31, 2013. This change is reflected in the new § 121.436(c). The extended compliance period will allow air carriers to make the appropriate modifications to their approved training programs and incorporate the type rating requirement into their recurrent training and transition training. In addition, it will alleviate the burden placed on the aircrew program designees and FAA employees who will need to administer the certification event for the large number of SICs who may require aircraft type ratings. The FAA notes that the extended compliance date will most benefit current SICs who hold ATP certificates and already have relevant experience operating the aircraft they are flying.

The FAA does not support a grandfather provision that would result in differing SIC certification requirements. Nor does it support certification by air carrier employees who are not designees of the Administrator. There is no precedent for an evaluation event that results in the issuance of an FAA certificate or rating being conducted by someone other than a designee of the Administrator. The commenters did not offer any persuasive arguments for why non-FAA employees or designees should be allowed to administer these evaluation events.

3. Aircraft Type Rating Requirement for SICs Serving in Operations Outside of Part 121

Fifteen commenters stated that SICs serving in operations outside of 14 CFR part 121 should hold a type rating if the PIC is also required to hold a type rating under the rule part. CAPA supported

the idea of requiring SICs serving in operations conducted under parts 91, 125, and 135 to hold a type rating because flying tasks are based on the pilot flying and pilot monitoring designations, not on seat specific maneuvers, as was once the case. FSI commented that even under normal operations there may be scenarios where the SIC does not have the knowledge and experience to successfully land the aircraft. FSI and an individual commenter also noted that SICs should hold a type rating as a way of ensuring they can safely fly the aircraft in the event the PIC is incapacitated. IATA stated in its comments that a type rating gives SICs more insight into the technical and operational characteristics and specifics of the aircraft and generates more confidence, which can be translated into increased operational safety. APA stated that all pilots should be required to accomplish the same training to the same standards. Delta commented that requiring SICs flying operations outside of part 121 to hold a type rating issued in accordance with the practical test standard would ensure that all pilots serving as flightcrew members and carrying passengers for hire meet the same standard.

Forty-five commenters including Rocky Mountain College, IFL Group, and Prairie Air Services, disagreed with requiring SICs serving in operations outside of part 121 to hold an aircraft type rating. KSU, Purdue, FSC, and Aviation Professional Development, LLC stated that the current rules for parts 91, 125 and 135 are sufficient and there is no need for a type rating requirement. GAMA also commented that there are sufficient regulations in place for parts 91, 125 and 135 operations and added there are no safety issues related to the SIC not having a type rating. Spartan College also stated that current regulations are sufficient and that the training received by SICs is adequately preparing them for line operations. Bemidji Aviation Services Inc. commented that a type rating evaluation is no different than the checkride that most airlines already make an SIC pass. Aerosim commented that type-rating training has not historically been any indicator of a properly trained pilot. Aerosim stated that real scenario-based training coupled with a structured training program would result in a more competent pilot.

AAL, RAA, Pilot Career Initiative, Cape Air, and PABC expressed concern that a type rating requirement for SICs serving in parts 91, 125, or 135 would restrict an important time building avenue for pilots aspiring to serve in part 121 operations. Additionally, the Pilot Career Initiative, Cape Air, ExpressJet Airlines, and Airlines for America noted that the Act only addresses part 121 operations. For this reason the type rating requirement should be limited to part 121 operations.

NATA commented that an SIC type rating requirement outside of part 121 is not relevant because the FAA did not propose such a requirement in the NPRM, nor did the FAA present conclusive evidence of a need for requiring a type rating for SIC serving in operations under parts 91, 125 or 135. Parks College commented that there is a clear potential safety benefit to requiring SICs under parts 91, 125 and 135 to possess a type rating; however, there is not enough data regarding the potential economic impacts of the proposal to offer a cost-benefit based recommendation. ERAU commented that it is unnecessary because operations under other rule parts are not similar.

The FAA agrees with commenters that the flight-related tasks are no longer based on seat position, but rather by the pilot flying versus pilot monitoring designations. Additionally, the FAA agrees that type-specific training could increase the technical and operational knowledge level of SICs on specific aircraft. The Act was specific to modifying the ATP certificate and part 121 operations. As such, the NPRM did not propose that SICs under other operating parts obtain an ATP certificate or aircraft type rating. Even though the FAA specifically solicited comments on requiring SICs serving outside of part 121 to obtain a type rating, a specific requirement was not included in the draft regulatory text in the NPRM. Additionally, the FAA did not provide any economic impact information in the regulatory evaluation that was provided with the NPRM. While the FAA did receive comments that supported extending the type rating requirement to operations outside of part 121, a majority of the commenters did not support such a requirement. As a result the FAA intends no action at this time.

G. Minimum of 1,000 Hours in Air Carrier Operations To Serve as PIC in Part 121 Operations (§ 121.436)

Prior to the issuance of this final rule, SICs in part 121 operations were only required to hold a commercial pilot certificate with an instrument rating, which can be obtained in as few as 190 flight hours. If hired by a part 121 air carrier with these minimums, SICs would acquire over 1,000 hours in air carrier operations before meeting the regulatory requirements for the ATP certificate, which is required to serve as PIC in part 121 operations. Therefore, regulations minimized the chance that two pilots with little or no air carrier experience could be paired together as a flightcrew. The Act's requirement for part 121 SICs to hold ATP certificates significantly changes the flightcrew composition for those operators who hire pilots with the minimum flight time requirements. By raising the certificate requirement of part 121 SICs, the natural mentoring period may no longer exist without additional regulation. The FAA notes that this requirement will create time for mentoring to occur for pilots new to the air carrier environment, which supports in part the objectives of Section 206 of the Act. That statutory requirement will be addressed in the Flight Crewmember Mentoring Leadership, and Professional Development rulemaking project.

The intent of the proposed 1,000-hour air carrier experience requirement in § 121.436 was to prevent two pilots in part 121 operations with little or no air carrier experience from being paired together as a flightcrew in line operations. In addition, it would ensure that pilots obtain at least one full year of relevant air carrier operational experience before assuming the authority and responsibility of a PIC in operations conducted in part 121 operations. As proposed, the 1,000 hours in air carrier operations could be a combination of time as PIC in operations conducted under § 91.1053(a)(2)(i), § 135.243(a)(1), or as an SIC in part 121 operations.[23]

1. Air Carrier Experience Requirement

Twenty-nine commenters, including AAL, A4A, ALPA, CAA, CAPA, PABC, Pilot Career Initiative, The Families of Continental Flight 3407, USAPA, UVU, and WMU, stated the proposed 1,000 hour requirement is appropriate.

Over 40 commenters, including CAE and KSU, believe the proposed rule is excessive with some proposing alternative hours of air carrier experience. Delta specifically stated that 750 hours is enough time for a pilot to complete initial training, meet operating experience requirements, and acquire approximately 18 months of flying experience. Additionally, over the 18-month period the pilot would be exposed to seasonal weather differences, mechanical issues, passenger issues, and air traffic control issues. GAMA, Rocky Mountain College, FSC, Purdue,

[23] The FAA has included an exception from this requirement for pilots who are serving as pilot in command in part 121 operations on July 31, 2013.

and Spartan College commented that the proposed time was too long and that upgrade from SIC to PIC should be based on competency, not on the number of flight hours. The UAA and SIU commented that the requirements for a PIC should be established by the air carrier and the air carrier's POI. UAA and SUI also commented that pilots who obtain an unrestricted ATP certificate with 1,500 hours would need a minimum of 2,500 total flight hours to upgrade to a part 121 PIC. SICs with an R–ATP certificate would need a minimum of 1,750 (military pilots) to 2,000 total flight hours (graduates of qualifying four-year aviation degree programs) to upgrade to a part 121 PIC. UAA and SIU are concerned that these flight hours may exceed what is necessary to train safe, competent PICs.

Fifteen commenters contended the requirement is unnecessary. Ameriflight, Inc., Boeing, JetBlue, and Kestrel commented that setting a flight time requirement for upgrade will not guarantee an increased level of operational safety or competency. These commenters assert that minimum hour requirements are not a guarantee that a desired experience has been gained and that flight time alone does not provide an opportunity to assess the pilot's ability to act as PIC. ExpressJet Airlines stated that the current requirements for a PIC in part 121 are sufficient because air carrier PIC candidates complete a rigorous training program, which is approved by the FAA. These pilots also receive continuous oversight through recurrent training and checking events. ERAU noted the proposed requirement is arbitrary, too long, and limits the air carrier's flexibility.

RAA supported the requirement for 1,000 hours of experience in air carrier operations for part 121 passenger service, but believes that requirement is excessive for part 121 all-cargo supplemental operations. RAA is concerned that because supplemental carriers providing feeder service are often limited to shorter flight legs, it could take three or more years for a pilot to gain 1,000 hours as an SIC. RAA states that these operations pose no threat to the flying public and a more suitable time requirement should be considered for part 121 supplemental carriers.

The FAA has considered all of the comments and determined that keeping the 1,000-hour air carrier experience requirement is appropriate for all operations under part 121. This requirement will ensure that an SIC has experienced an entire year of relevant air carrier operational experience before assuming the authority and responsibility of a part 121 operation as PIC. The FAA does not differentiate part 121 flightcrew member certification and qualification requirements based upon whether they are conducting passenger or supplemental (cargo) operations. The FAA acknowledges that this requirement will increase the minimum time required for a pilot prior to serving as PIC in part 121 operations. If a pilot is entering part 121 service with no previous air carrier experience, it may take more than one year for the pilot to upgrade to PIC. The FAA estimated in the initial regulatory evaluation for the NPRM that flightcrew members serving in part 121 operations fly on average 750 hours per year. However, the FAA notes that part 121 pilots are permitted by regulations to fly up to 1,000 hours per calendar year (§ 121.471). The FAA also notes that for most operators the 1,000-hour requirement will not be a factor given actual upgrade times for SICs exceed the minimum time it would take to acquire 1,000 hours, and thus we believe there will be minimal costs and benefits from this provision.

2. Part 135 and Part 91, Subpart K Time

The FAA received over fifty comments on whether to credit flight time earned in part 135 and subpart K of part 91 towards the 1,000 hours of air carrier experience requirement. The majority of commenters supported including the PIC flight time in these operations as proposed in the NPRM as part of the requirement. AAL, GAMA, KSU, and RACCA stated this time is similar to part 121 operations and provides a useful base of experience. FedEx, ExpressJet, ALPA, IFL Group, and Purdue specifically commented that other PIC time in part 135 operations should also count toward the 1,000-hour requirement. Conversely, five commenters, including APA, CAPA, and USAPA, stated operations under part 135 and subpart K of part 91 and should not count towards the proposed 1,000-hour experience requirement.

In the NPRM the FAA also asked commenters if SIC time outside of part 121 should count towards the 1,000 hour requirement to upgrade to PIC in part 121. The majority of commenters on this question offered that some SIC time outside of part 121 operations should count toward the requirement. Cape Air said that flight time as an SIC in scheduled part 135 operations should count. ExpressJet said that SIC time in subpart K of part 91 and part 135 operations should count. FedEx commented that subpart K to part 91, part 125, and part 135 operations can involve complex aircraft and experience relevant to part 121 operations; therefore, that time should count. FSI said that multicrew time accrued by SICs in subpart K of part 91 and parts 135 and 125 should count toward the 1,000 hours. ALPA commented that SIC time in part 135 and subpart K of part 91 should count if the time was acquired in a multiengine turboprop or turbojet airplane. NATA commented that SIC time outside part 121 should count because experience in multiple operational scenarios is beneficial. Purdue said that SIC time should count as long as it was acquired while flying in a multi-pilot crew under subpart K of part 91 or part 135. UPRTA said that SIC time outside of part 121 should count only if the SIC has completed upset prevention and recovery training.

Aviation Professional Development and FSC said that SIC time accrued outside of part 121 operations should not count because other operations are dissimilar. The PABC stated that SIC time accrued outside of part 121 operations should not count towards this requirement because the mentoring and experience needed to become an effective part 121 PIC cannot be received outside of part 121 operations. USAPA does not support counting flight time in subpart K of part 91 or part 135 operations towards the 1,000 hour requirement.

The FAA has decided that pilots should not be permitted to count any time as a required SIC in operations conducted outside of 14 CFR part 121. These SICs are not exercising the privileges of an ATP certificate and have not demonstrated leadership and command abilities necessary to exercise operational control of a flight in conditions most similar to operations conducted under part 121. The FAA has concluded that the time an SIC spends observing a PIC in part 121 operations plays an important role in preparing the SIC for eventual upgrade to PIC. A PIC in part 121 air carrier operations is expected to possess leadership and command abilities, including aeronautical decision making and the sound judgment necessary to exercise operational control of the flight. The FAA has determined that developing these abilities is most effectively done by performing the duties of an SIC in part 121 air carrier operations while under the supervision of an experienced PIC.

The FAA has determined that the ability to fly at the ATP certificate level and have demonstrated this proficiency during evaluation is an important regulatory differentiation. The FAA first proposed that certain operations under part 135 should require an ATP certificate in 1977. In that NPRM, the

FAA stated the requirement to hold an ATP certificate to act as PIC in some part 135 operations was ''[. . .] based in part on operational complexity and the number of persons carried, would provide a level of safety more comparable to that provided by Part 121.'' For these same reasons the FAA has determined that flight time acquired as a PIC in operations under § 91.1053(a)(2)(i),and § 135.243(a)(1) and flight time acquired as an SIC in part 121 operations should count towards the 1,000 hour air carrier experience requirement. Operations under § 91.1053(a)(2)(i) or § 135.243(a)(1) require an ATP certificate, are multicrew operations, and generally use turbine aircraft and therefore are the most applicable to part 121 operations. The FAA has determined that, while other part 91 and part 135 operations may involve certain elements that are relatable to part 121 operations, the varied nature of operations does not make credit toward the 1,000 hour requirement appropriate. As such, the proposed requirement that the 1,000 hours in air carrier operations may be a combination of time as PIC in operations conducted under § 91.1053(a)(2)(i) or § 135.243(a)(1) or as SIC in part 121 operations remains unchanged from the NPRM.

3. Military Time

Delta, A4A, AAL, and FedEx commented that flight time in military operations should count toward the 1,000-hour air carrier experience requirement. UPS specifically asked whether military flight time counted towards the 1,000-hour air carrier operating experience requirement. FSI indicated that multicrew flight time in the military should count. An individual commenter stated that military pilots who fly transport category aircraft as PIC should be able to credit up to 500 hours of their transport category military flight time. The commenter stated that this would still require them to fly 500 hours for an air carrier before being eligible to act as PIC for a part 121 operation.

The FAA recognizes that many pilots in the course of their military careers will obtain significant multicrew experience as PICs of transport category aircraft and therefore has added paragraph (c) to new § 121.436 to allow 500 hours of military flight time accrued as PIC of a multiengine turbine-powered, fixed-wing airplane in an operation requiring more than one pilot to be credited to the 1,000-hour requirement. While there is value in this experience, the FAA does agree with some of the commenters that these pilots operate in a unique system that is different from a part 121 air carrier environment. The FAA has determined that military pilots would benefit from spending some time serving as a required crewmember in a civilian air carrier operation before upgrading to PIC. This time would prepare them for operating in compliance with the regulations that govern civil aviation, the air carrier's particular operating specifications, and the airplane's operations manual.

4. Other Time

FedEx, A4A, and FSI said that flight time in part 125 should count toward the 1,000 hours of air carrier experience required to serve as PIC in part 121 operations. The FAA determined that flight time in part 125 should not count because, although these operations share certain characteristics with part 121 operations, they are not sufficiently similar to count toward the 1,000 hours of air carrier experience. Part 125 does not involve common carriage, a pilot is only required to have a commercial pilot certificate, and the operating rules in part 125 differ significantly from the operating rules in part 121.

FedEx, AA, A4A, and FSI commented that flight time in international air carrier operations should count toward the 1,000 hours required to serve as PIC in part 121 operations. The FAA concluded that, although foreign air carrier operations are similar to U.S. air carrier operations, there are significant differences related to the environment under which foreign air carrier operations are conducted, including possible cultural differences. Most importantly, pilots serving for foreign air carriers do not operate under U.S. regulations and may not have experience in the U.S. national airspace system. The FAA concluded that requiring these pilots to serve first as an SIC in part 121 operations before upgrading to PIC is appropriate.

CAE commented that the FAA should consider a minimum time in aircraft type if a pilot does not have sufficient flight time in subpart K of part 91, part 135, or part 121 to meet the requirement. While time in type is valuable, the proposed requirement is directed at gaining relevant experience in complex air carrier operational environments rather than in aircraft handling. The FAA has determined that the proposed requirement for SICs to obtain a type rating will provide additional experience and proficiency in aircraft-specific handling and knowledge. Therefore, the FAA has decided not to allow credit for time in the type of aircraft towards the 1,000 hours of air carrier operating experience.

H. Miscellaneous Issues

1. Pilot Supply

In the NPRM the FAA sought comment on the potential impact to pilot supply on part 121 and part 135 air carriers as well as part 141 pilot schools and part 142 training centers as a result of the requirement for all SICs in part 121 to hold an ATP certificate. The FAA received 267 comments regarding pilot supply from airlines, industry/trade groups, colleges and universities, pilot training centers, and pilots.

a. Part 121 Pilot Supply

More than 100 commenters specifically stated the proposed ATP requirements for part 121 SICs would hurt part 121 pilot supply. The University of Dubuque, SIU, and 58 other commenters stated the ATP certificate requirement for part 121 SICs would significantly affect air carriers' ability to hire new pilots, particularly regional air carriers.

Only a handful of commenters provided specific information to support the assertion that part 121 pilot supply will diminish. Among these commenters was the UAA. Their comments included data that suggests there is a diminishing supply of pilots in general at a time when forecasts suggest a consistent and growing global demand for pilots. UAA stated in their comments:

- Overall, U.S. airline domestic revenue passenger enplanements are expected to grow an average of 2.2 percent per year from 2011 to 2032 and international revenue passenger enplanements by U.S. carriers are expected to grow 4.2 percent per year from 2011 to 2032.
- Currently, Boeing forecasts a global need for 460,000 pilots through the year 2030, with 97,350 of those needed for North America. This demand is based upon projected fleet growth and pilot retirements.
- Pilots who turned 60 in the years 2007 to 2012 will be forced to retire beginning in 2012. UAA estimated that, beginning in 2018 or 2019, as many as 2,000 part 121 pilots will be forced to retire each year due to the Age 65 rule.
- FAA statistics demonstrate the number of new student pilot certificates issued has declined from 2007 to 2010 by more than 12,000. The number of new commercial pilot certificates issued also declined significantly from 2007 through 2010.
- A study conducted by the University of North Dakota indicates

only slightly more than half the flight instructors surveyed who initially planned on an airline career still have that long-term goal.

• The Pilot Source Study (2010) indicates a decrease in military pilots moving to air carriers. As the U.S. Armed Forces continue contraction, fewer military pilots are needed.

ALPA stated in their comments that there will be no impact on the pilot supply based on this rule because there are thousands of qualified pilots currently on furlough. They also noted that the availability of pilots is a function of the health of the air carrier industry.

CAPA stated the business practices and models of many of our nation's carriers have reduced the career expectations of entry-level pilots to a standard that will not allow a pilot to support a family. This new economic reality is what is driving many qualified pilots out of the job market. CAPA stated there will not be a pilot shortage but a shortage of pilots willing to work for low wages.

Several commenters, including RAA, ExpressJet, JetBlue, Ameriflight, Paradigm Shift Solutions, Inc., and GAMA stated this rule will exacerbate the pilot shortage caused by the Age 65 rule. Ameriflight added that no pilots will be available for operators of small aircraft as a result of talent drain to larger operators.

The AAI contended that within five years the proposed rule will result in a severe flight shortage to small communities. It also contends that the rule will threaten feeder routes and hub operations.

IATA contended that the proposed rule will be felt first in regional carriers but will eventually affect legacy carriers as well. ExpressJet, Delta, Parks College, and two other commenters state that the rule sacrifices quality pilot candidates by focusing on flight time instead of the quality of training. American Eagle Airlines, Inc., states that the rule will put U.S. air carriers at a disadvantage with foreign carriers.

Cape Air, UPS, FSC, CAA, ERAU, A4A, CAE, Human Capital Management and Performance, LLC, Aviation Professional Development, LLC, DSU, Spartan College, LeTourneau University, and three other commenters predict that the arbitrary hour requirements of the proposed ATP certificate with restricted privileges will discourage students from seeking air carrier careers.

b. Part 135, 141, and 142 Pilot Supply

The FAA also received comments on the impact the proposed rule would have on part 135 operators, 141 pilot schools, and 142 training centers. The RAA commented that students will be less attracted to part 141 schools that are not associated with a four-year university and college accredited aviation degree programs because those students could not take advantage of the R–ATP hour requirements.

SJSU commented that part 141 pilot schools and 142 training centers may see a decline in new student enrollment because some students already struggle to afford training costs and will not be willing to spend the extra money needed to meet the new requirements of a part 121 SIC position. On the other hand, ALPA commented that it expects enrollment at accredited colleges and universities with part 141 pilot training programs to increase. It also anticipates the rule ''could result in the creation of training partnerships between those accredited colleges and universities and training academies (e.g., CAE and FlightSafety International) that possess part 141/142 certificates to utilize the certified flight training simulators that these flight training academies may have.''

DSU commented that it already has a high attrition rate because the flight training component of its program doubles the cost of the aviation degree compared to other degrees offered by the university despite the fact that it makes no money on the flight training. It is concerned the rule would increase the attrition rate further.

CAE commented that part 141 operators might retain their instructors longer but may also suffer from reduced customer throughput as the new rule virtually eliminates their options to provide training at any level of reduction below the 1,500 hours.

Parks College commented that part 135 operators and part 91 subpart K operators may face negative impacts in two ways. First, if the supply of pilots qualified for part 121 operations diminishes significantly, causing entry wages to increase, there may be a shift of employees from part 91 and part 135 operations to part 121 operations. Secondly, the supply of pilots that gain their initial crew experience in part 121 operations as SIC, then move to part 135 operations or part 91 subpart K as PIC may decrease. It also anticipates that the proposed ATP CTP would increase training volume at part 142 training centers, as they currently operate the majority of Level ''C'' and ''D'' simulators. Additionally, training volume at part 142 certified training facilities would significantly increase, as only a limited number of part 141 and collegiate programs currently operate approved Level 4/5 FSTD devices.

NADA/F commented that the 1,500 flight hours and ATP requirement should benefit part 141 training centers and should have no impact on part 135 carriers as they already require an ATP and 1,500 hours.

Cape Air commented that it is likely that many part 135 pilots with ATP certificates will be recruited by the larger part 121 carriers who would then not have to incur the costs of the ATP CTP. This natural career progression essentially places the majority of the burden of acquiring ATP certificates to smaller airlines, with limited resources.

c. FAA Response

The FAA does not dispute the factual numbers of decreased pilot starts and the decreased number of commercial and flight instructor certificates issued over the past 10 years. However, the FAA also cannot change the requirement under the Act that all pilots in part 121 operations have an ATP certificate by August 2013. The FAA has decided to take advantage of the relieving option within the Act to offer an ATP certificate with restricted privileges, which would permit some pilots to obtain the ATP certificate with less than 1,500 hours. While pilot supply was not the reason the FAA considered such an option, the FAA has determined it would be a cost-relieving measure and would address some of the pilot supply concerns.

Despite the reduced pool of eligible pilots (i.e. pilots with the total flight hours for an ATP certificate), the current level of safety will be maintained because pilots must continue to meet certification and qualification standards before serving as a pilot in part 121 operations. As under current regulations, any pilot who fails to demonstrate satisfactory performance for the ATP certificate or successfully complete all of the requirements within the air carrier training program will not serve in part 121 operations. We do not see safety compromised because of a reduced eligible pilot pool.

The FAA acknowledges it is possible that as a result of the reduced pool of eligible pilots, some carriers with less competitive compensation packages may experience a higher failure rate due to an inability to attract the best candidates, which in turn is a cost to that carrier. Determining the actual cost is very difficult to identify due to lack of available data and long term hiring data is difficult to forecast. The FAA notes, however, the candidates who have traditionally performed the best in initial training, as identified by the ARC

and the pilot source study, are those candidates that will be eligible for a restricted privileges ATP certificate.

2. Benefits and Cost

Ameriflight questioned why the FAA calculated the cost of the proposed rule post-statute (meaning without the costs associated with the self-executing ATP certificate requirement), but claimed a $23 million dollar benefit [24] from the ATP certificate requirement. Ameriflight recommended the FAA not be allowed to take a benefit from any proposed rule it is not accounting for in its costs.

The FAA's Office of Accident Investigation and Prevention (AVP) conducted an accident analysis accidents of those accidents where the SIC had less than 1,500 hours and found no relationship with the ATP certificate requirement. AVP found the probable cause and contributing factors for those accidents to be other issues that are addressed by the ATP CTP and the aircraft type rating requirement. Therefore, the FAA did not attribute any benefit to the ATP certificate requirement. However, as reflected in the final regulatory evaluation, if one were to attribute all of the benefits claimed for those accidents to the ATP certificate requirement (meaning there was no other attributable cause for the accident other than the fact that the SIC did not have an ATP certificate and 1,500 hours), it would total $23 million (NPRM).

Ameriflight and RACCA believe that the cost of the final rule will exceed $141 million for the airline industry and should therefore precipitate a review under the Unfunded Mandates Reform Act of 1995. The $141 million dollar figure that triggers the Unfunded Mandates assessment relates to costs imposed in any one year on the private sector, which is not the case for this rule. The total costs attributable to the rule over a 20-year period are just $312.7 million and the highest cost in any year is under $20 million (2032). Consequently, the Unfunded Mandates Reform Act is not implicated by this final rule.

Ameriflight and RACCA objected to the finding of no economic impact on part 135 operators. RACCA questioned ''the thoroughness and validity of the economic impact analyses'' and suggested ''one reason for the FAA's inaccuracy is their complete disregard of Part 135 on-demand flying.'' Ameriflight and RACCA also object to the FAA's finding that the (annualized) cost of the rule is less than 0.5% of the operating revenues of all small firms affected by the rule and request that this finding be reevaluated taking into account RACCA members and other similarly-placed part 135 carriers.

In conducting the economic analysis, the FAA did not disregard part 135 on-demand operations as evidenced by the accident analysis conducted by AVP. For part 135 operators, the FAA determined that this rule would have had no economic impact on those operators. Operating revenue data is not available for most part 135 operators as most are privately held. However, the three part 135 operators for which we do have operating revenue, as measured by number of PICs (4 to 45 PICs), encompass almost the entire size range of part 135 operators (1 to 55 PICs). The finding that there would be an insignificant economic impact therefore applies to RACCA members and other similarly-placed part 135 carriers.

In commenting on the costs of the ATP CTP, AOPA indicated the FAA did not calculate the time required of air carriers to ''navigate the cumbersome schedules of part 142 training centers or airline in-house training centers'' to schedule simulator training and estimated the cost to be a minimum of two hours per ATP applicant. AOPA also stated the ATP CTP costs did not account for travel expenses because the FAA assumed the ATP CTP training would take place immediately prior to initial training for the air carrier, but ''the FAA does not address pilots seeking ATP certification outside of the air carrier environment.'' AOPA also questioned the training pay assumption, stating that ''It seems highly unlikely a pilot earns only $43 a day—$2 per day less than their daily per diem—while training. . . .''

The FAA estimates the social cost of the ATP CTP by estimating the impact on the low-cost providers of the training—part 121 air carriers and part 142 training centers. To also include the pecuniary impact on training schools would be double counting. The FAA does not agree with costing two hours per applicant to schedule training. Given the inventory availability of FSTDs discussed previously, the FAA believes the impact to training department administrators will be minimal. With respect to travel costs, the FAA has modified its assumption and believes that 50% of pilots will be trained directly by air carriers and 50% will be trained by part 142 training centers. We believe it is highly reasonable to assume that ATP certification training by air carriers will take place just prior to initial pilot training so there will be no incremental travel costs. However, we now include travel costs for pilots undergoing ATP certification training at part 142 training centers. We agree that we underestimated training pay in the NPRM and have increased our estimate for the final rule.

In reference to our estimate of the cost of the 1,500-hour requirement, the IFL Group disputed the assertion that a new pilot can easily fly 750 hours in a year outside of part 121 operations. The IFL group noted that kind of flight time has historically been obtained working for an air carrier, which the pilot will no longer be able to do. The commenter added, although flight instructing is another way to build time, as a result of the declining student pilot starts, the ability for pilots to earn that much time annually is not realistic. Upon review, the FAA has reduced its assumption to 500 hours of flight time annually.

With respect to the cost of the ATP CTP, NATA asserted the costs are borne by the individual, not an air carrier. ''Should the FAA reject NATA's comment that costs of the ATP CTP should be computed based upon impact to the regulated individual pilot, NATA asserts that the FAA still must modify its estimates to reflect the higher training costs faced by Part 135 and 91 subpart K operators'' due to smaller class sizes and the need to contract with training providers.

The FAA believes that most pilots will receive the ATP CTP through employment—either at large air carriers, with their own training facilities and simulators, or at part 142 training centers through training agreements. The inefficiencies of small size can be greatly mitigated by contracting out, and, in fact, many small operators already use contract training to meet existing training requirements. Moreover, the ATP CTP, as a general program, is not specific to any type aircraft, nor to any rule part (121, 135, 91K). Therefore, we believe that competitive part 142 training centers will deliver generic ATP CTP training to individuals, as well as air carriers, at costs no higher than our conservative estimate.

3. Alternative Licensing Structure

In the NPRM the FAA posed two questions which focused on an alternative pilot licensing structure for part 121 pilots. The FAA asked if it should consider an alternative licensing structure for pilots who desire only to fly for a part 121 air carrier (e.g. multicrew pilot license). The FAA also asked if it were to adopt a licensing

[24] In the NPRM initial regulatory evaluation, the FAA estimated that the total benefit for accidents involving SICs with fewer than 1,500 hours of flight time was $23 million. The final rule regulatory evaluation estimates it to be $16 million.

structure for a multicrew pilot license (MPL), what would be the appropriate amount and type of ground and flight training.

With respect to the question of whether the FAA should consider an alternative licensing structure for prospective part 121 pilots, a total of 79 commenters including IATA, JetBlue, NAFI, Boeing, PABC, FedEx, A4A, CAE, RAA, Delta, NADA/F, USAPA, ERAU, Spartan College, and UAA provided input. Just over half of the commenters were supportive of the FAA considering an alternative method to certificate part 121 air carrier pilots. NTAS supplied the results of their industry polling; their responders reflected similar results. Sixty-two percent of their responders were in favor of the FAA considering an MPL-like structure. FAA's harmonization with ICAO was the most selected reasoning for support according to the NTAS poll.

Some commenters including IATA and Boeing, noted the benefits of an alternative licensing structure for pilots who desire only to fly for a part 121 air carrier. IATA noted results show pilots training in a multicrew environment exhibit proficiency and safety. Boeing stated the graduates of these programs are highly competent in the knowledge and skills required for air carrier operations. An individual commenter stated training for such a license specifically develops the core competencies necessary to operate as a part 121 SIC. Another individual commenter noted MPL is one of the most rigorous structured pilot training programs.

CAE stated its top recommendation is for the FAA to adopt a U.S. MPL. Another individual commenter noted the MPL would allow applicant pilots to save time and money in reaching their goal. Aerosim stated the MPL has been proven to be effective training outside the United States and should be considered in the United States. LETU noted many other countries are using the ICAO MPL to address pilot shortage. The RAA stated there is more than enough experience in alternate pilot training and licensing approaches elsewhere in the world to support FAA consideration of such an approach.

Several commenters including ERAU disagreed with an alternative licensing structure for pilots who desire only to fly for a part 121 air carrier and noted the lack of information regarding MPL programs. ERAU noted not enough performance data exists on pilots from MPL programs. CAPA stated an MPL-like structure would replace fully qualified and type rated pilots with ones that have limited knowledge and experience thus reducing safety.

The Families of Continental Flight 3407, NADA/F, GAMA, USAPA, and Bemidji Aviation Services, Inc., disagreed with an alternative licensing structure for pilots who desire only to fly for a part 121 air carrier. Families of Continental Flight 3407 suggested an ATP should be the minimum for SICs. NADA/F stated they are opposed to altering the ATP requirements and noted the option of multicrew license is not part of the legislation. USAPA stated the FAA should keep the current ATP standard. Bemidji Aviation Services, Inc., stated pilots need to have more experience than an MPL. FSI noted their ATP courses already include appropriate CRM training. American Flyers and NOVA Southeastern University stated the FAA should not accept a lower standard of skill.

With respect to the question of what would be the appropriate amount and type of ground and flight training for an MPL-like certification structure, 35 commenters provided specific recommendations on the ground and flight training for an MPL-like structure. Seventeen commenters recommended looking to existing ICAO standards or rules in place in other countries. ExpressJet recommended the FAA should review the existing MPL structure as outlined in Annex 1 to the International Convention on Civil Aviation and consider the desired outcomes and harmonizing with ICAO before determining the amounts and types of training.

JetBlue supported an alternative licensing structure and stated ground and flight training should be determined by a comprehensive task analysis and qualification standard, derived from an Instructional Systems Design (ISD) process, and in alignment with the requirements of ICAO. Similarly, CAE states MPL candidates meet the requirements of a pilot operating in multicrew transport category aircraft in all environments developed through an ISD approach. It is not determined by hours, but by meeting objectives of the required competencies through theoretical and flight training, as specified by the ICAO Procedures for Air Navigation Services (PANS) Training Document. Consistent with the concepts of Advanced Qualification Program (AQP), MPL is a continuous improvement training process validated by empirical data.

FedEx, AAL, and A4A each stated the FAA should consider MPL requirements in accordance with ICAO standards or as recommended from an ARC. JetBlue recommended an ARC be convened to propose an alternate licensing structure for pilots seeking employment with a part 121 air carrier. Delta, ALPA, and CAE also recommended the FAA form an MPL ARC to develop recommendations for the adoption of MPL program.

The FAA is appreciative of the comments received regarding an alternative certification avenue for part 121 air carrier pilots. Whereas the FAA recognizes the potential benefits of such a certification structure, it is also cognizant of the potential risks such a dramatic departure from traditional certification and experience requirements could present. The FAA also agrees with commenters on the limited data points available for a comprehensive evaluation of existing MPL programs abroad. Although the FAA cannot commit to a timetable for the organization of an ARC, the FAA believes such an industry group could properly research, study, and provide detailed recommendations to the FAA for additional consideration.

4. Accident Effectiveness Ratings

In the NPRM the FAA sought comment on the effectiveness ratings for the specific accidents identified in Appendix 4 of the Initial Regulatory Evaluation. Appendix 4 contained the list of part 121 and part 135 accidents that may have been prevented as a result of this rulemaking. The accident analysis was conducted by the FAA's Office of Accident Investigation and Prevention (AVP) in the Assessment of the Effectiveness of Public Law 111–216 in Reducing Accident Risk posted to the docket. Only six commenters addressed the effectiveness ratings of the accident analysis.

Ameriflight and an individual commenter quoted AVP's assessment that it found little relationship between the 1,500 hour requirement and airplane accidents, and therefore found little benefit for that requirement. Only seven of the 31 accidents used for the 14 CFR Part 121 benefit analysis had SICs with less than 1,500 hours. The individual commenter also stated that it appears that since the 1,500 hour requirement is mandated by statute, the FAA found it unnecessary to examine the 1,500 hour requirement as a tool for improving safety. Aerosim disagreed with the accident analysis because none of the accidents reviewed were caused by low time SIC. UPS commented that it was unaware of any evidence to suggest the accidents cited by the FAA as the benchmark for both benefit and prevention would have been avoided if the proposals in this NPRM had been in place.

A4A states that the FAA should ''exclude the 24 part 121 accidents that include SICs with more than 1,500 hours as not relevant to this rulemaking.'' A4A questioned the effectiveness ratios on several specific accidents [25] because the NTSB determined that the probable causes of the accidents were failures by the PIC not the SIC. A4A based its conclusion on the fact that this final rule ''mandates additional experience for a SIC'' and, therefore, any accident based primarily on an NTSB finding that the PIC was primarily responsible for the accident should be excluded.

The FAA did consider the 1,500 hour requirement for SICs as a regulatory baseline, since it is required by the Act, when reviewing the accidents. However, both the proposed rule and final rule would have affected the eligibility of both the PIC and the SIC involved in the accidents cited in AVP's analysis. The eligibility of flight crews is based on the ATP certificate requirement for SICs and the 1,000 hours of air carrier experience for the PIC. In all 3 accidents that received ''high'' effectiveness scores (meaning there is a 75% reduction in the likelihood of the accident under the proposed rule), crew performance essentially explained the accidents and the rule would have affected the eligibility of both pilots, as neither the PIC nor the SIC met the proposed minimum experience for their respective positions under the proposed and final rule. AVP concluded that more experience and seasoning would have affected the outcome of these accidents.

AVP also acknowledged in its analysis that, as a matter of analytical principle, no accident received an effectiveness score higher than 0.9 based on the assumption that the FAA can never be certain that any intervention would eliminate all risk in a particular scenario. The accident analysis considered the entire proposal, not just the requirement for part 121 SICs to hold an ATP certificate. AVP found the rulemaking to be effective at least to some degree against 31 accidents analyzed, and in most cases the effectiveness scores were ''low'' or ''low-to-moderate.''

As a result of the comments and the changes incorporated into the final rule, AVP re-evaluated the part 121 and part 135 accidents and made some adjustments. The full review of the accident analysis is available as part of the Final Regulatory Impact Analysis for the final rule, which is included in the docket for this rulemaking.

5. Considerations for Offering the ATP CTP

In the NPRM, the FAA sought comment on what factors parts 121, 135, 141, and 142 certificate holders would principally consider in determining whether to offer the ATP CTP. The FAA received 39 comments to this question.

Of the comments received, a majority of the commenters including Ameriflight, CAE, SIU, and ERAU, indicated having a Level C or higher FFS would be a consideration. UND commented that it does not have a Level C or D FFS. The cost to acquire, house, operate, and maintain the device would be prohibitive. UND was quoted $8 million dollars to purchase a Level C FFS. This means UND would have to charge $1,000 per hour to operate the simulator. This cost does not include the cost to build a building to house the FSTD or the cost to hire staff to operate the equipment. The UAA commented that the proposed requirement for a Level C FFS severely limits the number of 141 certificate holders who could provide the training. UAA stated that none of its member colleges or universities own Level C FFSs. UAA stated the proposal would thrust more training on part 121 operators and the large part 141 pilot schools and 142 training centers.

Another consideration by many of the commenters was whether the certificate holder had instructors that met the proposed requirement of two years of experience in airline operations. Boeing, SIU, and UAA commented that the requirement for ATP CTP instructors to have two years of experience under § 91.1053(a)(2)(i), or § 135.243(a)(1), or in any part 121 operation does not assure proficiency in instructing. Boeing further commented that the instructor requirement is overly burdensome on part 141 and 142 certificate holders as these organizations have no ability to qualify instructors that did not already meet the requirement.

Additional comments focused on which certificate holders might need to provide the ATP CTP. American Airlines commented that aviation colleges will be incentivized to offer the course; however costs to the certificate holder would be a significant factor in determining whether to develop and offer such a course. JetBlue speculates the ATP CTP requirement would necessitate part 135, regional part 121 carriers, and parts 141 and 142 certificate holders to offer the ATP CTP immediately to help alleviate pilot supply concerns. JetBlue added that an ATP certificate is a prerequisite to pilot employment for it, however, market forces and future pilot supply ''will ultimately determine our and other part 121 major airlines' decision to offer the course.''

The FAA appreciates the commenters input on what the considerations will be for offering the ATP CTP and took the identified concerns into consideration in developing this final rule.

6. Administrative Law Issues

This final rule will be effective immediately upon publication in the **Federal Register**. Section 553(d)(3) of the Administrative Procedure Act provides that publication of a rule shall be made not less than 30 days before its effective date, except ''for good cause found and published with the rule.'' 5 U.S.C. 553(d)(3). Consistent with section 553(d)(3) and for reasons discussed below, the FAA finds good cause exists to publish this final rule with an immediate effective date.

As noted earlier, independent of any rulemaking action by the FAA, all flightcrew members in part 121 operations must hold an ATP certificate by August 2, 2013. Under this final rule, certain pilots will be able to obtain an ATP certificate with fewer than 1,500 hours based on specific academic training courses. The FAA has established a process by which institutions of higher education may apply for authority to certify graduates for an R–ATP certificate. Without an immediate effective date, the FAA cannot begin to issue this authority, which will delay issuance of R–ATP certificates. Such a delay could result in hardship for those pilots currently serving in part 121 air carrier operations who would otherwise qualify for an R–ATP certificate. To minimize disruptions to part 121 operations and reduce the impact on pilots currently serving in part 121 with commercial pilot certificates, the FAA finds good cause exists for this rule to take effect immediately upon publication in the **Federal Register**.

7. Miscellaneous Amendments

The FAA proposed several miscellaneous amendments to parts 61 and 142. These amendments—maintained in the final rule—are non-substantive technical amendments intended to define terms, remove obsolete provisions, and make minor conforming changes to existing regulations. In addition, the FAA has made a slight modification to § 61.71(c). This change makes clear that a person may be considered to meet the aeronautical experience, aeronautical

[25] A4A specifically questioned the effectiveness ratios in Great Lakes Aviation accident (6/20/2007), the Air Tahoma accident (8/13/2004), the Mesa Airlines accident (10/16/2001), and the Avjet accident (3/29/2001).

knowledge, and areas of operation requirements of part 61 under the terms of a Bilateral Aviation Safety Agreement (BASA) and associated Implementation Procedures for Licensing (IPL). As previously written, the provision could have given the impression that a person who holds a foreign pilot license and is applying for a U.S. pilot certificate on the basis of a BASA is automatically considered to have met the requirements of part 61. In fact, a foreign pilot is only considered to have met those requirements specifically identified in the BASA and IPL.

IV. Regulatory Notices and Analyses

A. Regulatory Evaluation

Changes to Federal regulations must undergo several economic analyses. First, Executive Order 12866 and Executive Order 13563 direct that each Federal agency shall propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs. Second, the Regulatory Flexibility Act of 1980 (Pub. L. 96–354) requires agencies to analyze the economic impact of regulatory changes on small entities. Third, the Trade Agreements Act (Pub. L. 96–39) prohibits agencies from setting standards that create unnecessary obstacles to the foreign commerce of the United States. In developing U.S. standards, this Trade Act requires agencies to consider international standards and, where appropriate, that they be the basis of U.S. standards. Fourth, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires agencies to prepare a written assessment of the costs, benefits, and other effects of proposed or final rules that include a Federal mandate likely to result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more annually (adjusted for inflation with base year of 1995). This portion of the preamble summarizes the FAA's analysis of the economic impacts of this final rule. We suggest readers seeking greater detail read the full regulatory evaluation, a copy of which we have placed in the docket for this rulemaking.

In conducting these analyses, FAA has determined this final rule has benefits that justify its costs, satisfies a Congressional requirement to improve aviation safety, and is a ''significant regulatory action'' as defined in section 3(f) of Executive Order 12866 because it raises novel policy issues contemplated under that executive order. The rule is also ''significant'' as defined in DOT's Regulatory Policies and Procedures. The final rule, if adopted, will not have a significant economic impact on a substantial number of small entities, will not create unnecessary obstacles to international trade, and will not impose an unfunded mandate on state, local, or tribal governments, or on the private sector.

Total Benefits and Costs of This Rule

In the Act, Congress mandated that all part 121 pilots serving as second in command (SICs) have an airline transport pilot (ATP) certificate with at least 1,500 flight hours. This statutory requirement is self-executing, it will take effect whether or not the FAA issues a regulation. We estimate the costs of the ATP certificate requirement to be $6.4 billion ($2.2 billion in present value), almost all of which stems from the 1,500-hour flight time requirement. The statute allows the FAA Administrator to specify academic training as an offset to the 1,500-hour flight time requirement provided the training enhances safety. This rule provides cost savings benefits from its provision of such academic training credits toward the 1,500-hour requirement (by means of the R–ATP certificate) and also by its provision allowing pilots with a minimum age of 21 to be eligible for the R–ATP certificate. Our estimate of these cost savings are $2.3 billion with a present value savings of $0.8 billion.

The final rule requires that all SICs serving in part 121 operations hold a type rating in the airplane flown and requires that an ATP CTP be completed by all applicants for an ATP certificate with an airplane category multiengine class rating (or an ATP certificate obtained concurrently with an airplane type rating). The costs of the final rule training and aircraft type rating requirements total $312.7 million ($138.7 million in present value). The expected benefits from the new training requirements are $576.8 million with a present value of $251.7 million.

For part 121 operators the final rule is cost-beneficial as present value benefits, at $127.5 million, exceed present value costs, at $124.6 million. For part 135 operators present value benefits, at $124.2 million, exceed present value costs, at $9.8 million. Although the FAA does not have a quantitative estimate of benefits for part 91, subpart K, operators, we believe that the ATP CTP will sufficiently enhance safety for part 91, subpart K, operators to make the rule cost-beneficial for these operators as well. Because of the similarity of their operations, we believe that part 91 subpart K operators are subject to similar risks as part 135 operators. The lack of identifiable rule-related accidents reflects the significantly smaller scope of part 91 subpart K operations compared to part 135 operations and a possible under-recording of part 91 subpart K accidents. Additional discussion can be found in the full regulatory evaluation.

Statute and Rule Costs and Benefits

TABLE 5A—STATUTE COSTS AND BENEFITS

Statute costs	Total cost ($ mil)	PV cost ($ mil)
ATP Certificate Requirement—Knowledge & Practical Tests	$29.9	$31.1
ATP Certificate Requirement—Eligibility Restrictions	6,344.5	2,181.9
Part 121 ATP Certificate Requirement	6,374.4	2,213.0
Statute Benefits	No Identifiable Accident Benefits.	

TABLE 5B—FINAL RULE COSTS

Final rule costs	Total cost ($ mil)	PV cost ($ mil)
Part 121 Operators	$280.4	$124.6
Part 135 Operators	22.4	9.8

TABLE 5B—FINAL RULE COSTS—Continued

Final rule costs	Total cost ($ mil)	PV cost ($ mil)
Part 91, Subpart K, Operators	9.8	4.3
Total Training/Type Rating Costs	312.7	138.7

TABLE 5C—FINAL RULE SAFETY BENEFITS

Final rule safety benefits	Total benefits ($ mil)	PV benefits ($ mil)
Part 121 Safety Benefits	$292.5	$127.5
Part 135 Safety Benefits	284.3	124.2
All Safety Benefits	576.8	251.7

TABLE 5D—COST SAVINGS BENEFITS OF FINAL RULE

Final rule cost savings	Total cost savings ($ mil)	PV cost savings ($ mil)
Military Academic Training Credit (750 hrs)	$547.1	$188.2
4-Year Degree Academic Training Credit (500 hrs)	972.0	333.0
2-Year Degree Academic Training Credit (250 hrs)	490.1	165.8
Pilots with 1,500 Hrs Flight Time Eligible for Restricted ATP Certificate at Age 21	300.1	102.8
Cost Savings from Rule Relief	2,309.3	789.8

Notes: 1. Part 121 PV cost of $124.6 million includes $123.1 million in ATP CTP costs and $1.5 million in type rating costs.
2. Details may not add up to totals due to rounding.

Who is potentially affected by this rule?

Pilots working for or seeking employment by air carriers operating under part 121 will be affected. It could also impact pilots working for or seeking employment by operators in parts 135 and 91, subpart K. Certificate holders approved under parts 121, 135, 141, or 142 will be affected if they choose to offer the ATP CTP. Institutions of higher education that seek the authority to certify their graduates have met the requirements for a restricted privileges ATP certificate may also be affected.

Assumptions:

• We use a 20-year period of analysis in order to more fully account for costs that will accumulate over time as new pilots replace retiring pilots unaffected by the rule. All monetary values are expressed in 2010 dollars. In calculating present values, we discount back to the end of 2010/beginning of 2011.

• All monetary values are expressed in 2010 dollars. Present value discount rate is 7 percent (Office of Management & Budget, Circular A–4, ''Guidelines and Discount Rates for Benefit-Cost Analysis of Federal Programs,'' October 29, 1992, p. 8, *www.whitehouse.gov/omb/circulars/index.html*).

• Value of statistical life (VSL) begins at $8.86 million in 2010, and increases to $10.7 million in 2032 by an annual growth factor of 1.0107.[26] Memorandum: Guidance on Treatment of the Economic Value of a Statistical Life in Departmental Analyses [February 2013]. United States Office of the Secretary of Transportation (OST).

• Number of rule-related accidents and associated number of fatalities, number of minor & serious injuries, and aircraft damage: FAA, Office of Accident Investigation and Prevention (AVP).

• Market value of aircraft and restoration costs: APO update to 2008 of data in Economic Values for FAA Investment and Regulatory Decisions, A Guide, Section 5, Office of Aviation Policy and Plans, U.S. Federal Aviation Administration, Wash., DC, Dec. 31, 2004. The 2008 data is updated from 2008 to 2010 by the GDP implicit price deflator.

• Number of part 121 PICs and SICs by airline, part 135 ATP pilots, and part 91, subpart K, fractional ownership program PICs: FAA, Flight Standards Service, National Vital Information Subsystem (NVIS) database (Nov. 22, 2010; Dec. 10, 2010).

• Pilot growth rate (0.6%): U.S. DOT, FAA, Aviation Policy & Plans. FAA Aerospace Forecast: 2010–2030. Table 29, ''Active Pilots by Type of Certificate'', Air Transport, Avg Annual Growth, 2009–2030.

• Cost of ATP CTP and cost of type rating: Estimated from 2010 FAA industry survey and FAA Flight Standards Service.

• Percentage of part 121 SICs without an ATP certificate (regional = 85 percent; major/cargo = 15 percent): Estimated from 2010 FAA industry survey.

• Percentage of part 121 SICs without a type rating (regional = 90 percent; major/cargo = 30 percent): Estimated from 2010 FAA industry survey.

• Typical number of years for upgrade from SIC to PIC (Major airlines: 10 years, Regional airlines: 5 years): Estimated from 2010 FAA industry survey.

• Typical number of years after which PIC will move from regional airline to major airline (2 years): Estimated from 2010 FAA industry survey.

• Pilot salary data by airline (2008): *www.airlinepilotcentral.com.*

• Early and medical part 121 pilot retirement rate (0.5%): Email from Kit Darby, President, *KitDarby.com* Aviation Consulting, LLC, Peachtree City, GA, 12/18/2010.

• Part 121 pilot retirement rate (3.6%): Email from Kit Darby, President, *KitDarby.com* Aviation Consulting, LLC, Peachtree City, GA, 12/20/2010.

[26] Due to a decline in real income in 2011 and 2012, the growth factors for these years are 0.98246 and 0.99702, respectively. Email from OST, March 7, 2013.

- Part 135 and part 91, subpart K, retirement rate (3.0%): We used this rate in the FOQ Initial Regulatory Evaluation (p. 17) and received no comments.
- Flight experience of military pilots leaving the service: FAA Flight Standards Service.
- Hiring minimums by airline & airline group and percentage of pilots hired with military training: Kit Darby, President, *KitDarby.com* Aviation Consulting, LLC, Peachtree City, GA.
- Number of baccalaureates with aviation-related degrees: Aviation Accreditation Board International (AABI), Gary W. Kiteley, Executive Director, 3410 Skyway Drive, Auburn, AL.

Benefits of This Rule

The benefits of this final rule are that it provides some mitigation of the cost of the Airline Safety and Federal Aviation Extension Act of 2010 mandate and will provide accident prevention safety benefits from the rule's training program in response to Congressional direction. We estimate the cost to be $6.4 billion ($2.2 billion in present value) to be the Congressionally-mandated self-executing requirement that all part 121 SICs have an ATP certificate with at least 1,500 flight hours. The FAA found no quantifiable relationship between the 1,500-hour requirement and airplane accidents because all part 121 PICs have an ATP certificate and 1,500 flight hours, and, in most accident cases, the SICs had 1,500 flight hours. Very importantly, because the 1,500-hour requirement will become law regardless of FAA action, the costs for this requirement do not require an FAA benefit justification for such costs. Congress allowed, and the final rule provides, cost-savings benefits from the rule's provision for academic training credits (including credit for military training) toward the 1,500-hour requirement. The final rule also provides cost savings by reducing the minimum age requirement for pilots with 1,500 flight hours to 21 years. The cost savings that result from these provisions are $2.3 billion, with a present value of $0.8 billion.

Primarily because of the training requirements of this rule, the FAA expects that the rule will reduce the number of future accidents. The quantified benefits from this rule are based upon the value of preventing future accidents. The methodology begins by identifying previous accidents that this rule could have prevented, or mitigated. We then estimate the probability that such accidents would be prevented in the future were the rule in place.

The ATP CTP is designed to address the gap in knowledge identified by the FOQ ARC between a commercial pilot and the knowledge a pilot should have when entering an air carrier environment. The basic concepts addressed by these requirements are applicable to pilots operating in part 135 and part 91, subpart K operations as well as pilots in part 121 operations. The ATP CTP has a comprehensive topic list to address these deficiencies that are the underlying causes of many airplane accidents:

- Aerodynamics
  - Stall recognition/recovery
  - Upset prevention/recovery
  - High altitude operations
  - Energy management
  - Operating in a multicrew environment
- Air Carrier Operations
  - Physiology/Fitness for duty
  - Communications
  - Ground operations
  - Aircraft systems and performance
- Crew Resource Management
- Knowledge-based decision-making
- Leadership and Professional development
- Manual Aircraft Handling Skills
- Pilot Monitoring Responsibilities
  - Communication
  - Risk management
  - Decision making
  - Threat and error management

The FAA determined that 58 accidents were partially attributable to pilot qualification issues, over the 2001–2010 period of accident analysis. We estimated the value of preventing these 58 accidents in the future to be worth $838.6 million. After taking into account probability that pilot certification and qualification training would prevent these accidents, we derived part 121 safety benefits of about $292.5 million, with present value $127.5 million, and part 135 safety benefits of about $284.3 million, with present value $124.2 million.

Costs of This Rule

Without this final rule, the Act's mandate would cost $6.4 billion ($2.2 billion in present value). Because the mandate of the SIC 1,500-hour requirement will become law regardless of FAA action, the costs for this requirement are not a cost of this rule. The final rule provides cost savings by reducing the minimum total hours for an ATP certificate for military pilots and graduates of bachelor's and associate's degree programs with aviation majors, and by reducing the minimum age requirement for pilots with 1,500 flight hours to 21 years. The cost savings that result from these provisions are $2.3 billion, with a present value of $0.8 billion. The costs of the final rule training requirements for ATP certificate applicants and the aircraft type rating requirement total $312.7 million ($138.7 million in present value). Of these costs part 121 operators are estimated to incur $280.4 million ($124.6 million in present value).

Cost Benefit Summary

The purpose of this final rule is to meet pilot certification and qualification requirements imposed by Congress in Sections 216 and 217 of the Act. Congress mandated the ATP certificate requirement—the most expensive requirement of this final rule, $6.4 billion ($2.2 billion in present value), although Congress allowed the FAA to provide academic training credits (by means of the R–ATP) which result in cost savings of $2.0 billion ($0.7 billion in present value) that partially offset the requirement. The final rule also partially offsets the requirement by reducing the R–ATP minimum age requirement for pilots with 1,500 hours to age 21. This relief provides an additional cost savings of $0.3 billion ($0.1 billion in present value). Lastly, the costs of the final rule training requirements for ATP certificate applicants and the aircraft type rating requirement total $312.7 million ($138.7 million in present value) with expected benefits of $576.8 million ($251.7 million in present value).

B. Regulatory Flexibility Determination

1. Introduction and Purpose of This Analysis

The Regulatory Flexibility Act of 1980 (Pub. L. 96–354) (RFA) establishes ''as a principle of regulatory issuance that agencies shall endeavor, consistent with the objectives of the rule and of applicable statutes, to fit regulatory and informational requirements to the scale of the businesses, organizations, and governmental jurisdictions subject to regulation. To achieve this principle, agencies are required to solicit and consider flexible regulatory proposals and to explain the rationale for their actions to assure that such proposals are given serious consideration.'' The RFA covers a wide-range of small entities, including small businesses, not-for-profit organizations, and small governmental jurisdictions.

Agencies must perform a review to determine whether a rule will have a significant economic impact on a substantial number of small entities. If the agency determines that it will, the agency must prepare a regulatory

flexibility analysis as described in the RFA.

However, if an agency determines that a rule is not expected to have a significant economic impact on a substantial number of small entities, section 605(b) of the RFA provides that the head of the agency may so certify and a regulatory flexibility analysis is not required. The certification must include a statement providing the factual basis for this determination, and the reasoning should be clear.

As required by Section 603(a) of the RFA, we prepared and published an initial regulatory flexibility analysis (IRFA) as part of the NPRM for this rule (77 FR 12374, February 29, 2012). As a result of that analysis we determined this rule would not have a significant impact on a substantial number of small entities for the following reason: The annualized cost [27] of the rule is less than 2% of operating revenues for all small firms that would be affected by the rule.

Section 604 of the RFA also requires an agency to publish a final regulatory flexibility analysis (FRFA) in the **Federal Register** when issuing a final rule. Section 604(a) requires that each FRFA contain:

(1) A succinct statement of the need for, and objectives of, the rule;

(2) a summary of the significant issues raised by the public comments in response to the IRFA, a summary of agency's assessment of such issues, and a statement of any changes made to the proposed rule resulting from such comments;

(3) a description of and an estimate of the number of small entities for which the final rule will apply;

(4) a description of the projected reporting, recordkeeping and other compliance requirements of the rule, including an estimate of the classes of small entities which will be subject to the requirement and the type of professional skills necessary for preparation of the report or record; and

(5) a description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statues, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected.

[27] Annualized cost is the annual cash flow of an annuity that yields the same present value as the total present value cost.

2. Objectives of This Rule

The purpose of this final rule is to meet pilot certification and qualification requirements imposed by Congress in Sections 216 and 217 of the Airline Safety and Federal Aviation Extension Act of 2010 (Pub. L. 111–216). The provisions of this Act were the result of the fatal accident of Colgan Air Flight 3407 that occurred in Buffalo, New York, on February 12, 2009. In addition to specific mandated requirements, the Act requires the FAA to address certain issues in pilot qualification and certification. This rule addresses those issues, most importantly with training requirements to qualify pilots for the ATP certificate mandated by the Act.

3A. Summary of the Significant Issues Raised by the Public Comments in Response to the IRFA, a Summary of the Assessment of the Agency of Such Issues, and a Statement of Any Changes Made to the Proposed Rule Resulting From Such Comments

The FAA received more than 200 comments on the requirement that all pilots, including SICs, hold an ATP certificate (requiring 1,500 flight hours), many in opposition to the requirement. These comments were made in response to the proposed rule, not the IRFA per se. Several commenters also objected to our finding in the Initial Regulatory Flexibility Analysis that there was no significant impact on a substantial number of small entities. These objections appear to stem from the commenters' belief that the cost we attribute to the statute is a cost of the rule. But the requirement for all pilots in part 121 operations to hold an ATP certificate is Congressionally-mandated and self-executing, so the significant costs associated with this requirement are attributable to the statute, not the rule.

The statute allows the FAA to grant academic training credits, effectively reducing the costs of the 1,500-hour requirement. As a result of the comments on the ATP certificate requirement and the R–ATP certificate, in the final rule the FAA will broaden the scope of academic credits to include pilots with a two-year degree with an aviation major. The FAA will also permit a pilot with 1,500 hours of flight time to obtain an R–ATP certificate at the age of 21.

With regard to the costs associated with the ATP certification training program, NATA stated that ''Since no requirement exists or is proposed that require air carriers to provide the ATP CTP, we believe the FAA must perform its analysis of this proposal assuming the impact is on individual pilots pursuing ATP certification.'' NATA also stated that the FAA failed to account for dramatically higher training costs for part 135 and 91 subpart K operators compared to part 121 operators owing to far smaller class sizes, often one or two pilots at a time, and their inability to use in-house training personnel to the same extent as a large airline. This lack of ability to use efficiencies the way large airlines do would lead to significantly higher costs.

The FAA believes that most pilots will receive the ATP CTP through employment—either at air carriers, with their own training facilities and simulators, or at part 142 training centers through training agreements, as these are the organizations that have the FFSs required for the ATP CTP. The inefficiencies of small size can be greatly mitigated by contracting out this training, and, in fact, many of the smallest operators already use contract training to meet existing training requirements. Moreover, the ATP CTP, as a general program, is not specific to any type aircraft, nor to any rule part (121, 135, 91K). Therefore, we believe that competitive part 142 training centers will deliver generic ATP CTP training to individuals, as well as air carriers, at costs no higher than our conservative estimate.

3.B. A Description of the Steps the Agency Has Taken To Minimize a Significant Economic Impact on Small Entities and * * * Why Other Significant Alternatives to the Rule That Affect Small Entities Were Rejected

The FAA has no discretion with respect to the Congressionally-mandated requirement that all part 121 pilots hold an ATP certificate. Although not specific to small entities, the FAA has mitigated the cost of the 1,500 flight hour requirement for an ATP certificate by allowing credits towards total flight time based on academic training courses. These credits are provided by means of a new R–ATP certificate. The final rule also reduces the minimum age requirement for the R–ATP certificate to age 21. The regulatory evaluation estimates this relief provided in the final rule will reduce the cost of the Congressionally-mandated ATP certificate requirement by $2.3 billion (present value cost: $0.8 billion).[28]

Several commenters believe removing the ability for pilots to receive training for the multiengine airplane ATP

[28] The FAA has also modified the compliance date for the ATP CTP and the type rating requirements to provide additional time to all pilots and operators to accommodate the new requirements.

certificate under part 61 will hurt local fixed-base operators (FBOs) and CFIs. These commenters believe that allowing FBOs and CFIs to provide the ATP CTP would reduce the cost of the training and the negative impact on part 61 instructors and part 61 flight schools. The FAA notes that prior to this final rule there were no training requirements for the multiengine airplane ATP certificate so pilots who sought the certificate on their own did not seek training with an instructor except when they were ready to take their practical test. Because most ATP certificates are currently accomplished through evaluation events conducted by employers under other rule parts (i.e., parts 121 or 135) rather than through part 61 instruction, the FAA does not believe that there will be a significant impact on part 61 instructors and part 61 flight schools by excluding those groups from providing the ATP CTP.

As for the new requirement for pilots to complete the ATP CTP, the FAA has determined that the safest and most effective way to ensure that applicants for an ATP certificate have met the requirements of section 217 of the Act is to establish specific requirements that include training in an FSTD. The requirements specifically relating to training at high altitude, in adverse weather, and in difficult operational conditions cannot be safely or effectively accomplished in aircraft. For that reason, the ATP CTP can be provided only by certificate holders who can sponsor an FSTD.

The FAA does not believe that there is an alternative to the ATP CTP requirement that could be applied to small entities. The Act identified several critical areas that must be part of the training required to apply for an ATP certificate to prepare pilots to operate in an air carrier environment. To allow smaller operators who conduct operations that require pilots to hold an ATP certificate to meet a reduced training standard would not be responsive to the Act and would create two different standards for pilots who are exercising the privileges of an ATP certificate.

To the extent that small businesses were concerned about the costs associated with the type rating, as noted earlier, the FAA has adjusted the compliance date from August 2, 2013, to January 1, 2016, for those pilots who are employed as a pilot by a part 121 certificate holder by July 31, 2013. Although not specific to small entities, this will reduce the impact on small entities. In any case, type rating costs for new-hire pilots are minimal given the statutory requirement for an ATP certificate.

4. Description of the Small Entities to Which the Final Rule Will Apply and an Estimate of Their Number

The final rule would affect firms in part 121, part 135, and part 91, subpart K, operations in the following North American Industry Classification System (NAICS) industries, for all four of which the Small Business Administration (SBA) size standard is 1,500 employees.[29] The SBA size standard as defined in 13 CFR 121.201, is the largest size that a business (including its subsidiaries and affiliates) may be to remain classified as a small business by the SBA. As the size standard is identical at 1,500 employees for all four air transportation industries, we do not attempt to classify affected firms by particular air transportation industry.

TABLE 6—SBA SIZE STANDARD FOR NAICS AIR TRANSPORTATION INDUSTRIES

NAICS code	2002 U.S. NAICS title	SBA Size standard
481111	Scheduled Passenger Air Transportation	1,500 employees.
481112	Scheduled Freight Air Transportation	1,500 employees.
481211	Nonscheduled Chartered Passenger Air Transportation	1,500 employees.
481212	Nonscheduled Chartered Freight Air Transportation	1,500 employees.

The FAA database (2010) has 92 operators classified as part 121 air carriers. Using Department of Transportation 2009 employment data,[30] we identified 32 of these part 121 operators as large and an identical number as small. Using other employment data, we identified eight more part 121 operators as large, seven as subsidiaries of a group with more than 1,500 employees and one known to be large (UPS). We identified one more part 121 operator as small, as a subsidiary of a group with less than 1,500 employees. We inferred 19 more operators to be small on the basis of pilot numbers.[31] So in all, we identified 40 of the 92 part 121 operators as large and 52 as small. Therefore, there are a substantial number of small entities operating as part 121 air carriers.

We also identified five of the nine part 91, subpart K, operators as small on the basis of employment data available from the FAA database. We had no corresponding employment data for part 135 operators. The largest part 135 operator, however, had just 55 PICs, so we infer that all 1,106 part 135 operators are small. Table 7 below lists our identified small entities operating under part 121, part 135, and part 91 subpart K operators along with data to assess the impact of the final rule on them, as discussed below. We list all 52 small part 121 operators and all nine small part 91 subpart K operators, but, owing to their large numbers, only the three part 135 operators for which we have operating revenue data. Revenue data is not available for most part 135 operators as most are privately held. However, the three part 135 operators for which we do have operating revenue, as measured by number of PICs (4 to 45 PICs), encompass almost the entire size range of part 135 operators.

5. Description of the Projected Reporting, Recordkeeping and Other Compliance Requirements of the Final Rule

Reporting and Recordkeeping Requirements

The final rule levies requirements that must be met by certificate holders who wish to offer or provide the ATP CTP. While requiring the gathering and maintaining of information and, in certain cases, the reporting of some of that information to the FAA, these sections require no additional burdens on the certificate holders beyond what is required by the current rule or that which is currently borne by certificate holders in regular practice. Exceptions to this are the following:

[29] U.S. Small Business Administration. Table of Small Business Size Standards Matched to North American Industry Classification System Codes, July 21, 2006. Web site: *www.SBA.gov.*

[30] *www.bts.gov/programs/airline_information/number_of_employees/.*

[31] The largest small part 121 operator has 1,446 employees and 391 pilots, the largest number of pilots for any part 121 operator identified as small. The largest operator that we inferred to be small had 231 pilots.

a. One-time development and submission of an ATP CTP to the FAA for approval.

b. One-time record keeping costs for pilot training pertaining to completion of the ATP CTP.

c. One-time application to the FAA by an institution of higher education seeking the authority to certify its graduates of a degree program with an aviation major for an R–ATP certificate.

d. One-time cost per student to the institution of higher education for an academic advisor to review graduate transcripts to determine eligibility for an R–ATP certificate.

TABLE 7—ECONOMIC IMPACT OF THE FINAL RULE ON SMALL PART 121, PART 135, AND PART 91 SUBPART K OPERATORS

Operator name	Air carrier category	Primary operations	Pilot numbers	Total 2009 emp	Pilots (parts 121, 135, or 91K) (percent)	Ann. cost ($1000s)	Cost as % of operating revenue	Operating revenue ($1000)	Operating revenue source
ABX AIR INC	Cargo	Part 121	313	1435	0.54	46	0.00	1,173,146	DOT.
AEKO KULA INC (Aloha Air Cargo)	Cargo	Part 121	22	315	0.04	3	0.00	280,309	DOT.
AERO MICRONESIA INC	Cargo	Part 121	12						
AIR TRANSPORT INTERNATIONAL LLC	Cargo	Part 121	113	396	0.20	17	0.01	273,016	DOT.
AMERIJET INTERNATIONAL INC	Cargo	Part 121	56	540	0.10	8	0.01	138,372	DOT.
AMERISTAR AIR CARGO INC	Cargo	Part 121	17		0.03	3	0.04	6,942	DOT.
ARROW AIR INC	Cargo	Part 121	50	613	0.09	7	0.00	206,805	DOT.
ASTAR AIR CARGO INC	Cargo	Part 121	85	631	0.15	13	0.00	347,018	DOT.
AVIATION SERVICES LTD	Cargo	Part 121	18						
CAPITAL CARGO INTERNATIONAL AIRLINES INC.	Cargo	Part 121	100	223	0.17	15	0.03	53,209	DOT.
CENTURION AIR CARGO INC	Cargo	Part 121	47	567	0.08	7	0.00	164,905	DOT.
CORPORATE AIR	Cargo	Part 121	75						
EVERGREEN INTERNATIONAL AIRLINES INC.	Cargo	Part 121	132	442	0.23	19	0.00	518,843	DOT.
FALCON AIR EXPRESS INC	Cargo	Part 121	25		0.04	4	0.03	11,665	DOT.
FLORIDA WEST INTERNATIONAL AIRWAYS INC.	Cargo	Part 121	32	51	0.06	5	0.00	113,736	DOT.
GULF AND CARIBBEAN CARGO INC	Cargo	Part 121	42	63	0.07	6	0.02	25,270	DOT.
KALITTA AIR LLC	Cargo	Part 121	231	860	0.40	34	0.01	666,161	DOT.
KALITTA CHARTERS II LLC	Cargo	Part 121	23		0.04	3	0.02	14,048	DOT.
LYNDEN AIR CARGO L L C	Cargo	Part 121	49	175	0.08	7	0.01	88,289	DOT.
MERIDIAN ASSOCIATES	Cargo	Part 121	8						
MIAMI AIR INTERNATIONAL INC	Cargo	Part 121	80	409	0.14	12	0.01	151,868	DOT.
MOUNTAIN AIR CARGO INC	Cargo	Part 121	126						
NATIONAL AIR CARGO GROUP INC	Cargo	Part 121	23	500	0.04	3	0.02	20,882	DOT.
NORTHERN AIR CARGO INC	Cargo	Part 121	24	197	0.04	4	0.01	47,197	DOT.
OMNI AIR INTERNATIONAL INC	Cargo	Part 121	255	1032	0.44	38	0.01	438,327	DOT.
PRESCOTT SUPPORT CO	Cargo	Part 121	13		0.02	2	0.02	8,614	DOT.
RHOADES AVIATION INC	Cargo	Part 121	4						
SIERRA PACIFIC AIRLINES INC	Cargo	Part 121	10		0.02	1	0.01	11,199	DOT.
SKY KING INC	Cargo	Part 121	32		0.06	5	0.03	16,583	DOT.
SKY LEASE I INC (Tradewinds Airlines)	Cargo	Part 121	49	47	0.08	7	0.01	63,683	DOT.
SOUTHERN AIR INC	Cargo	Part 121	186	589	0.32	27	0.02	170,478	DOT.
SWIFT AIR L L C	Cargo	Part 121	29		0.05	4	0.05	8,643	DOT.
TATONDUK OUTFITTERS LTD	Cargo	Part 121	47	288	0.08	7	0.02	40,371	DOT.
USA JET AIRLINES INC	Cargo	Part 121	70	244	0.12	10	0.01	128,053	DOT.
DYNAMIC AIRWAYS LLC	Charter	Part 121	8						
AERODYNAMICS INC	Charter PAX	Part 121	14	211	0.02	2	0.00	53,595	DOT.
RYAN INTERNATIONAL AIRLINES INC	Charter PAX	Part 121	151	540	0.26	22	0.02	142,069	DOT.
TEM ENTERPRISES INC (Xtra Airways)	Charter PAX	Part 121	40	120					
VISION AIRLINES INC	Charter PAX	Part 121	116	131	0.20	17	0.03	62,366	DOT.
WORLD AIRWAYS INC	Charter PAX	Part 121	391	1446	0.68	58	0.01	653,144	DOT.
BRENDAN AIRWAYS LLC (USA 3000 Airlines).	Mainline	Part 121	54	390	0.09	8	0.00	227,850	DOT.
MN AIRLINES LLC (Sun Country Airlines)	Mainline	Part 121	143	642	0.25	21	0.01	224,232	DOT.
VIRGIN AMERICA INC	Mainline	Part 121	330	1421	0.57	49	0.01	326,023	DOT.
CHAMPLAIN ENTERPRISES INC (CommutAir).	Regional	Part 121	150	300					
EMPIRE AIRLINES INC	Regional	Part 121	111	250					
ERA AVIATION INC (In Frontier Alaska Group).	Regional	Part 121	57						
GREAT LAKES AVIATION LTD	Regional	Part 121	231		1.12	128	0.13	100,033	10–K.
GULFSTREAM INTERNATIONAL AIRLINES INC.	Regional	Part 121	156						
HAWAII ISLAND AIR INC	Regional	Part 121	38		0.18	21	0.08	24,907	DOT.
HYANNIS AIR SERVICE INC	Regional	Part 121	212	850					
PENINSULA AIRWAYS INC	Regional	Part 121	119						
SEABORNE VIRGIN ISLAND INC	Regional	Part 121	21		0.10	12	1.73	670	CLEAR.
USA JET AIRLINES INC		Part 135	45		0.62	6	0.02	27,380	DOT.
AVIATION CONCEPTS		Part 135	10		0.14	1	0.05	2,568	DOT.
VICTORY AIR TRANSPORT INC.		Part 135	4		0.05	0	0.02	2,745	DOT.
AIRSPRINT US		Part 91K	5	27	0.16	1			
AVANTAIR		Part 91K	136	340	4.25	17	0.01	149,001	CLEAR.
CORPORATE EAGLE MGT SVCS		Part 91K	13	33	0.41	2	0.01	11,419	CLEAR.
EXECUTIVE FLT SVCS		Part 91K	60	100	1.87	7	0.00	2,024,000	CLEAR.
PLANE SENSE		Part 91K	61	160	1.90	7	0.01	94,000	CLEAR.

Other Compliance Requirements

This final rule will require the following:

1. An ATP certificate for all pilots operating in part 121. This requirement codifies the Congressionally-mandated 1,500 hours flight time required for an ATP certificate, but will allow an R–ATP certificate to be held by (a) military pilots with 750 hours of flight experience and (b) graduates of four-year or two-year degree programs with aviation majors who obtain their commercial pilot certificate with instrument rating from an affiliated part 141 pilot school. To be eligible for an R–ATP, graduates of a four-year program will be required to have 1,000 hours of flight experience, while graduates of a two-year program will be required to have 1,250 hours of flight experience.

a. The R–ATP certificate will allow a pilot to serve in part 121 air carrier operations as an SIC only. With an R–ATP certificate, however, part 121 SICs need only hold a second class medical certificate, not the first class medical certificate that is the requirement for PICs.

b. The minimum age for an R–ATP certificate will be reduced to 21 years.[32] The current age requirement for an ATP certificate will remain at 23 years.

2. A minimum of 50 hours of multiengine flight experience. This requirement will apply not just to pilots serving in part 121 operations, but to all pilots who apply for an ATP certificate with an airplane category multiengine class rating.[33] This will include PICs in part 135 operations that require an ATP certificate, and PICs in part 91, subpart K, Fractional Ownership Programs, which require the PIC to hold an ATP certificate.

3. An ATP Certification Training Program for applicants for an ATP certificate with an airplane category multiengine class rating or an ATP certificate obtained concurrently with an aircraft type rating. This is a foundational course that will include academic study as well as flight training in FSTDs to meet the Act's requirements that pilots have the necessary training and experience discussed previously to function effectively in an air carrier environment. The course will provide training necessary to overcome the knowledge gap (between the commercial pilot certificate and the knowledge required for an air carrier SIC) and will address the current lack of a training requirement for ATP certification. These competencies include crew coordination, checklist/briefing items, low energy states/stalls, and adverse weather conditions, including icing, thunderstorms, and crosswinds with gusts. The course topics will be incorporated into the ATP knowledge test. In addition to applying to all pilots in part 121 operations, this requirement will apply to PICs in part 135 operations that require an ATP certificate, and PICs in part 91, subpart K, Fractional Ownership Operations, which require the PIC to hold an ATP certificate.

4. An aircraft type rating for all SICs serving in part 121 operations. The FOQ ARC made the same recommendation and this requirement responds to the objectives of section 216 of the Act, which requires the Administrator to determine the appropriate multiengine airplane flight experience for pilot flightcrew members. Currently only PICs in part 121 operations, and SICs in flag or supplemental operations requiring three or more pilots, are required to hold an aircraft type rating. The FAA has determined that requiring aircraft type ratings for all pilots in part 121 operations will improve safety by further exposing pilots to an advanced multiengine aircraft and a multicrew environment. Also the provision for an airplane type rating requires a pilot who serves as SIC to be tested to the same standard as the PIC and to demonstrate proficiency in difficult operational conditions, including adverse weather and high altitude operations.

5. A minimum of 1,000 hours in air carrier operations to serve as PIC in part 121 operations. Under the final rule, SICs must accumulate 1,000 flight hours in air carrier operations before becoming eligible for upgrade to PIC. Without the 1,000-hour requirement, SICs with an unrestricted ATP certificate would be eligible to upgrade to PIC as soon as they attain 1,500 flight hours, regardless of their experience. The 1,000-hour requirement will ensure that a pilot will have at least one full year of relevant operational experience before upgrading to PIC. The final rule allows a pilot to count PIC time in part 135 operations that require an ATP and in part 91, subpart K, operations, as well as SIC time in part 121 operations. Pilots with experience as PICs in military transport operations will be allowed to count up to 500 hours of such experience as well.

The FAA estimates that cost will be minimal for the requirement of 50 hours of multiengine time for the ATP certificate with an airplane category multiengine class rating. As noted in the regulatory evaluation and preamble, multiengine hours are typically acquired while engaged in other commercial aviation activities such as flight instruction or part 135 operations on the way to obtaining the ATP certificate. Moreover, minimums for multiengine time vary among airlines from 50 hours to as much as 1,500 hours.[34]

The FAA also estimates as minimal the costs of the requirement that a part 121 SIC have 1,000 hours of air carrier operating experience before upgrade from SIC to PIC. According to a 2010 FAA survey of industry, the average number of years to upgrade is about five years for regional airlines and more than ten years for major airlines. Even without air carrier operating experience in part 135 or part 91, subpart K operations, at an average number of 750 flight hours a year, an SIC will accumulate the required hours in less than one and a half years.

Compliance Cost by Part 121 Operators

Table 5 shows the cost of the final rule for the part 121 operators. Costs of the ATP CTP are allocated between the regional airlines and the major/cargo airlines by the percentage of pilots employed by the two airlines (Nov. 2010 part 121 pilots, 78,258: Regionals—20,565 [26.3%], Major/cargo airlines—57,693 [73.7%]).

As explained in the regulatory evaluation, the FAA expects that the compliance cost of the ATP CTP for part 121 air carriers will fall heavily, if not exclusively, on the regional airlines. So in assessing the economic impact on small regional airlines, we assume the entire ATP CTP costs fall on regional airlines. But in order to assess the economic impact on small cargo airlines, we assume the impact is proportional to the number of pilots. We do the same with the type rating costs, although the magnitudes are small compared to the ATP CTP costs.

Economic Impact on Small Entities

In order to assess the economic impact of this final rule on small firms, we allocate annualized costs to small firms based on the number of affected pilots and measure the economic impact on small firms by each firms' annualized costs as a percentage of their average 5-year, 2005–2009 operating revenues.[35] While the economic burden

[32] This is a change from the NPRM that will allow pilots of age 21 or 22, with 1,500 hours flight time, to obtain the R–ATP certificate.

[33] The rule applies to the airplane class, so applicants for an ATP certificate with single-engine class rating will be required to have 50 hours of single-engine time.

[34] Kit Darby, President, *www.KitDarby.com,* Aviation Consulting, LLC, Peachtree City, GA.

[35] Operating Revenue—*www.transtat.bts.gov,* Air Carrier Financial Reports (Form 41 Financial Data), Schedules P1.1 & P1.2. We average for as many of the five years of data as is available. Operating

of this rule will have a disproportionate impact on small entities, the compliance cost will not result in a significant economic cost on small entities. This analysis measures the economic impact on small entities in a two-step process. All of the compliance costs are training costs for new pilots (plus type rating costs for part 121 operators). Again, the Congressional mandate that all pilots have an ATP certificate is self-enacting and not an FAA requirement. Thus the 1,500 hour requirement costs are not included in these compliance costs. While the FAA believes the annual estimates of new pilots are reasonably accurate for the part 121, part 135, or part 91 subpart K industry, we do not know the turnover per operator. The annual new pilot hires per operator are estimated as a percentage of total industry pilots (part 121, part 135, or par 91 subpart K) multiplied by the system-wide number of new pilots. The estimated new pilot hires for each operator are then multiplied by the annualized training cost to obtain the total annualized cost per operator.

The annual training cost is simply the per-pilot training cost multiplied by the annual number of newly hired pilots. The annualized training cost is less than $3,300 per pilot. This per-pilot training cost estimate is $3,242 for a part 121 operator and $3,178 for a part 135 operator and also for a part 91 subpart K operator. The higher cost for part 121 operators is due to the additional type rating cost. As a point of reference, the average cost per pilot over the 20-year estimation period of the rule is approximately $4,000 (based on total cost, not present value). Clearly the per-pilot training cost is not a significant economic impact.

The number of new pilots per year equals the number of retired pilots plus the additional pilots above the previous year (net growth). On average the annual number of new pilots is 3,531 for part 121; 282 for part 135; and 124 for part 91, subpart K. The estimated number of new pilots per operator equals the operator's current percentage of industry pilots (part 121, part 135, or part 91 subpart K) [36] multiplied by the total number of new pilots. Table 7 lists that percentage for many small entities. To calculate the cost per operator, that percentage per operator is then multiplied by the total annualized cost, $11.51 million for part 121 operators, $0.897 million for part 135 operators, and $0.394 million for part 91, subpart K operators. These annualized costs are based on the present value training costs (and type rating costs for part 121 operators) calculated in the regulatory evaluation.

While Table 7 provides economic impact estimates for many operators, a generic estimate more simply makes the point that the compliance costs of this rule do not create a significant economic impact per operator. In general, the annual number of new pilots per operator is substantially less than 10 percent of the operator's total pilots. For this case, an operator with a 100 pilots will have no more than 10 new pilots per year. With training costs of $3,300 per pilot the annual training cost is less than $33,000. As long as the operator receives operating revenue greater than $2 million these costs will be less than 2 percent of annual operating revenue. The FAA does not believe costs less than 2 percent of annual operating revenue to have a significant economic impact. As Table 7 shows the percentage of annual compliance cost is nearly always less than 0.05 percent and never over 2 percent of annual operating revenue.

The rule will have a disproportionate impact on small entities. Given the Congressional mandate that all pilots have an ATP certificate and that this mandate disproportionally affects small entities, the FAA considered, but had limited alternatives with which to provide more relief to small operators. In considering the economic impact of this rule, the FAA created the R–ATP certificate based on education credits, and for pilots with 1,500 flight hours, a minimum age of 21, instead of age 23. This rule imposes only training costs on new pilots and small type rating costs on part 121 pilots. The compliance period for the type rating requirement for those pilots serving in part 121 by July 31, 2013, has been extended in the final rule. As both the per-pilot training costs are modest and the annual number of new pilots is small, the compliance cost relative to annual operating revenue is always less than 2 percent and almost always less than 0.05 percent. Therefore, as the FAA Administrator, I certify that this final rule will not have a significant economic impact on a substantial number of small entities.

C. International Trade Impact Assessment

The Trade Agreements Act of 1979 (Pub. L. 96–39), as amended by the Uruguay Round Agreements Act (Pub. L. 103–465), prohibits Federal agencies from establishing standards or engaging in related activities that create unnecessary obstacles to the foreign commerce of the United States. Pursuant to these Acts, the establishment of standards is not considered an unnecessary obstacle to the foreign commerce of the United States, so long as the standard has a legitimate domestic objective, such the protection of safety, and does not operate in a manner that excludes imports that meet this objective. The statute also requires consideration of international standards and, where appropriate, that they be the basis for U.S. standards. The FAA has assessed the potential effect of this final rule and determined that it would have only a domestic impact and therefore would not create unnecessary obstacles to the foreign commerce of the United States.

D. Unfunded Mandates Assessment

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires each Federal agency to prepare a written statement assessing the effects of any Federal mandate in a proposed or final agency rule that may result in an expenditure of $100 million or more (adjusted annually for inflation with the base year 1995) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector; such a mandate is deemed to be a ''significant regulatory action.'' The FAA currently uses an inflation-adjusted value of $143.1 million. Excluding the Congressionally driven costs, the compliance costs of this rule never exceed $100 million in any one year. This final rule does not contain such an unfunded mandate; therefore, the requirements of Title II of the Act do not apply.

E. Paperwork Reduction Act

Title: Pilot Certification and Qualification Requirements for Air Carrier Operations.

This proposal contains the following new information collection requirements. As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), the FAA has submitted the information requirements associated with this proposal to the Office of Management and Budget for its review.

The Office of Management and Budget approved these new information collection requirements associated with this final rule and assigned OMB Control Number 2120–0755.

Summary: The paperwork burden is comprised of two areas. First, this final rule amends the requirements for

revenue for Great Lakes Aviation is from its SEC 10–K filing. Operating revenues for part 91 subpart K air carriers is from the CLEAR database and is for 2011.

[36] For part 121 operations since regional airlines and major/cargo airlines are analyzed separately, operator pilot percentages are calculated with respect to the total number of pilots in the relevant group.

obtaining an airline transport pilot (ATP) certificate by requiring pilot applicants for an ATP certificate with an airplane category multiengine class rating or an ATP certificate obtained concurrently with an airplane type rating to complete a new ATP Certification Training Program. Any part 142 training center, part 141 pilot school, or air carrier wishing to offer the new training program would be required to submit the curriculum to the FAA for approval.

In addition, the final rule provides a method for an institution of higher education to seek the authority to certify its graduates of a degree program with an aviation major to apply for a restricted privileges ATP certificate. The final rule will require the institution to hold a part 141 pilot school certificate from the FAA to provide pilot training within the degree program(s) listed in their letter of authorization. The institution of higher education seeking this authority will be required to submit an application on a new form that was developed for this purpose.

Public Comments: With regard to the FAA's paperwork estimates, NAFI was the only commenter. Their comment stated—without providing specific details—that ''the accuracy of the agency's estimate of the burden is significantly lacking in areas of consideration that have been included, representative estimates of costs, and the effects that will result from the proposed changes.'' NAFI added that it was unaware of any data that has been developed that accurately allows for proper costing of these effects and recommended ''that this data be sought prior to any long term changes in order to more accurately study and make decisions regarding proposed changes.''

Without additional detail from the commenter, the FAA is uncertain how to respond to NAFI's concerns regarding the accuracy of its estimates. The FAA believes that the estimates in the NPRM accurately reflected the paperwork burden of the proposal. Notwithstanding, the FAA has reevaluated the paperwork burden of the final rule and has made some adjustments to the ATP CTP paperwork costs. In addition, the FAA has added additional paperwork costs for institutions of higher education who seek the authority to certify its graduates of a degree program with an aviation major to apply for a restricted privileges ATP certificate by requiring them to submit an application.

Use of: The information collection for the ATP Certification Training Program will ensure pilots seeking employment in an air carrier environment are adequately trained on the knowledge and skills they need to function in a multicrew environment in a variety of operating conditions. The requirement to submit the ATP Certification Training Program curriculum to the FAA for approval will provide greater oversight of the training programs and ensure consistency of both course and instructional quality among the training centers, pilot schools, and air carriers. Part 121, 135, 141, or 142 certificate holders that wish to offer or provide the ATP Certification Training Program are required to develop and submit a course for approval by the FAA. For those that provide this training, additional pilot training record keeping would also be required.

Industry ATP CTP Development Costs

Initial number of certificate holders offering the ATP CTP = 20
Time needed to develop the ATP CTP = 120 hours
Salary of a ground instructor = $32.55
First-Year Cost (2014) [37]
Cost: 20 × 120 × $32.55 = $78,120
Time: 20 × 120 = 2,400 hours
Subsequent Years: Per-Year Costs
Cost: 1 × 120 × $32.55 = $3,906
Time: 1 × 120 = 120 hours
Total Costs Over 20 Years (2013–2032)
Cost: $78,120 + (18 × $3,906) = $148,428
Time: 2,400 + (18 × 120) = 4,560 hours
Average per Year
Cost: $148,428/20 = $7,421
Time: 4,560/20 = 228 hours

Industry Record Keeping Costs

Initial number of ATP certificate applicants = 3,731
Time needed for record keeping per pilot = 0.1 hours
Salary of a ground instructor = $32.55
First-Year Cost (2014)
Cost: 3,731 × 0.1 × $32.55 = $12,145
Time: 3,731 × 0.1 = 373 hours
Subsequent Years Costs (assume 0.6% annual growth rate)
Cost: $231,501
Time: 7,112 hours
Total Costs Over 20 Years (2013–2032)
Cost: $12,145 + $231,501 = $243,646
Time: 373 + 7,112 = 7,485 hours
Average per Year
Cost: $243,646/20 = $12,182
Time: 7,485/20 = 374 hours

FAA ATP CTP Review Costs

Initial number of certificate holders requesting ATP CTP approval = 20
Time needed to review the ATP CTP for initial and final approval = 44 hours
Salary of an aviation safety inspector = $61.50
First-Year Cost (2014)
Cost: 20 × 44 × $61.50 = $54,120
Time: 20 × 44 = 880 hours
Subsequent Years: Per-Year Costs
Cost: 1 × 44 × $61.50 = $2,706
Time: 1 × 44 = 44 hours
Total Over 20 Years (2013–2032)
Cost: $54,120 + (18 × $2,706) = $102,828
Time: 880 + (18 × 44) = 1,672 hours
Average per Year
Cost: $102,828/20 = $5,141
Time: 1,672/20 = 83.6 hours

FAA Approval Letter Costs

Initial number of certificate holders requesting ATP CTP approval = 20
Time needed to issue the approval letter = 0.5 hours
Salary of clerk/secretary = $24.67
First-Year Cost (2014)
Cost: 20 × 0.5 × $24.67 = $246.70
Time: 20 × 0.5 = 10 hours
Subsequent Years: Per-Year Costs
Cost: 1 × 0.5 × $24.67 = $12.34
Time: 1 × 0.5 = 0.5 hours
Total Over 20 Years (2013–2032)
Cost: $246.70 + (18 × $12.34) = $469
Time: 10 + (18 × 0.5) = 19 hours
Average per Year
Cost: $469/20 = $23
Time: 19/20 = 0.95 hours

The information collection for the authority to certify graduates of a degree program in an aviation major will ensure pilots who seek eligibility for a restricted privileges ATP certificate based on academic training at an institution of higher education have the option to complete aviation coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot. Institutions of higher education who seek the authority to certify its graduates of a degree program with an aviation major to apply for a restricted privileges ATP certificate are required to submit the necessary information about the degree program(s), including aviation and aviation-related coursework, in order to obtain the authority to certify a graduate has met the restricted privileges ATP certificate requirements established in this final rule.

Institution of Higher Education Application Costs

Initial number of institutions of higher education applying for the authority to certify graduates = 150
Time needed to complete the application = 8 hours
College professor hourly wage = $53.33
First-Year Cost (2013)
Cost: 150 × 8 × $53.33 = $63,966

[37] For 2013 there are no Paperwork Reduction Act costs for the ATP CTP. All costs begin in 2014.

Time: 150 × 8 = 1,200 hours
Subsequent Years: Per-Year Costs
Cost: 1 × 8 × $53.33 = $427
Time: 1 × 8 = 8 hours
Total Over 20 Years (2013–2032)
Cost: $63,966 + (19 × $427) = $72,109
Time: 1,200 + (19 × 8) = 1,352 hours
Average per Year
Cost: $72,109/20 = $3,605
Time: 1,352/20 = 68 hours

Review of Transcripts Costs

Initial number of graduates = 648
Time needed to review a graduate's transcript = 0.5 hours
Academic advisor hourly wage = $53.33
First-Year Cost (2013)
Cost: 648 × 0.5 × $53.33 = $17,279
Time: 648 × 0.5 = 324 hours
Subsequent Years Costs (assume 0.6% annual growth rate)
Cost: $348,696
Time: 6,538 hours
Total Over 20 Years (2013–2032)
Cost: $17,279 + $348,696 = $365,973
Time: 324 + 6,538 = 6,862 hours
Average per-Year
Cost: $365,973/20 = $18,299
Time: 6,862/20 = 343 hours

FAA Review of Application Costs

Initial number of applications to review = 150
Time needed to review the application = 6 hours
Salary of an aviation safety inspector = $61.50
First-Year Cost (2013)
Cost: 150 × 6 × $61.50 = $55,350
Time: 150 × 6 = 900 hours
Subsequent Years: Per-Year Costs
Cost: 1 × 6 × $61.50 = $369
Time: 1 × 6 = 6 hours
Total Over 20 Years (2013–2032)
Cost: $55,350 + (19 × $369) = $62,361
Time: 900 + (19 × 6) = 1,014 hours
Average per Year
Cost: $62,361/20 = $3,118
Time: 1,014/20 = 51 hours

F. International Compatibility

In keeping with U.S. obligations under the Convention on International Civil Aviation, it is FAA policy to conform to International Civil Aviation Organization (ICAO) Standards and Recommended Practices to the maximum extent practicable. The FAA has reviewed the corresponding ICAO Standards and Recommended Practices and has identified the following differences.

The FAA notes that, although pilots will be able to obtain a restricted privileges ATP certificate in fewer than the ICAO standard of 1,500 hours, those pilots will not have the pilot in command privileges of pilots who hold unrestricted ATP certificates. This pilot in command restriction will be reflected on the pilot's certificate. The experience and qualifications of the pilots who hold restricted privileges ATP certificates will exceed the ICAO standards for second-in-command.

The FAA also notes certain long-standing U.S. differences on file with certain ICAO Medical Assessment standards continue to apply under this action. Although this rule permits SICs in part 121 to hold only a second-class medical certificate, those SICs who serve in international operations will need to obtain an FAA first-class medical certificate to compensate for the electrocardiography difference between a first class medical certificate and a second class medical certificate. As such, U.S. pilots who fly internationally must continue to comply with this international aviation standard.

G. Environmental Analysis

FAA Order 1050.1E identifies FAA actions that are categorically excluded from preparation of an environmental assessment or environmental impact statement under the National Environmental Policy Act in the absence of extraordinary circumstances. The FAA has determined this rulemaking action qualifies for the categorical exclusion identified in paragraph 308(c) and involves no extraordinary circumstances.

V. Executive Order Determinations

A. Executive Order 13132, Federalism

The FAA has analyzed this final rule under the principles and criteria of Executive Order 13132, Federalism. The agency determined that this action will not have a substantial direct effect on the States, or the relationship between the Federal Government and the States, or on the distribution of power and responsibilities among the various levels of government, and, therefore, does not have Federalism implications.

B. Executive Order 13211, Regulations that Significantly Affect Energy Supply, Distribution, or Use

The FAA analyzed this final rule under Executive Order 13211, Actions Concerning Regulations that Significantly Affect Energy Supply, Distribution, or Use (May 18, 2001). The agency has determined that it is not a ''significant energy action'' under the executive order and it is not likely to have a significant adverse effect on the supply, distribution, or use of energy.

VI. How To Obtain Additional Information

A. Rulemaking Documents

An electronic copy of a rulemaking document may be obtained by using the Internet—

1. Search the Federal eRulemaking Portal (*http://www.regulations.gov*);
2. Visit the FAA's Regulations and Policies Web page at *http://www.faa.gov/regulations_policies/* or
3. Access the Government Printing Office's Web page at *http://www.gpoaccess.gov/fr/index.html.*

Copies may also be obtained by sending a request (identified by notice, amendment, or docket number of this rulemaking) to the Federal Aviation Administration, Office of Rulemaking, ARM–1, 800 Independence Avenue SW., Washington, DC 20591, or by calling (202) 267–9680.

B. Comments Submitted to the Docket

Comments received may be viewed by going to *http://www.regulations.gov* and following the online instructions to search the docket number for this action. Anyone is able to search the electronic form of all comments received into any of the FAA's dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.).

C. Small Business Regulatory Enforcement Fairness Act

The Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 requires FAA to comply with small entity requests for information or advice about compliance with statutes and regulations within its jurisdiction. A small entity with questions regarding this document, may contact its local FAA official, or the person listed under the **FOR FURTHER INFORMATION CONTACT** heading at the beginning of the preamble. To find out more about SBREFA on the Internet, visit *http://www.faa.gov/regulations_policies/rulemaking/sbre_act/*.

List of Subjects

14 CFR Part 61

Aircraft, Airmen, Aviation safety.

14 CFR Part 121

Air carriers, Aircraft, Airmen, Aviation safety.

14 CFR Part 135

Air taxis, Aircraft, Airmen, Aviation safety.

14 CFR Part 141

Airmen, Educational facilities.

14 CFR Part 142

Airmen, Educational facilities.

The Amendment

In consideration of the foregoing, the Federal Aviation Administration amends Chapter I of Title 14, Code of Federal Regulations, as follows:

PART 61—CERTIFICATION: PILOTS, FLIGHT INSTRUCTORS, AND GROUND INSTRUCTORS

■ 1. The authority citation for part 61 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40113, 44701–44703, 44707, 44709–44711, 45102–45103, 45301–45302.

■ 2. Amend § 61.1 as follows:
■ A. Remove paragraph designations (b)(1) through (b)(19);
■ B. Add new definitions of *Accredited, Institution of higher education,* and *Nationally recognized accrediting agency* to paragraph (b) in alphabetical order;
■ C. Revise paragraph (iii) of the definition of *Authorized instructor* in paragraph (b);
■ D. Revise the definition of *Cross country time;* and
■ E. Remove definitions of *Flight simulator* and *Flight training device.*

The additions and revisions read as follows:

§ 61.1 Applicability and definitions.

* * * * *

(b) * * *

Accredited has the same meaning as defined by the Department of Education in 34 CFR 600.2.

* * * * *

Authorized instructor means—

* * * * *

(iii) A person authorized by the Administrator to provide ground training or flight training under part 61, 121, 135, or 142 of this chapter when conducting ground training or flight training in accordance with that authority.

Cross-country time means—

(i) Except as provided in paragraphs (ii) through (vi) of this definition, time acquired during flight—

(A) Conducted by a person who holds a pilot certificate;

(B) Conducted in an aircraft;

(C) That includes a landing at a point other than the point of departure; and

(D) That involves the use of dead reckoning, pilotage, electronic navigation aids, radio aids, or other navigation systems to navigate to the landing point.

(ii) For the purpose of meeting the aeronautical experience requirements (except for a rotorcraft category rating), for a private pilot certificate (except for a powered parachute category rating), a commercial pilot certificate, or an instrument rating, or for the purpose of exercising recreational pilot privileges (except in a rotorcraft) under § 61.101 (c), time acquired during a flight—

(A) Conducted in an appropriate aircraft;

(B) That includes a point of landing that was at least a straight-line distance of more than 50 nautical miles from the original point of departure; and

(C) That involves the use of dead reckoning, pilotage, electronic navigation aids, radio aids, or other navigation systems to navigate to the landing point.

(iii) For the purpose of meeting the aeronautical experience requirements for a sport pilot certificate (except for powered parachute privileges), time acquired during a flight conducted in an appropriate aircraft that—

(A) Includes a point of landing at least a straight line distance of more than 25 nautical miles from the original point of departure; and

(B) Involves, as applicable, the use of dead reckoning; pilotage; electronic navigation aids; radio aids; or other navigation systems to navigate to the landing point.

(iv) For the purpose of meeting the aeronautical experience requirements for a sport pilot certificate with powered parachute privileges or a private pilot certificate with a powered parachute category rating, time acquired during a flight conducted in an appropriate aircraft that—

(A) Includes a point of landing at least a straight line distance of more than 15 nautical miles from the original point of departure; and

(B) Involves, as applicable, the use of dead reckoning; pilotage; electronic navigation aids; radio aids; or other navigation systems to navigate to the landing point.

(v) For the purpose of meeting the aeronautical experience requirements for any pilot certificate with a rotorcraft category rating or an instrument-helicopter rating, or for the purpose of exercising recreational pilot privileges, in a rotorcraft, under § 61.101(c), time acquired during a flight—

(A) Conducted in an appropriate aircraft;

(B) That includes a point of landing that was at least a straight-line distance of more than 25 nautical miles from the original point of departure; and

(C) That involves the use of dead reckoning, pilotage, electronic navigation aids, radio aids, or other navigation systems to navigate to the landing point.

(vi) For the purpose of meeting the aeronautical experience requirements for an airline transport pilot certificate (except with a rotorcraft category rating), time acquired during a flight—

(A) Conducted in an appropriate aircraft;

(B) That is at least a straight-line distance of more than 50 nautical miles from the original point of departure; and

(C) That involves the use of dead reckoning, pilotage, electronic navigation aids, radio aids, or other navigation systems.

(vii) For a military pilot who qualifies for a commercial pilot certificate (except with a rotorcraft category rating) under § 61.73 of this part, time acquired during a flight—

(A) Conducted in an appropriate aircraft;

(B) That is at least a straight-line distance of more than 50 nautical miles from the original point of departure; and

(C) That involves the use of dead reckoning, pilotage, electronic navigation aids, radio aids, or other navigation systems.

* * * * *

Institution of higher education has the same meaning as defined by the Department of Education in 34 CFR 600.4.

* * * * *

Nationally recognized accrediting agency has the same meaning as defined by the Department of Education in 34 CFR 600.2.

* * * * *

■ 3. Amend § 61.23 as follows:
■ A. Revise paragraphs (a)(1) and (a)(2);
■ B. Revise paragraphs (d)(1)(i) and (ii) and (d)(2)(i).

The additions and revisions read as follows:

§ 61.23 Medical certificates: Requirement and duration.

(a) * * *

(1) Must hold a first-class medical certificate:

(i) When exercising the pilot-in-command privileges of an airline transport pilot certificate;

(ii) When exercising the second-in-command privileges of an airline transport pilot certificate in a flag or supplemental operation in part 121 of this chapter that requires three or more pilots; or

(iii) When serving as a required pilot flightcrew member in an operation conducted under part 121 of this chapter if the pilot has reached his or her 60th birthday.

(2) Must hold at least a second class medical certificate when exercising:

(i) Second-in-command privileges of an airline transport pilot certificate in part 121 of this chapter (other than operations specified in paragraph (a)(1)(ii) of this section); or

(ii) Privileges of a commercial pilot certificate; or

* * * * *

(d) *Duration of a medical certificate.* Use the following table to determine duration for each class of medical certificate:

If you hold	And on the date of examination for your most recent medical certificate you were	And you are conducting an operation requiring	Then your medical certificate expires, for that operation, at the end of the last day of the
(1) A first-class medical certificate.	(i) Under age 40	an airline transport pilot certificate for pilot-in-command privileges, or for second-in-command privileges in a flag or supplemental operation in part 121 requiring three or more pilots.	12th month after the month of the date of examination shown on the medical certificate.
	(ii) Age 40 or older	an airline transport pilot certificate for pilot-in-command privileges, for second-in-command privileges in a flag or supplemental operation in part 121 requiring three or more pilots, or for a pilot flightcrew member in part 121 operations who has reached his or her 60th birthday..	6th month after the month of the date of examination shown on the medical certificate.
*	*	* * *	* *
(2) A second-class medical certificate.	(i) Any age	an airline transport pilot certificate for second-in-command privileges (other than the operations specified in paragraph (d)(1) of this section), a commercial pilot certificate, or an air traffic control tower operator certificate.	12th month after the month of the date of examination shown on the medical certificate.
*	*	* * *	* *

■ 4. Amend § 61.35 by removing the word ''and'' at the end of paragraph (a)(1), redesignating paragraph (a)(2) as paragraph (a)(3), adding a new paragraph (a)(2), and revising redesignated paragraph (a)(3)(iii) to read as follows:

§ 61.35 Knowledge test: Prerequisites and passing grades.

(a) * * *

(2) After July 31, 2014, for the knowledge test for an airline transport pilot certificate with an airplane category multiengine class rating, a graduation certificate for the airline transport pilot certification training program specified in § 61.156; and

(3) * * *

(iii) Date of birth, which shows:

(A) For issuance of certificates other than the ATP certificate with an airplane category multiengine class rating, the applicant meets or will meet the age requirements of this part for the certificate sought before the expiration date of the airman knowledge test report; and

(B) For issuance of an ATP certificate with an airplane category multiengine class rating obtained under the aeronautical experience requirements of § 61.159 or § 61.160, the applicant is at least 18 years of age at the time of the knowledge test;

* * * * *

■ 5. Amend § 61.39 to revise paragraphs (a) and (b); redesignate paragraphs (c) through (e) as paragraphs (e) through (g); and add paragraphs (c) and (d) to read as follows:

§ 61.39 Prerequisites for practical tests.

(a) Except as provided in paragraphs (b), (c), and (e) of this section, to be eligible for a practical test for a certificate or rating issued under this part, an applicant must:

(1) Pass the required knowledge test:

(i) Within the 24-calendar-month period preceding the month the applicant completes the practical test, if a knowledge test is required; or

(ii) Within the 60-calendar month period preceding the month the applicant completes the practical for those applicants who pass the knowledge test after completing the airline transport pilot certification training program in § 61.156;

(2) Present the knowledge test report at the time of application for the practical test, if a knowledge test is required;

(3) Have satisfactorily accomplished the required training and obtained the aeronautical experience prescribed by this part for the certificate or rating sought;

(4) Hold at least a third-class medical certificate, if a medical certificate is required;

(5) Meet the prescribed age requirement of this part for the issuance of the certificate or rating sought;

(6) Have an endorsement, if required by this part, in the applicant's logbook or training record that has been signed by an authorized instructor who certifies that the applicant—

(i) Has received and logged training time within 2 calendar months preceding the month of application in preparation for the practical test;

(ii) Is prepared for the required practical test; and

(iii) Has demonstrated satisfactory knowledge of the subject areas in which the applicant was deficient on the airman knowledge test; and

(7) Have a completed and signed application form.

(b) An applicant for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate with an airplane type rating may take the practical test with an expired knowledge test only if the applicant passed the knowledge test after July 31, 2014, and is employed:

(1) As a flightcrew member by a part 119 certificate holder conducting operations under parts 125 or 135 of this chapter at the time of the practical test and has satisfactorily accomplished that operator's approved pilot-in-command training or checking program; or

(2) As a flightcrew member by a part 119 certificate holder conducting operations under part 121 of this chapter at the time of the practical test and has satisfactorily accomplished that operator's approved initial training program; or

(3) By the U.S. Armed Forces as a flight crewmember in U.S. military air transport operations at the time of the practical test and has completed the pilot in command aircraft qualification training program that is appropriate to the pilot certificate and rating sought.

(c) An applicant for an airline transport pilot certificate with a rating other than those ratings set forth in paragraph (b) of this section may take the practical test for that certificate or rating with an expired knowledge test report, provided that the applicant is employed:

(1) As a flightcrew member by a part 119 certificate holder conducting operations under parts 125 or 135 of this chapter at the time of the practical test and has satisfactorily accomplished that operator's approved pilot-in-command training or checking program; or

(2) By the U.S. Armed Forces as a flight crewmember in U.S. military air transport operations at the time of the practical test and has completed the pilot in command aircraft qualification training program that is appropriate to the pilot certificate and rating sought.

(d) In addition to the requirements in paragraph (a) of this section, to be eligible for a practical test for an airline transport pilot certificate with an airplane category multiengine class rating or airline transport pilot certificate obtained concurrently with an airplane type rating, an applicant must:

(1) If the applicant passed the knowledge test after July 31, 2014, present the graduation certificate for the airline transport pilot certification training program in § 61.156, at the time of application for the practical test;

(2) If applying for the practical test under the aeronautical experience requirements of § 61.160(a), the applicant must present the documents required by that section to substantiate eligibility; and

(3) If applying for the practical test under the aeronautical experience requirements of § 61.160(b), (c), or (d), the applicant must present an official transcript and certifying document from an institution of higher education that holds a letter of authorization from the Administrator under § 61.169.

* * * * *

■ 6. Amend § 61.55 by revising paragraph (a)(3) and by removing the phrase ''part 121,'' from paragraph (e) introductory text to read as follows:

§ 61.55 Second-in-command qualifications.

(a) * * *

(3) At least a pilot type rating for the aircraft being flown unless the flight will be conducted as domestic flight operations within the United States airspace.

* * * * *

■ 7. Amend § 61.57 by revising paragraph (e)(2) to read as follows:

§ 61.57 Recent flight experience: Pilot in command.

* * * * *

(e) * * *

(2) This section does not apply to a pilot in command who is employed by an air carrier certificated under part 121 or 135 and is engaged in a flight operation under part 91, 121, or 135 for that air carrier if the pilot is in compliance with §§ 121.435 or 121.436, as applicable, and § 121.439, or §§ 135.243 and 135.247 of this chapter, as appropriate.

* * * * *

■ 8. Amend § 61.71 by revising paragraphs (b) and (c) to read as follows;

§ 61.71 Graduates of an approved training program other than under this part: Special rules.

* * * * *

(b) A person may apply for an airline transport pilot certificate, type rating, or both under this part, and will be considered to have met the applicable requirements under § 61.157, except for the airline transport pilot certification training program required by § 61.156, for that certificate and rating, if that person has:

(1) Satisfactorily accomplished an approved training program and a proficiency check for that airplane type that includes all the tasks and maneuvers required to serve as pilot in command in accordance with the requirements of subparts N and O of part 121 of this chapter; and

(2) Applied for an airline transport pilot certificate, type rating, or both within the 60-day period from the date the person satisfactorily accomplished the requirements of paragraph (b)(1) for that airplane type.

(c) A person who holds a foreign pilot license and is applying for an equivalent U.S. pilot certificate on the basis of a Bilateral Aviation Safety Agreement and associated Implementation Procedures for Licensing may be considered to have met the applicable aeronautical experience, aeronautical knowledge, and areas of operation requirements of this part.

■ 9. Amend § 61.153 as follows:

■ A. Revise paragraph (a);

■ B. Redesignate paragraphs (e) through (h) as paragraphs (f) through (i); and

■ C. Add a new paragraph (e).

The addition and revisions read as follows:

§ 61.153 Eligibility requirements: General.

* * * * *

(a) Meet the following age requirements:

(1) For an airline transport pilot certificate obtained under the aeronautical experience requirements of §§ 61.159, 61.161, or 61.163, be at least 23 years of age; or

(2) For an airline transport pilot certificate obtained under the aeronautical experience requirements of § 61.160, be at least 21 years of age.

* * * * *

(e) After July 31, 2014, for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate obtained concurrently with an airplane type rating, receive a graduation certificate from an authorized training provider certifying completion of the airline transport pilot certification training program specified in § 61.156 before applying for the knowledge test required by paragraph (g) of this section;

* * * * *

■ 10. Amend § 61.155 as follows:

■ A. Remove the word ''and'' after the semicolon in paragraph (c)(12);

■ B. Remove the period from the end of paragraph (c)(13) and add the phrase ''; and'' in its place; and

■ C. Add paragraphs (c)(14) and (d).

The additions read as follows:

§ 61.155 Aeronautical knowledge.

* * * * *

(c) * * *

(14) After July 31, 2014, for airplane category multiengine class rating or airplane type rating, the content of the airline transport pilot certification training program in § 61.156.

(d) An applicant who successfully completes the knowledge test for an airline transport pilot certificate prior to August 1, 2014, must successfully complete the practical test within 24 months from the month in which the knowledge test was successfully completed. An applicant who passes the knowledge test prior to August 1, 2014, but fails to successfully complete the practical test within 24 months must complete the airline transport pilot certification training program specified

in § 61.156 and retake the knowledge test prior to applying for the practical test.

■ 11. Add § 61.156 to read as follows:

§ 61.156 Training requirements: Airplane category—multiengine class rating or airplane type rating concurrently with airline transport pilot certificate.

After July 31, 2014, a person who applies for the knowledge test for an airline transport pilot certificate with an airplane category multiengine class rating must present a graduation certificate from an authorized training provider under part 121, 135, 141, or 142 of this chapter certifying the applicant has completed the following training in a course approved by the Administrator.

(a) *Academic training.* The applicant for the knowledge test must receive at least 30 hours of classroom instruction that includes the following:

(1) At least 8 hours of instruction on aerodynamics including high altitude operations;

(2) At least 2 hours of instruction on meteorology, including adverse weather phenomena and weather detection systems; and

(3) At least 14 hours of instruction on air carrier operations, including the following areas:

(i) Physiology;

(ii) Communications;

(iii) Checklist philosophy;

(iv) Operational control;

(v) Minimum equipment list/configuration deviation list;

(vi) Ground operations;

(vii) Turbine engines;

(viii) Transport category aircraft performance;

(ix) Automation, navigation, and flight path warning systems.

(4) At least 6 hours of instruction on leadership, professional development, crew resource management, and safety culture.

(b) *FSTD training.* The applicant for the knowledge test must receive at least 10 hours of training in a flight simulation training device qualified under part 60 of this chapter that represents a multiengine turbine airplane. The training must include the following:

(1) At least 6 hours of training in a Level C or higher full flight simulator qualified under part 60 of this chapter that represents a multiengine turbine airplane with a maximum takeoff weight of 40,000 pounds or greater. The training must include the following areas:

(i) Low energy states/stalls;

(ii) Upset recovery techniques; and

(iii) Adverse weather conditions, including icing, thunderstorms, and crosswinds with gusts.

(2) The remaining FSTD training may be completed in a Level 4 or higher flight simulation training device. The training must include the following areas:

(i) Navigation including flight management systems; and

(ii) Automation including autoflight.

(c) *Deviation authority.* The Administrator may issue deviation authority from the weight requirement in paragraph (b)(1) of this section upon a determination that the objectives of the training can be met in an alternative device.

■ 12. Amend § 61.157 by revising paragraph (c) to read as follows:

§ 61.157 Flight proficiency.

* * * * *

(c) *Exceptions.* A person who applies for an aircraft type rating to be added to an airline transport pilot certificate or an aircraft type rating concurrently with an airline transport pilot certificate, and who is an employee of a certificate holder operating under part 121 or part 135 of this chapter, does not need to comply with the requirements of paragraph (b) of this section if the applicant presents a training record that shows completion of that certificate holder's approved training program for the aircraft type rating.

* * * * *

■ 13. Amend § 61.159 as follows:

■ A. Redesignate paragraphs (a)(3) through (a)(5) as paragraphs (a)(4) through (a)(6);

■ B. Add a new paragraph (a)(3);

■ C. Remove the phrase ''paragraph (a)(3)(ii)'' from newly redesignated paragraph (a)(4)(i) and add the phrase ''paragraph (a)(4)(ii)'' in its place;

■ D. Remove the phrase ''paragraph (a)(3)'' from newly redesignated paragraph (a)(4)(ii) and add the phrase ''paragraph (a)(4)'' in its place; and

■ E. Revise newly redesignated paragraph (a)(5).

The addition and revision read as follows

§ 61.159 Aeronautical experience: Airplane category rating.

(a) * * *

(3) 50 hours of flight time in the class of aircraft for which the rating is sought. A maximum of 25 hours of training in a full flight simulator representing a multiengine airplane may be credited toward the flight time requirement of this paragraph if the training was accomplished as part of an approved training course in parts 121, 135, 141, or 142 of this chapter. A flight training device or aviation training device may not be used to satisfy this requirement.

* * * * *

(5) Not more than 100 hours of the total aeronautical experience requirements of paragraph (a) of this section may be obtained in a full flight simulator or flight training device that represents an airplane, provided the aeronautical experience was accomplished as part of an approved training course in parts 121, 135, 141, or 142 of this chapter.

* * * * *

■ 14. Add § 61.160 to read as follows:

§ 61.160 Aeronautical experience—airplane category restricted privileges.

(a) Except for a person who has been removed from flying status for lack of proficiency or because of a disciplinary action involving aircraft operations, a U.S. military pilot or former U.S. military pilot may apply for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate concurrently with an airplane type rating with a minimum of 750 hours of total time as a pilot if the pilot presents:

(1) An official Form DD–214 (Certificate of Release or Discharge from Active Duty) indicating that the person was honorably discharged from the U.S. Armed Forces or an official U.S. Armed Forces record that shows the pilot is currently serving in the U.S. Armed Forces; and

(2) An official U.S. Armed Forces record that shows the person graduated from a U.S. Armed Forces undergraduate pilot training school and received a rating qualification as a military pilot.

(b) A person may apply for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate concurrently with an airplane type rating with a minimum of 1,000 hours of total time as a pilot if the person:

(1) Holds a Bachelor's degree with an aviation major from an institution of higher education, as defined in § 61.1, that has been issued a letter of authorization by the Administrator under § 61.169;

(2) Completes 60 semester credit hours of aviation and aviation-related coursework that has been recognized by the Administrator as coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot;

(3) Holds a commercial pilot certificate with an airplane category and instrument rating if:

(i) The required ground training was completed as part of an approved part 141 curriculum at the institution of higher education; and

(ii) The required flight training was completed as part of an approved part 141 curriculum at the institution of higher education or at a part 141 pilot school that has a training agreement under § 141.26 of this chapter with the institution of higher education; and

(4) Presents official transcripts or other documentation acceptable to the Administrator from the institution of higher education certifying that the graduate has satisfied the requirements in paragraphs (b)(1) through (3) of this section.

(c) A person may apply for an airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate concurrently with an airplane type rating with a minimum of 1,250 hours of total time as a pilot if the person:

(1) Holds an Associate's degree with an aviation major from an institution of higher education, as defined in § 61.1, that has been issued a letter of authorization by the Administrator under § 61.169;

(2) Completes at least 30 semester credit hours of aviation and aviation-related coursework that has been recognized by the Administrator as coursework designed to improve and enhance the knowledge and skills of a person seeking a career as a professional pilot;

(3) Holds a commercial pilot certificate with an airplane category and instrument rating if:

(i) The required ground training was completed as part of an approved part 141 curriculum at the institution of higher education; and

(ii) The required flight training was completed as part of an approved part 141 curriculum at the institution of higher education or at a part 141 pilot school that has a written training agreement under § 141.26 of this chapter with the institution of higher education; and

(4) Presents official transcripts or other documentation acceptable to the Administrator from the institution of higher education certifying that the graduate has satisfied the requirements in paragraphs (c)(1) through (3) of this section.

(d) A graduate of an institution of higher education who completes fewer than 60 semester credit hours but at least 30 credit hours and otherwise satisfies the requirements of paragraph (b) may apply for airline transport pilot certificate with an airplane category multiengine class rating or an airline transport pilot certificate concurrently with an airplane type rating with a minimum of 1,250 hours of total time as a pilot.

(e) A person who applies for an airline transport pilot certificate under the total flight times listed in paragraphs (a), (b), and (c) of this section must otherwise meet the aeronautical experience requirements of § 61.159, except that the person may apply for an airline transport pilot certificate with 200 hours of cross-country flight time.

(f) A person who has 1,500 hours total time as a pilot, 200 hours of cross-country flight time, and otherwise meets the aeronautical experience requirements of § 61.159 may apply for an airline transport pilot certificate under this section.

(g) An airline transport pilot certificate obtained under this section is subject to the pilot in command limitations set forth in § 61.167(b) and must contain the following limitation, ''Restricted in accordance with 14 CFR 61.167.'' The pilot is entitled to an airline transport pilot certificate without the limitation specified in this paragraph when the applicant presents satisfactory evidence of having met the aeronautical experience requirements of § 61.159 and the age requirement of § 61.153(a)(1).

(h) An applicant who meets the aeronautical experience requirements of paragraphs (a), (b), (c), and (d) of this section is issued an airline transport pilot certificate with the limitation, ''Holder does not meet the pilot in command aeronautical experience requirements of ICAO,'' as prescribed under Article 39 of the Convention on International Civil Aviation if the applicant does not meet the ICAO requirements contained in Annex 1 ''Personnel Licensing'' to the Convention on International Civil Aviation. An applicant is entitled to an airline transport pilot certificate without the ICAO limitation specified under this paragraph when the applicant presents satisfactory evidence of having met the ICAO requirements and otherwise meets the aeronautical experience requirements of § 61.159.

■ 15. Amend § 61.165 as follows:

■ A. Redesignate paragraphs (c)(2) through (c)(5) as paragraphs (c)(3) through (c)(6);

■ C. Add new paragraph (c)(2);

■ D. Revise newly redesignated paragraphs (c)(3) and (c)(5);

■ E. Revise paragraph (e) introductory text and paragraph (e)(1);

■ F. Redesignate paragraph (f) as paragraph (g);

■ G. Add new paragraph (f);

■ H. Remove the phrase ''paragraphs (a) through (e)'' from newly redesignated paragraph (g) introductory text and add the phrase ''paragraphs (a) through (f)'' in its place; and

■ I. Remove the phrase ''paragraph (f)(1)'' from newly redesignated paragraph (g)(3) and add the phrase ''paragraph (g)(1)'' in its place.

The revisions and additions read as follows:

§ 61.165 Additional aircraft class category and ratings.

* * * * *

(c) * * *

(2) After July 31, 2014, successfully complete the airline transport pilot certification training program specified in § 61.156;

(3) Pass a knowledge test for an airplane category multiengine class rating or type rating on the aeronautical knowledge areas of § 61.155(c);

* * * * *

(5) Meet the aeronautical experience requirements of § 61.159 or § 61.160; and

* * * * *

(e) *Additional class rating within the same aircraft category.* Except as provided in paragraph (f) of this section, a person applying for an airline transport pilot certificate with an additional class rating who holds an airline transport certificate in the same aircraft category must—

(1) Meet the eligibility requirements of § 61.153, except paragraph (g) of that section;

* * * * *

(f) *Adding a multiengine class rating or airplane type rating to an airline transport pilot certificate with a single engine class rating.* A person applying to add a multiengine class rating or airplane type rating to an airline transport pilot certificate with an airplane category single engine class rating must—

(1) Meet the eligibility requirements of § 61.153;

(2) Pass a required knowledge test on the aeronautical knowledge areas of § 61.155(c), as applicable to multiengine airplanes;

(3) Comply with the requirements in § 61.157(b), if applicable;

(4) Meet the applicable aeronautical experience requirements of § 61.159; and

(5) Pass a practical test on the areas of operation of § 61.157(e)(2).

* * * * *

■ 16. Revise § 61.167 to read as follows:

§ 61.167 Airline transport pilot privileges and limitations.

(a) *Privileges.* (1) A person who holds an airline transport pilot certificate is entitled to the same privileges as a person who holds a commercial pilot certificate with an instrument rating.

(2) A person who holds an airline transport pilot certificate and has met the aeronautical experience requirements of § 61.159 and the age requirements of § 61.153(a)(1) of this part may instruct—

(i) Other pilots in air transportation service in aircraft of the category, class, and type, as applicable, for which the airline transport pilot is rated and endorse the logbook or other training record of the person to whom training has been given;

(ii) In flight simulators, and flight training devices representing the aircraft referenced in paragraph (b)(1) of this section, when instructing under the provisions of this section and endorse the logbook or other training record of the person to whom training has been given;

(iii) Only as provided in this section, except that an airline transport pilot who also holds a flight instructor certificate can exercise the instructor privileges under subpart H of this part for which he or she is rated; and

(iv) In an aircraft, only if the aircraft has functioning dual controls, when instructing under the provisions of this section.

(3) Excluding briefings and debriefings, an airline transport pilot may not instruct in aircraft, flight simulators, and flight training devices under this section—

(i) For more than 8 hours in any 24-consecutive-hour period; or

(ii) For more than 36 hours in any 7-consecutive-day period.

(4) An airline transport pilot may not instruct in Category II or Category III operations unless he or she has been trained and successfully tested under Category II or Category III operations, as applicable.

(b) *Limitations.* A person who holds an airline transport pilot certificate and has not satisfied the age requirement of § 61.153(a)(1) and the aeronautical experience requirements of § 61.159 may not:

(1) Act as pilot in command in operations conducted under part 121, § 91.1053(a)(2)(i), or § 135.243(a)(1) of this chapter, or

(2) Serve as second in command in flag or supplemental operations in part 121 of this chapter requiring three or more pilots.

■ 17. Add § 61.169 to read as follows:

§ 61.169 Letters of authorization for institutions of higher education.

(a) An institution of higher education that is accredited, as defined in § 61.1, may apply for a letter of authorization for the purpose of certifying its graduates for an airline transport pilot certificate under the academic and aeronautical experience requirements in § 61.160. The application must be in a form and manner acceptable to the Administrator.

(b) An institution of higher education must comply with the provisions of the letter of authorization and may not certify a graduate unless it determines that the graduate has satisfied the requirements of § 61.160, as appropriate.

(c) The Administrator may rescind or amend a letter of authorization if the Administrator determines that the institution of higher education is not complying or is unable to comply with the provisions of the letter of authorization.

PART 121—OPERATING REQUIREMENTS: DOMESTIC, FLAG, AND SUPPLEMENTAL OPERATIONS

■ 18. The authority citation for part 121 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40113, 40119, 41706, 44101, 44701–44702, 44705, 44709–44711, 44713, 44716–44717, 44722, 46105.2.

■ 19. Amend § 121.409 by revising paragraph (b) introductory text to read as follows:

§ 121.409 Training courses using airplane simulators and other training devices.

* * * * *

(b) Except for the airline transport pilot certification training program approved to satisfy the requirements of § 61.156 of this chapter, a course of training in an airplane simulator may be included for use as provided in § 121.441 if that course—

* * * * *

■ 20. Add § 121.410 to read as follows:

§ 121.410 Airline transport pilot certification training program.

(a) A certificate holder may obtain approval to establish and implement a training program to satisfy the requirements of § 61.156 of this chapter. The training program must be separate from the air carrier training program required by this part.

(b) No certificate holder may use a person nor may any person serve as an instructor in a training program approved to meet the requirements of § 61.156 of this chapter unless the instructor:

(1) Holds an airline transport pilot certificate with an airplane category multiengine class rating;

(2) Has at least 2 years of experience as a pilot in command in operations conducted under § 91.1053(a)(2)(i) or § 135.243(a)(1) of this chapter, or as a pilot in command or second in command in any operation conducted under this part;

(3) Except for the holder of a flight instructor certificate, receives initial training on the following topics:

(i) The fundamental principles of the learning process;

(ii) Elements of effective teaching, instruction methods, and techniques;

(iii) Instructor duties, privileges, responsibilities, and limitations;

(iv) Training policies and procedures; and

(v) Evaluation.

(4) If providing training in a flight simulation training device, hold an aircraft type rating for the aircraft represented by the flight simulation training device utilized in the training program and have received training within the preceding 12 months from the certificate holder on:

(i) Proper operation of flight simulator and flight training device controls and systems;

(ii) Proper operation of environmental and fault panels;

(iii) Data and motion limitations of simulation;

(iv) Minimum equipment requirements for each curriculum; and

(v) The maneuvers that will be demonstrated in the flight simulation training device.

(c) A certificate holder may not issue a graduation certificate to a student unless that student has completed all the curriculum requirements of the course.

(d) A certificate holder must conduct evaluations to ensure that training techniques, procedures, and standards are acceptable to the Administrator.

■ 21. Revise § 121.419 to read as follows:

§ 121.419 Pilots and flight engineers: Initial, transition, and upgrade ground training.

(a) Except as provided in paragraph (b) of this section, initial, transition, and upgrade ground training for pilots and flight engineers must include instruction in at least the following as applicable to their assigned duties:

(1) General subjects—

(i) The certificate holder's dispatch or flight release procedures;

(ii) Principles and methods for determining weight and balance, and runway limitations for takeoff and landing;

(iii) Enough meteorology to insure a practical knowledge of weather phenomena, including the principles of frontal systems, icing, fog, thunderstorms, and high altitude weather situations;

(iv) Air traffic control systems, procedures, and phraseology;

(v) Navigation and the use of navigation aids, including instrument approach procedures;

(vi) Normal and emergency communication procedures;

(vii) Visual cues prior to and during descent below DA/DH or MDA;

(viii) Approved crew resource management initial training; and

(ix) Other instructions as necessary to ensure competence.

(2) For each airplane type—

(i) A general description;

(ii) Performance characteristics;

(iii) Engines and propellers;

(iv) Major components;

(v) Major airplane systems (e.g., flight controls, electrical, hydraulic); other systems as appropriate; principles of normal, abnormal, and emergency operations; appropriate procedures and limitations;

(vi) Procedures for—

(A) Recognizing and avoiding severe weather situations;

(B) Escaping from severe weather situations, in case of inadvertent encounters, including low-altitude windshear, and

(C) Operating in or near thunderstorms (including best penetrating altitudes), turbulent air (including clear air turbulence), icing, hail, and other potentially hazardous meteorological conditions;

(vii) Operating limitations;

(viii) Fuel consumption and cruise control;

(ix) Flight planning;

(x) Each normal and emergency procedure; and

(xi) The approved Airplane Flight Manual.

(b) Initial ground training for pilots who have completed the airline transport pilot certification training program in § 61.156 must include instruction in at least the following as applicable to their assigned duties:

(1) Ground training specific to the certificate holder's—

(i) Dispatch or flight release procedures;

(ii) Method for determining weight and balance and runway limitations for takeoff and landing;

(iii) Meteorology hazards applicable to the certificate holder's areas of operation;

(iv) Approved departure, arrival, and approach procedures;

(v) Normal and emergency communication procedures; and

(vi) Approved crew resource management training.

(2) The training required by paragraph (a)(2) of this section for the airplane type.

(c) Initial ground training for pilots and flight engineers must consist of at least the following programmed hours of instruction in the required subjects specified in paragraph (a) of this section and in § 121.415(a) unless reduced under § 121.405:

(1) Group I airplanes—

(i) Reciprocating powered, 64 hours; and

(ii) Turbopropeller powered, 80 hours.

(2) Group II airplanes, 120 hours.

(d) Initial ground training for pilots who have completed the airline transport pilot certification training program in § 61.156 must consist of at least the following programmed hours of instruction in the required subjects specified in paragraph (b) of this section and in § 121.415(a) unless reduced under § 121.405:

(1) Group I airplanes—

(i) Reciprocating powered, 54 hours; and

(ii) Turbopropeller powered, 70 hours.

(2) Group II airplanes, 110 hours.

■ 22. Add § 121.435 to read as follows:

§ 121.435 Pilot qualification: Certificate and experience requirements.

(a) No pilot may act as pilot in command of an aircraft (or as second in command of an aircraft in a flag or supplemental operation that requires three or more pilots) unless he holds an airline transport pilot certificate and an appropriate type rating for that aircraft.

(b) No certificate holder may use nor may any pilot act as a pilot in a capacity other than those specified in paragraph (a) of this section unless the pilot holds at least a commercial pilot certificate with appropriate category and class ratings for the aircraft concerned, and an instrument rating. Notwithstanding the requirements of § 61.63(b) and (c) of this chapter, a pilot who is currently employed by a certificate holder and meets applicable training requirements of subpart N of this part, and the proficiency check requirements of § 121.441, may be issued the appropriate category and class ratings by presenting proof of compliance with those requirements to a Flight Standards District Office.

(c) The requirements of this section will expire on July 31, 2013. After that date, the requirements of § 121.436 apply.

■ 23. Add § 121.436 to read as follows:

§ 121.436 Pilot Qualification: Certificates and experience requirements.

(a) No certificate holder may use nor may any pilot act as pilot in command of an aircraft (or as second in command of an aircraft in a flag or supplemental operation that requires three or more pilots) unless the pilot:

(1) Holds an airline transport pilot certificate not subject to the limitations in § 61.167 of this chapter;

(2) Holds an appropriate aircraft type rating for the aircraft being flown; and

(3) If serving as pilot in command, has 1,000 hours as second in command in operations under this part, pilot in command in operations under § 91.1053(a)(2)(i) of this chapter, pilot in command in operations under § 135.243(a)(1) of this chapter, or any combination thereof. For those pilots who are employed as pilot in command in part 121 operations on July 31, 2013, compliance with the requirements of this paragraph (a)(3) is not required.

(b) No certificate holder may use nor may any pilot act as second in command unless the pilot holds an airline transport pilot certificate and an appropriate aircraft type rating for the aircraft being flown. A second-in-command type rating obtained under § 61.55 does not satisfy the requirements of this section.

(c) For the purpose of satisfying the flight hour requirement in paragraph (a)(3) of this section, a pilot may credit 500 hours of military flight time obtained as pilot in command of a multiengine turbine-powered, fixed-wing airplane in an operation requiring more than one pilot.

(d) Compliance with the requirements of this section is required by August 1, 2013. However, for those pilots who are employed as second in command in part 121 operations on July 31, 2013, compliance with the type rating requirement in paragraph (b) of this section is not required until January 1, 2016.

§ 121.437 [Removed]

■ 24. Remove § 121.437.

■ 25. Amend § 121.543(b)(3)(i) to read as follows:

§ 121.543 Flight crewmembers at controls.

* * * * *

(b) * * *

(3) * * *

(i) In the case of the assigned pilot in command during the en route cruise portion of the flight, by a pilot who holds an airline transport pilot certificate not subject to the limitations in § 61.167 of this chapter and an

appropriate type rating, is currently qualified as pilot in command or second in command, and is qualified as pilot in command of that aircraft during the en route cruise portion of the flight. A second in command qualified to act as a pilot in command en route need not have completed the following pilot in command requirements: The 6-month recurrent flight training required by § 121.433(c)(1)(iii); the operating experience required by § 121.434; the takeoffs and landings required by § 121.439; the line check required by § 121.440; and the 6-month proficiency check or simulator training required by § 121.441(a)(1); and

* * * * *

Appendix H to Part 121 [Amended]

■ 26. Amend Appendix H to Part 121 by removing the reference ''§ 61.153(g)'' from the last paragraph of the appendix and adding the reference ''§ 61.153(h)'' in its place.

PART 135—OPERATING REQUIREMENTS: COMMUTER AND ON DEMAND OPERATIONS AND RULES GOVERNING PERSON ONBOARD SUCH AIRCRAFT

■ 27. The authority citation for part 135 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 41706, 40113, 44701–44702, 44705, 44709, 44711–44713, 44715–44717, 44722, 45101–45105.

■ 28. Add § 135.336 to read as follows:

§ 135.336 Airline transport pilot certification training program.

(a) A certificate holder may obtain approval to establish and implement a training program to satisfy the requirements of § 61.156 of this chapter. The training program must be separate from the air carrier training program required by this part.

(b) No certificate holder may use a person nor may any person serve as an instructor in a training program approved to meet the requirements of § 61.156 of this chapter unless the instructor:

(1) Holds an airline transport pilot certificate with an airplane category multiengine class rating;

(2) Has at least 2 years of experience as a pilot in command in operations conducted under § 91.1053(a)(2)(i) of this chapter, § 135.243(a)(1) of this part, or as a pilot in command or second in command in any operation conducted under part 121 of this chapter;

(3) Except for the holder of a flight instructor certificate, receives initial training on the following topics:

(i) The fundamental principles of the learning process;

(ii) Elements of effective teaching, instruction methods, and techniques;

(iii) Instructor duties, privileges, responsibilities, and limitations;

(iv) Training policies and procedures; and

(v) Evaluation.

(4) If providing training in a flight simulation training device, holds an aircraft type rating for the aircraft represented by the flight simulation training device utilized in the training program and have received training and evaluation within the preceding 12 months from the certificate holder on:

(i) Proper operation of flight simulator and flight training device controls and systems;

(ii) Proper operation of environmental and fault panels;

(iii) Data and motion limitations of simulation;

(iv) Minimum equipment requirements for each curriculum; and

(v) The maneuvers that will be demonstrated in the flight simulation training device.

(c) A certificate holder may not issue a graduation certificate to a student unless that student has completed all the curriculum requirements of the course.

(d) A certificate holder must conduct evaluations to ensure that training techniques, procedures, and standards are acceptable to the Administrator.

■ 29. Amend § 135.341 by adding a sentence to the end of paragraph (a) to read as follows:

§ 135.341 Pilot and flight attendant crewmember training programs.

(a) * * * This deviation authority does not extend to the training provided under paragraph (c) of this section.

* * * * *

PART 141—PILOT SCHOOLS

■ 30. The authority citation for part 141 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40113, 44701–44703, 44707, 44709, 44711, 45102–45103, 45301–45302.

■ 31. Amend § 141.11 by adding paragraph (b)(2)(viii) to read as follows:

§ 141.11 Pilot school ratings.

* * * * *

(b) * * *

(2) * * *

(viii) Airline transport pilot certification training program.

* * * * *

■ 32. Revise § 141.26 to read as follows:

§ 141.26 Training agreements.

(a) A training center certificated under part 142 of this chapter may provide the training, testing, and checking for pilot schools certificated under this part and is considered to meet the requirements of this part, provided—

(1) There is a training agreement between the certificated training center and the pilot school;

(2) The training, testing, and checking provided by the certificated training center is approved and conducted under part 142;

(3) The pilot school certificated under this part obtains the Administrator's approval for a training course outline that includes the training, testing, and checking to be conducted under this part and the training, testing, and checking to be conducted under part 142; and

(4) Upon completion of the training, testing, and checking conducted under part 142, a copy of each student's training record is forwarded to the part 141 school and becomes part of the student's permanent training record.

(b) A pilot school that provides flight training for an institution of higher education that holds a letter of authorization under § 61.169 of this chapter must have a training agreement with that institution of higher education.

■ 33. Amend § 141.33 by adding paragraph (a)(4) to read as follows:

§ 141.33 Personnel.

(a) * * *

(4) In addition to meeting the requirements of paragraph (a)(3) of this section, each instructor used for the airline transport pilot certification training program in § 61.156 of this chapter must:

(i) Hold an airline transport pilot certificate with an airplane category multiengine class rating;

(ii) Have at least 2 years of experience as a pilot in command in operations conducted under § 91.1053(a)(2)(i) or § 135.243(a)(1) of this chapter, or as a pilot in command or second in command in any operation conducted under part 121 of this chapter; and

(iii) If providing training in a flight simulation training device, have received training and evaluation within the preceding 12 months from the certificate holder on—

(A) Proper operation of flight simulator and flight training device controls and systems;

(B) Proper operation of environmental and fault panels,

(C) Data and motion limitations of simulation;

(D) Minimum equipment requirements for each curriculum; and

(E) The maneuvers that will be demonstrated in the flight simulation training device.

* * * * *

■ 34. Amend Appendix K to Part 141 as follows:

■ A. Revise paragraph 4.(b) and 4.(c).

■ B. Add paragraph 13.

Appendix K to Part 141—Special Preparation Courses

* * * * *

4. * * *

(b) Except for the airline transport pilot certification program in paragraph 13 of this appendix, training in a flight simulator that meets the requirements of § 141.41(a) of this part, may be credited for a maximum of 10 percent of the total flight training hour requirements of the approved course, or of this section, whichever is less.

(c) Except for the airline transport pilot certification program in paragraph 13 of this appendix, training in a flight training device that meets the requirements of § 141.41(b) of this part, may be credited for a maximum of 5 percent of the total flight training hour requirements of the approved course, or of this section, whichever is less.

* * * * *

13. Airline transport pilot certification training program. An approved airline transport pilot certification training program must include the academic and FSTD training set forth in § 61.156 of this chapter. The FAA will not approve a course with fewer hours than those prescribed in § 61.156 of this chapter.

PART 142—TRAINING CENTERS

■ 35. The authority citation for part 142 is revised to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40113, 40119, 44101, 44701–44703, 44705, 44707, 44709–44711, 45102–45103, 45301–45302.

■ 36. Amend § 142.1 by revising paragraphs (a) and (b)(2) to read as follows:

§ 142.1 Applicability.

(a) This subpart prescribes the requirements governing the certification and operation of training centers. Except as provided in paragraph (b) of this section, this part provides an alternative means to accomplish training required by parts 61, 63, 65, 91, 121, 125, 135, or 137 of this chapter.

(b) * * *

(2) Approved under subpart Y of part 121 of this chapter, Advanced Qualification Programs, for the authorization holder's own employees;

* * * * *

■ 37. Amend § 142.3 by revising paragraph (3) of the definition of *Course* and the definition of *Flight training equipment* to read as follows:

§ 142.3 Definitions.

* * * * *

Course means—

* * * * *

(3) A curriculum, or curriculum segment, as defined in subpart Y of part 121 of this chapter.

* * * * *

Flight training equipment means full flight simulators, as defined in § 1.1 of this chapter, flight training devices, as defined in § 1.1 of this chapter, and aircraft.

* * * * *

■ 38. Amend § 142.49 by revising paragraph (c)(3)(iv) to read as follows:

§ 142.49 Training center instructor and evaluator privileges and limitations.

* * * * *

(c) * * *

(3) * * *

(iv) If instructing or evaluating in an aircraft in flight while serving as a required crewmember, holds at least a valid second class medical certificate; and

* * * * *

■ 39. Add § 142.54 to read as follows:

§ 142.54 Airline transport pilot certification training program.

No certificate holder may use a person nor may any person serve as an instructor in a training program approved to meet the requirements of § 61.156 of this chapter unless the instructor:

(a) Holds an airline transport pilot certificate with an airplane category multiengine class rating;

(b) Has at least 2 years of experience as a pilot in command in operations conducted under § 91.1053(a)(2)(i) or § 135.243(a)(1) of this chapter, or as a pilot in command or second in command in any operation conducted under part 121 of this chapter;

(c) Except for the holder of a flight instructor certificate, receives initial training on the following topics:

(1) The fundamental principles of the learning process;

(2) Elements of effective teaching, instruction methods, and techniques;

(3) Instructor duties, privileges, responsibilities, and limitations;

(4) Training policies and procedures; and

(5) Evaluation.

(d) If providing training in a flight simulation training device—

(1) Holds an aircraft type rating for the aircraft represented by the flight simulation training device utilized in the training program and have received training and evaluation within the preceding 12 months from the certificate holder on the maneuvers that will be demonstrated in the flight simulation training device; and

(2) Satisfies the requirements of § 142.53(a)(4).

(e) A certificate holder may not issue a graduation certificate to a student unless that student has completed all the curriculum requirements of the course.

(f) A certificate holder must conduct evaluations to ensure that training techniques, procedures, and standards are acceptable to the Administrator.

§ 142.55 [Amended]

■ 40. Amend § 142.55 as follows:

■ A. In paragraph (a)(2), remove the phrase ''part 187'' and add in its place the phrase ''part 183''; and

■ B. In paragraph (d), remove the phrase ''SFAR 58'' and add in its place the phrase ''subpart Y of part 121 of this chapter''.

Issued in Washington, DC, under the authority provided by 49 U.S.C. 106(f), 44701(a), and Secs. 216–217, Public Law 111–216, 124 Stat. 2348 on July 10, 2013.

Michael P. Huerta,

Administrator.

[FR Doc. 2013–16849 Filed 7–10–13; 4:15 pm]

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Part IV

Department of Health and Human Services

Food and Drug Administration

21 CFR Parts 1 and 16

Administrative Detention of Drugs Intended for Human or Animal Use; Draft Guidance for Industry on Circumstances That Constitute Delaying, Denying, Limiting, or Refusing a Drug Inspection; Availability; Proposed Rule and Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 1 and 16

[Docket No. FDA–2013–N–0365]

Administrative Detention of Drugs Intended for Human or Animal Use

AGENCY: Food and Drug Administration, HHS.

ACTION: Proposed rule.

SUMMARY: The Food and Drug Administration (FDA) is proposing a regulation to implement administrative detention authority with respect to drugs intended for human or animal use as authorized by amendments made to the Federal Food, Drug, and Cosmetic Act (the FD&C Act) by the Food and Drug Administration Safety and Innovation Act (FDASIA). Once the applicable regulation is finalized, FDA's administrative detention authority with respect to drugs will allow FDA to better protect the integrity of the drug supply chain. Specifically, FDA will be able to administratively detain drugs encountered during an inspection that an officer or employee conducting an inspection has reason to believe are adulterated or misbranded. This authority is intended to protect the public by preventing distribution or subsequent use of drugs encountered during inspections that are believed to be adulterated or misbranded, until FDA has had time to consider what action it should take concerning the drugs, and to initiate legal action, if appropriate.

DATES: Submit either electronic or written comments on the proposed rule by September 13, 2013.

ADDRESSES: You may submit comments, identified by Docket No. FDA–2013–N–0365, by any of the following methods.

Electronic Submissions

Submit electronic comments in the following way:

• *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

Written Submissions

Submit written submissions in the following ways:

• *Mail/Hand delivery/Courier* (for paper or CD–ROM submissions): Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

Instructions: All submissions received must include the Agency name and Docket No. FDA–2013–N–0365. All comments received may be posted without change to *http://www.regulations.gov,* including any personal information provided. For additional information on submitting comments, see the ''Comments'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

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

FOR FURTHER INFORMATION CONTACT: Charlotte Hinkle, Office of Regulatory Affairs, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Rm. 4345, Silver Spring, MD 20993–0002, 301–796–5300, *FDASIA ImplementationORA@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Executive Summary

Purpose of the Regulatory Action

FDA's administrative detention authority with respect to drugs intended for human or animal use will allow FDA to better protect the integrity of the drug supply chain. Specifically, administrative detention is intended to protect the public by preventing distribution or subsequent use of drugs encountered during inspections that may be adulterated or misbranded, until FDA has had time to consider what action it should take concerning the drugs, and to initiate legal action, if appropriate. FDA already has the authority to administratively detain devices, tobacco, and foods that FDA has reason to believe are adulterated or misbranded.

FDA is issuing this proposed rule under section 304(g) of the FD&C Act, as amended by section 709 of FDASIA, and section 701 of the FD&C Act (21 U.S.C. 334(g) and 371). Section 304(g) also authorizes FDA to administratively detain devices and tobacco products.

Summary of the Major Provisions

This notice contains a proposed rule regarding the administrative detention of drugs. FDA proposes to amend parts 1 and 16 (21 CFR parts 1 and 16) to create an implementing rule for this authority. The proposed changes set forth the procedures for detention of drugs believed to be adulterated or misbranded and amend the scope of FDA's part 16 regulatory hearing procedures to include the administrative detention of drugs.

Costs and Benefits

The primary public health benefits from adoption of the proposed rule would be the value of the illnesses or deaths prevented because the Agency administratively detained a drug it has reason to believe is adulterated or misbranded; this benefit occurs only if the drug would not have been prevented from entering the market using one of the Agency's other enforcement tools. The estimated primary costs to FDA include marking or labeling the detained product and costs associated with appeals of detention orders. The Agency estimates the net annual social costs to be between $0 and $591,480.

I. Background

On July 9, 2012, President Obama signed the Food and Drug Administration Safety and Innovation Act (FDASIA, Pub. L. 112–144) into law. Title VII of FDASIA provides FDA with important new authorities to help it better protect the integrity of the drug supply chain. One of those new authorities is section 709, which amends section 304(g) of the FD&C Act (21 U.S.C. 334(g)) to provide FDA with administrative detention authority with respect to drugs. Section 304(g) of the FD&C Act, as amended by FDASIA, provides FDA the same authority to detain drugs that section 304(g) already provides FDA with respect to devices and tobacco products. Once implementing regulations with respect to drugs are finalized, the amendments to section 304(g) of the FD&C Act will take effect, allowing FDA to administratively detain drugs that an officer or employee conducting an inspection under section 704 of the FD&C Act has reason to believe are adulterated or misbranded.

FDA's administrative detention authority with respect to drugs will allow FDA to drive safety and quality through the drug supply chain. Use of this authority is intended to protect the public by preventing distribution or subsequent use of drugs encountered during inspections that may be adulterated or misbranded, until FDA has had time to consider what action it should take concerning the drugs, and to initiate legal action, if appropriate.

Section 709 of FDASIA requires the Secretary to ''consult with stakeholders, including manufacturers of drugs'' before issuing implementing regulations. Section 709 of FDASIA also requires FDA to issue a notice of proposed rulemaking that includes the proposed regulation and provides a period of at least 60 days for comments on the proposed regulation. Finally,

section 709 of FDASIA states that FDA must ''publish the final regulation not less than 30 days before the regulation's effective date'' and states that FDA must issue regulations no later than 2 years after enactment of FDASIA.

On April 9, 2013, FDA published a document in the **Federal Register** that opened a 30-day public docket to solicit input from all relevant stakeholders regarding FDA's issuance of regulations for the administrative detention of drugs (78 FR 21085). The docket was intended to ensure that stakeholders had an opportunity to provide comments before FDA issued proposed regulations on administrative detention with respect to drugs and to ensure that such information submitted to FDA was available to all interested persons in a timely fashion.

The 30-day public docket closed on May 9, 2013. FDA received one responsive, non-substantive comment. The Agency did not consider nonresponsive comments in developing this proposed rule. FDA notes that this announcement regarding the proposed rule also solicits input from all relevant stakeholders before FDA issues final regulations to implement its administrative detention authority with respect to drugs. FDA modeled the proposed regulations for the administrative detention of drugs on the existing regulations covering administrative detention of devices (see 21 CFR 800.55). FDA did so because of identical statutory authority underlying the regulations (21 U.S.C. 334(g)).

II. Proposed Changes to Current Regulations

A. Proposed Revisions to Part 1

FDA proposes to amend part 1 (21 CFR part 1) to create an implementing regulation for the administrative detention of drugs. The proposed amendment to part 1 consists of one section, § 1.501, under a new subpart, which is titled ''Subpart L—Administrative Detention of Drugs Intended for Human or Animal Use.'' Proposed § 1.501 sets forth the procedures for the administrative detention of drugs encountered during an inspection that are believed to be adulterated or misbranded. The new regulation is closely modeled on the current regulation for the administrative detention of devices (21 CFR 800.55). There are minor differences from the device regulation, including updates to statutory references to refer to drugs instead of devices and changes to language to conform to current **Federal Register** requirements.

B. Proposed Revisions to Part 16

The proposed amendment to part 16 is a technical change. This change amends a statement in § 16.1 so that the scope of part 16 regulatory hearing procedures will also include administrative detention authority with respect to drugs.

III. Effective Date

FDA intends that the effective date of the new requirements will be 30 days after publication of a final rule in the **Federal Register**. Section 709 of FDASIA states that FDA's new authority under section 304(g) of the FD&C Act shall not take effect until FDA issues a final regulation, and section 709 requires FDA to ''publish the final regulation not less than 30 days before the regulation's effective date.'' Finally, section 709 of FDASIA requires that no later than 2 years after enactment of FDASIA, regulations to implement administrative detention authority with respect to drugs must be issued. Therefore, FDA intends to issue the final rule for administrative detention authority with respect to drugs by July 9, 2014, with an effective date for the final rule no later than August 8, 2014.

IV. Legal Authority

FDA is issuing this proposed rule under sections 304(g) and 701 of the FD&C Act and section 709 of FDASIA. Section 709 of FDASIA provides FDA authority to issue regulations regarding administrative detention authority with respect to drugs. Section 304(g) of the FD&C Act includes FDA's administrative detention authority with respect to drugs. The proposed rule is necessary for efficient enforcement of the FD&C Act.

V. Analysis of Impacts (Summary of the Initial Regulatory Impact Analysis)

FDA has examined the impacts of the proposed rule under Executive Order 12866, Executive Order 13563, the Regulatory Flexibility Act (5 U.S.C. 601–612), and the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4). Executive Orders 12866 and 13563 direct Agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Agency believes that this proposed rule would not be an economically significant regulatory action as defined by Executive Order 12866.

If a rule has a significant economic impact on a substantial number of small businesses, the Regulatory Flexibility Act requires Agencies to analyze regulatory alternatives that would minimize any significant impact of a rule on small entities. FDA has determined that this proposed rule would not have a significant economic impact on a substantial number of small entities.

Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that Agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before proposing ''any 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 $100,000,000 or more (adjusted annually for inflation) in any one year.'' The current threshold after adjustment for inflation is $141 million, using the most current (2012) Implicit Price Deflator for the Gross Domestic Product. FDA does not expect this proposed rule to result in any 1-year expenditure that would meet or exceed this amount.

The primary public health benefits from adoption of the proposed rule would be the value of the illnesses or deaths prevented because the Agency administratively detained a drug it has reason to believe is adulterated or misbranded; this benefit occurs only if the drug would not have been prevented from entering the market using one of the Agency's other enforcement tools. There may also be benefits from deterrence if administrative detention increases the likelihood misbranded or adulterated products will not be marketed in the future.

The estimated primary costs to FDA include marking or labeling the detained product and costs associated with appeals of the detention orders. However, other costs, such as loss in market value of a detained drug, may be incurred if FDA revokes the detention order on appeal. Given the history of administrative detention use with medical devices and foods, the likelihood is low of FDA issuing a detention order that is later revoked on appeal.

We estimate the annual costs using a range of 0 to 20 administrative detentions performed each year. The Agency estimates the net annual social costs to be between $0 and $591,480. The present discounted value over 20 years would be in the range of $0 to $8,799,729 at a 3 percent discount rate and in the range of $0 to $6,266,148 at a 7 percent discount rate.

FDA has examined the economic implications of the final rule as required by the Regulatory Flexibility Act. If a rule will have a significant economic impact on a substantial number of small entities, the Regulatory Flexibility Act requires agencies to analyze regulatory options that would lessen the economic effect of the rule on small entities. We find that this proposed rule would not have a significant economic impact on a substantial number of small entities. This analysis, together with other relevant sections of this document, serves as the Initial Regulatory Flexibility Analysis, as required under the Regulatory Flexibility Act.

VI. Paperwork Reduction Act of 1995

FDA concludes that the requirements proposed in this proposed rule are not subject to review by the Office of Management and Budget because they do not constitute a ''collection of information'' under the Paperwork Reduction Act of 1995 (44 U.S.C. 3518(c)(1)(B)(ii)).

VII. Federalism

FDA has analyzed this proposed rule in accordance with the principles set forth in Executive Order 13132. FDA has determined that the proposed rule, if finalized, would not contain policies that would have substantial direct effects 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. Accordingly, the Agency tentatively concludes that the proposed rule does not contain policies that have federalism implications as defined in the Executive order and, consequently, a federalism summary impact statement is not required.

VIII. Environmental Impact

The Agency has determined under 21 CFR 25.30(h) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

IX. Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see **ADDRESSES**). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov*.

List of Subjects

21 CFR Part 1

Cosmetics, Drugs, Exports, Food labeling, Imports, Labeling, Reporting and recordkeeping requirements.

21 CFR Part 16

Administrative practice and procedure.

Therefore, under the Federal Food, Drug, and Cosmetic Act and the Public Health Service Act, and under authority delegated to the Commissioner of Food and Drugs, it is proposed that 21 CFR parts 1 and 16 be amended as follows:

PART 1—GENERAL ENFORCEMENT REGULATIONS

■ 1. The authority citation for 21 CFR part 1 is revised to read as follows:

Authority: 15 U.S.C. 1333, 1453, 1454, 1455, 4402; 19 U.S.C. 1490, 1491; 21 U.S.C. 321, 331, 332, 333, 334, 335a, 343, 350c, 350d, 352, 355, 360b, 360ccc, 360ccc–1, 360ccc–2, 362, 371, 374, 381, 382, 387, 387a, 387c, 393; 42 U.S.C. 216, 241, 243, 262, 264.

■ 2. Add subpart L, consisting of § 1.501, to read as follows:

Subpart L—Administrative Detention of Drugs Intended for Human or Animal Use

§ 1.501 Administrative detention of drugs.

(a) *General.* This section sets forth the procedures for detention of drugs believed to be adulterated or misbranded. Administrative detention is intended to protect the public by preventing distribution or use of drugs encountered during inspections that may be adulterated or misbranded, until the Food and Drug Administration (FDA) has had time to consider what action it should take concerning the drugs, and to initiate legal action, if appropriate. Drugs that FDA orders detained may not be used, moved, altered, or tampered with in any manner by any person during the detention period, except as authorized under paragraph (h) of this section, until FDA terminates the detention order under paragraph (j) of this section, or the detention period expires, whichever occurs first.

(b) *Criteria for ordering detention.* Administrative detention of drugs may be ordered in accordance with this section when an authorized FDA representative, during an inspection under section 704 of the Federal Food, Drug, and Cosmetic Act, has reason to believe that a drug, as defined in section 201(g) of the Federal Food, Drug, and Cosmetic Act, is adulterated or misbranded.

(c) *Detention period.* The detention is to be for a reasonable period that may not exceed 20 calendar days after the detention order is issued, unless the FDA District Director in whose district the drugs are located determines that a greater period is required to seize the drugs, to institute injunction proceedings, or to evaluate the need for legal action, in which case the District Director may authorize detention for 10 additional calendar days. The additional 10-calendar-day detention period may be ordered at the time the detention order is issued or at any time thereafter. The entire detention period may not exceed 30 calendar days, except when the detention period is extended under paragraph (g)(6) of this section. An authorized FDA representative may, in accordance with paragraph (j) of this section, terminate a detention before the expiration of the detention period.

(d) *Issuance of detention order.* (1) The detention order must be issued in writing, in the form of a detention notice, signed by the authorized FDA representative who has reason to believe that the drugs are adulterated or misbranded, and issued to the owner, operator, or agent in charge of the place where the drugs are located. If the owner or the user of the drugs is different from the owner, operator, or agent in charge of the place where the drugs are detained, a copy of the detention order must be provided to the owner or user of the drugs if the owner's or user's identity can be readily determined.

(2) If detention of drugs in a vehicle or other carrier is ordered, a copy of the detention order must be provided to the shipper of record and the owner of the vehicle or other carrier, if their identities can be readily determined.

(3) The detention order must include the following information:

(i) A statement that the drugs identified in the order are detained for the period shown;

(ii) A brief, general statement of the reasons for the detention;

(iii) The location of the drugs;

(iv) A statement that these drugs are not to be used, moved, altered, or tampered with in any manner during that period, except as permitted under paragraph (h) of this section, without the written permission of an authorized FDA representative;

(v) Identification of the detained drugs;

(vi) The detention order number;

(vii) The date and hour of the detention order;

(viii) The period of the detention;

(ix) The text of section 304(g) of the Federal Food, Drug, and Cosmetic Act and paragraphs (g)(1) and (g)(2) of this section;

(x) A statement that any informal hearing on an appeal of a detention order must be conducted as a regulatory hearing under part 16 of this chapter, with certain exceptions described in paragraph (g)(3) of this section; and

(xi) The location and telephone number of the FDA district office and the name of the FDA District Director.

(e) *Approval of detention order.* A detention order, before issuance, must be approved by the FDA District Director in whose district the drugs are located. If prior written approval is not feasible, prior oral approval must be obtained and confirmed by written memorandum within FDA as soon as possible.

(f) *Labeling or marking a detained drug.* An FDA representative issuing a detention order under paragraph (d) of this section must label or mark the drugs with official FDA tags that include the following information:

(1) A statement that the drugs are detained by the U.S. Government in accordance with section 304(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 334(g)).

(2) A statement that the drugs must not be used, moved, altered, or tampered with in any manner for the period shown, without the written permission of an authorized FDA representative, except as authorized in paragraph (h) of this section.

(3) A statement that the violation of a detention order or the removal or alteration of the tag is punishable by fine or imprisonment or both (section 303 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 333).

(4) The detention order number, the date and hour of the detention order, the detention period, and the name of the FDA representative who issued the detention order.

(g) *Appeal of a detention order.* (1) A person who would be entitled to claim the drugs, if seized, may appeal a detention order. Any appeal must be submitted in writing to the FDA District Director in whose district the drugs are located within 5 working days of receipt of a detention order. If the appeal includes a request for an informal hearing, as defined in section 201(x) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(x)), the appellant must request either that a hearing be held within 5 working days after the appeal is filed or that the hearing be held at a later date, which must not be later than 20 calendar days after receipt of a detention order.

(2) The appellant of a detention order must state the ownership or proprietary interest the appellant has in the detained drugs. If the detained drugs are located at a place other than an establishment owned or operated by the appellant, the appellant must include documents showing that the appellant would have legitimate authority to claim the drugs if seized.

(3) Any informal hearing on an appeal of a detention order must be conducted as a regulatory hearing under regulation in accordance with part 16 of this chapter, except that:

(i) The detention order under paragraph (d) of this section, rather than the notice under § 16.22(a) of this chapter, provides notice of opportunity for a hearing under this section and is part of the administrative record of the regulatory hearing under § 16.80(a) of this chapter;

(ii) A request for a hearing under this section should be addressed to the FDA District Director;

(iii) The last sentence of § 16.24(e) of this chapter, stating that a hearing may not be required to be held at a time less than 2 working days after receipt of the request for a hearing, does not apply to a hearing under this section;

(iv) Paragraph (g)(4) of this section, rather than § 16.42(a) of this chapter, describes the FDA employees, i.e., regional food and drug directors, who preside at hearings under this section.

(4) The presiding officer of a regulatory hearing on an appeal of a detention order, who also must decide the appeal, must be a regional food and drug director (i.e., a director of an FDA regional office listed in part 5, subpart M of this chapter) who is permitted by § 16.42(a) of this chapter to preside over the hearing.

(5) If the appellant requests a regulatory hearing and requests that the hearing be held within 5 working days after the appeal is filed, the presiding officer must, within 5 working days, hold the hearing and render a decision affirming or revoking the detention.

(6) If the appellant requests a regulatory hearing and requests that the hearing be held at a date later than within 5 working days after the appeal is filed, but not later than 20 calendar days after receipt of a detention order, the presiding officer must hold the hearing at a date agreed upon by FDA and the appellant. The presiding officer must decide whether to affirm or revoke the detention within 5 working days after the conclusion of the hearing. The detention period extends to the date of the decision even if the 5-working-day period for making the decision extends beyond the otherwise applicable 20-calendar-day or 30-calendar-day detention period.

(7) If the appellant appeals the detention order but does not request a regulatory hearing, the presiding officer must render a decision on the appeal affirming or revoking the detention within 5 working days after the filing of the appeal.

(8) If the presiding officer affirms a detention order, the drugs continue to be detained until FDA terminates the detention under paragraph (j) of this section or the detention period expires, whichever occurs first.

(9) If the presiding officer revokes a detention order, FDA must terminate the detention under paragraph (j) of this section.

(h)(1) *Movement of detained drugs.* Except as provided in this paragraph, no person may move detained drugs within or from the place where they have been ordered detained until FDA terminates the detention under paragraph (j) of this section or the detention period expires, whichever occurs first.

(2) If detained drugs are not in final form for shipment, the manufacturer may move them within the establishment where they are detained to complete the work needed to put them in final form. As soon as the drugs are moved for this purpose, the individual responsible for their movement must orally notify the FDA representative who issued the detention order, or another responsible district office official, of the movement of the drugs. As soon as the drugs are put in final form, they must be segregated from other drugs, and the individual responsible for their movement must orally notify the FDA representative who issued the detention order, or another responsible district office official, of their new location. The drugs put in final form must not be moved further without FDA approval.

(3) The FDA representative who issued the detention order, or another responsible district office official, may approve, in writing, the movement of detained drugs for any of the following purposes:

(i) To prevent interference with an establishment's operations or harm to the drugs;

(ii) To destroy the drugs;

(iii) To bring the drugs into compliance;

(iv) For any other purpose that the FDA representative who issued the detention order, or other responsible district office official, believes is appropriate in the case.

(4) If an FDA representative approves the movement of detained drugs under paragraph (h)(3) of this section, the detained drugs must remain segregated from other drugs and the person responsible for their movement must immediately orally notify the official who approved the movement of the drugs, or another responsible FDA district office official, of the new location of the detained drugs.

(5) Unless otherwise permitted by the FDA representative who is notified of, or who approves, the movement of drugs under this paragraph, the required tags must accompany the drugs during and after movement and must remain with the drugs until FDA terminates the detention or the detention period expires, whichever occurs first.

(i) *Actions involving adulterated or misbranded drugs.* If FDA determines that the detained drugs, including any that have been put in final form, are adulterated or misbranded, or both, it may initiate legal action against the drugs or the responsible individuals, or both, or request that the drugs be destroyed or otherwise brought into compliance with the Federal Food, Drug, and Cosmetic Act under FDA's supervision.

(j) *Detention termination.* If FDA decides to terminate a detention or when the detention period expires, whichever occurs first, an FDA representative authorized to terminate a detention will issue a detention termination notice releasing the drugs to any person who received the original detention order or that person's representative and will remove, or authorize in writing the removal of, the required labels or tags.

(k) *Recordkeeping requirements.* (1) After issuance of a detention order under paragraph (d) of this section, the owner, operator, or agent in charge of any factory, warehouse, other establishment, or consulting laboratory where detained drugs are manufactured, processed, packed, or held, must have, or establish, and maintain adequate records relating to how the detained drugs may have become adulterated or misbranded, records on any distribution of the drugs before and after the detention period, records on the correlation of any in-process detained drugs that are put in final form under paragraph (h) of this section to the completed drugs, records of any changes in, or processing of, the drugs permitted under the detention order, and records of any other movement under paragraph (h) of this section. Records required under this paragraph must be provided to the FDA on request for review and copying. Any FDA request for access to records required under this paragraph must be made at a reasonable time, must state the reason or purpose for the request, and must identify to the fullest extent practicable the information or type of information sought in the records to which access is requested.

(2) Records required under this paragraph must be maintained for a maximum period of 2 years after the issuance of the detention order or for such other shorter period as FDA directs. When FDA terminates the detention or when the detention period expires, whichever occurs first, FDA will advise all persons required under this paragraph to keep records concerning that detention whether further recordkeeping is required for the remainder of the 2-year, or shorter, period. FDA ordinarily will not require further recordkeeping if the Agency determines that the drugs are not adulterated or misbranded or that recordkeeping is not necessary to protect the public health, unless the records are required under other regulations in this chapter (e.g., the good manufacturing practice regulation in part 211 of this chapter).

PART 16—REGULATORY HEARING BEFORE THE FOOD AND DRUG ADMINISTRATION

■ 3. The authority citation for 21 CFR part 16 is revised to read as follows:

Authority: 15 U.S.C. 1451–1461; 21 U.S.C. 141–149, 321–394, 467F, 679, 821, 1034; 42 U.S.C. 201–262, 263b, 364.

■ 4. Revise the first sentence of § 16.1 paragraph (b)(1) to read as follows:

§ 16.1 Scope.

* * * * *

(b) * * *

(1) Statutory provisions:

Section 304(g) of the act relating to the administrative detention of devices and drugs (see §§ 800.55(g) and 1.501(g) of this chapter). * * *

Dated: July 10, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16843 Filed 7–12–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–D–0710]

Draft Guidance for Industry on Circumstances That Constitute Delaying, Denying, Limiting, or Refusing a Drug Inspection; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled ''Circumstances that Constitute Delaying, Denying, Limiting, or Refusing a Drug Inspection.'' The Food and Drug Administration Safety and Innovation Act (FDASIA) added a new provision to the Food, Drug, and Cosmetic Act (FD&C Act) concerning inspections that would make a drug adulterated. This guidance defines, by way of example, the circumstances that FDA would consider to constitute delaying, denying, or limiting inspection, or refusing to permit entry or inspection for the purposes of making a drug adulterated.

DATES: Although you can comment on any guidance at any time (see 21 CFR 10.115(g)(5)), to ensure that the Agency considers your comment on this draft guidance before it begins work on the final version of the guidance, submit either electronic or written comments on the draft guidance by September 13, 2013.

ADDRESSES: Submit written requests for single copies of the draft guidance to the Office of Policy and Risk Management, Office of Regulatory Affairs, Food and Drug Administration, 12420 Parklawn Dr., Rm. 4138, Rockville, MD 20857. Send one self-addressed adhesive label to assist that office in processing your requests. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance document.

Submit electronic comments on the draft guidance to *http://www.regulations.gov*. Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Emily M. Leongini, Office of Policy and Risk Management, Office of Regulatory Affairs, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 32, Rm. 4339, Silver Spring, MD 20903, 301–796–5300.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a draft guidance for industry entitled ''Circumstances That Constitute Delaying, Denying, Limiting, or Refusing a Drug Inspection.'' On July 9, 2012, FDASIA (Pub. L. 112–144) was signed into law. Section 707 of FDASIA adds 501(j) to the FD&C Act (21 U.S.C. 351(j) to make a drug adulterated that ''has been manufactured, processed, packed, or held in any factory, warehouse, or establishment and the owner, operator, or agent of such factory, warehouse, or establishment delays, denies, or limits an inspection, or refuses to permit entry or inspection.'' As required by section 707, FDA is issuing this guidance to define the types of action, inaction, and circumstances that FDA considers to constitute delaying, denying, or limiting inspection, or refusing to permit entry or inspection for the purposes of section 501(j) of the FD&C Act.

This draft guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the Agency's current thinking on ''Circumstances That Constitute Delaying, Denying, Limiting, or Refusing a Drug Inspection.'' It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see **ADDRESSES**). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov*.

III. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/RegulatoryInformation/Guidances/ucm122044.htm* or *http://www.regulations.gov*.

Dated: July 9, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–16841 Filed 7–12–13; 8:45 am]

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